Intervention Study on Migration, Poverty & Access to Health Care

A Multi-Centric Study on People's Access & Health Systems Responsiveness in Nasik City of Maharashtra

Supported by

Indian Council of Medical Research, New Delhi

Final Report (May 2011- July 2014)

Indian Institute of Public Health-Delhi,
Public Health Foundation of India

Disha Foundation, Nasik

Acknowledgement

Indian Institute of Public Health Delhi- Public Health Foundation of India (PHFI) acknowledges support of Indian Council of Medical Research, Delhi to conduct the study on '**Intervention Study on Migration, Poverty & Access to Health Care: A Multi-Centric Study on People's Access & Health Systems Responsiveness in Nashik City ofMaharashtra'**

PHFI is grateful to 'Disha Foundation', Nasik (www.dishafoundation.wordpress.com) for their excellent support in successful implementation of this research study in Nasik. Their rapport with migrant communities and various government departments has benefited a lot for the uptake of this study.

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1. Initial details of the project

- **Title of the Project:**

  "Intervention Study on Migration, Poverty & Access to Health Care: A Multi-Centric Study on People's Access & Health Systems Responsiveness in Nashik City of Maharashtra"

- **Principal Investigator and Co-Investigators:**
  - Principal Investigator: Anjali Borhade
  - Co-Principal Investigator: Dr Subhojit Dey
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- **Implementing Institution and other collaborating Institutions:**
  - Indian Institute of Public Health Delhi- Public Health Foundation of India (PHFI): Implementing Institution
  - Disha Foundation: Collaborating Institution

- **Date of commencement:** May 2011

- **Duration:** 3 years

- **Date of completion: 31** July 2014

1. Goal and Objectives:

Goal: To develop, implement and evaluate a supportive strategy of healthcare, which would achieve the desired levels of access to health care services by migrants living in fast-growing smaller cities in India.

Specific Objectives:

1. To implement a supportive interventional package through the following components:
    - ✓ Advocacy through findings of formative research at higher levels of administration (city level-political, administrative and health care)
    - ✓ Building partnership with potential people/groups from community, civic society and health and non-health governmental departments, NGOs and CBOs, employers of migrants.
    - ✓ Advocacy, motivation and training for migrant-sensitive health care to all levels of health care workers.
    - ✓ Generating demand for healthcare at community level – use of community level capital/resources, empowerment of the community and facilitation of community participation through CBOs.
    - ✓ Identifying and addressing the issues, based on the formative research that need to be intervened through above approaches.

2. To assess the feasibility of executing this intervention.
    - ✓ Identifying the prerequisites for implementing the model of intervention
    - ✓ Identifying obstacles in implementation of above intervention

3. To assess the impact of the intervention by process evaluation and impact evaluation.

ANNEXURE-1(Details of experimental setup and Methodology):

Part 1: Formative Phase:

The formative study was undertaken in the Nasik city- study area, among the migrant communities and health system, specifically the public sector primary healthcare system (e.g. health facilities working under the government and local bodies like Municipal Corporation). This phase of research used to assess the healthcare access the healthcare access to the migrant communities and to identify the obstacles, facilitators from both the migrants and health system's perspective and to identify specific communication channels and for identifying various stakeholders that can take part in the intervention for improving health care access to the migrants. Accordingly the study has started from May 2012.

Both quantitative and qualitative data pertaining to socio-economic, demographic details, healthcare-seeking behavior are collected by covering 4004 individual interviews of migrants from **30 sectors, 10 FGDs, 6 Case Studies& 96 Key Interviews**.

Part 2: Intervention Phase:

Goal: "To enhance the access of health care facilities by migrants' resulting in improved health status".

Objectives:

- To improve access to health care facilities among migrant population in Nasik city
- To improve the government health care delivery for migrant population in Nasik city

Study Design:

This study will have a Quasi-experimental design& the entire Nashik city will be divided in the middle in the east-west direction creating a north cluster and a south cluster. Migrant worker sites in the north cluster will be our intervention area. Migrant worker sites in south cluster will be used as controls.

Details of Case and Control Clusters

Sectors that needs to be included in the intervention	Sectors to be excluded from the intervention
• **Construction** • **Agriculture – Grapes** • **Stone quarry** • **Brick Kiln** • **Daily wage labors (Naka workers)** • **Furniture** • **Hotel** • **Industry** • **Small business**	• Agriculture – Sugarcane • Marble cutter • Gold smith • Bakery • Garage • Dairy farm • Beggars • Jogava • Vegetable seller • Trench diggers • Tailor • Commercial sex workers • Idliwal • File makers • Saw mill • Sculpture • Waste Picker

Area of Coverage for intervention:

Sectors	**Sample size population**	**Sample size for outcome evaluation in intervention population**	**Sample size for outcome evaluation in control population**
Construction	2597	260	260
Industry	1948	195	195
Stone quarry	1299	130	130
Hotel	974	97	97
Daily wage laborers (Non-notified slum)	974	97	97
Agriculture-grape	779	78	78
Small business	649	65	65
Brick Kiln	584	58	58
Furniture	195	19	19
Total	9999	999	999

***Sample size population includes: 10% of total population size of each sector (Total population of each sector within Nashik city).**

****Sample size for outcome evaluation shows 10% of sample size population**

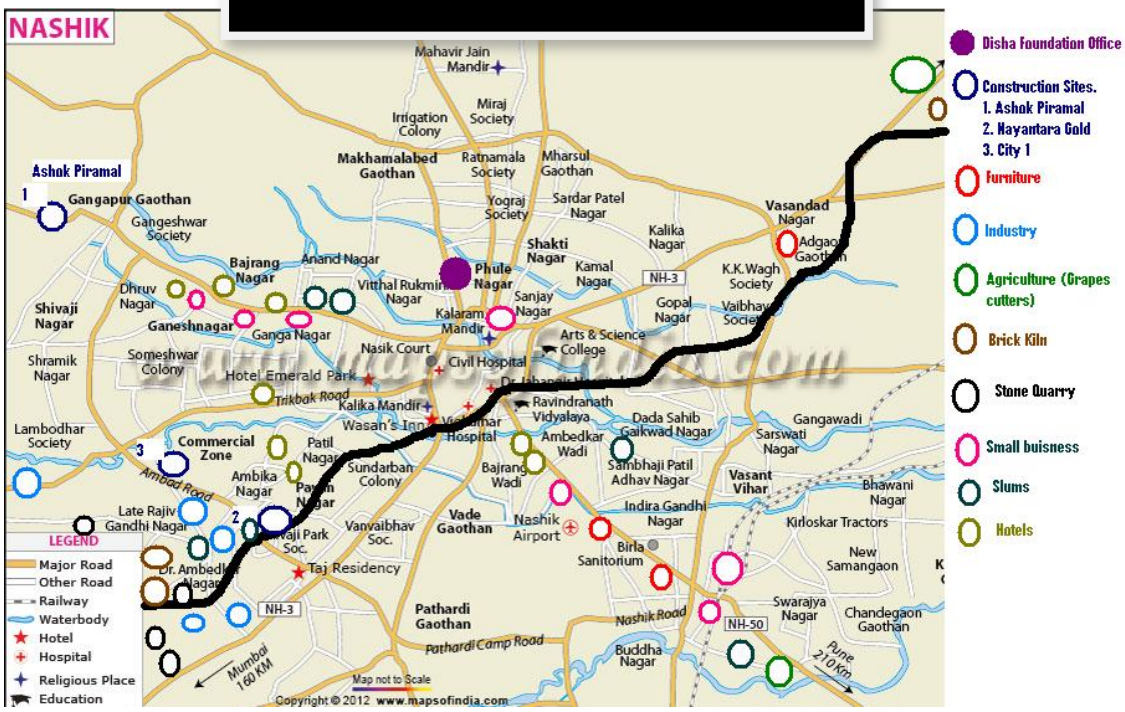
Geographical Area of Intervention:

For every site we choose in the north cluster for intervention we will choose a similar migrant worker site matched by type of work and size (± 100 workers) in both parts of city

We will exclude four types of migrant workers from our intervention: sari sellers, commercial sex workers, tailors and beggars (ongoing intervention, population is less, or not available on either side of city)

- Following the intervention for 1 year, we will evaluate our north and south clusters for outcomes and possibly impact

North Cluster: Case Area of intervention



South Cluster-Intervention Area

Working Sites:		
Sector	**Intervention sites**	**Control sites**
Construction	1.Ashok P, 2.Nayantara City1, 3.Nayantara Gold (Three sites)	Suyojit & Karda, SinnarPhata
Industry	Jyoti structure (satpur), Mayuresh(Plastic), Nandini (Bhagar Mill)	Ambad sites 3
Stone quarry	Viloli 1	Viloli2
Hotel	Kaka ka dhaba, Diwatya Budhlya, Ganesh Nagar, Panchawati Group of hotel, shree palace, makalu, Ginger	Kamath Group, Purohit Hotel, Organ set,
Daily wage laborers (Non-notified slum)	Morwadi (Ambad Area), Mangalnagar(Notified), Swarbabanagar, Prabudhanagar	Amrapali (Notified slum), Eklahare
Agriculture-grape	Pimpalgaon	Adgaon Road
Small business	Singhaniya Dharma Shala, aurangabad road	Road side sellers at Nashikroad area
Brick Kiln	Viloli 1, Pimpalgaon	Niphad road, Sinnar Phata
Furniture	Adgaon Naka	Nashik road

Development, Implementation and Process Evaluation of Intervention:

According to the study design the first phase has been completed in successful way. The study includes both quantitative & qualitative data covering 4004 individual interviews of migrants from 30 sectors & 112 Key interviews.

Issues Identified for Intervention:

The study shows that poor living & working condition of migrants, lack of awareness, information & number of barriers in accessing health services increases their health vulnerability. There is need to aware migrants about living conditions, nutritional status, personal hygiene, occupational safety. At the same time it is found that many adult and young women face risks related to maternal health issues (including sexual and reproductive health). There is need to generate knowledge and skills to make informed choices and use these services effectively.

Based on these findings, the main three health issues are identified for intervention. The three issues are:

1. **Mother and Child Health**
2. **Occupation Health**
3. **Tuberculosis, Malaria & Infectious diseases**

The study shows that Migrant populations often cannot access the services/programmes due to their migration status, timings of their work and distance to services and language barriers. In addition there is also lack of outreach of the health system to such migrant workers which further distances them from accessing any kind of healthcare adequately. Providing accurate information about health and facilitating access to services is clearly necessary for migrants. Govt. Health providers need to be sensitized for providing basic healthcare to migrants.

Intervention components:

The intervention will address below components:

- Low awareness regarding ANC and other health needs / misconceptions as well as Availability and location of health facilities.
- Vulnerable living condition & infectious diseases.
- Working condition & use of safety measures.
- Timings and Distance of health facility
- Non-availability of free medicines
- No free investigations
- Non-availability of services due to lack of BPL card
- Provision of visits of Health workers
- Attitude and behaviour of doctors and other staff towards poor patients
- Procedures at health facilities

Intervention Strategies:

It became very clear that on the above health issues there is need to aware, mobilize & train the migrant community to access health care services. There is also need to sensitize service providers, develop linkages among migrant community, referral health system, service providers for the access of government health services. At the same time inclusive partnership will be developed with Government & Non-government stakeholders for the health care services, sensitization, and education on health issues. The intervention will be carried out at cluster level and will be targeted at all migrants in the selected clusters for intervention.

Advocacy, Partnership Building & Community Mobilization:

1. Advocacy: To understand the response of health system towards health needs of migrant community, facilitating access of health care services to the migrants, improving the service delivery for migrants, continuity of the health care access for migrants comprehensive advocacy will be carried out with Government & Non- Government stakeholders, NGO etc. For basic health care services as well as basic services like water, sanitation etc. for migrants an advocacy will be done with Municipal Corporation, and other key government departments. The key persons will be identified in these departments who can instruct and direct the implementation level health and non-health government functionaries.

2. Inclusive Partnership Building:

It will involves diverse & inclusive representation of all stakeholders from migrant and host communities (the local/settled communities amongst whom recent-migrants usually live), community-based organizations, personnel from health, political and other social development sectors of local administration, non-governmental agencies. Inclusive partnership with government & non-government stakeholders, NGO for Providing Primary Health care services & referral system will be formed. Through partnership health education on various issues like personal health hygiene, mother & child health, occupational health, T B & malaria etc. will be carried out. Through these partnerships health care services will be provided to the migrants. Disha Foundation's (a local NGO) model will be replicated for the government health referral system for the access of health care services by migrants.

3. Community Mobilization:

At the first phase of the intervention phase focus would be on community mobilization. Community will be mobilized for their health issues, access to health care services . During community mobilization process the volunteers would be identified from the community as key community leaders who can facilitate their issues. The community leaders, heads and key community members (including government functionaries) will be contacted and their cooperation would sought for smooth implementation of intervention. The purpose of the project will be explained to the community leaders and community members. The community mobilization for improved uptake of health care (including adequate antenatal, delivery and post natal care) can be achieved by forming peer group educators, community base health care units, and active groups of community. They will work as community mobilizers. Training on health education will be imparted and will be actively involved in the development, planning and implementation of the intervention package.

To ensure active participation at every stage, meetings and small workshops will be convened by involving community mobilizers, health systems personnel (health/municipal/programme implementation officers and peripheral health workers) and the research team. The research team mainly works as a facilitator. For community mobilization knowledge about the importance of adequate and timely antenatal care, skilled birth attendance and adequate, postnatal care, as well occupational health and infectious diseases will be imparted. It will also focus on raising awareness regarding location, procedures and provisions from the government health system. The community mobilizers will be actively involved in identifying the pregnant women and motivating them to seek care from the health facilities through periodical visits. ANMs, Angawadi workers, ASHAs (in some places) and other health workers will be approached for their active involvement.

Proposed Advocacy & Network Building Activities

- Advocacy & Networking with Government Stakeholders.
- Advocacy & Networking with Non-Government stakeholders.
- Meetings with the stakeholders.
- Alliance building with NGO, Government & Non-Government health care services.
- Local & state level Workshop, conferences, event organising, seminars
- Advocate the issues of basic amenities like drinking water, sanitation, shelter etc. for migrants at community level.
- Advocate the issue for the special provision for migrant health.
- To arrange for outreach health programme by Government Health department for migrant population.
- To build network with local NGO working on the issues of Migrants.
- Involve the non-formal groups like CBO, Labour Union, Youth groups, Mahila Mandal (Women's Group), SHG etc.
- Formation of pressure group for policy changes & influences.

List of Key Stakeholders: The proposed list of stakeholders who would be part of project activities

Sr. No	Department	Affiliation	Expected Services
1	Nasik municipal corporation Slum department	Urban local body	• Basic services for migrants.
2	Health department	Urban local body	• Health care services for migrants, • sanitation facilities, spraying insecticides
3	Medical Department	Urban local body	• Health check-up camps, • Free Medicines. • Free Diagnostic tests.

4	Civil Hospital	State government	• Special health care quota for migrant community. • Free health check-up for migrant population. • Health check-up camp. • ANC & PNC services • Immunization services for migrants children.
5	Primary Health care centre	State government	• Free health check-up for migrant population. • Health check-up camp. • ANC & PNC services • Immunization services for migrants children.
6	Employees State Insurance, Hospital	Central Government	• Health care services for migrants • Free health check-up for migrant population. • Health check-up camp. • ANC & PNC services • Immunization services for migrants children.
7	Integrated Child Development Scheme	State Government	• Mobile Crèches for children • Nutrition or mid-day meal facility. • Awareness on Mother & Child Health. • ANC & PNC information.
8	Integrated Child & women Development Scheme	State Government	• Counseling& legal aid for domestic violence. • Child rights • Women's Rights.
9	Labour Department	State Government	• Grievances handling. • Legislative implementation.

			• Legal aid support
10	Tribal Department	State Government	• Training for livelihood • Education for children of migrants
11	District collector	State Government	• Temporary ration card and other need based administrative services and alliance
12	Community Volunteers	Migrant communities	• To raise local resources. • Community mobilization.
13	Nashik Industries &Manufacturers Association.	Local Non-government governing body.	• For the implementation of existing • Legislation & protection of legal rights of migrants.
14	Confederation of Real Estate Developers Association of India.	Local Non-government governing body.	• For the implementation of existing • Legislation & protection of legal rights of migrants.
15	Builders , Contractors & employers	Local partners	• For the implementation of existing • legislation & protection of legal rights of migrants. • Basic services for migrants. • Develop linkages for referral health care services.
16	NGO & CBO	Local social organizations.	• Community mobilization, information generation. • Develop linkages of referral health care services.
17	Health Institutions/health personal.	Non-government institutions.	• Health care services for migrants. • Develop referral health care services.

Project Steering Committee: A committee will be formed for the execution of the proposed intervention. The committee members will comprise high-level government officials and private stakeholders. These members will give their inputs, suggestion on the issues of migrant health & will play role of advisor for the intervention.

Data management and Documentation of Project Activities:

1. Process Evaluation*:* All the processes in terms of actions taken by various partners, their involvement, etc. will be documented.

2. Monitoring& Evaluation Indicators:

Initiative	**Indicator**	**Specific Outcome Measures for Impact Evaluation**
Community Mobilization	• No of awareness programs • No. of migrants attending the programs. • No of active volunteers • Sensitization amongst migrants regarding their issues	• Increased awareness among migrant about health care access. • Access of health care services by migrants. • Fewer incidences of cases of TB and other infectious diseases. • Mass awareness on personal health hygiene. • Increase use of safety measures at work place. • Increased immunization • Less numbers of workdays lost due to health problems • Increased access of government health services • Community members as a volunteers playing vital role in linkages of health cases to the health care centre. • Community leaders actively involved in advocating their issues.

Inclusive Partnership	• Initiative & collaboration of NGO, builders, employers on the issues of migrant health, basic services, health information etc. • Participation of various stakeholders to advocate the issues of migrants. • Coordination committee. i) Regularity/frequency of meetings ii) Inputs given by members. iii) Willingness to contribute resources (details of contribution)	• Number of contacts. • Key persons (urban/health administration, political head, etc.). • Collaboration by builders, contractors, employers in providing health information & services. • Effective collaboration of community leaders & their participation in advocating their issues. • Committee as a pressure group for the health care policy for migrants.
Community empowerment	• Number of peer group educators. • Number people aware of health care & accessing health care services. • Use of community level resources for spread of information • Empowerment in the community and facilitation of community participation through CBOs.	• Peer group or community leaders involved in the linkages of health cases with the health care services.
Advocacy & Network Building	• Initiative by the stakeholders for the health care services of migrants. • Motivation & training for migrant-sensitive health care to all levels of health care workers	• Training for migrant-sensitive health care to all levels of health care workers by Government. • Community based health care programmes by government health care services.

3. Specific Outcome Measures for Impact Evaluation:

1. Treatment seeking patterns – usual source of health care, frequency of visits of HW, frequency of visits to govt. health facility, money spent availability of drugs and other services, timings, problems etc. Quality of care: Health system's responsiveness.

2. Utilization of Health Care Services

I. Increased and adequate utilization of antenatal care services, increased proportion of women utilizing ANC services, getting early registration in the first trimester, reception of all components of antenatal care timely.

II. Maximum utilization of the health services like counseling, check-up of TB/other infectious diseases like Malaria.

III. Increased awareness & sensitization amongst migrants regarding personal hygiene as well as surrounding cleanliness &empowered community to access the health care services from local governing body.

IV. Increased number of use of occupational safety measures.

3. **Increased number of deliveries conducted by a skilled birth attendant, doctor or trained nurse & facility based deliveries.**

4. **Improved practices** of birth preparedness such as planning for delivery in advance regarding place of delivery, assurance of resources, attendant.

5. **Increased and improved post-partum care**, visits to health facility or home visits by health workers after delivery, reception of advices on breast feeding, family planning, childhood immunization.

6. **Child immunization coverage.**

Data Management & Analysis

An analysis matrix will be developed by identifying objective-wise indicators, data sources and statistics to be used and its outcome. The quantitative and qualitative data will be analysed by SPSS and ATLAS.ti, respectively.

IEC Material Development: This material will be designed by considering the requirement, learning capacity and understanding of migrant communities. It will include:

Printing Material like Poster, banner, pamphlet, immunization card, booklets, flip-cards, etc.

Audio-video material like documentaries, short films etc.

Overall Intervention Strategy:

Non-Formal Stakeholders (NGO, CBO, Builders, Contractors, Naka committees, NIMA

- Health education for migrant
- Network building & for policy influences
- Health care services for migrants
- Sensitization on health needs of migrants.
- Formation of referral service system.

INTERVENTION WITH MIGRANT LABOUR

- **Health awareness & Education**
- **Community Empowerment**
- **Facilitating Health care Services**
- **Referral Health care services**

INTERVENTION WITH STAKEHOLDERS

- Sensitization on health needs of migrants.
- Advocacy for Health care services for migrants as per the legislative provisions (paticularly employers)
- Basic Amenities for Migrants. Like sanitation, and water
- Health education & IEC material for migrant
- Outreach programme for migrant population like health camp etc.

Part 3: Impact Evaluation Phase:

Sampling:

The statistical considerations for sample size estimation for evaluation survey were shown as an appendix. Sample size is estimated based on the presumption that the rate of government health care access is 45% (P1) and will be improved by 10% due to the intervention undertook (i.e. 55% after intervention) (P2). With these presumptions, and 95% confidence level and 80% power, the required sample size would be 391 (rounded to 400). This number would be 440, if 10% of non-response rate is considered. Hence, a sample of 440 from intervention clusters and 440 from control clusters will be drawn. These 440 households will be selected from all clusters equally. Within the cluster, care will be taken to cover all areas, and all communities.

Quantitative and qualitative approaches:

Both quantitative and qualitative data collection techniques will be used during the evaluation.

Quantitative surveys:

The quantitative data was collected through three questionnaires: (i) household questionnaire on general health care access and health system's responsiveness, (ii) questionnaire for women on antenatal/obstetric care, and (iii) questionnaire on childhood immunization.

(i) Household questionnaire on general health care access and health systems responsiveness: The first questionnaire was used to collect data on general health care access and health systems responsiveness from 880 households (440 from intervention + 440 from control clusters) by sampling as explained above. The respondent may be head of the household/adult member in the family, who migrated within in the time range of 6 months to 12 years.

(ii) Questionnaire for women on antenatal/obstetric care: For collecting data on antenatal/obstetric care, women who are currently pregnant or recently delivered and

who resided at least for 3 months of her pregnancy in the study area (intervention area or control area) were identified and questionnaire were administered. Efforts were made to cover all eligible women in both intervention and control clusters. They would be identified during the survey of first questionnaire, and will be covered through a separate survey.

(iii) Questionnaire on childhood immunization: For collecting data on immunization, women/care takers of children of up to 1 year of age were identified and questionnaires were administered. The reference child must be resided at least for 3 months in the study area(intervention area or control area). Efforts were made to cover all eligible children in both intervention and control clusters. These children and corresponding mothers/care takers would be identified during the survey with first questionnaire, and also will be covered through a separate survey.

Qualitative research methods:

The qualitative data was collected through in-depth interviews with key-informants, health system personnel and key personnel from partners involved in the intervention. Two categories of key-informants were used – (i) those who have knowledge on general health care access and the impact of intervention and (ii) preferably women, and who have knowledge on women's access to government health care for antenatal care/maternal and child health care. The health system personnel include health care staff at three levels – city level (e.g., municipal health officer, district medical officer, etc.), health facility level officer (e.g., MO, immunization officer, etc.) and field level staff like health workers. Key people from different partners who worked with health system/researchers in implementing intervention were identified. These partners were NGOs, CBOs, other government sectors, etc. who involved in the intervention. In addition, a few case studies were taken to document special/peculiar situations and experiences.

Data processing and analysis:

Quantitative data: The quantitative data collected through household coverage survey and surveys on ANC/obstetric care and immunization was processed and analysed through SPSS. Separate SPSS data editor files (SAV files) will be developed for each of the three questionnaires, and will be sent to all PIs. No PI will be allowed to enter data in her/his own way. The data files from all centres will be merged for common analysis.

Qualitative data: All the in-depth interviews will be undertaken in local language. The entire interview will be recorded on audiocassettes. At the end of the interview, the audiocassettes will be played back and transcribed in to the language in which interview is conducted with the help of field notes. These scripts will be translated to English and will be entered in to personal computer in MS Word as text files. The content analysis will be done by using ATLAS/ti.

A. Detailed analysis of results indicating contributions made towards increasing the state of knowledge in the subject (ANNEXURE-2)

I. Part 1: Brief Report of Formative Phase based onQuantitative & Qualitative Data: 1st year (2012-2013)

Both quantitative and qualitative data pertainingto socio-economic, demographic details, healthcare-seeking behavior are collected by covering 4004 individual interviews of migrantsfrom 30 sectors, 10 FGDs, 6 Case Studies & 96 Key Interviews. Major Findings of Formative Research are as follows:

Demographic Characteristic of Migrants: The demographic profile of migrants who participatedin this study depicts that the majority of them were males (N = 2926; 73.1%) andmost of the migrant workers <20 years old (N= 2650; 66.2%). Study clearly shows that migrationan integral part of the livelihood strategies pursued by a majority of study

populationfrom drought prone parts of Maharashtra (63%) and other states like UP (10%) , Bihar(5%), Madhya Pradesh (5%), Gujarat (4%), West Bengal (4%).

Living Condition of Migrants: Maximum number of migrants lived in migrant camps (69%) followed by non-notified slums (10.9%) and open spaces (10.7%). Most migrants lived in katcha houses that were free or rented and has 1-2 rooms without separate kitchens. Water is mostly obtained from public taps (46%) with very few people getting water piped into their houses (18%) or getting it from hand pumps (16%). Almost half (51%) of the houses did not have proper drainage although others had drainage to a closed drain (42%). About a quarter houses migrant workers (31%) lived in where they do not have any electrical connection although rest had metered connections. Most migrant workers (47%) practiced open air defecation while other (34%) went to a community toilet.

Socio-economic Condition of Migrants: Socioeconomic condition of workers was quite poor with more than 80% workers lacking any ration card or voter id card. Distribution of APL and BPL cards was almost equal among workers having any ration card.

Migration & Health: Atthe work site the group is most probable victims of occupational hazards as they are poorlyprovided with safety measures at work sites such as at construction site, in furniture sector,and are not aware of using the safety instrument. Lots of health problems due to occupation are found amongst the migrant population. Due to these poor living and work condition migrants are more vulnerable to infectious diseases such as TB, Malaria etc.

Health Access of Migrants: Study clearly shows that healthcare utilization rates among migrants are often found to be poor due to their migration status, timings of their work and distance to services and language barriers. In addition there is also lack of outreach of the health system to such migrant workers which further distances them from accessing any kind of healthcare adequately. In terms of healthcare access, about 77% of migrant people are using the facility of Pvt. Doctors & while only 7% of migrant workers using the government health care services. Almost 95% of workers did not have any type of health insurance. Less than 10% of the workers had any information about health workers. Only about 1% of migrant workers reported any visit by health worker and that too most reporting only one visit. In matters of maternal

health, our analysis discovered that only about 300 women out of the 1078 in the study have had pregnancies. About 296 women had live births and had similar number of surviving children; about 267 women had accessed antenatal healthcare services while 196 women hadaccessed postnatal services. 337 women had access immunization services from the health system while 244 women had accessed family planning services.

Health System's Responsiveness: Study shows that urban local bodies (ULBs) and state both do not have focused programs to address health problems among for urban migrants. At present, these bodies undertake very limited outreach activities pertaining to health mainly focused on polio immunization. ULBs are statutorily responsible for provision and maintenance of basic infrastructure and services in cities and towns. The local urban administration, i.e., municipality is expected to provide both preventive and curative health services to the urban population. However, the infrastructure and manpower of municipalities are not sufficient to cater to the needs of the growing urban population, particularly the migrant influx. Study shows that currently there are no structural policies or programs targeting the urban migrant's issues in totality and this segment of the population still faces exclusion from the various mainstream programs.

Conclusion:

This population is normally missed out population at source and destination from all health and social welfare development programs, such as family planning, mother and child health care, primary health care, insurance. It has become clear from the study that migrants suffer from lack of knowledge and poor utilization of health services. Since they are away from their usual place of residence, the dependence on their regular system for seeking health care is compromised. Also, as they are new to the city and not residing in authorized settlements their access to health care is restricted in the absence of any outreach program.

The living & working condition increases their vulnerability towards infectious diseases & occupational health issues. Even Maternal health care issues of women are not considered properly as they are particularly isolated with respect to health care including during pregnancy. Providing accurate information about maternal health and facilitating access to services is clearly

necessary. There is also lack of outreach of the health system to such migrant workers which further distances them from accessing any kind of healthcare adequately.

It is clear that public health services need to initiate and reinforce more "migrant-friendly" approach focusing on the health of the underserved poor urban migrant population dwelling in slums and other temporary sites (like construction sites). The programs should aims to provide essential primary care to all urban migrants, through partnerships with the private sector, social insurance schemes and community involvement. Sensitizing and training of concerned policy makers and health stakeholders such as NGOs, employers association of migrants, insurance companies, financial institutions, academic institutions and health professionals involved with migrants' health also needs to be done on a large scale. Building partnership with NGOs working at destination levels of migration towards raising awareness, and encouraging strong collaborations on migrant's health can enable migrants to stay more aware and updated about health services available to them.

II. Part 2: Intervention Undertaken:

Intervention report: 2nd Year (2013-2014)

Introduction:

To develop, implement and evaluate a supportive strategy of healthcare, which would achieve the desired levels of access to health care services for migrants living in Nasik, an inclusive intervention plan has been developed for implementation. With the focus on community mobilization, advocacy and, inclusive partnership PHFI New Delhi has started the implementation of the proposed action plan from March 2013**.** The report of actual intervention is narrated as below:

Orientation on the Proposed Intervention Plan: Orientation of team on proposed intervention plan has been conducted by PI Anjali Borhade, Co-PI Dr. Subhojit Dey & Anjali Singh. During the orientation meeting both case & control areas have been finalized, field visits were arranged for the involvement of the community. With the focus on three issues Mother & Child Health,

Occupational Health & TB & Infectious diseases intervention plan for community mobilization, empowerment, inclusive partnership & advocacy on migrant health has been designed, along with required IEC resource material bank.

Selection of the Intervention Area: This study has a Quasi-experimental design& the entire Nashik city is divided in the middle in the east-west direction creating a north cluster and a south cluster. Migrant worker sites in the north cluster are selected as intervention area. Migrant worker sites in south cluster works as controls. (As specified in protocol)

Execution of Action Plan:

A. **Community Mobilization:** Community mobilization includes the mobilization of migrants for their health issues, health care services & its access by them. This process involves:-

   Community Meetings: Community meetings & field visits were organized within the proposed area of intervention. Through this visits intervention plan along with the working strategy & expected support & participation of the community, their role has been discussed. The community also shared their expectations & needs. The visits helped us to develop rapport, involvement of community, identification of the volunteers& active participation of the community members for the active involvement of the project goals and activities to the community leaders and community members.

   Identification of Volunteers: Active community members are identified as key community leaders on the basis of their interest, who can facilitate their issues &who are acceptable in their community as their leaders, for smooth implementation of intervention. Four community leaders from four different sites have been identified

Community meetings for sharing working strategy & intervention plan

Community mobilization on Child Immunization at brick-kiln

Community volunteer welcoming resorce person at intervention site

B. **Awareness & Knowledge Generation:** Awareness & knowledge generation has been designed & implemented in consultation with the respective experts, addressing the needs & demands of the community with the focus on Mother & Child Health, Occupational Health & TB &other infectious diseases. Various awareness programs on all the three

issues are conducted with the inclusive partnership with Disha Foundation and other local experts on these issues.

1. **Mother& Child Health:** The issue of mother & child Health is vast so at first stage we have focused to develop understanding of community people on the concept of mother & child health & the context of migration. Accordingly we are generating awareness on daily diet of mother & child, cooking & eating habits & nutritious food at low cost in available resources. While facilitating the program we have involved dietician, pediatrician for imparting knowledge, solve queries of community people, demonstrated cooking of low cost food etc. Information on child immunization also has been given to the community & is informed about the vaccination schedule. With the help of health workers vaccination program are organized at construction site & children are immunized. Two cases of nutritional deficiency had been referred for further treatment to local pediatrician Dr. Tushar Godbole.

Grapes cutter women are mobilized on child immunization

Child immunization by health worker at construction site

Dietician Anagha Sathye demonstrating cooking nutritious food.

Various awareness activities on mother and child health

2. **Occupational Health:** Awareness on occupational health is generated focusing on the safe working habits, use of safety measures, coping up with mental stress, etc.

Project officer of Sankleshya group facilitating the programme on occupational health

Tetanus injection given at construction site

In collaboration of Disha Foundation we have organized health camp & given Tetanus injection to construction workers at working site itself. Health camps are organized in tie up with Red Cross society. These activities had received very positive response from migrant workers as well from their employers, and we have received demands for such activities on regular basis. Many employers have started now providing safety measures to workers on their worksite after these programs.

3. **Tuberculosis & Malaria:** As the migrants are more vulnerable to these infectious diseases due to the living and work, condition we focused to generate knowledge on TB & Malaria and its treatment at government health facilities. Community people are informed about the symptoms of TB & Malaria, its impact on health, care to be taken & referral services, procedures and provisions from the government health system for medical aid. The programs are conducted in collaboration of DOTS, working on awareness generation, health services on TB. With the collaboration of local NGO Disha Foundation a health check-up camp has been organized at the

construction site, Nayantara Gold. About 60 labourers from construction site have participated & went through health check-up camp. For medical aid, Red Cross Society has supported.

General health check-up camp is organised at Nayantara Gold Construction in partnership with Disha Foundation & Red Cross

DOTS Team facilitating TB awareness programme at construction site

C. **Inclusive Partnership:** The intervention plan is implemented in Inclusive partnership with local Organization Disha Foundation, Nasik, an NGO working on Migrants Right since 2002. Along with Disha Foundation partnership with various government and non-government stakeholders has been developed to implement & execute the action plan.

Migration Health Committee: For the inclusive partnership & execution of the proposed intervention with government &non-government stakeholders we have formed project steering/ migrant health committee. The committee has been formed for the inputs, support & cooperation for effective implementation of the intervention. While finalizing the committee meeting with the respective stakeholders was conducted to share the findings of study, goals and expected outcomes of intervention, the expected roles of committee member. Meeting of below committee members was organized under chairmanship of district Collector and Tribal Commissioner to finalize the intervention and other related activities. The government officials had agreed to work as members of the committee and leverage their resources for the project activities mainly for awareness, referral services and linkages for their existing programs.

Project Steering committee Formation meet with - high level govt. officers from key departments

List of Project Steering Committee Members:

Sr no	Name	Position	Organization
1	Vilas patil	Dist collector	Dist Collectorate office, Nasik
2	Mr. DilipHivrale	Social Welfare Officer	ICDS dept
3	Dr. Shinge	Civil surgeon	Civil Hospital, Nasik
4	Dr. D. B. Patil	Medical Superintendent	Nasik Municipal Corporation, Medical Department
5	Dr. Sachin Hire	Health Officer	Health department, NMC
6	Mr. Sanjay Khandare		
7	Dr. Gavit	Residential Medical Officer	ESI hospital Satpur, Nasik
8	Ms AnjaliBohrade	Assistant professor	Public Health Foundation of India, New Dehli
9	Adv. Milind Babar	Head Operation	Disha Foundation, Nashik
10	VimaltaiPagar	President	KashtakamaiSanghatana
11	KiranChavan	President	CREDAI
12	Mr. Panmand/Mr Thube	Tribal Commissioner/project officer	Tribal Department
13	Mr. DhananjayBele	NIMA Chair Person	NIMA
14	Mr. Jadhav	Labour Commissioner	Labour Department
15	Mr. Kardak		MGNREGA
16	Mr. Game	Additional collector	Public Distribution System
17	Mr. YogeshPatil	President	GavkariKrushiManch
18	Mr. Kulwant Kumar Sangal	Police Commissioner	Police Department, Nashik Road, Nashik

D. **Advocacy:** To address the health needs of migrant community, Access of health care services to the migrants, advocacy need to be carried out with Government & Non-Government stakeholders, NGO etc. Below advocacy efforts are done with various government and non-government stakeholders for the same.

Government Stakeholders: For basic health care services as well as primary services like water, sanitation etc. we have started advocacy with Municipal Corporation, Government Hospital, ESI Hospital, ICDS & Tribal department. We have involved health department of Municipal Corporation, Civil Hospital in our migrant health committee proposed for health referral system for migrants & IEC material for information generation on various diseases, its symptoms, preventive care, and health care services available. Meeting with tribal commissioner has been organized to share the learning of the study & need of intervention, intervention plan & formation of Migrant health committee.

Non-Government Stakeholders: Advocacy efforts are also initiated with the non-government stakeholders. It is to involve the non-government stakeholders for addressing health care needs of migrants.

Builders and other Employers of Migrants: Interaction with the builders and other employers has been initiated for their active role to provide basic services for migrants as well as various health activities. We have interaction with builders of Metro Zone, Nayantara Construction site for organizing various activities. Builders with the positive response have made available the resources like hall for migrant's assistance, started Muskan day care Centre for children at 2 construction sites, providing nutritious food as well as informal education and information Centre for migrants and their children on health issues. We will use this Centre for the information Centre for health educations, informal education for their children, and also for other project activities.

Health Institutions: For the information generation as well as health care services we have initiated interaction with nongovernment health providers such as Red Cross

society, medical colleges and few NGOs. Medical college and Red Cross have proposed to conduct health outreach programmes, health awareness programs and referral services.

Referral Services: Project has developed below referral services with various government and non-government stakeholders based on various advocacies meeting with them.

Health Referral form system for migrants by Disha Foundation is replicated through the intervention.

Issue	Referral Services	
	Non-Government	**Government**
Mother and child health care	➢ Dr. Tushar Godbole ➢ (Pediatrician) ➢ Dr. ShitalMogal ➢ (Pediatrician) ➢ Red Cross Society (NGO	➢ Jijamata Hospital (Municipal corporation.) ➢ Indira Gandhi Rugnalaya ➢ (Municipal corporation.) ➢ Civil Hosp. (state govt. hosp.)
Infectious Diseases (T.B. and Malaria)	➢ DOTS (NGO) ➢ Disha Foundation (NGO)	➢ Jijamata Hospital (govt. hosp.) ➢ Indira Gandhi Rugnalaya ➢ (Municipal corporation.) ➢ Civil Hosp. (govt. hosp.)
Occupational Health	➢ Dr. Girish Autade ➢ Disha Foundation (NGO)	➢ ESI Hospital (Satpur, Central ➢ Govt) ➢ Civil Hosp. (State govt. hosp.)

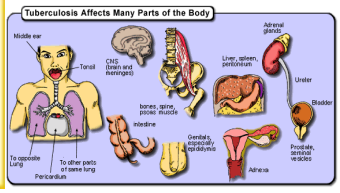
E. **Formation of IEC Material Resource Bank:** Information generation on various health issues, health services is the key concern of intervention. For generating any information IEC material plays an important role. We have developed IEC material resource Bank of the material on Mother & child Health, Occupational Health & TB & infectious diseases. The bank includes printing as well as audio-visual materials. We have collected existing IEC material from respective departments like Health Department of Municipal Corporation, Civil Hospital, and DOTS etc. We also have designed some material by considering the requirement and need of migrant communities.

IEC Resource Bank Includes:

- ❖ Printing materials like banner, poster, pamphlet, immunization card, booklets, flip-cards, etc.
- ❖ Audio-video material like documentaries, short films etc.
- ❖ Other material: Puppets, demonstrative

The IEC material helps for knowledge generation

Snapshot of IEC Resource Bank:

Issue	Type	
Mother and Child Health care	Poster	 
Mother and Child Health care	Pamphlet	 
TB	Poster	 
TB	Pamphlet	
Malaria	Poster	
Occupational health	Poster	

Part 3: 3rd year progress and Impact evaluation (Feb 2014-July 2014):

- The 3rd year progress report can be divided into three sections:

I. Intervention: From Feb 2014-April 2014

Community meetings: House visits and group meetings with key stake holders, peers were done to get regular feedback from the community. Through the meetings progress of the intervention activities were assessed and changes were made as per the requirement of the respective sectors.

Community meeting taken at construction site

Community meeting taken at stone quarry site

Group meeting taken at agriculture site

house visits done at bricklin sector

Awareness programs: The main aim of community awareness programs were to make the community more informed, alert, self-reliant and capable of using informed choices and facilities available around their locality. The awareness programs not only promoted community participation but also enabled them with the ability to help an individual, a family or community to access various beneficial facilities available to them.

1. **Mother and child health:** Through the awareness programs Lactating and Pregnant women and community people got aware about the importance of proper food intake during pregnancy, information of nutritional deficiencies like anaemia & proper intake of iron, iodine and vitamins in their diet. Also about food intake of infants less than 1 year of age (importance of colostrum, exclusive breast feeding). The community people at various intervention sites were also informed about the importance of child immunization & nearby health facilities available for immunization**.**

MCH activities taken at intervention sites

2. **Tuberculosis and Malaria:** Through the awareness programs community people got information on preventive measures of reducing chances of Infectious diseases (TB& Malaria). They were also informed about the sputum detection and importance of early screening of TB & Malaria through signs and symptoms. Preventive measures like using masks, keeping environment clean etc were taken at specific sectors to reduce incidence of the disease.

Malaria Awareness program taken at Agriculture sector

Malaria awareness program taken at stone quarry sector

TB awareness program taken at mangal nagal

TB awareness program taken at satpur naka

3. **Occupational hazards:** Through sector specific feedback various awareness activities were conducted under occupational hazards like because of summer programs on prevention of heat strokes, dehydration, convulsions and burns were conducted in migrants sectors exposed to more heat like construction, stone quarry, agriculture. At hotel sector the employers requested for de-addiction program.

Awareness program on heat stroke and dehdration at construction sector

Safety measures demonstrated at construction site

De-addiction program at hotel sector

awareness program on occupational hazzard at furniture sector

4. **Health services for migrants:** Migrant workers because of their poor financial status, being new to the place and unfamiliarity with the local language often neglect their health problems. Keeping in mind about their health status, health camps were conducted for early screening and detection of the health problems. So that on priority basis they can be referred to government facilities for better treatment.

Medical check-up camp at daily wage sector

Medical check-up camp at furniture sector

medicines provided

Medical check-up camp at stone quarry sector

Community rehabilitation activities: For the family members of the migrant community special rehabilitation activities were also conducted at sectors as per the requirement.

Post operative advices given to the migrant patient from industry sector

Assessing neurological deformities of the child at stone quarry sector

physiotherapeutic advices given to migrants regarding back pain

Explaining physiotherapeutic exercises to the family members

Inclusive Partnership: As like the earlier part of the intervention, similar linkages with health department, non-government stake holders and employers were established to maximize the results of the intervention activities.

Resource person from Red Cross society taking sessions on maternal health

Collaboration with private doctors for medical check-up camps

Advocacy and Networking: As per the need of the intervention advocacy and networking meetings were conducted with various stake holders. In the health department, Dr. Gaikwade (CMO, NMC Nasik), Dr Nikam (TB Department), Dr. Bukane, Dr. Gandal and Ms Vaishali (Malaria Department), Dr. Charu Jakta (Maternal and child health department) were regularly given feedback on the progress of the intervention activities.

Intervention to address other social determinants of migrant health:

In order to address other social determinants of migrant health we have started various activities and programs in collaboration with Disha Foundation and their network with government and private stake holders to provide improved living conditions, linkages and job opportunities, legal support in case of wages harassment and or domestic violence for the migrant workers.
The activities are as follows:

1. **Financial Inclusion with Bank of Baroda and State Bank of India:** Identity at destination is major issue for migrants to open their bank account in any nationalized bank. We have collaboration with Disha Foundation; they have tie up with Bank of Baroda & SBI for opening bank accounts of the migrant workers at "ZERO balance" on showing minimal but essential documents. 480 migrants could open their bank account during the project period.

2. **Livelihood Training and job linkages:** During the project period, we collaborated with Disha Foudantion to facilitated various livelihood trainings and job linkages for migrants. We have started a unique concept of providing on job training for the construction workers in order to upgrade their skills and efficiency levels. We have qualified resource person, well-planned training module along with certifications, to be provided by Disha Foundation. Mazdoor Adda, an online portal has been created by Disha Foundation to provide better linkages and job opportunities for migrant workers.

3. **Social Security:** Registration of the workers under "Building and other construction workers act, 1996" was initiated under this board so that the migrants can avail various benefits offered by Ministry of Labour and employment such as insurance, children's education, old age pension. During the project period we could enroll 350 migrants under the said board.

4. **Education for migrant children:** At various intervention sites we facilitated opening of Anganwadi Kendra with support of Disha Foundation in order to provide formal education to migrant workers children's. We used these centers to conduct various health programs for migrants, educate pregnant and lactating mothers on their health issues at migrants locations.

5. **Legal support**: The project facilitated legal support to migrants in the project via Disha Foundation's legal aid cell. This platform initiated jointly by Labour Department, The National Legal Services Authority of India (NLSAI) and Disha Foundation and is specifically arranged for handling grievances of Migrants on employment, wages or related grievances. It is a First kind of initiative to address issues of unorganized sector migrant workers. Two Grievances handling board has been set up at two labour markets of Nasik.

A complaint form has been developed through which any worker can raise his/her problems. These complaints can be dropped in the complaint box, which is available on two labour markets. Labour department twice in a month address these complaints and also pay an immediate attention in case of emergency cases. In case labour is illiterate, Disha's social workers facilitate the process on his/her behalf.

By implementing above-mentioned developmental activities we made sincere efforts to ensuring better health status, living conditions, social and financial security to the migrant workers.

Snapshots of activities

Finalcial Inclusion with Bank of Baroda

Legal Aid awareness at nakka's

Creative activites at Anganwadi Kendra's

Adressing Social securities- Adhar card enrollment

Skill development training at migrant sites

Majdoor Adda website inaugration on Labour's Day 2014 for job placements

II. Impact Evaluation (From May 2014-June 2014)& Report writing (June 2014)

After successful completion of the intervention activities, evaluation phase started. It was divided into 2 sections Qualitative and Quantitative analysis.

Qualitative analysis

Qualitative analysis was done under following heads:

S.No.	Method	Minimum Number
1.	In-Depth Interview with Key-Informant on General Health Care Issues	10
2.	In-Depth Interview with Key-Informant on MCH Issues	10
3.	In-depth interview with medical/health officers at city level or Medical Officer responsible for slums/mobile population	1
4.	In-depth interview with medical officers at government health facilities	4
5.	In-depth interview with health workers/ASHA	6
6.	IDI with members of Partners (NGOs, CBOs, clubs, etc.)	4
7.	IDI with members of Partners (Government, Municipality, Health-Related Groups)	4
8.	Case studies – success stories	1
9.	Case studies – Failures	1

Total 39 in depth interviews were taken from key informants on general health, MCH, government officials, health workers, and members of partners. The accumulated data was compiled and coded in ATLAS Ti

Collaboration with the partners:

The involvement of the processes partners have been an important factor for the success of the intervention program. The support from the NGOs working in Nashik has been commendable, each partner has played specific roles and their efforts are worth mentioning. Firstly starting from Disha Foundation, the Head Operations has been an asset for the program. Their innovative thought process and huge experience about the migrant population has helped in effective and efficient running of the intervention activities. Prior background of Disha foundation working on different migrant sectors and the rapport which they had amongst the migrant workers has helped in reaching the desired population with a lot of success. Disha foundation was involved from the start of the program and has served as a back bone for the planning, implementation and evaluation phases.

Representatives from Red Cross Society, their participation as resource person for intervention activities as well as for providing medical check-ups has helped in providing better health Care services to the migrant population. The doctors were available for conducting medical check-up and tetanus camps at the intervention sites. Awareness programs on maternal and child health conducted by competent resource persons has helped the female migrant workers and their knowledge on antenatal care, post natal care and immunization for the infants has improved a lot which is clearly visible through the behavioural change towards access to health care services.

Smt. Vimaltai Pagar, President, Kashtakamai Sanghatana has been a source of motivation for all the stakeholders associated with the intervention program. Her active involvement in the awareness programs has helped in mobilizing the migrant community to a great extent.

The field coordinator from Santulan NGO has helped in reaching migrants from difficult sectors like stone quarry and bricklin. There major area of work is on the livelihood issues of the migrant worker, when combined with the objectives of PHFI on health aspects have produced remarkable results for the migrant population.

Collaboration with Baglan Seva Samiti, has also produced fruitful results. Combined awareness programs done on infectious disease like HIV and association of HIV with TB has benefitted the

migrants resulting in increased number of HIV testing and Sputum examination amongst the migrants.

The role of employers at the intervention site has also helped in improving the intervention activities. While taking community meeting and assessing the impact of the activities their sincere suggestion have helped us to reassess the program activities and make it more migrant friendly. To explain these with examples, Programs at a Hotel sector were conducted and sincere efforts were made by PHFI staff to help the cause. But, during the community meeting it was suggested by the manager of the hotel that if we could have more awareness programs on De-addiction that would be beneficial for their staff as tobacco use was quite prominent amongst them and was a major cause of concern. So, as per the requirement of the migrant community such programs were conducted and impact is worth mentioning. The hotel staff themselves have admitted about decrease in the tobacco use amongst them.

Similar sort of reassessment was done for Industry, Stone Quarry and Bricklin sectors were occupation health and related hazards were given more focus. For the construction sector and daily wages more programs on maternal and child health issues were conducted because of more female and infant population. Behavior change techniques were used with the employers of furniture sector specifically to reduce the number of TB cases amongst the migrant population. With the active participation and involvement of safety officers at construction sites Anganwadi Sewa Kendra were established for the education of migrant's children. These Anganwadi Kendra's were also used as platforms for discussing maternal and child related issues.

The referral forms used during the medical check-up camps had a great impact in the process of migrants availing the government health care service. Through the referral forms the migrants have lesser difficulties in getting health care services at government facilities.

Difficulties and challenges were also faced during collaborating with partner organizations and employers. Proper coordination had to be made regarding time and availability of the resource persons to conduct various intervention activities. Language barrier at certain intervention sites also at times made it difficult for the resource persons to convey exact information. Sudden

mobility of the community was also a cause of concern as new migrant population had to be re-informed and their need had to be re-assessed.

Seeing the results and impact of the intervention activities almost majority of the partner NGOs and employers have shown keen interest in collaborating in the near future and has stressed on further replicating the intervention activities to ensure long term behavior changes in the migrant population.

Collaboration with the health system:

The response of the health system towards the healthcare access of the migrant population was an important indicator for the intervention program. Proper planning to assess the demand of the target population and to ensure efficient and smooth supply to the end level beneficiaries had to be assured.

The officials from the health department: TB, Malaria, Maternal and child health were visited on regular basis to discuss about the planning, implementation and progress of the intervention. Before the start of the month tentative plan of the intervention activities were made in consideration with the action plan of the health workers of the respective departments. As per the availability and time the resource persons were designated for the intervention activities along with the staff of PHFI.

The resource persons from the respective health departments played an important role in developing good rapport in the community as the service providers were directly interacting with the community, which made the awareness programs more meaningful and ensured more participation from the community.

The contributions made by the health department towards the intervention program can be summarized as follows. Printed IEC materials on TB, Malaria, Maternal and Child Health issues were being provided from the respective departments. The active members of the community who were made peer educators were trained by the health system, they also provided free diagnostic services and free medicines at the intervention sites. And the most important

contribution made was there presence at intervention sites which motivated the migrant population and also helped in developing rapport.

The impact of the intervention program was huge; before the start of the intervention in some of the migrant sites outreach workers from the health system were not permitted inside for routine immunization activities. As a result of which the target of routine immunization were not achieved at those areas and small infants and children were left unimmunized. But, through the intervention program advocacy meeting were conducted in those site with the employers and they were made to understand the significance and the positive outcomes of conducting such programs. As a result of which the employers allowed the entry of the outreach workers at their sites. Similar impact can be seen in the action plan of the outreach health workers. Now the migrant locations are listed in the monthly action plan of the health workers and are monitored and visited on regular basis.

The health seeking behavior of the community and the health system has a strong association with the intervention activities carried out. The target population is now aware of the health services offered to them and also about the service providers.

The major challenge faced during the intervention program was the availability of time from the resource persons. The work environment of the migrant sites could not be disturbed, so the intervention activities were conducted on times which were suited to the migrants. Mobile nature of the target population and collaboration with other stakeholders like the employers were also at time challenging.

The officials of the health department are very happy with the initiative taken through the intervention for reaching the unreached population and felt that through these efforts their staffs were also motivated towards providing services to migrant population.

Community perspective:

The success of the intervention program depends upon the active participation of the community members which includes involvement of the elders, local and religious leaders, government

institutions and private organizations. Community participation is not just utilization of services and being passive users. It is the process of bringing together and empowering members of the community to raise awareness and demand for a program. It facilitates in better decision making and implementation of the intervention program which within a period of time leads to self-reliance, ownership and sustainability of the community members.

All the intervention activities were planned by keeping in mind the limitations and practical aspect of migrant's environment and daily routine. The programs were conducted only after discussing with the community about their needs, problems and as per the timings convenient to them. Like at small business site migrants were free only during late evenings so programs were planned accordingly. In the stone quarry sector majority of the people were available only on Saturday, while it was Friday in the Industry sector. The employers and community leader were informed about the intervention activities on prior basis to make necessary arrangements and adjustments.

The contributions made by community towards the success of the various program activities were the most fruitful aspect of the intervention. The workers from the migrant community took active interest in making the intervention a success, they actively volunteered in mobilizing the community to ensure maximum participation during the program. The migrants selected as peer educators took the role of mentors and guardian in spreading the awareness. Apart from the employers, at times facilities for the intervention activities were managed by the community itself like for medical check-up camps, awareness programs etc. And the most important contribution made by the community was their presence and availability during the intervention activities.

By the end of the intervention the change in the behaviour of the migrants towards their health issues and its access were visible. Under mother and child health, the number of Antenatal check-ups increased and more pregnant women's preferred institutional delivery, also the percentage of child immunization was improving. Under infectious diseases, preventive measures for reducing the impact of infectious disease were taken which resulted in reduction in the number of such cases. Use of mask in furniture sector is an example of such for prevention of TB. Under Occupational hazards also preventive and safety measures were taken by the

migrants, maintaining proper postures while lifting heavy weight is an example of it. Overall with more knowledge and information about the informed choices available to them, the migrants felt more confident in visiting government health facilities and availing health care services.

The major difficulty that remained constant throughout the intervention phase was frequent migration status of the workers. As because of work and other financial constraints most of the migrants changed their location constantly which made things difficult. Apart from that, ignorance about the program was also an important factor during the start phase as it took time to change the mind-set of the migrants towards the intervention activities. Language was also a barrier at times as it made difficult to ensure that all the participants were interested and were able to grab cent per cent.

However at the end the intervention had a very successful impact towards the access of health services by migrants and migrants themselves were quite happy with the transition and the behaviour change that became part of their daily activities. The migrants clearly wanted to be benefited by such activities in the near future also.

Case Studies: Success stories

A. Access granted at construction sites for immunization coverage and other health related activity:

Before the start of the intervention in some of the migrant sites outreach workers from the health system were not permitted inside for routine immunization activities. As a result of which the target of routine immunization were not achieved at those areas and small infants and children were left unimmunized. But, through the intervention program advocacy meeting were conducted in those sites with the employers and they were made to understand the significance and the positive outcomes of conducting such programs. As a result of which the employers allowed the entry of the outreach workers at their sites. Similar advocacy efforts done with health system to make the outreach at migrants work sites for immunization and other health services for TB and Malaria. Several meetings were conducted with high-level health authority both state and municipal

corporation. The municipal authorities were sensitized with the volume of migration, and their exclusion from basic health services, especially women and children. Efforts were made to influence the planning of health department and to make it more migrant inclusive, which was resulted in involvement of our project team in their monthly planning meetings and cover most of migrants locations for health programs. Similar impact can be seen in the action plan of the outreach health workers. Now the migrant locations are listed in the monthly action plan of the health workers and are monitored and visited on regular basis. Nearly 4 major constructions sites of migrants are now enlisted and included in the national immunization coverage plan.

On the other hand, there are few sites, where access was completely denied by builders. We couldn't conduct even a single awareness programs for migrants there. It was a failure of the project to convince builders for their participation in the project.

B. **Community participation and regular feedback which led behavioral changes amongst migrants:** While taking community meeting and assessing the impact of the activities their sincere suggestion have helped us to reassess the program activities and make it more migrants friendly. To explain these with examples, Programs at a Hotel sector were conducted and sincere efforts were made by PHFI staff to help the cause. But, during the community meeting it was suggested by the manager of the hotel that if we could have more awareness programs on De-addiction that would be beneficial for their staff as tobacco use was quite prominent amongst them and was a major cause of concern. So, as per the requirement of the migrant community such programs were conducted and impact is worth mentioning. The hotel staff themselves have admitted about decrease in the tobacco use amongst them.

Similar sort of reassessment was done for Industry, Stone Quarry and Bricklin sectors were occupation health and related hazards were given more focus. For the construction sector and daily wages more programs on maternal and child health issues were conducted because of more female and infant population. Behavior change techniques were used with the employers of furniture sector specifically to reduce the number of TB cases amongst the migrant population. With the active participation and involvement of safety officers at construction sites Anganwadi Sewa Kendra were established for the

education of migrant's children. These Anganwadi Kendra's were also used as platforms for discussing maternal and child related issues.

Awareness programs on maternal and child health conducted by competent resource persons has helped the female migrant workers and their knowledge on antenatal care, post natal care and immunization for the infants has improved a lot which is clearly visible through the behavioral change towards access to health care services.

C. **Informed and aware about health issues**: By the end of the intervention the change in the behaviour of the migrants towards their health issues and its access were visible. Under mother and child health, the number of Antenatal check-ups increased and more pregnant women's preferred institutional delivery, also the percentage of child immunization was improving. Under infectious diseases, preventive measures for reducing the impact of infectious disease were taken which resulted in reduction in the number of such cases. Use of mask in furniture sector is an example of such for prevention of TB. Under Occupational hazards also preventive and safety measures were taken by the migrants, maintaining proper postures while lifting heavy weight is an example of it. Overall with more knowledge and information about the informed choices available to them, the migrants felt more confident in visiting government health facilities and availing health care services.

Failure stories:

1. **Mobile nature of the community, which deprived healthcare services due to sudden unavailability:** The major difficulty that remained constant throughout the intervention phase was frequent migration status of the workers. As because of work and other financial constraints most of the migrants changed their location constantly which made things difficult. There were lot of cases were through medical check-up camps migrants were screened with diseases (acute and chronic stage both) but there treatment were either stopped in between or did not started because they left from the migrant site in search of work.

QUANTITATIVE DATA ANALYSIS

440 samples each from Intervention and control clusters were taken and analysis was done through SPSS software. The sector-wise distributions of the samples are as follows:-

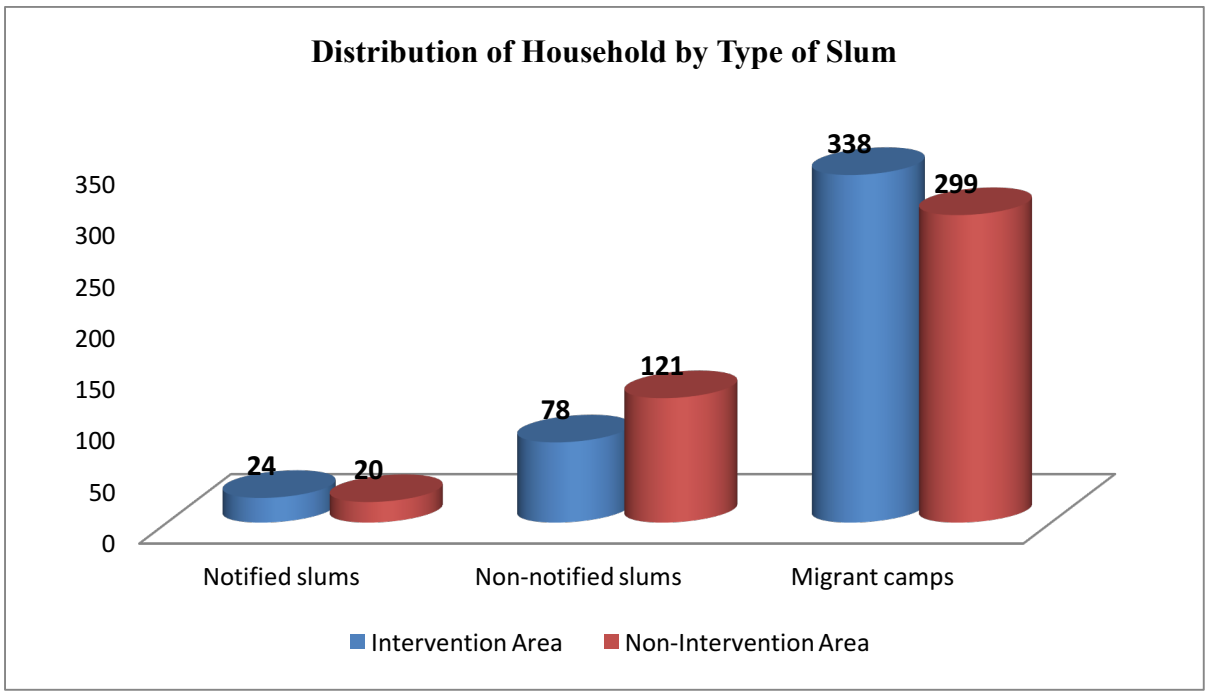
Sector	Quantity	Intervention	Non-Intervention	Remarks
1. Daily wages labourer	50	54	50	
2. Small Business	20	16	20	In intervention site singhania dharamshala most of the migrants have left, will come back in October
3. Furniture	20	20	20	
4. Industry	80	80	80	
5. Agriculture	40	40	40	
6. Hotel	40	40	40	
7. Bricklin	30	30	30	
8. Stone quarry	60	60 `	60	
9. Construction	100	100	100	
SPSS Entry	**General**		**ANC**	**Immunization**
Non intervention	440		19	23
Intervention	440		17	25

Detailed analysis of the quantitative data with triangulation and sector-specific interpretation:

Part 1: GENERAL HEALTH CARE ANALYSIS:

1. **Table 1: Distribution of households by type of slum**

Household type	Number of households Intervention Area (%)	Number of households Non Intervention Area (%)
Notified slums	24(5.5%)	20 (4.5%)
Non-notified slums	78 (17.7%)	121 (27.5%)
Migrant camps	338 (76.8%)	299 (68%)
Total	440	440



In the study population, majority of the respondents live in migrant camps (76.8 percent and 68 percent) in intervention and non- intervention areas respectively, followed by non-notified slums (17.7 percent and 27.5 percent) in intervention and non-intervention areas respectively.

Sector-wise household type distribution

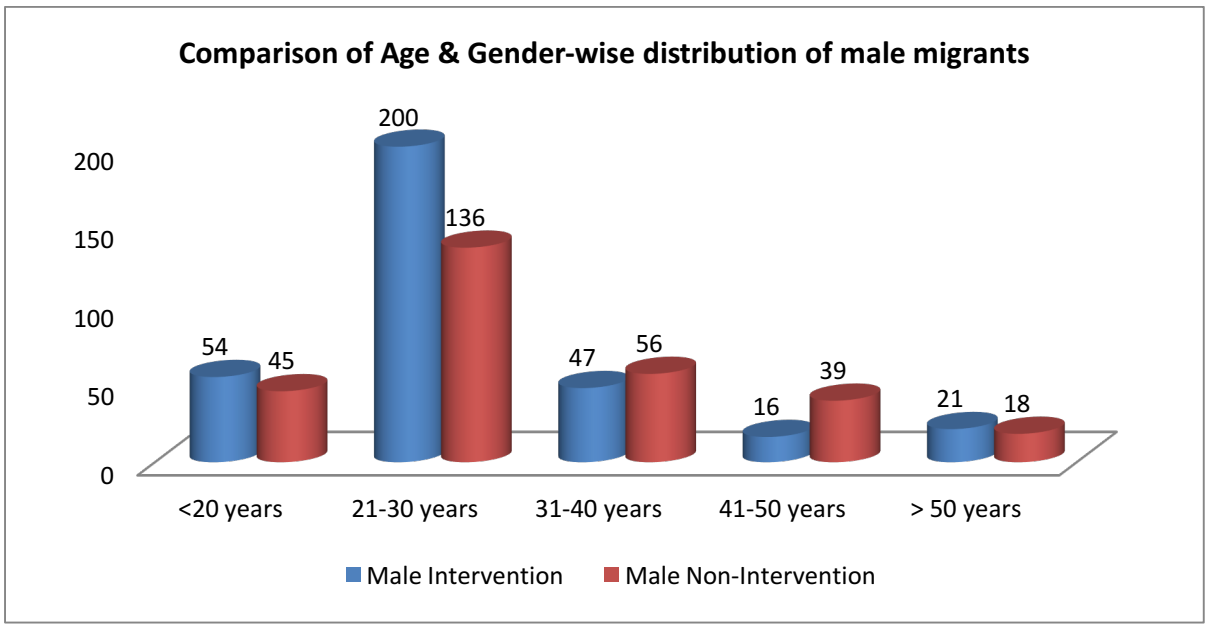
Sector	Number of household intervention area				Number of household Non-intervention area			
	Notified Slum	Non-Notified Slum	Migrant camp	Total	Notified Slum	Non-Notified Slum	Migrant camp	Total
Agriculture	0	0	40(9.1%)	**40(9.1%)**	0	0	40(9.1%)	**40(9.1%)**
Bricklin	0	0	30(6.8%)	**30(6.8%)**	0	0	30(6.8%)	**30(6.8%)**
Construction	0	0	100(22.7%)	**100(22.7%)**	0	0	100(22.7%)	**100(22.7%)**
DWG	24(5.5%)	30(6.8%)	0	**54(12.3%)**	0	41(9.3%)	9(2%)	**50(11.4%)**
Furniture	0	0	20(4.5%)	**20(4.5%)**	0	0	20(4.5%)	**20(4.5%)**
Hotel	0	0	40(9.1%)	**40(9.1%)**	0	0	40(9.1%)	**40(9.1%)**
Industry	0	0	80(18.2%)	**80(18.2%)**	0	80(18.2%)	0	**80(18.2%)**
SMB	0	0	16(3.6%)	**16(3.6%)**	20(4.5%)	0	0	**20(4.5%)**
Stone quarry	0	48(10.9%)	12(2.7%)	**60(13.7%)**	0	0	60(13.6%)	**60(13.6%)**
Total	**24(5.5%)**	**78(17.7%)**	**338(76.8%)**	**440(100%)**	**20(4.5%)**	**121(27.5%)**	**299(68%)**	**440(100%)**

If we see the sector-wise distribution of the migrants, In the Intervention area only Daily Wage labourers were found to be staying at notified slums (5.5 percent of the total study population). Under Non-notified slums the household was distributed between Daily Wages Labourer and Stone Quarry workers (6.8 percent and 10.9 percent respectively of the study population). Rest all the migrants in the study population lived in migrant camps (76.8 percent of the study population). It was noted that none of the migrants under Daily wages stayed in migrant camps.

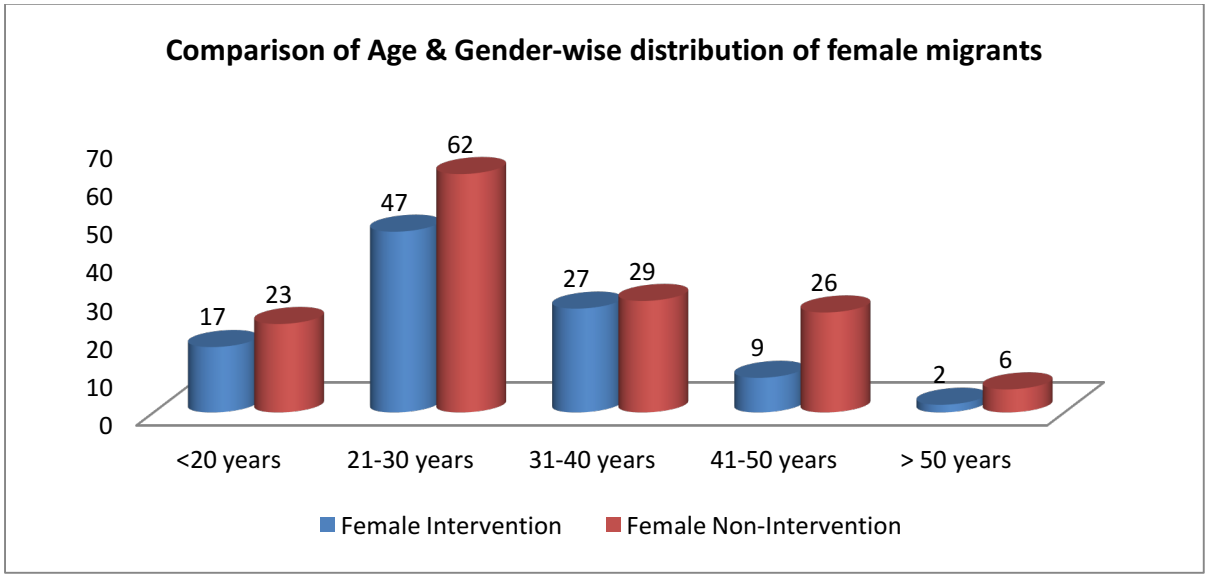
In the non-intervention area, only Small Business migrants were found to be staying in the non-notified slums (4.5 percent of the study population). Under non-notified slums the households was distributed between Daily Wage Labourers and Industry workers (9.3 percent and 18.2 percent respectively). Rest all the migrants in the study population lived in migrant camps (68 percent of the study population). It was noted that none of the migrants under Industry and Small Business stayed in migrant camps.

Table 2: Age and gender-wise distribution of participants

	Intervention			Non-Intervention		
	Gender		Total	Gender		Total
Age group	Male	Female		Male	Female	
<20 years	54(12.3%)	17(3.9%)	**71(16.1%)**	45(10.2%)	23(5.2%)	**68(15.5%)**
21-30 years	200(45.5%)	47(10.7%)	**247(56.1%)**	136(30.9%)	62(14.1%)	**198(45%)**
31-40 years	47(10.7%)	27(6.1%)	**74(16.8%)**	56(12.7%)	29(6.6%)	**85(19.3%)**
41-50 years	16(3.6%)	9(2%)	**25(5.7%)**	39(8.9%)	26(5.9%)	**65(14.8%)**
> 50 years	21(4.8%)	2(0.5%)	**23(5.2%)**	18(4.1%)	6(1.4%)	**24(5.5%)**
Total	**338(76.8%)**	**102(23.2%)**	**440(100%)**	**294(66.8%)**	**146(33.2%)**	**440(100%)**



While cross tabbing the two variables Age and Gender amongst the study population it was found that, In the Intervention area around 16 percent of the migrants fall under age group less than 20 years of age. Majority of the respondents (56 percent) fall under the age group 21 to 30 years. While only 5.2 percent of the respondents were more than 50 years of age.

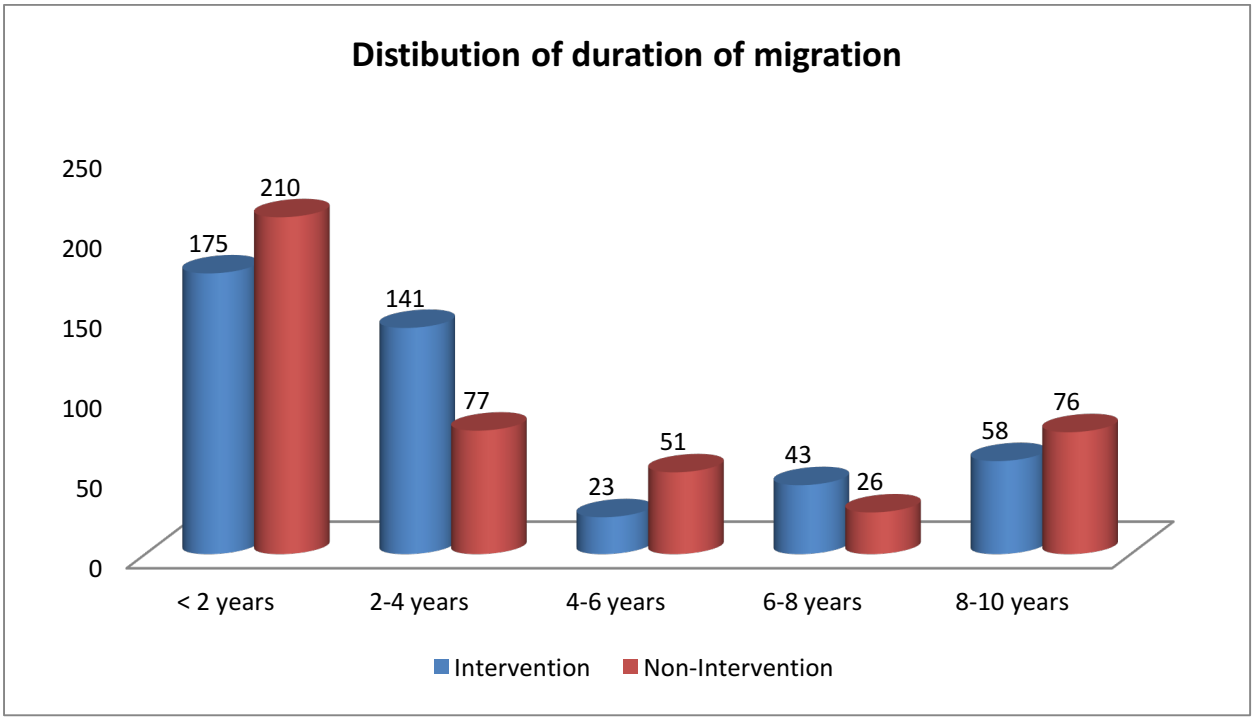


In the Non-Intervention area, 15.5 percent of the study population falls under age group less than 20 years. Majority of the respondents (45 percent) are between age group 21 to 30 years. While only 5.5 percent of the respondents were more than 50 years of age.

Table 3: Distribution of households by duration of migration

Duration of migration	Number of households (Intervention)	Number of households (Non-Intervention)
< 2 years	175(39.8%)	210(47.7%)
2-4 years	141(32%)	77(17.5%)
4-6 years	23(5.2%)	51(11.6%)
6-8 years	43(9.8%)	26(5.9%)
8-10 years	58(13.2%)	76(17.3%)
Total	440(100%)	440(100%)

In the study population, it was found that in majority of the respondents (39.8 percent and 47.7 percent) in intervention and non-intervention area respectively migrated at the destination point for less than 2 years, followed by stay between two to four years (32 percent and 17.5 percent) in intervention and non-intervention area respectively. It is to be noted that a good number of migrants (13.2 percent and 17.3 percent) in intervention and non-intervention area respectively have migrated for a duration of 8 to 10 years. They visit their native place 2 to 3 times a year on an average.



	Duration of Migration (Non-Intervention)					
	<2 years	**2-4 years**	**4-6 years**	**6-8 years**	**8-10 years**	**Total**
Agriculture	40(9.1%)	0	0	0	0	**40(9.1%)**
Bricklin	15(3.4%)	6(1.4%)	3(0.7%)	2(0.5%)	4(0.9%)	**30(6.8%)**
Construction	81(18.4%)	16(3.6%)	2(0.5%)	0	1(0.2%)	**100(22.7%)**
Daily wage labourers	9(2%)	5(1.1%)	6(1.4%)	5(1.1%)	25(5.7%)	**50(11.4%)**
Hotel	19(4.3%)	14(3.2%)	4(0.9%)	1(0.2%)	2(0.5%)	**40(9.1%)**
Industry	24(5.5%)	15(3.4%)	18(4.1%)	9(2%)	14(3.2%)	**80(18.2%)**
Small Business	4(0.9%)	1(0.2%)	3(0.7%)	2(0.5%)	10(2.3%)	**20(4.5%)**
Stone Quarry	11(2.5%)	17(3.9%)	13(3%)	3(0.7%)	16(3.6%)	**60(13.6%)**
Furniture	7(1.6%)	3(0.7%)	2(0.5%)	4(0.9%)	4(0.9%)	**20(4.5%)**
Total	**210(47.7%)**	**77(17.5%)**	**51(11.6%)**	**26(5.9%)**	**76(17.3%)**	**440(100%)**

Now if we see sector-wise distribution of the duration. In non-intervention area, it was found that cent percent migrants in the agriculture sector were staying for a duration less than 2 years (which is 9.1 percent of the total study population). Similar trends were found for the construction and hotel sectors were 81 percent and 47.5 percent migrants stayed for less than 2 years from their respective sectors. For the category between 2 to 4 years majority of the duration of the stay was found in Hotel, Stone quarry, Industry, construction sectors (35 percent,

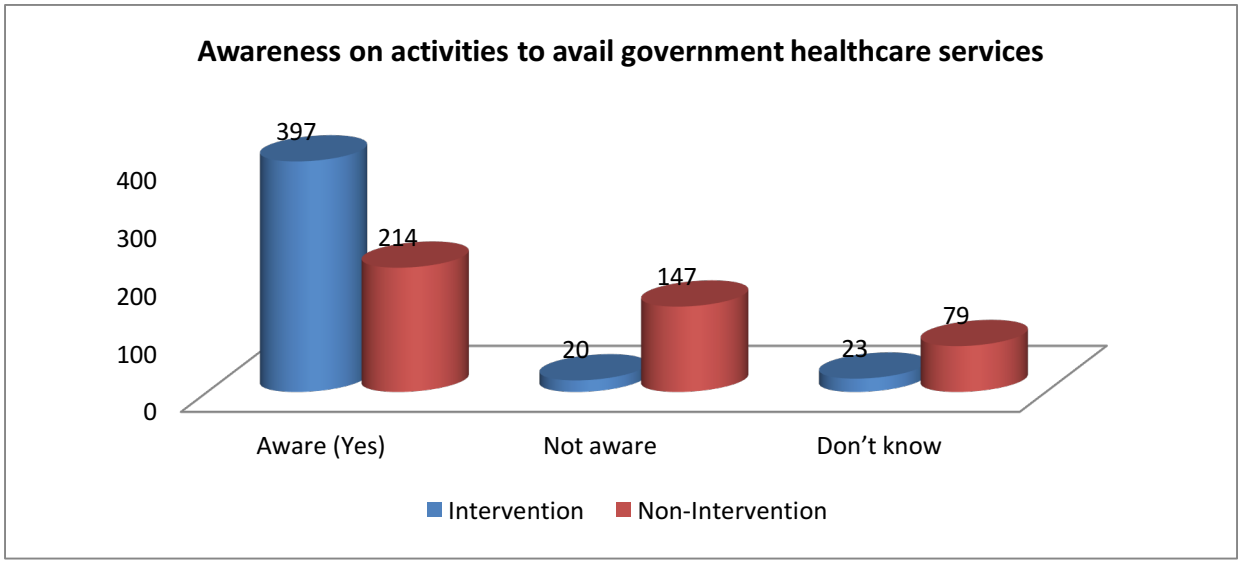
28.3 percent, 18.8 percent, and 16 percent of their individual sectors respectively).For the category between 4 to 6 years maximum duration of migration was found in Industry sector (4.1 percent of the total study population). Very few migrants fall under the category between 6 to 8 years. 50 percent of the migrants under daily wage sector are staying for 8 to 10 years (which is 5.7 percent of the total study population), followed by migrants from stone quarry, Industry and small business sectors (3.6 percent, 3.2 percent and 2.3 percent of the total study population respectively.

Sectors	Duration of Migration (Intervention)					
	<2 years	2-4 years	4-6 years	6-8 years	8-10 years	Total
Agriculture	35(8%)	3(0.7%)	1(0.2%)	0	1(0.2%)	**40(9.1%)**
Bricklin	24(5.5%)	6(1.4%)	0	0	0	**30(6.8%)**
Construction	17(3.9%)	79(18%)	1(0.2%)	2(0.5%)	1(0.2%)	**100(22.7%)**
Daily wage labourers	1(0.2%)	5(1.1%)	4(0.9%)	6(1.4%)	38(8.6%)	**54(12.3%)**
Hotel	26(5.9%)	6(1.4%)	8(1.8%)	0	0	**40(9.1%)**
Industry	57(13%)	21(4.8%)	2(0.5%)	0	0	**80(18.2%)**
Small Business	7(1.6%)	6(1.4%)	0	1(0.2%)	2(0.5%)	**16(3.6%)**
StoneQuarry	6(1.4%)	12(2.7%)	5(1.1%)	33(7.5%)	4(0.9%)	**60(13.6%)**
Furniture	2(0.5%)	3(0.7%)	2(0.5%)	1(0.2%)	12(2.7%)	**20(4.5%)**
Total	**175(39.8%)**	**141(32%)**	**23(5.2%)**	**43(9.8%)**	**58(13.2%)**	**440(100%)**

In Intervention area, it was found that 87.5 percent migrants in the agriculture sector were staying for a duration less than 2 years (which is 8 percent of the total study population). Similar trends were found for Bricklin, Industry and Hotel sectors were 80 percent, 71.3 percent and 65 percent migrants stayed for less than 2 years from their respective sectors. For the duration between 2 to 4 years majority of the duration of stay was found in Construction, Industry and Stone quarry sectors (79 percent, 26.3 percentand 20 percent of their individual sectors respectively). Very few migrants fall under the duration of stay between 4 to 6 years.For the category between 6 to 8 years maximum duration of stay was found in Stone Quarry sector (7.5 percent of the total study population). 70 percent of the migrants under daily wage sector are staying for 8 to 10 years (which is 8.6 percent of the total study population), followed by migrants from furniture sectors (2.7 percent of total study population).

Table 4: Distribution of respondents based on their awareness on activities to avail government healthcare services:

	Number (Intervention)	Number (Non-Intervention)
Aware (Yes)	**397(90.2%)**	**214(48.6%)**
Not aware	**20(4.5%)**	**147(33.4%)**
Don't know	**23(5.2%)**	**79(18%)**
Total	**440(100%)**	**440(100%)**



In the study population, majority of the respondents (90 percent) in the intervention area are aware of the various activities that are going on in their locality to make government healthcare services available for them, whereas only 48.6 percent of the study population are aware in the non-intervention area.

	Awareness on activities (Intervention)			Total
	Aware	Not aware	Don't Know	
Agriculture	34(7.7%)	5(1.1%)	1(0.2%)	**40(9.1%)**
Bricklin	27(6.1%)	0	3(0.7%)	**30(6.8%)**
Construction	99(22.5%)	1(0.2%)	0	**100(22.7%)**
Daily wage labourers	50(11.4%)	2(0.5%)	2(0.5%)	**54(12.3%)**
Furniture	18(4.1%)	1(0.2%)	1(0.2%)	**20(4.5%)**
Hotel	40(9.1%)	0	0	**40(9.1%)**
Industry	58(13.2%)	10(2.3%)	12(2.7%)	**80(18.2%)**
Small Business	16(3.6%)	0	0	**16(3.6%)**
Stone Quarry	55(12.5%)	1(0.2%)	4(0.9%)	**60(13.6%)**
Total	**397(90.2%)**	**20(4.5%)**	**23(5.2%)**	**440(100%)**

Now, if we see the sector-wise distribution of the awareness in the intervention area, majority of the respondents knew about the intervention activities in all the sectors. Around 27.5 percent migrant in Industry sector were either not aware of the activities or didn't knew about it.

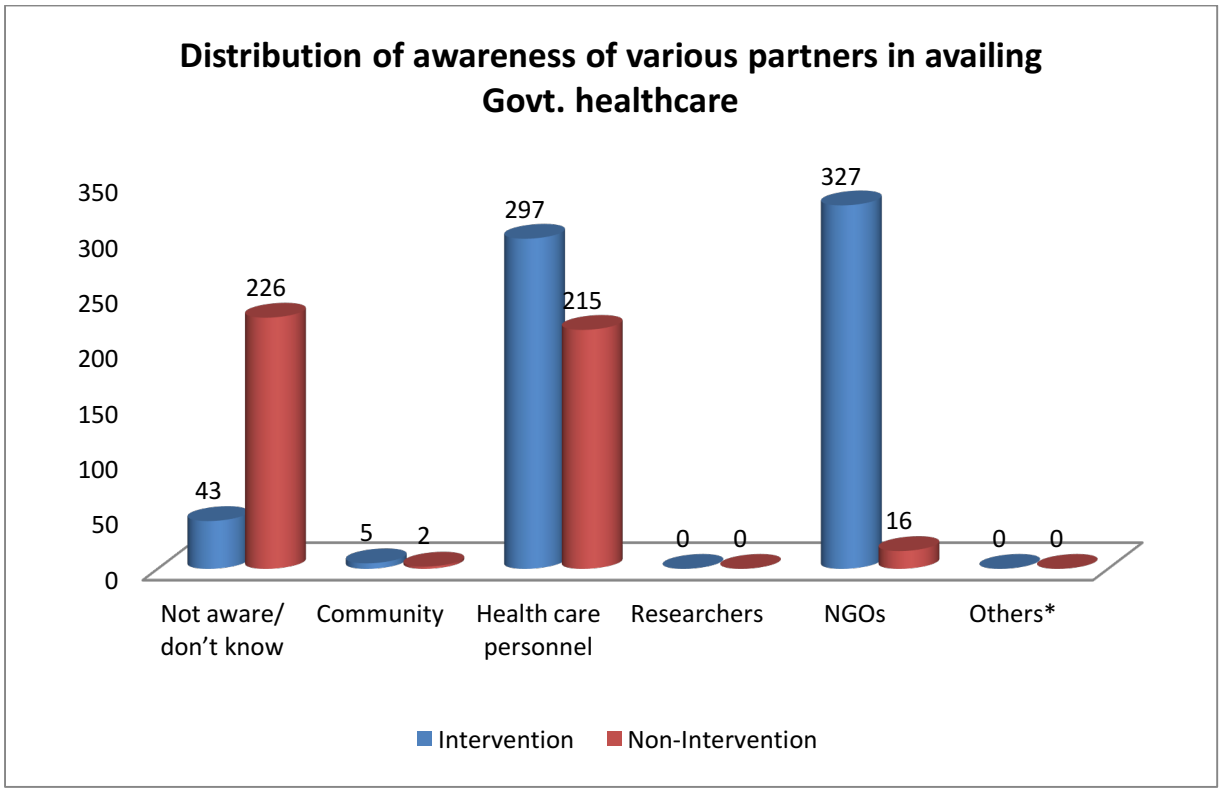
	Awareness on activities (Non-Intervention)			Total
	Aware	Not aware	Don't Know	
Agriculture	1 ((0.2%)	39(8.9%)	0	**40(9.1%)**
Bricklin	15(3.4%)	10(2.3%)	5(1.1%)	**30(6.8%)**
Construction	47(10.7%)	19(4.3%)	34(7.7%)	**100(22.7%)**
Daily wage labourers	37(8.4%)	5(1.1%)	8(1.8%)	**50(11.4%)**
Furniture	3(0.7%)	16(3.6%)	1(0.2%)	**20(4.5%)**
Hotel	3(0.7%)	17(3.9%)	20(4.5%)	**40(9.1%)**
Industry	60(13.6%)	16(3.6%)	4(0.9%)	**80(18.2%)**
Small Business	20(4.5%)	0	0	**20(4.5%)**
Stone Quarry	28(6.4%)	25(5.7%)	7(1.6%)	**60(13.6%)**
Total	**214(48.6%)**	**147(33.4%)**	**79(18%)**	**440(100%)**

In non-intervention area, in the agriculture sector 97.5 percent of the respondents were not aware about any kind of activities. Similar trends were found in Furniture and Hotel sector were only 15 percent and 7.5 percent respondents respectively knew about any kind of activities. In sectors like Small Business, Industry and Daily Wages considerable number of migrants (100 percent, 75 percent and 74 percent respectively) knew about the activities. It was also found that in non-

intervention area majority of the awareness was because of Pulse Polio program; apart from polio negligible number activities were done.

Table 5: Distribution of respondents based on their awareness on the involvement of various partners in the intervention

	Number Intervention	Number Non-Intervention
Not aware of the programme or don't know any	43(9.8%)	226(51.4%)
Community	5(1.1%)	2(0.5%)
Health care personnel	297(67.5%)	215(48.9%)
Researchers	0	0
NGOs	327(74.3%)	16(3.6%)
Others*	0	0



If we see the distribution of awareness of involvement of various partners in order to make government facilities accessible, 67.5 percent respondents in the intervention area responded positively that they are aware about the health care personnel (Doctors, ANM, outreach workers and ASHA) who come in their locality. On the other hand, only 48.9 percent respondents in non-intervention area are aware about the health personnel visiting them. In intervention area, around 74.3 percent of the migrants responded positively regarding presence of NGO staff at their locality.

		Involvement of Various partners(Intervention)				
	Not Aware/Don't Know	Community	Health personnel	Researcher	NGOs	others
Agriculture	6(1.4%)	0	31(7%)	0	21(4.8%)	0
Bricklin	3(0.2%)	0	21(4.8%)	0	20(4.5%)	0
Construction	1(0.2%)	0	92(20.9%)	0	97(22%)	0
Daily wage labourers	4(0.9%)	3(0.7%)	48(10.9%)	0	20(4.5%)	0
Furniture	2(0.5%)	1(0.2%)	3(0.7%)	0	17(3.9%)	0
Hotel	0	0	0	0	40(9.1%)	0
Industry	22(5%)	0	48(10.9%)	0	54(12.3%)	0
Small Business	0	0	3(0.7%)	0	15(3.4%)	0
Stone Quarry	5(1.1%)	1(0.2%)	51(11.6%)	0	43(9.8%)	0
Total	43(9.8%)	5(1.1%)	297(67.5%)	0	327(74.3%)	0

This is a multiple response question. If we see the sector-wise distribution of the awareness in involvement of various partners, in the intervention area 20.9 percent of migrants of total study population (N=440) knew about the healthcare personnel visiting their place, which is 92 percent of the migrants working in construction sector. Similar trends were seen in Daily Wage; Stone Quarry and Agriculture sectors were 89 percent, 85 percent and 77.5 percent migrants from respective sectors were aware of the health personnel. While at Hotel, Furniture and Small Business sectors negligible number of migrants are aware. The migrants working under these sectors are single migrants and are staying without their family, so are socially not connected

with the community as like migrants at other sectors. Majority of the migrants under these sectors, fall under the age group of 18 to 25 years.

Now if we see the distribution of involvement of NGO partners it was found that, Hotel and construction sector had majority of the share (cent percent and 97 percent respectively) were migrants responded positively. It was followed by Small Business, Furniture and Stone Quarry and Industry sectors (93 percent, 85 percent, 71.6 and 67.5 percent respectively).

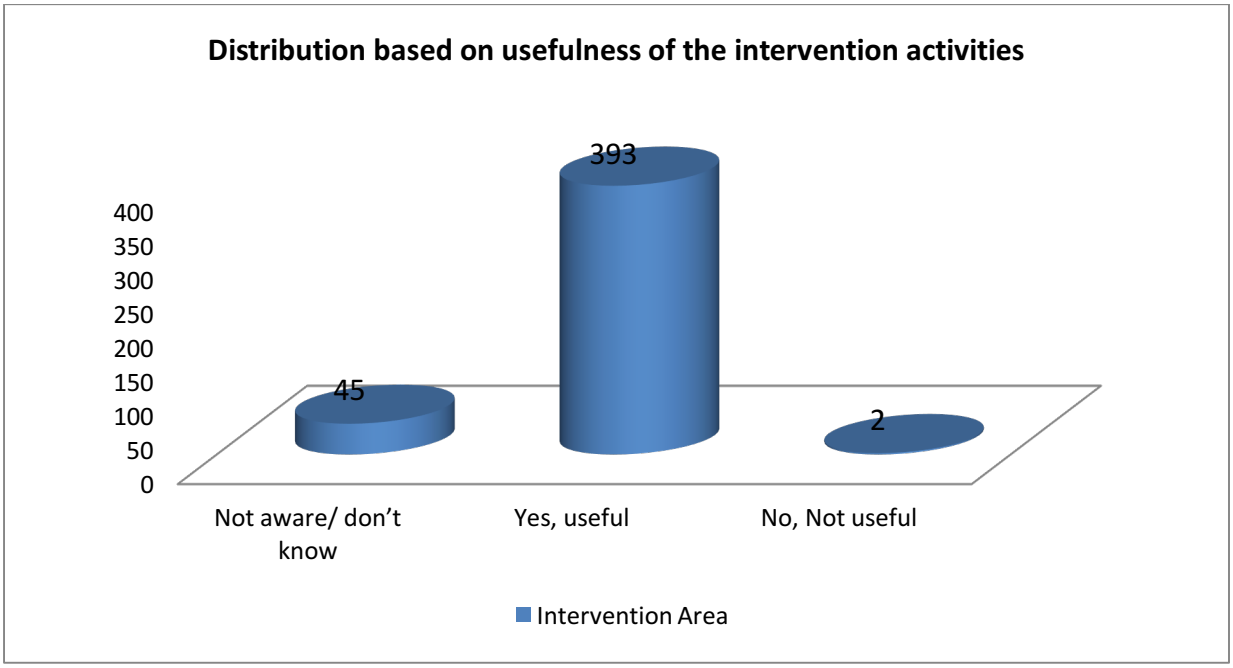
		Involvement of Various partners (Non-Intervention)				
	Not Aware/Don't Know	Community	Health personnel	Researcher	NGOs	others
Agriculture	39(8.9%)	1(0.2%)	0	0	0	0
Bricklin	15(3.4%)	0	15(3.4%)	0	0	0
Construction	53(12%)	1(0.2%)	45(10.2%)	0	1(0.2%)	0
Daily wage labourers	13(3%)	0	41(9.3%)	0	0	0
Furniture	17(3.9%)	0	3(0.7%)	0	0	0
Hotel	37(8.4%)	0	0	0	4(0.9%)	0
Industry	20(4.5%)	0	61(13.9%)	0	2(0.5%)	0
Small Business	0	0	20(4.5%)	0	0	0
Stone Quarry	32(7.3%)	0	30(6.8%)	0	9(2%)	0
Total	226(51.4%)	2(0.5%)	215(48.9%)	0	16(3.6%)	0

In non-intervention area, almost half (51.4 percent) of the respondent are not aware of the involvement of various partners. Only 3.6 percent of the migrants are aware of presence of NGO partners, while the presence of community and researchers is negligible in the study population.

Now if we see the distribution of involvement of healthcare personnel it was found that, Industry and Construction sector had majority of the share (76.3 percent and 45 percent respectively) were migrants responded positively. In the small business sector all the migrants (N=20) were aware of the presence of healthcare personnel. It was followed by stone quarry and Bricklin sectors (50 percent each in respective sectors).

Table 6: Distribution of respondents based on their view that intervention is useful to people to get health care better than earlier

	Number
Not aware of the programme or don't know about the programme/intervention	45(10.2%)
Yes, useful to improve health care	393(89.3%)
No, Not useful	2(0.5%)
Don't know about the benefit to the programme	0



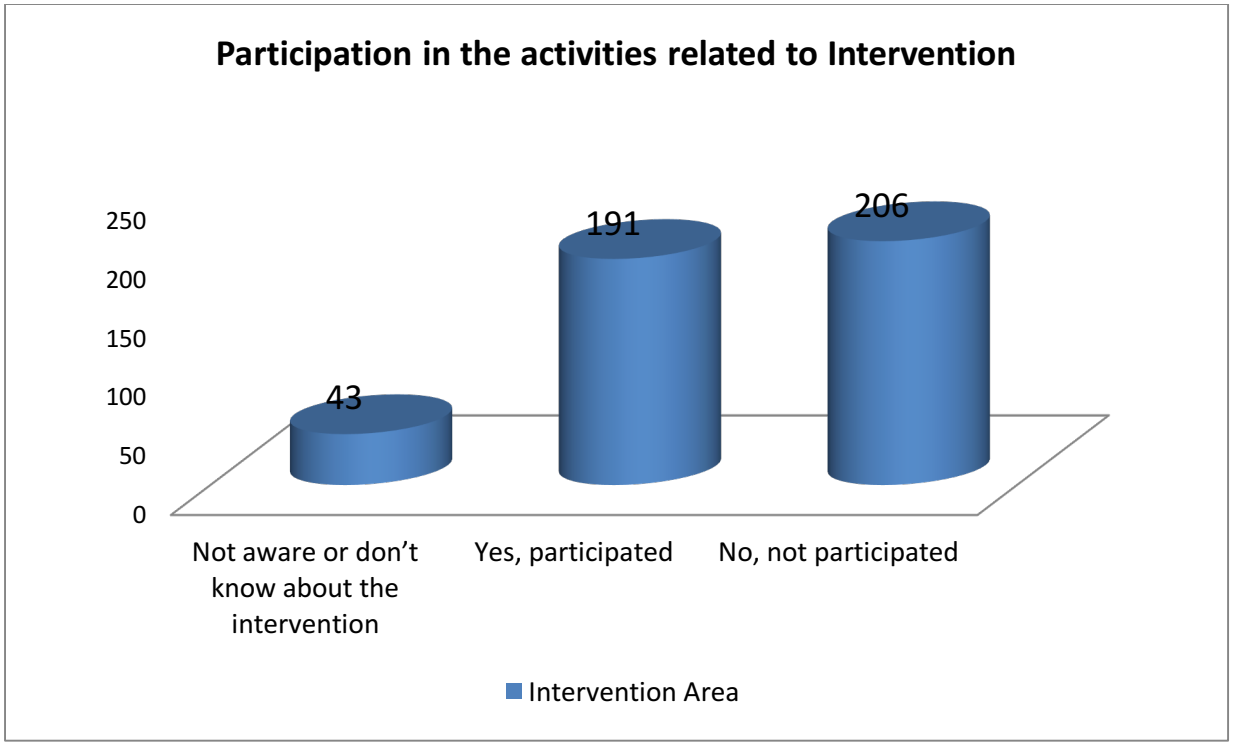
In the study population, majority of the respondents (89.3 percent) found the intervention activities useful for them, While 10.2 percent of the respondents were not aware about the intervention activities.

If we see the sector-wise distribution of the usefulness of the intervention activities similar sort of results are found almost all the respondents in individual sectors found the program useful, while negligible number of respondents from Industry and daily wage (0.2 percent each) did not find it useful.

		Intervention is useful to people to get health care		
	Not Aware/Don't Know	Yes, Useful	No, Not useful	Don't know the benefits
Agriculture	7(1.6%)	33(7.5%)	0	0
Bricklin	3(0.2%)	27(22.5%)	0	0
Construction	1(0.2%)	99(22.5%)	0	
Daily wage labourers	4(0.9%)	49(11.1%)	1(0.2%)	0
Furniture	2(0.5%)	18(4.1%)	0	0
Hotel	1(0.2%)	39(8.9%)	0	0
Industry	22(5%)	57(13%)	1(0.2%)	0
Small Business	0	16(3.6%)	0	0
Stone Quarry	5(1.1%)	55(12.5%)	0	0
Total	45(10.2%)	393(89.3%)	2(0.5%)	0

Table 7: Distribution of respondents based on their participation in the activities related to the intervention

	Number (%)
Not aware or don't know about the intervention	43(9.8%)
Yes, participated	191(43.4%)
No, not participated	206(46.8%)



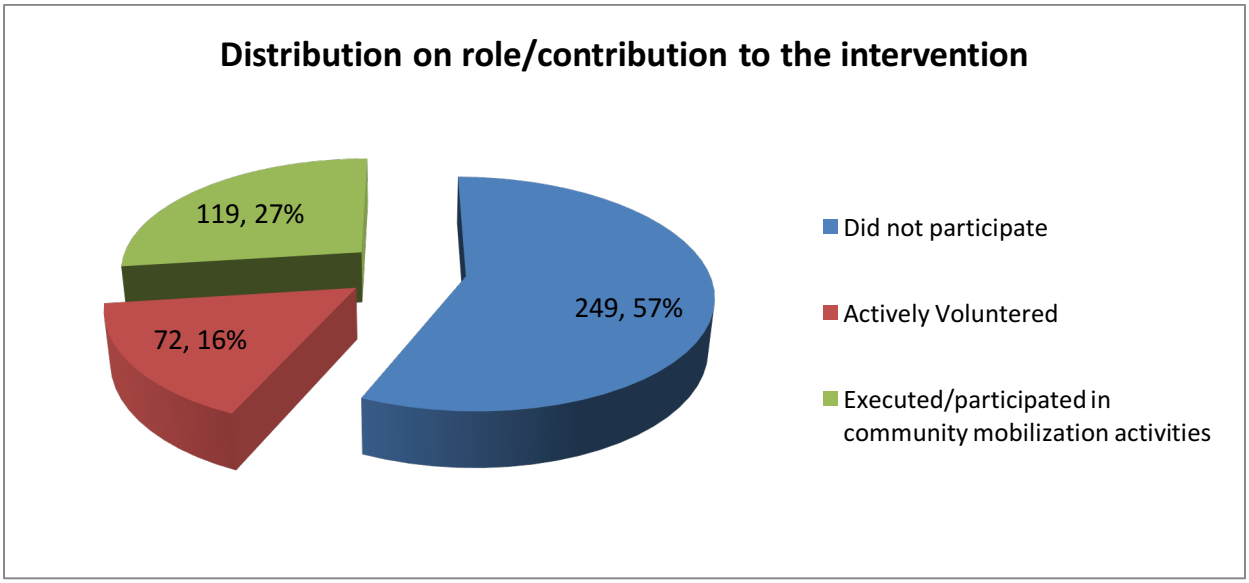
If we see the distribution of participation in the intervention activities 43.4 percent of the respondents participated actively. Around 9.8 percent respondents were not aware of the activities, while 46.8 percent did not participate in any activity.

		Participation in the activities related to the intervention	
	Not Aware/Don't Know	Yes, Participated	No, Not Participated
Agriculture	6(1.4%)	9(2%)	25(5.7%)
Bricklin	3(.7%)	8(1.8%)	19(4.3%)
Construction	1(0.2%)	89(20.2%)	10(2.3%)
Daily wage labourers	4(0.9%)	36(8.2%)	14(3.2%)
Furniture	2(0.5%)	13(3%)	5(1%)
Hotel	0	40(9.1%)	0
Industry	22(5%)	6(1.4%)	52(11.8%)
Small Business	0	14(3.1%)	2(0.5%)
Stone Quarry	5(1%)	16(3.6%)	39(8.9%)
Total	43(9.8%)	191(43.4%)	206(46.8%)

Now if we see the sector-wise distribution, 89 percent migrants in the Construction sector (N=100) actively participated in the intervention activities. Followed by cent percent in Hotel Sector (N=40) and 66.7 percent in Daily Wage labourers (N=54). Very less participation was seen in the Industry sector (N=80) where 65 percent of the migrants did not participated at all. Followed by Stone Quarry (N=60) and Agriculture (N=40) sectors were 65 percent and 62.5 percent migrants did not participate respectively.

Table 8: Distribution of respondents based on their role in/contribution to the intervention

Activity/Role	**Number (%)#**
Did not participate	249(56.6%)
Actively Volunteered	72(16.4%)
Executed/participated in community mobilization activities	119(27%)



In the study population, 27 percent of the respondents participated in executing community mobilization activities. While 16 percent of the respondents actively volunteered in making the intervention activities successful.

	Role in contribution to the intervention		
	Not participated	Actively Volunteered	Community mobilization
Agriculture	31(7%)	1(0.2%)	8(1.8%)
Bricklin	22(5%)	4(0.9%)	4(0.9%)
Construction	11(2.5%)	26(5.9%)	63(14.3%)
Daily wage labourers	18(4.1%)	3(0.7%)	33(7.5%)
Furniture	9(2%)	9(2%)	2(0.5%)
Hotel	40(9.1%)	0	0
Industry	73(16.6%)	5(1.1%)	2(0.5%)
Small Business	2(0.5%)	11(2.5%)	3(0.7%)
Stone Quarry	43(9.8%)	13(3%)	4(0.9%)
Total	249(56.6%)	72(16.4%)	119(27%)

If we see the sector-wise distribution of the roles played by the migrants, under construction sector (N=100) 26 percent of the migrants actively volunteered. Followed by Stone Quarry (N=60) and Small Business sectors (N=16) were 21.7 per cent and 81.2 per cent migrants actively volunteered in the interventionrespectively. In the community mobilization activities

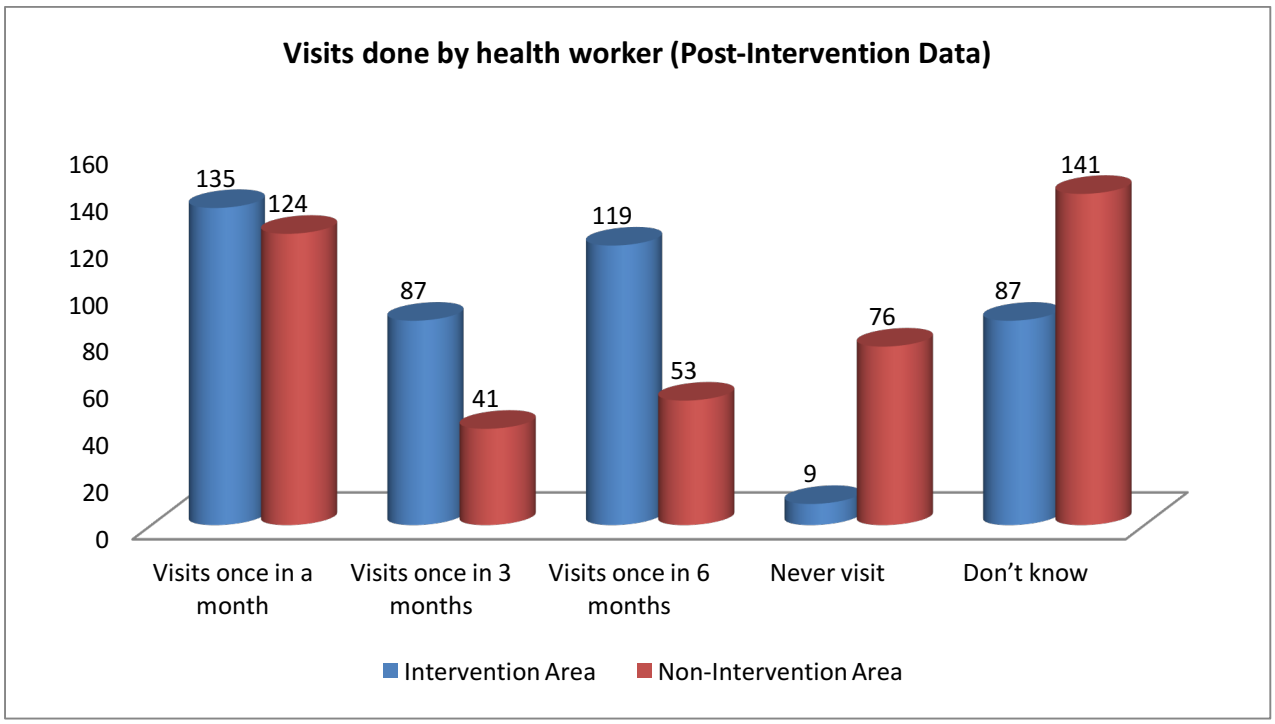
maximum participation was from construction sector migrants (N=100) were 63 percent participated followed by daily wages labourers were 61 per cent migrants participated.

Table 9: Pre and post intervention information on visits of health workers (regularity)

	Intervention clusters No. (%)	Control clusters No. (%)
Pre-intervention data		
Visits once in a month	323(8.1%)	
Visits once in 3 months	51(1.3%)	
Visits once in 6 months	20(0.5%)	
Visits once in a year	14(0.3%)	
Never visit	3427(85.5%)	
Don't know	170(4.3%)	
Post-intervention data		
Visits once in a month	135(30.7%)	124(28.2%)
Visits once in 3 months	87(19.8%)	41(9.3%)
Visits once in 6 months	119(27%)	53(12%)
Visits once in a year	3(0.7%)	5(1.1%)
Never visit	9(2%)	76(17.3%)
Don't know	87(19.8%)	141(32%)

From the table above, in the pre intervention study it was found that around 85.5 per cent (N=3427) migrants responded that health worker never visited them regularly; followed by 8.1 per cent migrants were visited by health worker once in a month.

Now if we compare the visits in intervention and control clusters, health worker visited once in a month is slightly higher in Intervention area (30.7 per cent) as compared to control area (28.2 per cent). Visit done by health worker once in 3 month is two times more in the intervention area (19.8 per cent). Visit done once in 6 months by health workers is also much better in intervention area (27 per cent).



	Visits of Health Worker - Intervention						
	At least once in a month	**At least once in three months**	**At least once in six months**	**Once in a year**	**Never**	**Don't know**	**Total**
Agriculture	2(0.5%)	1(0.2%)	24(5.5%)	3(0.7%)	5(1.1%)	5(1.1%)	**40(9.1%)**
Bricklin	7(1.6%)	13(3%)	7(1.6%)	0	0	3(0.7%)	**30(6.8%)**
Construction	99(22.5%)	0	1(0.2%)	0	0	0	**100(22.7%)**
Daily wage labourers	42(9.5%)	10(2.3%)	2(0.5%)	0	0	0	**54(12.3%)**
Furniture	2(0.5%)	7(1.6%)	1(0.2%)	0	0	10(2.3%)	**20(4.5%)**
Hotel	0	0	0	0	0	40(9.1%)	**40(9.1%)**
Industry	4(0.9%)	13(3%)	43(9.8%)	0	2(0.5%)	18(4.1%)	**80(18.2%)**
Small Business	0	12(2.7%)	0	0	2(0.5%)	2(0.5%)	**16(3.6%)**
Stone Quarry	9(2%)	31(7%)	17(3.9%)	0	0	3(0.7%)	**60(13.6%)**
Total	**165(37.5%)**	**87(19.8%)**	**95(21.6%)**	**3(0.7%)**	**9(2%)**	**81(18.4%)**	**440**

If we see the sector-wise distribution about the visits done by health workers, in the intervention area, under the category visited at least once in a month, we can see that 99 percent of Construction sector (N=100) were visited by the health followed by Daily wage sector were 78 percent of the migrants (N=54) responded positively. While in hotel and small business sectors no health workers visited. Under the category visited once in 3 months around 50 percent of the migrants in stone quarry sector were visited. In Construction and hotel sector no health worker visited. Under the category visited once in 6 months majority of positive response were given from Industry sector which is 53 percent of the sector population (N=80). Negligible amount of responses were seen from other sectors.

	Visits of Health Worker (Non-Intervention)						
	At least once in a month	**At least once in three months**	**At least once in six months**	**Once in a year**	**Never**	**Don't know**	**Total**
Agriculture	9(2%)	0	0	0	13(3%)	18(4.1%)	**40(9.1%)**
Bricklin	9(2%)	1(0.2%)	2(0.5%)	1(0.2%)	10(2.3%)	7(1.6%)	**30(6.8%)**
Constructio n	9(2%)	17(3.9%)	21(4.8%)	1(0.2%)	17(3.9%)	35(8%)	**100(22.7%)**
Daily wage labourers	29(6.6%)	5((1.1%)	2(0.5%)	0	8(1.8%)	6(1.4%)	**50(11.4%)**
Furniture	0	1(0.2%)	1(0.2%)	0	11(2.5%)	7(1.6%)	**20(4.5%)**
Hotel	0	0	0	0	0	40(9.1%)	**40(9.1%)**
Industry	28(6.4%)	13(3%)	22(5%)	0	8(1.8%)	9(2%)	**80(18.2%)**
Small Business	16(3.6%)	3(0.7%)	1(0.2%)	0	0	0	**20(4.5%)**
Stone Quarry	24(5.5%)	1(0.2%)	4(0.9%)	3(0.7%)	9(2%)	19(4.3%)	**60(13.6%)**
Total	**124(28.2%)**	**41(9.3%)**	**53(12%)**	5(1.1%)	**76(17.3%)**	**141(32%)**	**440**

Meanwhile in the non-intervention area, we found that majority respondents (32 percent) didn't know about the visits done by health workers, followed by 28.2 per cent respondents who responded positively on visits by the health worker at least once in a month.

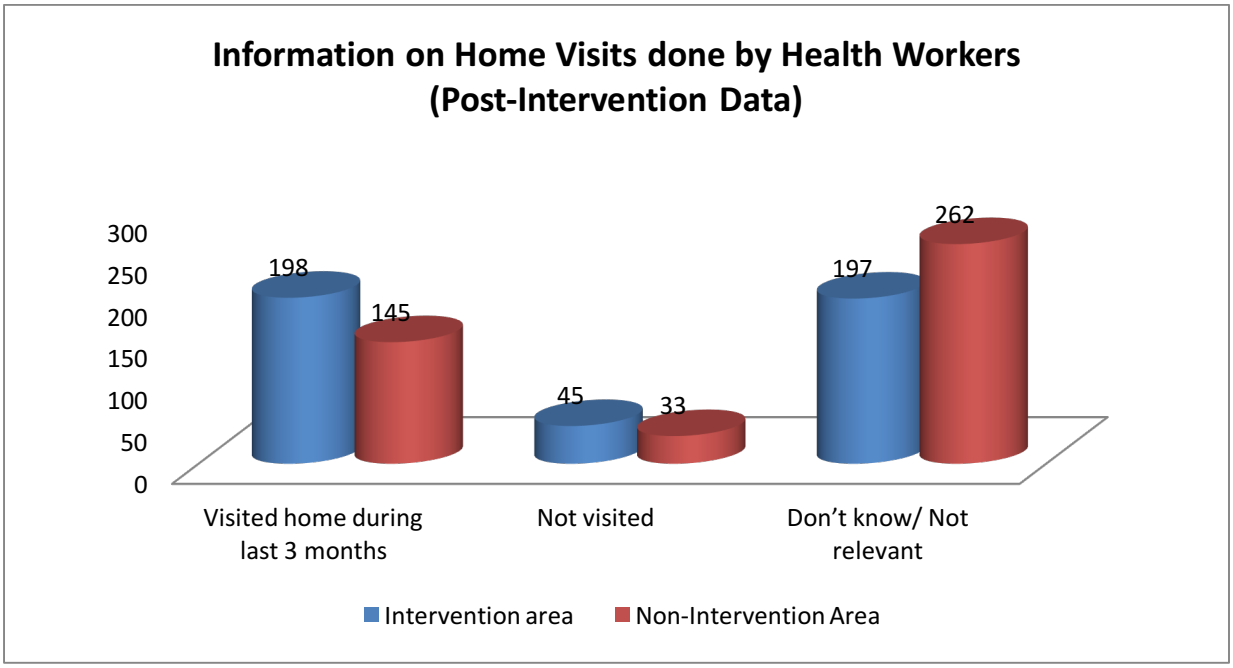
If we see the sector-wise distribution, In non-intervention area it was found that under category visits done at least once in a month majority of the respondents from daily wages sector (58 per cent, N=50) responded positively, followed by Industry, Stone Quarry and Small Business sectors were the distributions were 46.7 per cent, 40 per cent and 80 per cent from their respective sectors. Under the category visited once in 3 months majority of the response came from the construction sector (N=100) were 17 per cent migrants responded positively. Under the category visited once in 6 months majority of positive responses were given from Industry (27.5 per cent) and construction sectors (21 per cent) from their respective sectors.

Under the category never visited by health worker and don't know single migrant sectors like furniture (90 per cent of the respective sector), Hotel (cent per cent of the respective sector) had the maximum distributions along with construction sector.

Table 10: Pre and post intervention information on visits of health workers (home visits)

	Intervention clusters	**Control clusters**
Pre-intervention data		
Visited home during last 3 months	**225(5.6%)**	
Not visited	**182(4.5%)**	
Don't know/ Not relevant	**3601(89.9%)**	
Post-intervention data		
Visited home during last 3 months	**198(45%)**	**145(33%)**
Not visited	**45(10.2%)**	**33(7.5%)**
Don't know/ Not relevant	**197(44.8%)**	**262(59.5)**

In the pre intervention data it can be clearly seen that around 90 per cent of the respondents did not knew about the health workers visit in their locality. Only 5.6 per cent responded positively that health workers visited their home during the last 3 months.



Now if we compare the post intervention data from Intervention and control clusters, out of 440 respondents in each cluster the distribution of homes visited by health workers in Intervention area(45 per cent) is 12 per cent more than in Non-Intervention area.

	Did the health workers visit your house during last 3 months?(Intervention)			
	Yes	**No**	**Don't know**	**Total**
Agriculture	7 (1.6%)	4 (0.9%)	29 (6.6%)	**40(9.1%)**
Bricklin	20 (4.5%)	0	10 (2.3%)	**30(6.8%)**
Construction	69 (15.7%)	4 (0.9%)	27 (6.1%)	**100 (8.0%)**
Daily Wage Labourers	34 (4.1%)	18 (2.7%)	2 (0.5%)	**54 (6.8%)**
Furniture	8 (1.8)	1 (0.2%)	11 (2.5%)	**20 (4.5%)**
Hotel	0	0	40(9.1%)	**40 (4.1%)**
Industry	8 (1.8%)	13 (3.0%)	59 (13.4%)	**80 (18.2%)**
Small Business	12 (2.7%)	0	4 (0.9%)	**16(3.6%)**
Stone Quarry	40 (9.1%)	5 (1.1%)	15 (1.6%)	**48 (10.9%)**
Total	**198 (45.0%**	**45 (10.2%)**	**197 (44.7)**	**440 (100%)**

If we see the sector-wise distribution, in the intervention area out of the total household visited by the health workers majority is visited under the construction sector (34.8 percent of the total house visited), followed by stone Quarry (20.2 per cent of the total house visited) and Daily Wage Labourer (17.1 per cent of the total house visited) sectors. It is to be noted that no health workers visited the hotel sector migrants at home.

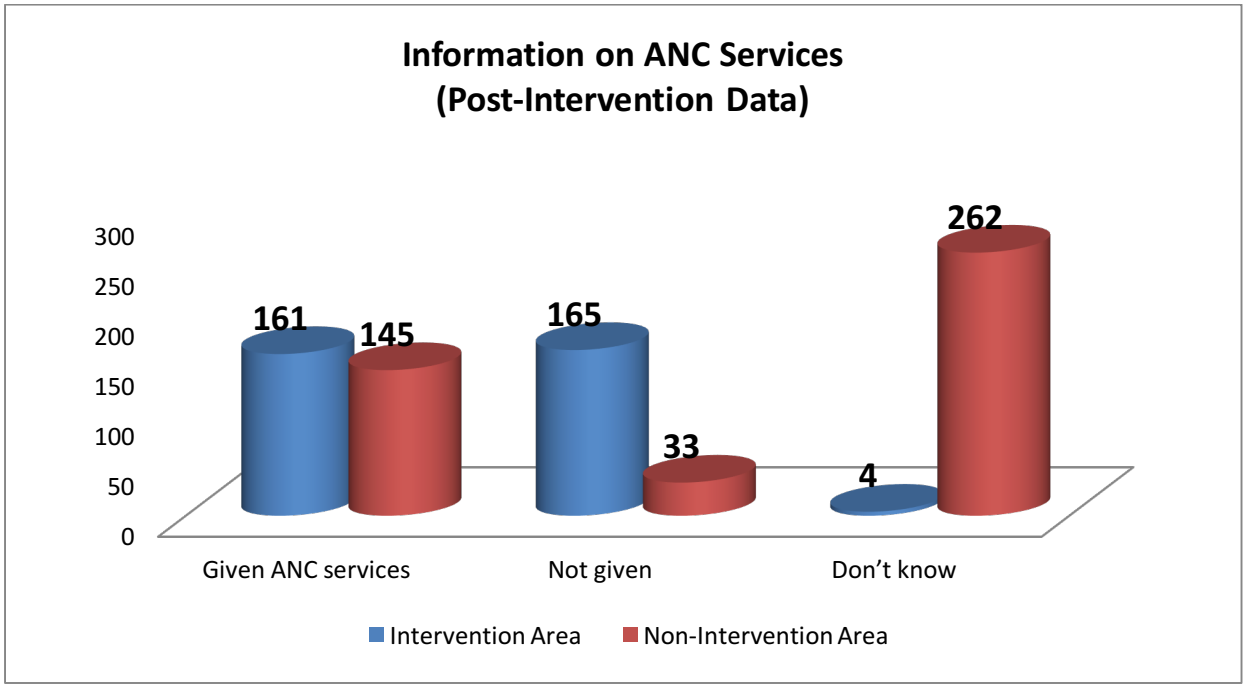
	Did the health workers visit your house during last 3 months?(Non-Intervention)			
	Yes	**No**	**Don't Know**	**Total**
Agriculture	4 (0.9%)	7 (1.6%)	29 (6.6%)	**40(9.1%)**
Bricklin	5 (1.1)	8 (1.8%)	17 (3.9%)	**30(6.8%)**
Construction	5 (5.7%)	2 (0.4%)	73 (16.6%)	**105 (22.7%)**
Daily wage labourers	30 (6.8%)	6 (1.4%)	14 (3.2%)	**50 (11.3%)**
Furniture	1 (0.2%)	1 (0.2%)	18 (4.1%)	**20 (4.5%)**
Hotel	0	0	40 (9.1%)	**40 (9.1%)**
Industry	36 (8.2%)	6 (1.4%)	38 (8.6%)	**80 (18.2%)**
Small Business	18 (4.1%)	1 (0.2%)	1 (0.2%)	**20 (4.5%)**
Stone Quarry	26 (5.9%)	2 (0.5%)	32 (7.3%)	**60 (13.6%)**
Total	**145 (33.0%)**	**33 (7.5%)**	**262 (59.5%)**	**440 (100%)**

In the Non-intervention area out of the total household visited (N=145) by the health workers majority is visited under the industry sector (24.8 per cent of the total house visited), followed by Daily Wage Labourers (20.6 per cent of the total house visited) and Stone Quarry (17.9 per cent of the total house visited) sectors. Similar like Intervention area Hotel sector is not visited by health worker, visits at furniture sector is also negligible.

Table 11: Pre and post intervention information on services of health workers - antenatal care services (ANC)

	Intervention clusters No. (%)	Control clusters No. (%)
Pre-intervention data		
Given ANC services	**267 (6.7 %)**	
Not given	**95 (2.4 %)**	
Don't know	**46 (1.1 %)**	
Not relevant	**3600 (89.9%)**	
Post-intervention data		
Given ANC services	**161 (36.6%)**	**145 (33.0%)**
Not given	**165 (37.5%)**	**33 (7.5%)**
Don't know	**4 (0.9%)**	**262 (59.5%)**
Not relevant	**110 (25.0%)**	**0**

If we see the services being provided by the health workers, in the pre intervention data only 6.7 per cent of the total respondents received antenatal care services. The results in the post intervention data are far better than this.



Now if we compare the post intervention data from Intervention and control clusters, out of 440 respondents in each cluster the distribution of households receiving ANC care in Intervention area(36.6 per cent) is slightly better than the Non-Intervention area(33 per cent).

If we see the sector-wise distribution, in the intervention area out of the total household visited (N=161) by the health workers for ANC services majority is visited under the construction sector (42.9 per cent of the total ANC services received), followed by Daily Wage Labourer (21.7 per cent of the total ANC services received) and Stone Quarry (18 per cent of the total ANC services received visited) sectors. It is to be noted that no ANC services is being provided in the Hotel and Industry sectors.

	Did the health worker provide a) Antenatal care services? (Intervention)				
	Yes	**No**	**Don't Know**	**Not Relevant**	**Total**
Agriculture	8 (1.8%)	3 (5.2%)	0	9 (2.0%)	**40 (9.1%)**
Bricklin	6 (1.4%)	20 (4.5%)	0	4 (0.9%)	**30 (6.8%)**
Construction	69 (15.7%)	24 (5.4%)	0	7 (1.6%)	**30 (22.8%)**
Daily wage labourers	35 (4.1%)	4 (0.9%)	3 (0.7%)	12 (2.7%)	**54 (6.8%)**
Furniture	2 (0.5%)	7 (1.6%)	1 (0.2%)	10 (2.3%)	**20 (4.5%)**
Hotel	0	0	0	40 (9.1%)	**40 (9.1%)**
Industry	0	59 (13.4%)	0	21 (4.8%)	**80 (18.2%)**
Small Business	12 (2.7%)	0	0	4 (0.9%)	**16 (3.6%)**
Stone Quarry	29 (6.6%)	28 (6.4%)	0	3 (0.7%)	**60 (13.6%)**
Total	**161 (36.6%)**	**165 (37.5%)**	**4 (0.9%)**	**110 (25.0%)**	**440 (100.0%)**

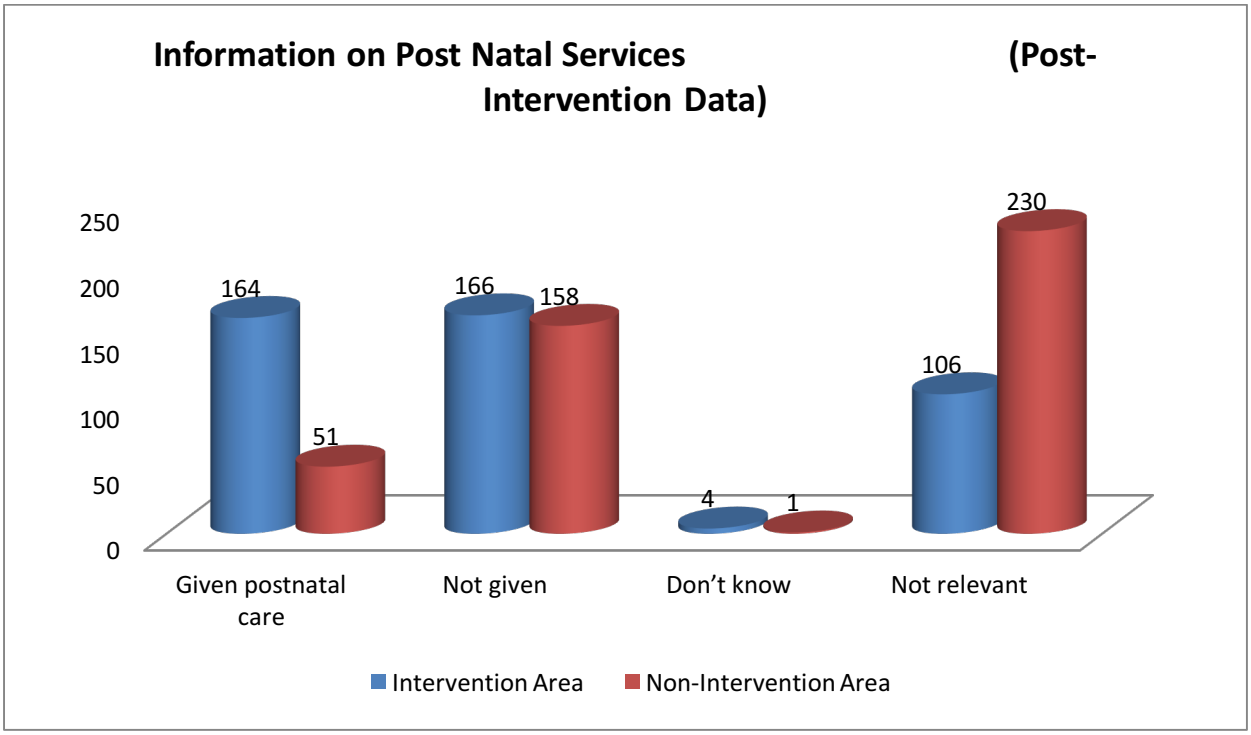
In the Non-intervention area out of the total household visited (N=145) by the health workers majority is visited under the industry sector (24.8 per cent of the total house visited), followed by Daily Wage Labourers (20.6 per cent of the total house visited) and Stone Quarry (17.9 per cent of the total house visited) sectors. No ANC services provided at the Hotel sector and services at furniture sector is also negligible.

	Did the health worker provide a) Antenatal care services? (Non-Intervention)			
	Yes	**No**	**Don't Know**	**Total**
Agriculture	4 (0.9%)	7 (1.6%)	29 (6.6%)	**40(9.1%)**
Bricklin	5 (1.1)	8 (1.8%)	17 (3.9%)	**30(6.8%)**
Construction	5 (5.7%)	2 (0.4%)	73 (16.6%)	**105 (22.7%)**
Daily wage labourers	30 (6.8%)	6 (1.4%)	14 (3.2%)	**50 (11.3%)**
Furniture	1 (0.2%)	1 (0.2%)	18 (4.1%)	**20 (4.5%)**
Hotel	0	0	40 (9.1%)	**40 (9.1%)**
Industry	36 (8.2%)	6 (1.4%)	38 (8.6%)	**80 (18.2%)**
Small Business	18 (4.1%)	1 (0.2%)	1 (0.2%)	**20 (4.5%)**
Stone Quarry	26 (5.9%)	2 (0.5%)	32 (7.3%)	**60 (13.6%)**
Total	**145 (33.0%)**	**33 (7.5%)**	**262 (59.5%)**	**440 (100%)**

Table 12: Pre and post intervention information on services of health workers – postnatal care services

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Given postnatal care	**197(4.9%)**	
Not given	**174(4.3%)**	
Don't know	**38(0.9%)**	
Not relevant	**3599(89.8%)**	
Post-intervention data		
Given postnatal care	**164(32.3%)**	**51(11.6%)**
Not given	**166(37.7%)**	**158(35.9%)**
Don't know	**4(0.9%)**	**1(0.2%)**
Not relevant	**106(24.1%)**	**230(52.3%)**

Now we see the services being provided by the health workers for post natal services, in the pre intervention data only 4.9 per cent of the total respondents received postnatal care services. If we compare the post intervention data from Intervention and control clusters, out of 440 respondents in each cluster the distribution of households receiving post natal care in Intervention area (32.3 per cent) is almost 2.5 times better than the Non-Intervention area (11.6 per cent).



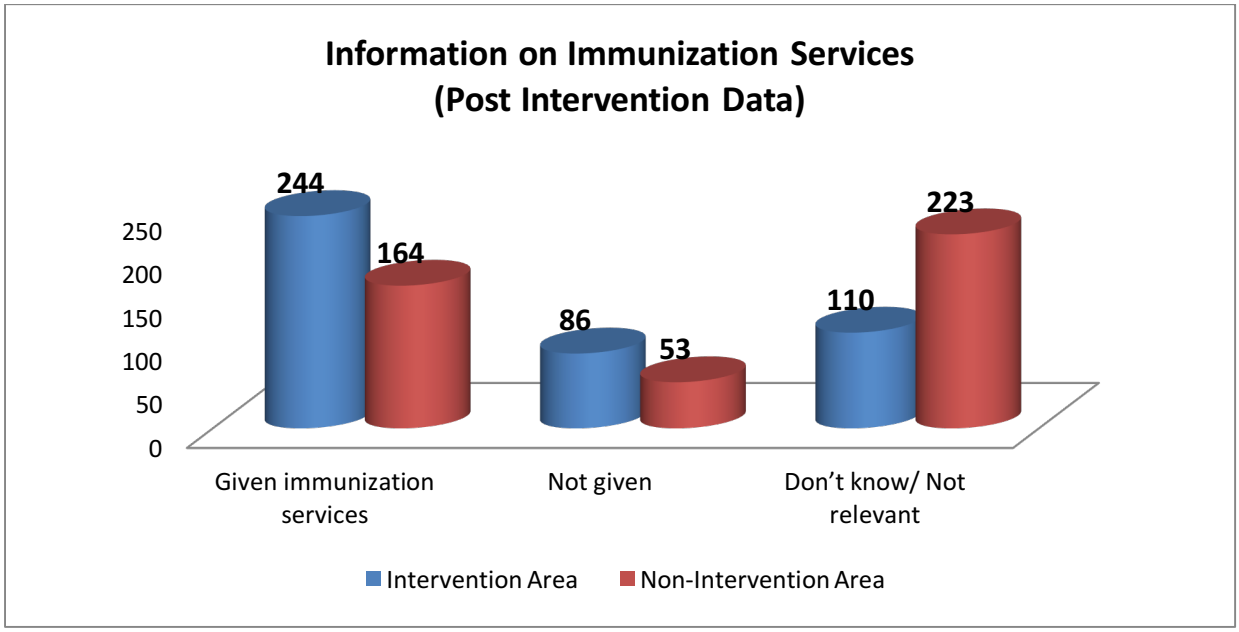
If we see the sector-wise distribution, in the intervention area out of the total household visited (N=164) by the health workers for PNC services majority is visited under the construction sector (42 per cent of the total PNC services received), followed by Daily Wage Labourer (22.6 per cent of the total PNC services received) and Stone Quarry (18.3 per cent of the total PNC services received visited) sectors. No PNC services are being provided in the Hotel and Industry sectors.

	Post-natal care services (Intervention)				Total
	Given postnatal care	Not given	Don't know	Not relevant	
Agriculture	8 (1.80%)	23 (5.20%)	0	9 (2.00%)	**40 (9.10%)**
Bricklin	6 (1.40%)	20 (4.50%)	0	4 (0.90%)	**30 (6.80%)**
Construction	69 (15.70%)	25 (5.70%)	0	6 (1.40%)	**100 (22.80%)**
DWG	37 (8.40%)	4 (0.90%)	3 (0.70%)	10 (2.30%)	**54 (12.30%)**
Furniture	2 (0.50%)	7 (1.60%)	1 (0.20%)	10 (2.30%)	**20 (4.50%)**
Hotel	0	0	0	40 (9.10%)	**40 (9.10%)**
Industry	0	60 (13.60%)	0	20 (4.50%)	**80 (18.20%)**
SMB	12 (2.70%)	0	0	4 (0.90%)	**16 (3.60%)**
Stone Quarry	30 (6.80%)	27 (6.10%)	0	3 (0.70%)	**60 (13.60%)**
Total	**164 (37.30%)**	**166 (37.70%)**	**4 (0.90%)**	**106 (24.10%)**	**440 100.00%**

Table 13: Pre and post intervention information on services of health workers – immunization services

	Intervention clusters No. (%)	Control clusters No. (%)
Pre-intervention data		
Given immunization services	**338 (8.4%)**	
Not given	**39 (1%)**	
Don't know	**32 (0.8%)**	
Not relevant	**3598 (89.0%)**	
Post-intervention data		
Given immunization services	**244 (55.5%)**	**164 (37.3%)**
Not given	**86 (19.5%)**	**53 (12.0%)**
Don't know	**2 (0.5%)**	**0**
Not relevant	**108 (24.5%)**	**223 (50.7%)**

In the pre intervention data for the immunization services only 8.4 per cent of the total households received immunization services.



If we compare the post intervention data from Intervention and control clusters, out of 440 respondents in each cluster the distribution of households receiving immunization services in Intervention area (55.5 per cent) is 18.2 per cent better than the Non-Intervention area (37.3 per cent).

	Did the health workers give Child Immunization?(Intervention)				
	Yes	**No**	**Don't Know**	**Not Relevant**	**Total**
Agriculture	30 (6.8%)	1 (0.2%)	0	9 (2.0%)	**40 (9.1%)**
Bricklin	26 (5.8%)	0	0	4 (0.9%)	**30 (6.8%)**
Construction	85 (19.4%)	9 (2.0%)	0	6 (1.4%)	**100 (22.8%)**
Daily wage labourers	38 (8.6%)	2 (0.5%)	2 (0.5%)	12 (2.7%)	**54 (12.3%)**
Furniture	5 (1.1%)	5 (1.1%)	0	10 (2.3%)	**20 (4.5%)**
Hotel	0	0	0	40 (9.1%)	**40 (9.1%)**
Industry	0	60 (13.6%)	0	20 (4.5%)	**80 (18.2%)**
Small Business	12 (2.7%)	0	0	4 (0.9%)	**16 (3.6%)**
Stone Quarry	48 (11.0%)	9 (2.0%)	0	3 (0.7%)	**60 (13.6%)**
Total	**244 (55.5%)**	**86 (19.5%)**	**2 (0.5%)**	**108 (24.5%)**	**440 (100.0%)**

If we see the sector-wise distribution, in the intervention area out of the total household visited (N=244) by the health workers for Immunization services majority is visited under the construction sector (34.8 per cent of the total immunization services received), followed by Daily Wage Labourer, Stone Quarry, Daily Wage Labourer, Agriculture and Bricklin sectors (were 22.6 per cent, 19.7 per cent, 15.6 per cent, 12.3 per cent and 10.7 per cent of the total immunization services were received respectively). No immunization services are being provided in the Hotel and Industry sectors because of single male migrants in these sectors.

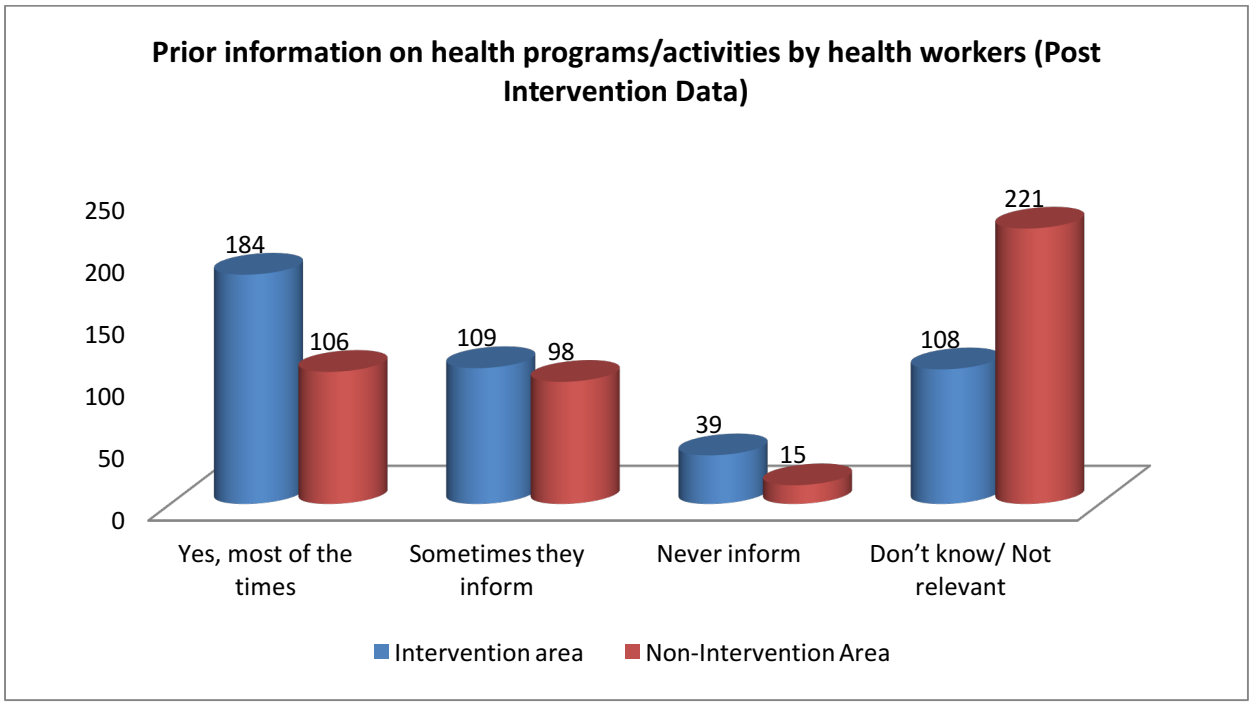
	Did the health workers give Child Immunization? (Non-Intervention)				
	Yes	**No**	**Don't Know**	**Not Relevant**	**Total**
Agriculture	4 (0.9%)	0	0	36 (8.2%)	**40 (9.1%)**
Bricklin	5 (1.1%)	9 (2.0%)	0	16 (3.6%)	**30 (6.8%)**
Construction	42 (9.6%)	6 (1.4%)	0	52 (11.8%)	**100 (2.7%)**
Daily wage labourers	22 (5.0%)	14 (3.2%)	0	14 (3.2%)	**50 (11.3%)**
Furniture	2 (0.2%)	0	0	18 (4.1%)	**20 (4.5%)**
Hotel	0	0	0	40 (9.1%)	**40 (9.1%)**
Industry	51 (11.6%)	12 (2,7%)	0	17 (3.9%)	**80 (18.2%)**
Small Business	8 (1.8%)	11 (2.5%)	0	1 (0.2%)	**20 (4.5%)**
Stone Quarry	30 (6.8%)	1 (0.2%)	0	29 (6.6%)	**60 (13.6%)**
Total	**164 (37.3%)**	**53 (12.0%)**	**0**	**223 (50.7%)**	**440 (100.0%)**

In the Non-intervention area out of the total household visited (N=164) by the health workers for Immunization services majority is under the industry sector (31 per cent of the total immunization services received), followed by construction, stone quarry and daily wage labourers sectors (were 25.6 per cent, 18.3 per cent, 13.4 per cent of the total immunization services were received respectively).

Table 14: Pre and post intervention information on services of health workers – information on government health programmes/activities

	Intervention clusters No. (%)	**Control clusters No. (%)**
Pre-intervention data		
Yes, most of the times	**117 (2.9%)**	
Sometimes they give	**31 (0.8%)**	
Never give	**255 (6.4%)**	
Don't know	**3605 (89.9%)**	
Not relevant	**0**	
Post-intervention data		
Yes, most of the times	**184 (41.8%)**	**106 (24.1%)**
Sometimes they give	**109 (24.8%)**	**98 (22.3%)**
Never give	**39 (8.9%)**	**15 (3.4%)**
Don't know	**108 (24.5%)**	**221 (50.2%)**

In the pre intervention data, for the distribution of information provided by the health workers on government health programs it was found that only 2.9 per cent of the total respondents said that they were informed on prior basis, whereas 6.4 per cent said that the health workers never informed them about the activities.



If we compare the post intervention data from Intervention and control clusters, out of 440 respondents in each cluster the distribution of households receiving prior information on health programs/activities, the percentage of health workers regularly informing the households in Intervention area (41.8 per cent) is better than the Non-Intervention area (24.1 per cent). The percentage of health workers informing sometimes is also slightly better in intervention area. Whereas, half of the population in the non-intervention area did not had any idea about the b=visits done by health workers.

	Do the health workers inform you, when there are any govt. health activities (like immunization to children, pulse polio, antenatal care, etc.)? (Intervention)				
	Yes, most of the times	Sometimes	Never	Don't Know	**Total**
Agriculture	9 (2.0%)	21 (4.8%)	1 (0.2%)	9 (2.0%)	**40 (9.1%)**
Bricklin	17 (3.9%)	9 (2.0%)	0	4 (0.9%)	**30 (6.8%)**
Construction	70 (16.0%)	16 (3.6%)	8 (1.8%)	6 (1.4%)	**100 (22.8%)**
Daily wage labourers	40 (9.1%)	2 (0.5%)	0	12 (2.7%)	**54 (12.3%)**
Furniture	5 (1.1%)	4 (0.9%)	1 (0.2%)	10 (2.3%)	**20 (4.5%)**
Hotel	0	0	0	40 (9.1%)	**40 (9.1%)**
Industry	0	33 (7,5%)	27 (6.0%)	20 (4.5%)	**80 (18.2%)**
Small Business	12 (2.7%)	0	0	4 (0.9%)	**16 (3.6%)**
Stone Quarry	31 (7.0%)	24 (5.4%)	2 (0.5%)	3 (0.7%)	**60 (13.6%)**
Total	**184 (41.8%)**	**109 (24.8%)**	**39 (8.9%)**	**108 (24.5%)**	**440 (100.0%)**

If we see the sector-wise distribution, in the intervention area out of the total household informed on health activities on regular basis (N=184) by the health workers majority falls under the construction sector (38 per cent of the total households informed), followed by Daily Wage Labourer were 21.7 per cent of the total households were informed on regular basis. No prior information provided at hotel and industry sectors.

For the 2nd category information provided sometimes, out of the total households (N=109) 30.2 per cent were from Industry sector. 19.7 per cent, 15.6 per cent, 12.3 per cent and 10.7 per cent of the total immunization services were received respectively). No immunization services are being provided in the Hotel and Industry sectors because of single male migrants in these sectors.

	Do the health workers inform you, when there are any govt. health activities (like immunization to children, pulse polio, antenatal care, etc.)? (Non-Intervention)				
	Yes, most of the times	Sometimes	Never	**Don't Know**	**Total**
Agriculture	4 (0.9%)	0	0	36 (8.2%)	**40 (9.1%)**
Bricklin	6 (1.4%)	6 (1.54%)	3 (0.7%)	15 (3.4%)	**30 (6.8%)**
Construction	9 (2.1%)	36 (8.2%)	3 (0.7%)	52 (11.8%)	**100 (2.7%)**
Daily wage labourers	19 (4.3%)	15 (3.4%)	1 (0.2%)	28 (3.5%)	**50 (11.3%)**
Furniture	0	1 (0.2%)	1 (0.2%)	18 (4.1%)	**20 (4.5%)**
Hotel	0	0	0	40 (9.1%)	**40 (9.1%)**
Industry	28 (6.4%)	29 (6.6%)	5 (1.1%)	18 (4.1%)	**80 (18.2%)**
Small Business	17 (3.9%)	2 (0.5%)	0	1 (0.2%)	**20 (4.5%)**
Stone Quarry	23 (5.2%)	9 (2.0%)	2 (0.5%)	26 (59%)	**60 (13.6%)**
Total	**106 (24.1%)**	**98 (22.3%)**	**15 (3.4%)**	**221 (50.2%)**	**440 (100.0%)**

In the Non-intervention area out of the total household informed on health activities on regular basis (N=106) by the health workers majority falls under the industry sector (26.4 per cent of the total households informed), followed by stone quarry, Daily Wage Labourer and Small business sectors were 21.7 per cent, 17.9 per cent and 16 per cent of the total households were informed on regular basis. No prior information provided at furniture and hotel sectors.

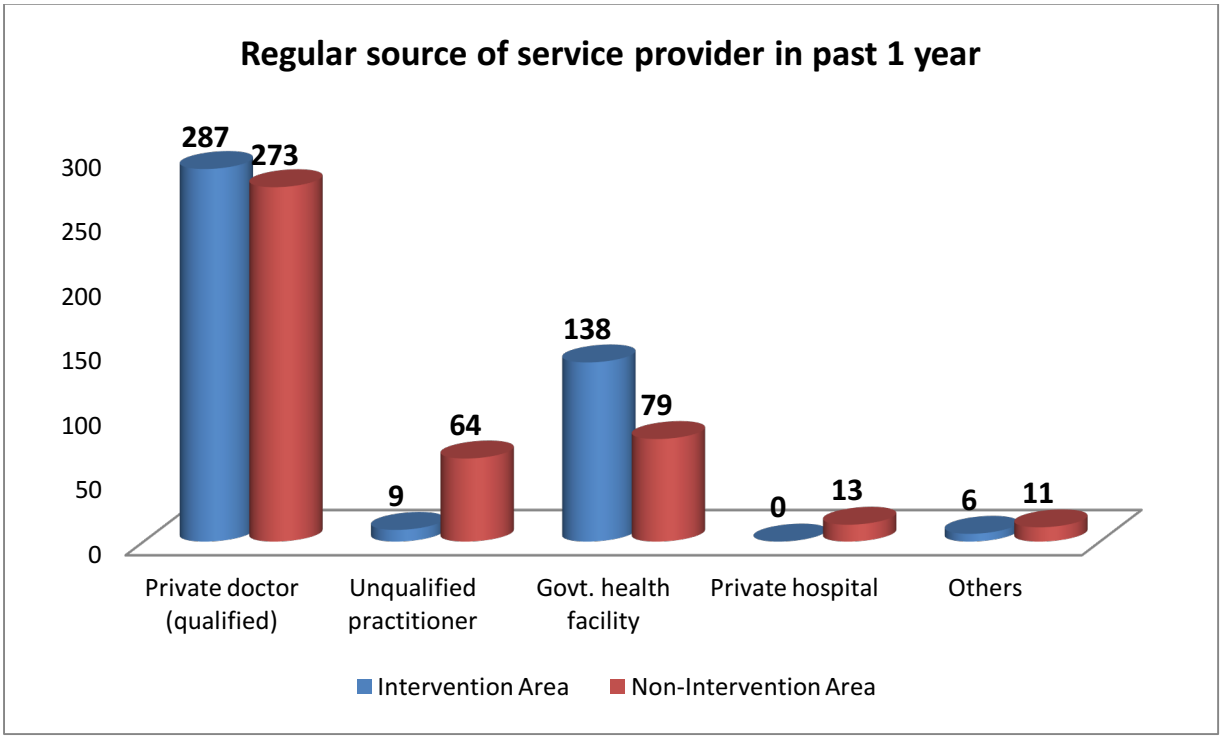
For the 2nd category information provided sometimes, out of the total households (N=98) 36.7 per cent were from construction sector, followed by Industry sector were 29.6 per cent households were informed.

Table 15: Pre and post intervention information on regular source of medical care since last one year

	Intervention	Control
Pre-intervention data		
Private doctor (qualified)	**3077 (76.8 %)**	
Unqualified practitioner	**116 (2.9%)**	
Govt. health facility	**279 (7.0%)**	
Private hospital	**350 (8.7%)**	
NGO/Trust hospital	**0**	
Traditional healer/spiritual healer	**40 (1%)**	
Other systems of medicine	**21 (0.5%)**	
Other sources	**85 (2.1%)**	
Didn't have any regular source of care	**40 (1%)**	
Post-intervention data		
Private doctor (qualified)	**287 (65.2%)**	**273 (5%)**
Unqualified practitioner	**9 (2.0%)**	**64 (14.5%)**
Govt. health facility	**138 (31.4%)**	**79 (18.0%)**
Private hospital	**0**	**13 (3.0%)**
NGO/Trust hospital	**2 (0.5%)**	**0**
Traditional healer/spiritual healer	**0**	
Other systems of medicine	**0**	**4 (0.9%)**
Other sources	**4 (0.9%)**	**2 (0.4%)**
Didn't have any regular source of care	**0**	**5 (1.1%)**

In the pre intervention data, for the distribution on information of regular source of medical care it was found that only 76.8 per cent of the total respondents went to private qualified doctors for seeking health care services, the distribution of migrants going to government health facilities was mere 7 per cent.

If we compare the post intervention data from Intervention and control clusters, out of 440 respondents in each cluster the distribution of regular source of service provider in the past one year, the percentage of respondents going to private doctors is almost same. But if we look at the distribution of migrants seeking government health facilities response in the intervention area (31.4 per cent) is 13.6 per cent higher than the Non-Intervention area (18 per cent). The migrants seeking services from unqualified practitioner is also very high in non-intervention area (14.5 per cent).



If we see the sector-wise distribution, in the intervention area out of the total household seeking health services from private qualified doctors (N=287) majority falls under the construction sector (33.1 per cent of the total respondents visiting private doctors). It is to be noted that in the hotel sector cent per cent of the respondents receive health care from private doctors.In the Industry sector least number of people visited private doctors (4.5 per cent of the total respondents visiting private doctors).

Under the category migrants visiting government health facility (N=138), majority falls under the industry sector (44.2 per cent of the total respondents visiting government health facilities). It

is to be noted that in the small business sector none of the respondents have visited the government health facilities.

	What is your regular source of medical care since a year? (Please take only one response)? (Intervention)					
	Private doctor (qualified)	Local practitioner (unqualified)	Govt. health Facility	NGO/ Trust hospital	Others	**Total**
Agriculture	19 (4.3%)	7 (1.6%)	14 (3.2%)	0	0	**40 (9.1%)**
Bricklin	16 (3.6%)	0	14 (3.2%)	0	0	**30 (6.8%)**
Construction	95 (21.6%)	0	3 (0.7%)	2 (0.5%)	0	**100 (22.8%)**
Daily wage labourers	39 (8.8%)	0	15 (3.4%)	0	0	**54 (12.3%)**
Furniture	14 (3.2%)	0	6 (1.4%)	0	0	**20 (4.5%)**
Hotel	40 (9.1%)	0	0	0	0	**40 (9.1%)**
Industry	13 (3.0%)	2 (0.5%)	61 (13.9%)	0	4 (0.9%)	**80 (18.2%)**
Small Business	16 (3.6%)	0	0	0	0	**16 (3.6%)**
Stone Quarry	35 (1.4%)	0	25 (5.7%)	0	0	**60 (13.6%)**
Total	**287 (65.2%)**	**9 (2.0%)**	**138 (31.4%)**	**2 (0.5%)**	**4 (0.9)**	**440 (100.0%)**

In the Non-intervention area out of the total household seeking health services from private qualified doctors (N=273) majority falls under the construction sector (27 per cent of the total respondents visiting private doctors). It is to be noted that in the hotel sector cent per cent of the respondents receive health care from private doctors.

We can also find the distribution of respondents seeking health care services from unqualified private doctors(N=64) in Industry, Stone Quarry, Agriculture and Construction sectors were 31.3 per cent, 26 .6 per cent, 25 per cent and 17.2 per cent respondents visited unqualified doctors in their respective sectors

Under the category migrants visiting government health facility (N=79), majority falls under the industry sector (41.8 per cent of the total respondents visiting government health facilities). It is

to be noted that in the hotel sector none of the respondents have visited the government health facilities.

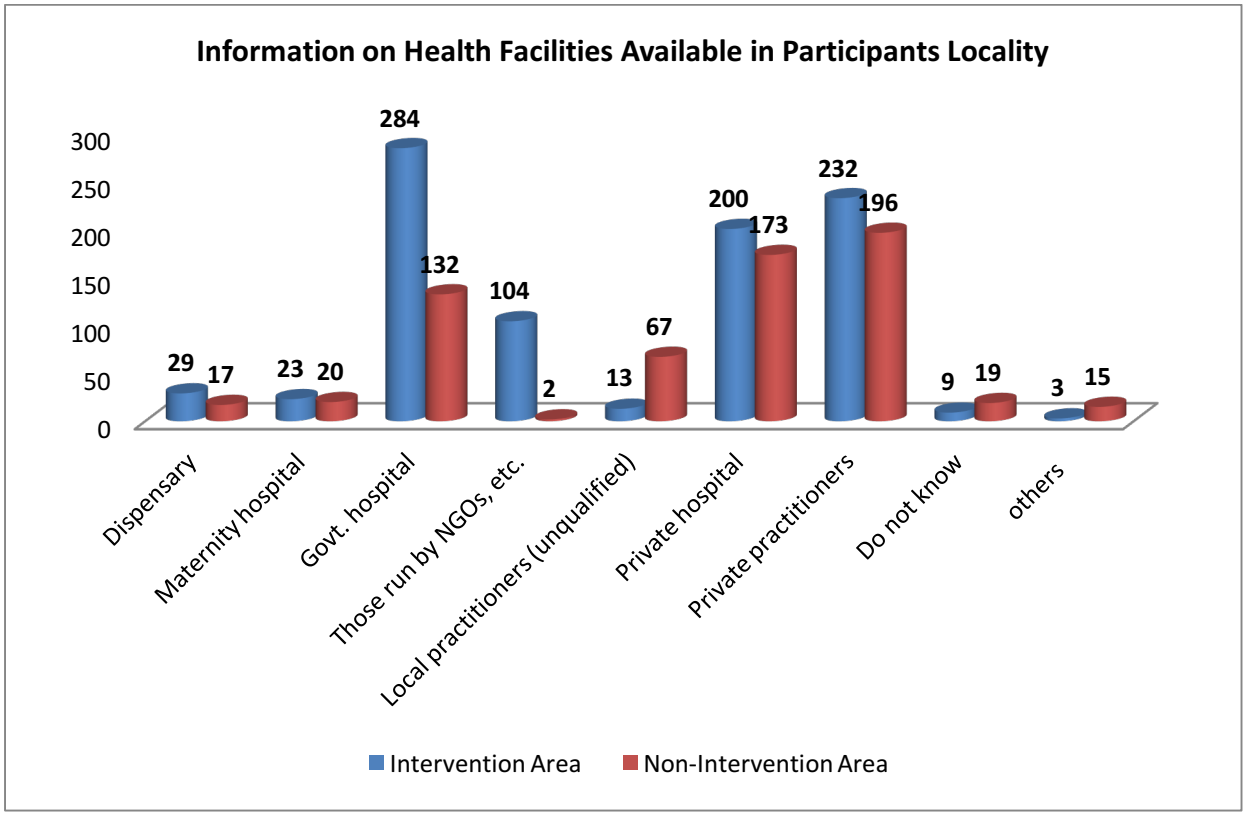
	What is your regular source of medical care since a year? (please take only one response)? (Non-Intervention)							
	Private doctor	**Local practitioner**	**Govt. health facility**	**Private Hospital**	**Other System**	**Did not have**	**Others**	**Total**
Agriculture	22 (5.0%)	16 (3.6%)	2 (0.5%)	0	0	0	0	**40 (9.1%)**
Bricklin	22 (5.0%)	0	6 (1.4%)	0	0	2 (0.5%)	0	**30 (6.8%)**
Construction	74 (16.8%)	11 (2.5%)	11 (2.5%)	3 (0.7%)	0	1 (0.2%)	0	**100 (2.7%)**
Daily wage labourers	29 (6.6%)	0	14 (3.2%)	5 (1.2%)	1 (0.2%)	0	1 (0.2%)	**50 (11.3 %)**
Furniture	16 (3.6%)	0	1 (0.2%)	2 (0.2%)	0	1 (0.2%)	0	**20 (4.5%)**
Hotel	40 (9.1%)	0	0	0	0	0	0	**40 (9.1%)**
Industry	24 (5.5%)	20 (4.5%)	33 (7.5%)	1 (0.2%)	2 (0.5%)	0	0	**80 (18.2 %)**
Small Business	8 (1.8%)	0	10 (2.3%)	2 (0.5%)	0	0	0	**20 (4.5%)**
Stone Quarry	38 (8.6%)	17 (3.9%)	2 (0.5%)	0	1 (0.2%)	1 (0.2%)	1 (0.2%)	**60 (13.6 %)**
Total	**273 (62.0%)**	**64 (14.5%)**	**79 (18.0%)**	**13 (3.0%)**	**4 (0.9%)**	**5 (1.1%)**	**2 (0.4%)**	**440 (100.0 %)**

Table 16: Pre and post intervention information on health facilities available in participants' locality

	Intervention clusters Number (%)	Control clusters Number (%)
Pre-intervention data		
None	**66 (1.6%)**	
Centre (UFWC)	**0**	
Dispensary	**154(3.8%)**	
Maternity hospital	**0**	
Mobile clinic	**100(2.5%)**	
Those run by NGOs, etc.	**24(0.6%)**	
Local practitioners (unqualified)	**6(0.1%)**	
Private hospital	**497(12.4)**	
Private practitioners	**313(7.8%)**	
Ayurvedic doctors	**9(0.2%)**	
Homeopathic doctors	**1**	
Unani doctors	**0**	
Traditional healer	**3(0.1%)**	
Govt. hospital	**2880(71.9%)**	
Others	**8(0.2%)**	
Do not know	**0**	
Post-intervention data		
None	**0**	**3 (0.5%)**
Centre (UFWC)	**1 (0.1%)**	**3 (0.5%)**
Dispensary	**29 (6.6%)**	**17 (3.9%)**
Maternity hospital	**23 (5.2%)**	**20 (4.5%)**
Mobile clinic	**0**	**7 (1.1%)**
Those run by NGOs, etc.	**104 (23.6%)**	**2 (0.5%)**
Local practitioners (unqualified)	**13 (3%)**	**64 (15.2%)**
Private hospital	**200 (45.5%)**	**173 (39.3%)**

Private practitioners	**232 (52.7%)**	**196 (44.5%)**
Ayurvedic doctors	**1 (0.1%)**	**5 (0.8%)**
Homeopathic doctors	**1 (0.1%)**	**0**
Unani doctors	**0**	**0**
Traditional healer	**0**	**0**
Govt. hospital	**284 (64.5%)**	**132 (30%)**
Others	**0**	**0**
Do not know	**9 (2.0%)**	**19 (4.3%)**

In the pre intervention data, for the distribution of information on health facilities available at participant locality it was found that majority of the respondents (71.9 per cent) knew about Government hospitals present nearby, followed by private hospitals and private practitioners (12.4 and 7.8 per cent respectively). 2.5 per cent of the respondents were aware of the mobile clinics also.



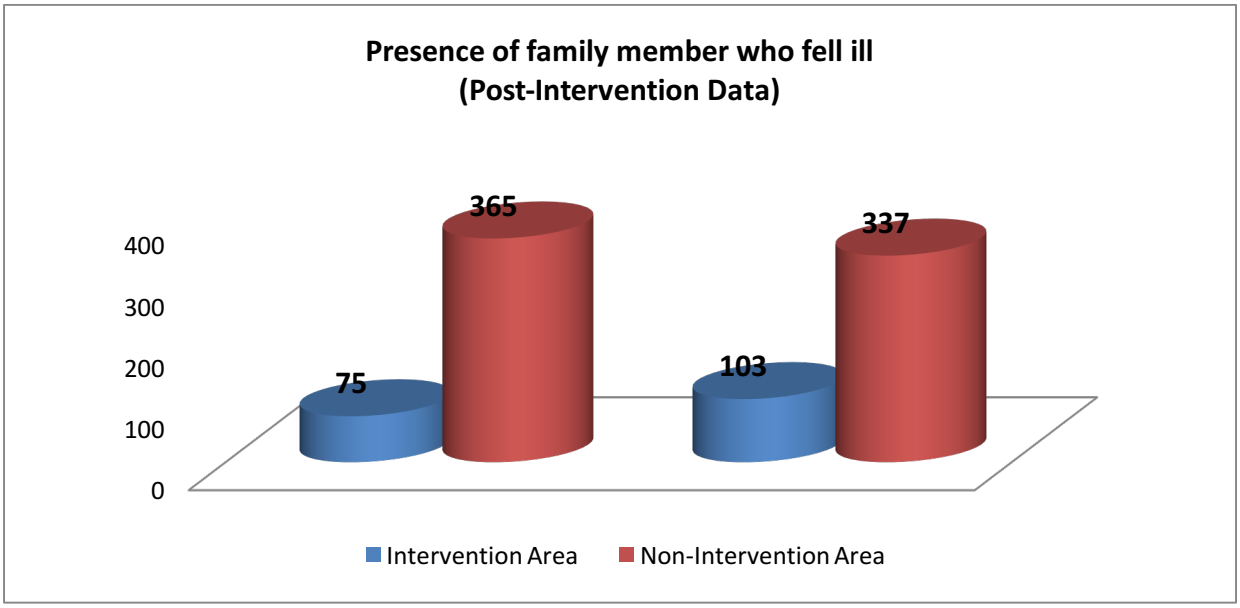
If we compare the post intervention data from Intervention and control clusters, out of 440 respondents in each cluster the distribution of information on health facilities available at participant locality it was found that the percentage of respondents knowing about Government Hospitals nearby in the intervention area (64.5 per cent) is more than 2 times than non-intervention area. Knowledge regarding Private hospitals and Practitioners is also higher in Intervention area.(45.5 and 52.7 per cent respectively).

It is to be noted that the knowledge regarding availability of unqualified private practitioners is 5 times more in Non-Intervention area.

Table 17: Distribution of households based on the presence of family members who fell ill in the last 1 year

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data		
Yes, respondent or other family member fell ill	**475(11.9%)**	
No	**3533(88.1%)**	
Post-intervention data		
Yes, respondent or other family member fell ill	**75 (17.0%)**	**103 (24.3%)**
No	**365 (83%)**	**337(76.6.%)**

In the pre intervention data, for the distribution of presence of family members who fell ill in the last 1 year, it was found that 88.1 per cent of the respondents did not fell ill while only 11.9 per cent respondents/ family members fell ill.



If we compare the post intervention data from Intervention and control clusters, out of 440 respondents in each cluster the distribution of presence of family members who fell ill in the last 1 year, the percentage of respondents/family members falling ill is lesser in Intervention area (17 per cent) as compared to Non-Intervention Area (24.3 per cent).

	Whether any of your family member or you fell ill in the past one year? (Intervention)			
	yes	no	not relevant	**Total**
Agriculture	4 (0.9%)	36 (8.1%)	2 (0.4%)	**40 (9.1%)**
Bricklin	6 (1.4%)	24 (5.5%)	0	**30 (6.8%)**
Construction	7 (1.6%)	93 (21.2%)	0	**100 (22.8%)**
Daily wage labourers	14 (3.2%)	40 (9.1%)	0	**54 (12.3%)**
Furniture	5 (1.1%)	15 (3.4%)	1 (0.2%)	**20 (4.5%)**
Hotel	7 (1.6%)	33 (7.5%)	0	**40 (9.1%)**
Industry	11 (2.5%)	69 (15.7%)	2 (0.5%)	**80 (18.2%)**
Small Business	1 (0.2%)	15 (3.4%)	0	**16 (3.6%)**
Stone Quarry	20 (4.5%)	40 (9.1%)	0	**60 (13.6%)**
Total	**75 (17.0%)**	**365 (82.9%)**	5 (1.1%)	**440 (100.0%)**

If we see the sector-wise distribution, in the intervention area out of the total households were respondents/family members fell ill the majority of the respondents who fell ill were from the stone quarry sector (26.7 per cent of the respondents who fell ill) followed by Daily Wages and Industry sectors (18.7 per cent and 14.7 per cent respectively). 82 per cent of the respondents did not fell ill.

	Whether any of your family member or you fell ill in the past one year? (Non-Intervention)			
	yes	no	Not relevant	**Total**
Agriculture	7 (1.7%)	33 (7.8%)	0	**40 (9.1%)**
Bricklin	6 (1.4%)	24 (5.7%)	0	**30 (6.8%)**
Construction	20 (4.8%)	60 (14.2%)	0 (4.8%)	**100 (2.7%)**
Daily wage labourers	15 (3.5%)	30 (7.1%)	5 (1.1%)	**50 (11.3%)**
Furniture	6 (1.4%)	13 (3.1%)	1 (0.2%)	**20 (4.5%)**
Hotel	5 (1.2%)	35 (8.3%)	0	**40 (9.1%)**
Industry	24 (5.7%)	55 (13.0%)	1 (0.2%)	**80 (18.2%)**
Small Business	8 (1.9%)	12 (2.8%)	0	**20 (4.5%)**
Stone Quarry	12 (2.8%)	26 (6.1%)	5 (1.2%)	**60 (13.6%)**
Total	**103 (24.3%)**	**288 (68.1%)**	32 (7.6%)	**440 (100.0%)**

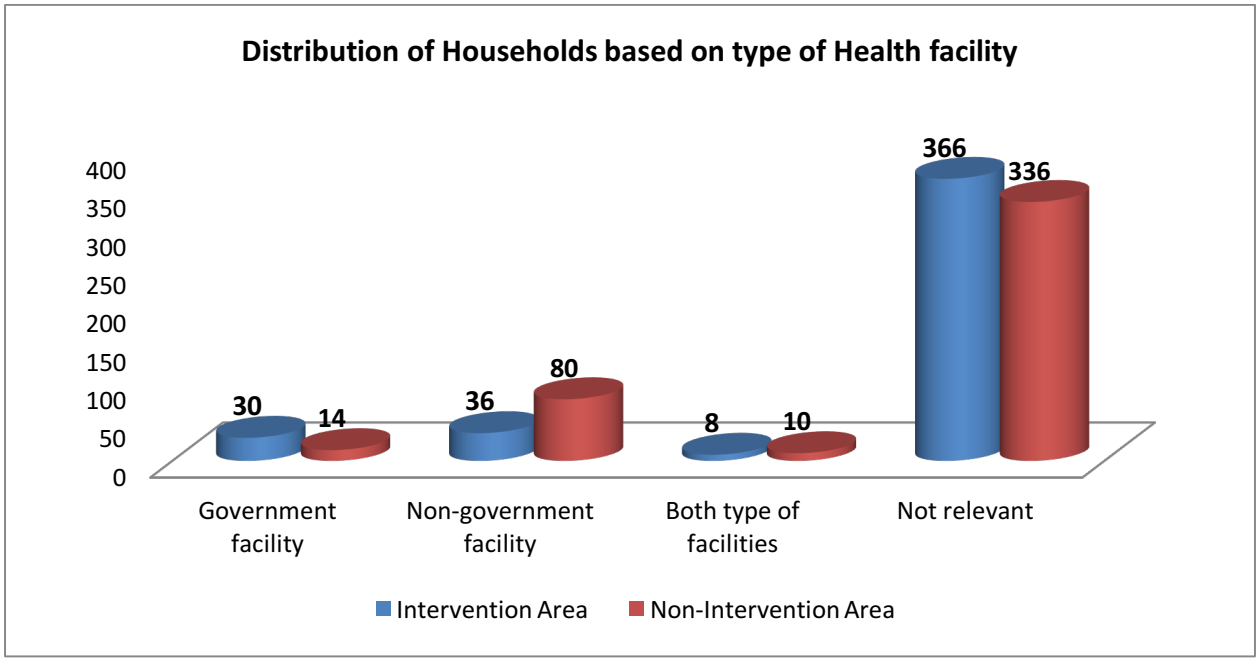
In the non-intervention area out of the total households were respondents/family members fell ill (N=103) the majority of the respondents who fell ill were from the industry sector (23.3 per cent of the respondents who fell ill) followed by Construction and Daily Wages sectors (19.4 per cent and 14.6 per cent respectively). 68.1 per cent of the respondents in the non-intervention area did not fell ill.

Table 18: Distribution of households based on the type of health facility respondents/their family members use in case of illness during last one year

	Intervention clusters Number (%)#	Control clusters Number (%)#
Pre-intervention data		
Government facility	**N/A**	
Non-government facility	**N/A**	
Both type of facilities	**N/A**	
Post-intervention data		
Government facility	**30 (6.8%)**	**14 (3.2%)**
Non-government facility	**36 (8.2%)**	**80 (18.2%)**
Both type of facilities	**8 (1.8%)**	**10 (2.3%)**
Not relevant	**366 (83.2%)**	**336 (76.4%)**

***No data available in pre-intervention area**

Data for the pre intervention phase is not available for the above mentioned variable. If we compare the post intervention data from Intervention and control clusters, out of 440 respondents in each cluster the distribution of households based on the type of health facilityvisited.



The percentage of respondents visiting government facilities in intervention area (6.8 per cent) is higher than in Non- intervention area (3.2 per cent). The respondents visiting non-government facility is higher in Non-intervention area (18.2 per cent) than in intervention area (6.2 per cent).

If we see the sector-wise distribution, in the intervention area out of the total households cluster the distribution of respondents based on the type of health facilityvisited, out of 30 migrants visiting government facility majority are from Industry and Stone quarry sector (33.3 per cent of the respondents visiting government facility in each sector). All sectors confessed that they used a non-government health facility as their regular medical care which less than 1.4 percent each. Only Daily Wage Labourers and Stone Quarry sector who used both (0.5 percent and 1.4 percent respectively).

	Type of healthcare facility:(Investigator has to classify the health facility whether it is govt. or not)- Intervention				
	Government	Not government	Both	Not Relevant	**Total**
Agriculture	1 (0.2%)	3 (0.7%)	0	36 (8.2%)	40 (9.1%)
Bricklin	3 (0.7%)	3 (0.7%)	0	24 (5.5%)	30 (6.8%)
Construction	1 (0.2%)	6 (1.4%)	0	93 (21.2%)	100 (22.8%)
Daily wage labourers	3 (0.7%)	9 (2.0%)	2 (0.5%)	40 (9.1%)	54 (12.3%)
Furniture	2 (0.5%)	3 (0.7%)	0	15 (3.4%)	20 (4.5%)
Hotel	0	6 (1.4%)	0	34 (7.7%)	40 (9.1%)
Industry	10 (2.3%)	1 (0.2%)	0	68 (15.7%)	80 (18.2%)
Small Business	0	1 (0.2%)	0	15 (3.4%)	16 (3.6%)
Stone Quarry	10 (2.3%)	4 (1.0%)	6 (1.4%)	40 (9.1%)	60 (13.6%)
Total	30 (6.8%)	36 (8.2%)	8 (1.8%)	366 (83.2%)	440 (100.0%)

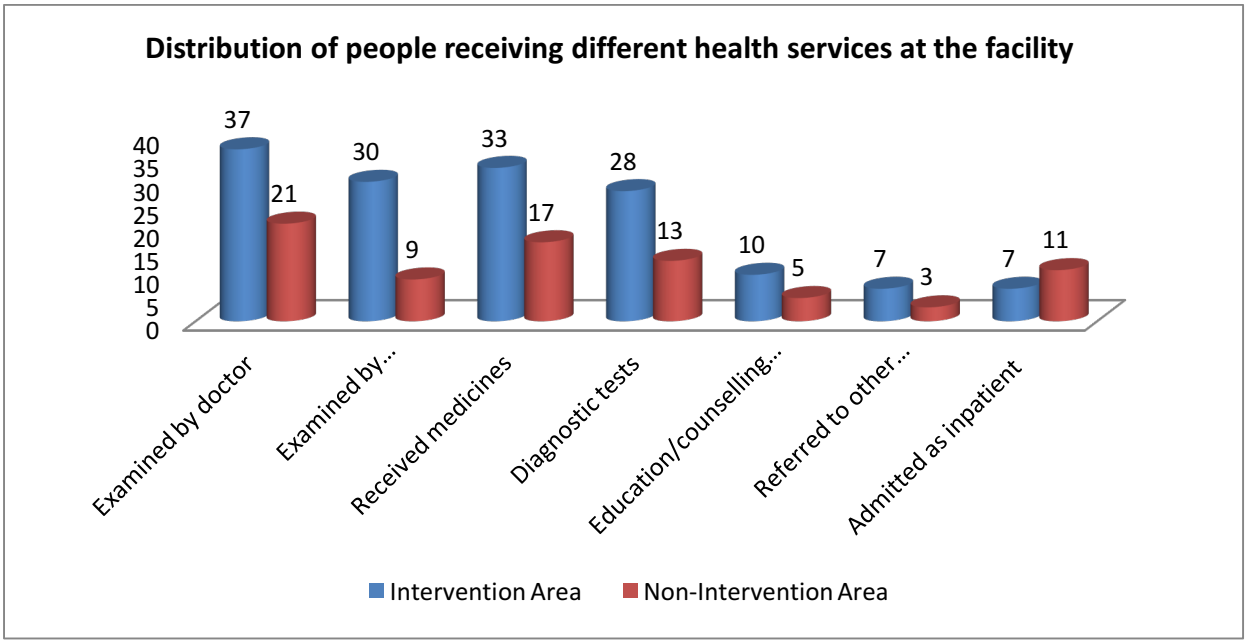
	Type of healthcare facility:(Investigator has to classify the health facility whether it is govt. or not)- Non Intervention				
	Government	Not government	Both	Not Relevant	**Total**
Agriculture	1 (0.2%)	6 (1.4%)	0	33 (7.5%)	40 (9.1%)
Bricklin	3 (0.7%)	3 (0.7%)	0	24 (5.5%)	30 (6.8%)
Construction	2 (0.5%)	15 (3.4%)	2 (0.4%)	81 (9.4%)	100 (22.7%)
Daily wage labourers	2 (0.5%)	12 (2.7%)	1 (0.2%)	35 (8.0%)	50 (11.3%)
Furniture	0	4 (0.9%)	0	16 (3.6%)	20 (4.5%)
Hotel	0	5 (1.1%)	0	35 (8.0%)	40 (9.1%)
Industry	5 (1.1%)	16 (3.6%)	1 (0.2%)	58 (13.2%)	80 (18.2%)
Small Business	1 (0.2%)	2 (0.5%)	5 (1.1%)	12 (2.7%)	20 (4.5%)
Stone Quarry	0	17 (3.9%)	1 (0.2%)	42 (9.5%)	60 (13.6%)
Total	14 (3.2%)	80 (18.2%)	10 (2.3%)	336 (76.4%)	440 (100.0%)

In the non-intervention area, around 3.2 percent respondents used a government health facility, and 18.2 percent used a non-government health facility. All sectors confessed used a non-government health facility with Stone Quarry sectors as the biggest contributor (28.3 percent, N=60). Only 6 of 9 sectors used a government health facility which less than 1.1 percent each. There were 5 sectors used both as their regular medical care which less than 1.1 percent each.

Table 19: Proportion of people received different services at government health facilities during their visit in last one year.

	Intervention	Control
Pre-intervention data		
Examined by doctor	**283**	
Examined by nurse/other staff	**39**	
Received medicines	**52**	
Diagnostic tests	**0**	
Education/counselling/information related to health	**0**	
Referred to other hospital	**0**	
Admitted as inpatient	**0**	
Others	**0**	
Post-intervention data		
Examined by doctor	**37 (97.4%)**	**21 (87.5%)**
Examined by nurse/other staff	**30 (78.9%)**	**9 (37.5%)**
Received medicines	**33 (86.8%)**	**17 (70.8%)**
Diagnostic tests	**28 (73.7%)**	**13 (54.2%)**
Education/counselling/information related to health	**10 (26.3%)**	**5 (20.8%)**
Referred to other hospital	**7 (18.4%)**	**3 (12.5%)**
Admitted as inpatient	**7 (18.4%)**	**11 (45.8%)**
Others	**0**	**0**

It is a multiple response answer, in the pre intervention data if we see the distribution of people receiving different health services at the facility, 283 respondents were examined by the doctor, while 39 respondents were also examined by the nurse and other staff. Only 52 respondents received medicines.



If we compare the post intervention data from Intervention and control clusters, out of 440 respondents in each cluster for people receiving different health services at the facility, the percentage of respondents examined by the doctor at Intervention area (97.4 per cent) is better than in Non-Intervention area (87.5 per cent). Similarly respondents examined by nurse and other staffs are also higher in Intervention area (78.09 per cent) as compared to Non-Intervention area (37.5 per cent). 86.8 per cent of the respondents received medicine in the Intervention area while only 70.8 per cent received medicines in Non-Intervention area. Distribution of Diagnostics, Education/counselling and referrals are also higher in Intervention area.

Table 20: Proportion of people felt difficulty in getting medical treatment from government health facility during the last illness episode (during last 6 months)

	Intervention	Control
Pre-intervention data		
Not felt any difficulty	**259**	
Lack/non availability of money	**7**	
Health facility is far away	**14**	
Had to wait for longer duration	**43**	
Did not receive medicines	**7**	
Did not receive diagnostic tests	**21**	
Delay in getting test reports	**3**	
Did not get referral	**0**	
Not seen by the doctor	**13**	
Other difficulties	**7**	
Post-intervention data		
Not felt any difficulty	**32(84.2%)**	**15(62.5%)**
Lack/non availability of money	**2(5.3%)**	**3(12.5%)**
Health facility is far away	**1(2.6%)**	**3(12.5%)**
Had to wait for longer duration	**4(10.5%)**	**4(16.7%)**
Did not receive medicines	**2(5.3%)**	**1(4.2%)**
Did not receive diagnostic tests	**1(2.6%)**	**0**
Delay in getting test reports	**1(2.6%)**	**0**
Did not get referral	**1(2.6%)**	**0**
Not seen by the doctor	**1(2.6%)**	**0**
Other difficulties	**1(2.6%)**	**0**

It is a multiple response answer, in the pre intervention data if we see the distribution of people who felt difficulty in getting medical treatment from government health facility, 259 respondents did not felt any difficulty, 7 respondents felt lack of money as a problem, 14 respondents felt that health facility is far, 43 respondents felt that the health facility is far away. While for 21 respondents diagnostic tests were not done.

If we compare the post intervention data from Intervention and control clusters, out of 440 respondents in each cluster who felt difficulty in getting medical treatment from government health facility, 84.2 per cent respondents in the Intervention area did not feel any difficulty (N=38), while 62 per cent in the non-intervention area did not fell any difficulty(N=24). Six respondent in the intervention area felt problem (N=38), out of which majority had to wait for long duration (10.5 per cent). While in Non-Intervention area, 9 respondents felt problem (N=24), of which majority had to wait for long duration (16.7 per cent).

Table 21: Proportion of people felt the availability of basic amenities at the government health facility – drinking water

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data		
Yes, drinking water is available	**335 (90.1%)**	
Not available	**4 (1.1%)**	
Don't know	**33 (8.9%)**	
Post-intervention data		
Yes, drinking water is available	**37 (97.4%)**	**20 (83.3%)**
Not available	**1(2.6%)**	**4(16.7%)**
Don't know	**0**	**0**

In the pre intervention data if we see the distribution of availability of drinking water at health facility, out of total respondent 90.1 per cent migrants responded positively, while 8.9 per cent didn't knew about it. If we compare the post-intervention data, almost all the respondent visiting health facility in the Intervention area (97.4, N=38) responded positively on availability of drinking water, while in non-intervention area out of 24 migrants visiting health facility 20 responded positively.

Table 22: Proportion of people felt the availability of basic amenities at the government health facility – toilets

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data		
Yes, toilets is available	**309 (83.1%)**	
Not available	**17 (4.6%)**	
Don't know	**3675 (12.4%)**	
Post-intervention data		
Yes, toilets is available	**30 (78.9%)**	**18 (75%)**
Not available	**8 (21.1%)**	**6 (25%)**
Don't know	**0**	**0**

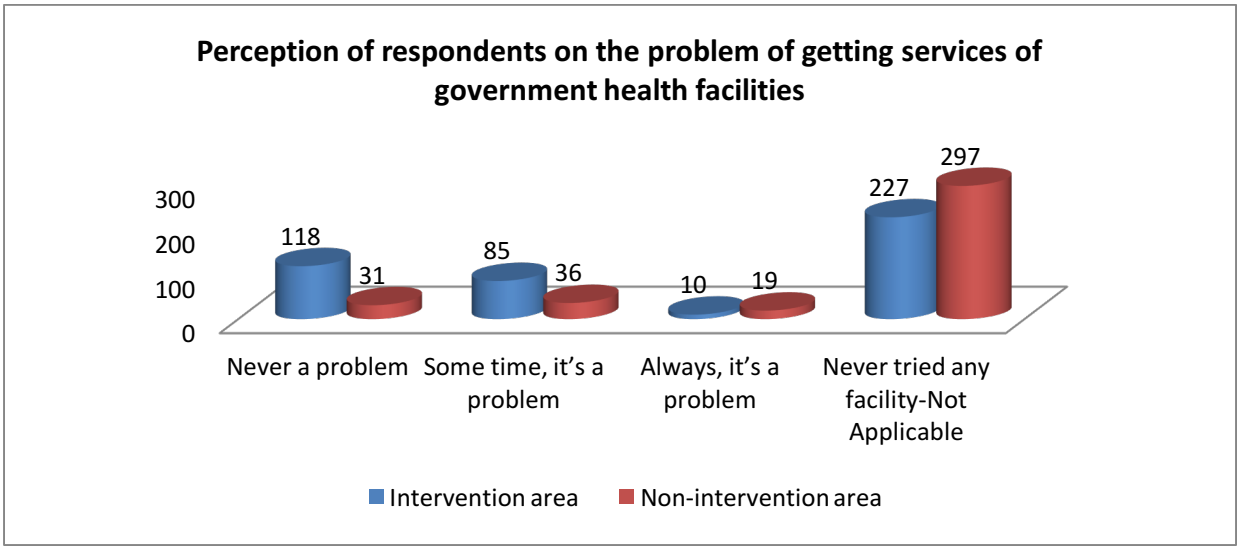
In the pre intervention data if we see the distribution of availability of toilets at health facility, out of total respondent 83.1 per cent migrants responded positively, while 12.4 per cent didn't knew about it. If we compare the post-intervention data, majority of the respondent visiting health facility in the Intervention area (78.9 %, N=38) responded positively on availability of toilets, while in non-intervention area out of 24 migrants visiting health facility 18 responded positively.

Table 23: Perception of respondents on the problem of getting services of government health facilities other than one they usually avail from

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data		
Never a problem	**5 (0.1%)**	
Some time, it's a problem	**226 (5.6%)**	
Always, it's a problem	**186 (4.6%)**	
Never tried any facility-Not applicable	**3591 (89.6)**	
Post-intervention data		
Never a problem	118 (26.8%)	31 (7.4%)
Some time, it's a problem	85 (19.3%)	36 (8.6%)
Always, it's a problem	10 (2.3%)	19 (4.5%)
Never tried any facility-Not Applicable	227 (51.8%)	297 (79.4%)

In the pre-intervention area majority respondents (89.6 percent) never tried any facilities, followed by 5.6 per cent respondents who sometimes got a problem of getting services of government health facilities. Meanwhile in the intervention area more than half respondents (51.6 percent) never tried any facilities, and another 26.8 percent respondents confessed never getting any problem of government health facilities. In the non-intervention area 79.4 percent respondents never tried any facilities, and followed by 8.6 percent respondents got any problem of government health facilities for sometimes.

If we see the sector-wise distribution, in the intervention area more than half respondents (51.4 per cent) never tried any facilities, and followed by 26.8 per cent respondents never got any problem to getting services of government health facility. It was only less than 2.3 per cent respondents who always got problem to get services of government health facility.



Meanwhile Industry sector has the biggest value (50 per cent) for never got any problem to get services of government health facility. Almost all sectors (8 of 9 sectors) never got any problem to get services of government health facility. Then 40 per cent of Furniture sector got problem to get services of government health facility for sometimes. Around 6 of 9 sectors always got problem to get services of government health facility, with the biggest value comes from Construction sector (5 per cent). 100 per cent respondents of Hotel sector never tried any facility yet.

	Over the last 6 months, how big a problem was to get services of government health facilities other than the one you usually avail from? - Intervention					
	Never a problem	**Sometimes**	**Always**	**Never tried**	**N/A**	**Total**
Agriculture	5 (1.1%)	4 (0.9%)	1 (0.2%)	30 (6.8%)	0	40 (9.1%)
Bricklin	12 (2.7%)	7 (1.6%)	0	11 (2.5%)	0	30 (6.8%)
Construction	26 (5.9%)	10 (2.2%)	5 (1.1%)	58 (13.2%)	1 (0.2%)	100 (22.8%)
Daily wage labourers	6 (1.4%)	11 (2.5%)	1 (0.2%)	36 (8.2%)	0	54 (12.3%)
Furniture	6 (1.4%)	8 (1.8%)	1 (0.2%)	5 (1.1%)	0	20 (4.5%)
Hotel	0	0	0	40 (9.1%)		40 (9.1%)
Industry	40 (9.1%)	19 (4.3%)	1 (0.2%)	20 (4.5%)	0	80 (18.2%)
Small Business	6 (1.4%)	3 (0.7%)	0	7 (1.6%)	0	16 (3.6%)
Stone Quarry	18 (3.8%)	23 (5.2%)	1 (0.2%)	19 (4.4%)	0	60 (13.6%)
Total	118 (26.8%)	85 (19.3%)	10 (2.3%)	226 (51.4%)	1 (0.2%)	440 (100.0%)

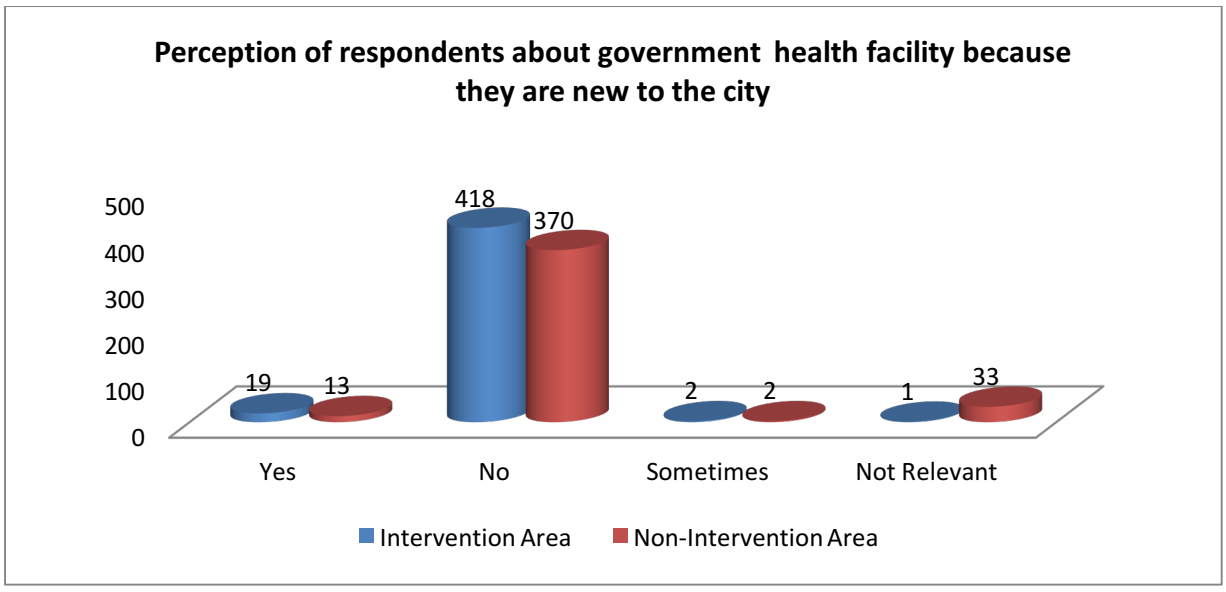
In the non-intervention area, more than half (71.1 per cent) respondents always got problem to get services of government medical care, and followed by 8.6 per cent got problem to get services of government health facility for sometimes. Meanwhile only 6 of 9 sectors never got problem to get services of government health facility, with the biggest contributor was Industry sector (16 per cent, N=80). Then 7 of 9 sectors sometimes got problems to get services of government health facility. It also noted that 12 per cent of Construction sector as the biggest value at the same category. 81.7 per cent respondents from Stone Quarry sector always got problem to get services of government health facility. Then 100 per cent respondents from Furniture and Hotel sector never tried any facilities yet.

	Over the last 6 months, how big a problem was to get services of government health facilities other than the one you usually avail from?- Non Intervention					
	Never a problem	Sometimes	Always	Never tried	Not applicable	**Total**
Agriculture	0	1 (0.2%)	1 (0.2%)	38 (9.1%)	0	40 (9.1%)
Bricklin	4 (1.0%)	5 (1.2%)	2 (0.5%)	19 (4.5%)	0	30 (6.8%)
Construction	1 (0.2%)	12 (2.9%)	3 (0.7%)	57 (13.7%)	21 (5.0%)	100 (22.7%)
Daily wage labourers	4 (1.0%)	8 (1.9%)	2 (0.5%)	12 (2.8%)	8 (1.9%)	50 (11.3%)
Furniture	0	0	0	20 (4.8%)	0	20 (4.5%)
Hotel	0	0	0	40 (9.6%)	0	40 (9.1%)
Industry	13 (3.1%)	6 (1.4%)	7 (1.7%)	53 (12.7%)	1 (0.2%)	80 (18.2%)
Small Business	6 (1.4%)	1 (0.2%)	4 (1.0%)	9 (2.2%)	0	20 (4.5%)
Stone Quarry	3 (0.7%)	3 (0.7%)	49 (11.7%)	49 (11.7%)	5 (1.2%)	60 (13.6%)
Total	31 (7.4%)	36 (8.6%)	19 (4.5%)	297 (71.1%)	35 (8.3%)	440 100.0%)

Table 24: Perception of respondents that the problems at government health facility are because of these people are newer to the city:

	Intervention	Control
Pre-intervention data (no such variables asked in pre-intervention phase)		
Yes	**N/A**	
No	**N/A**	
Sometimes	**N/A**	
Post-intervention data		
Yes	**19 (4.3%)**	**13 (3.1%)**
No	**418 (95.0%)**	**370 (88.5%)**
Sometimes	**2 (0.4%)**	**2 (0.5%)**
Not Relevant	**1 (0.2%)**	**33 (7.9%)**

Data for the pre intervention phase is not available for the above mentioned variable. If we compare the post intervention data from Intervention and control clusters, out of 440 respondents in each cluster 95 per cent respondents in the intervention area did not feel that problems in the government health facilities are because they are new to the city, while 88.5 per cent felt the same in non-intervention area. Only 4.3 per cent respondents felt problems in Intervention area because they were newer to the city, while 3.1 per cent respondents in the non-intervention area felt the same.



	Do you think any of the problems are because of you are newer to the city? - Intervention				
	Yes	No	Sometimes	Not Relevant	**Total**
Agriculture	1 (0.2%)	39 (8.9%)	0	0	40 (9.1%)
Bricklin	0	30 (6.8%)	0	0	30 (6.8%)
Construction	11 (2.5%)	87 (19.9%)	1(0.2%)	1(0.2%)	100 (22.8%)
Daily wage labourers	0	54 (12.3%)	0	0	54 (12.3%)
Furniture	2 (0.5%)	18 (4.2%)	0	0	20 (4.5%)
Hotel	0	40 (4.1%)	0	0	40 (9.1%)
Industry	4 (0.9%)	75 (17.0%)	1 (0.2%)	0	80 (18.2%)
Small Business	0	16 (3.6%)	0	0	16 (3.6%)
Stone Quarry	1 (0.2%)	59 (13.4%)	0	0	60 (13.6%)
Total	19 (4.3%)	418 (95.0%)	2 (0.4%)	1 (0.2%)	440 (100.0%)

If we see the sector-wise distribution, in intervention area around 95 percent respondents disagreed with statement that problem in government health facility were caused by they as the new comer to the city, out of 4.3 per cent respondents saying they had problems majority were from construction sector (11 out of 19).

	Do you think any of the problems are because of you are newer to the city? - Non Intervention				
	Yes	No	Sometimes	Not Relevant	**Total**
Agriculture	6 (1.4%)	33 (7.9%)	1 (0.2%)	0	40 (9.6%)
Bricklin	0	29 (6.9%)	1 (0.2%)	0	30 (7.2%)
Construction	4 (0.9%)	69 (16.5%)	0	21 (5.0%)	94 (22.5%)
Daily wage labourers	2 (0.4%)	25 (6.0%)	0	7 (1.7%)	34 (8.1%)
Furniture	0	20 (4.8%)	0	0	20 (4.8%)
Hotel	0	40 (9.6%)	0	0	40 (9.6%)
Industry	0	80 (19.1%)	0	0	80 (19.1%)
Small Business	1 (0.2%)	19 (4.5%)	0	0	20 (4.8%)
Stone Quarry	0	55 (13.2%)	0	5 (1.2%)	60 (14.4%)
Total	13 (3.1%)	370 (88.5%)	2 (0.5%)	33 (7.9%)	418 (100.0%)

In non-intervention areaaround 88.5 percent respondents disagreed with statement that problem in government health facility were caused by they as the new comer to the city, out of 3.1 per cent respondents saying they had problems majority were from agriculture sector (6 out 13).

Details on refusal:

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data		
Number - completed	**4008**	
- incomplete	**0**	
- refused	**0**	
Post-intervention data		
Number - completed	**440**	**440**
- Incomplete	**0**	**0**
- refused	**0**	**0**

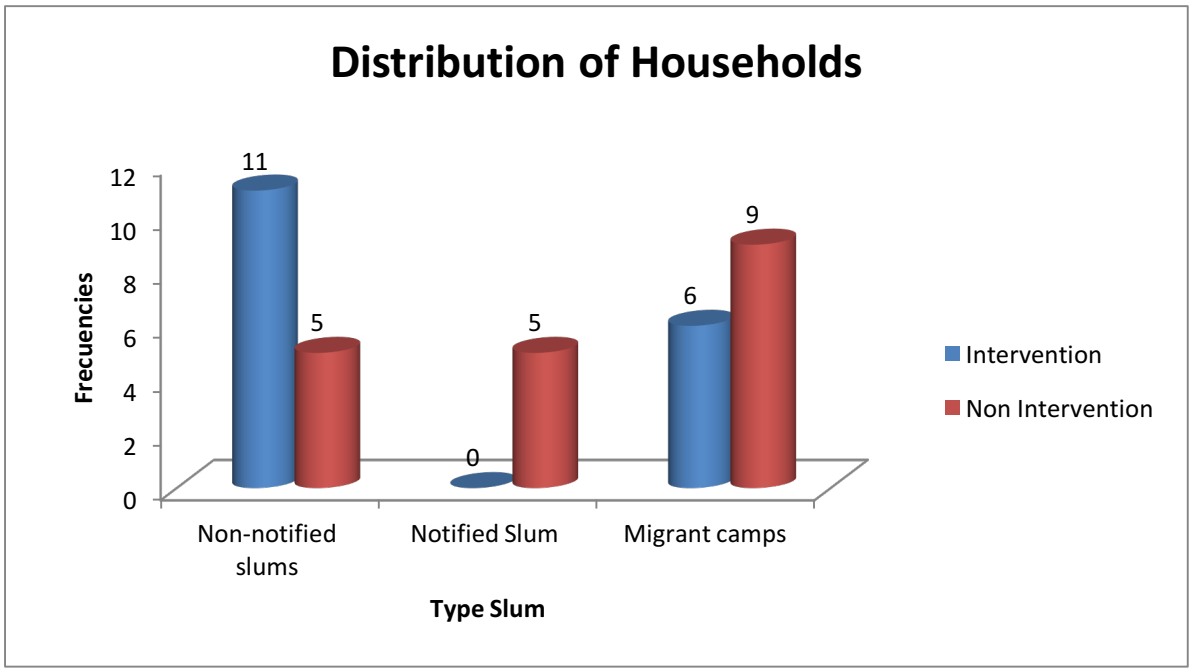
Reasons for refusal: (N/A)

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data (N/A)		
Post-intervention data (N/A)		

Part 2: Antenatal care Analysis

Table 1: Distribution of households by type of slum:

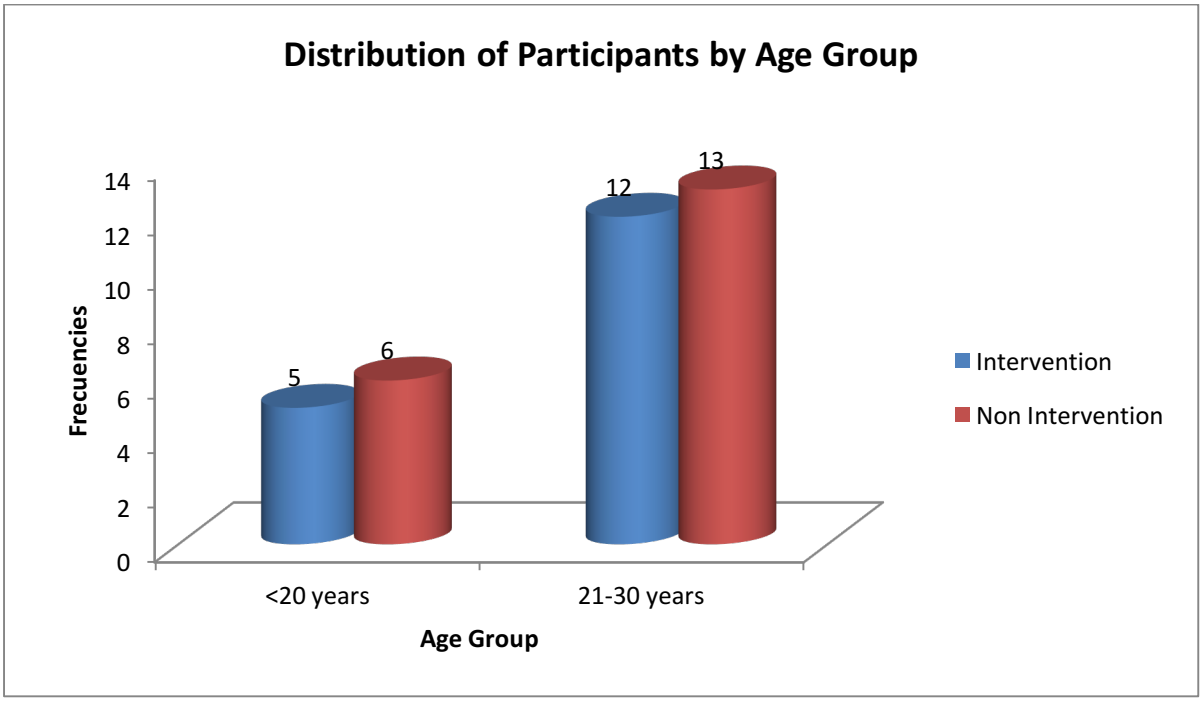
Duration of migration	Number of households (Intervention)	Number of households (Non-Intervention)
Non-notified slums	11(64.7%)	5(26.3%)
Notified Slum	0	5(26.3%)
Migrant camps	6(35.3%)	9(47.4%)
Total	17(100%)	19(100%)



In the study population, if we see the distribution of households by type of slums, 64.7 percent of migrants in intervention area live in non-notified slum while its only 26.3 per cent in non-intervention area. Under slum type migrant camps, the percentage of respondents were 35.3 per cent in intervention area and 47.4 per cent in non-intervention area.

Table 2: Age and gender-wise distribution of participants:

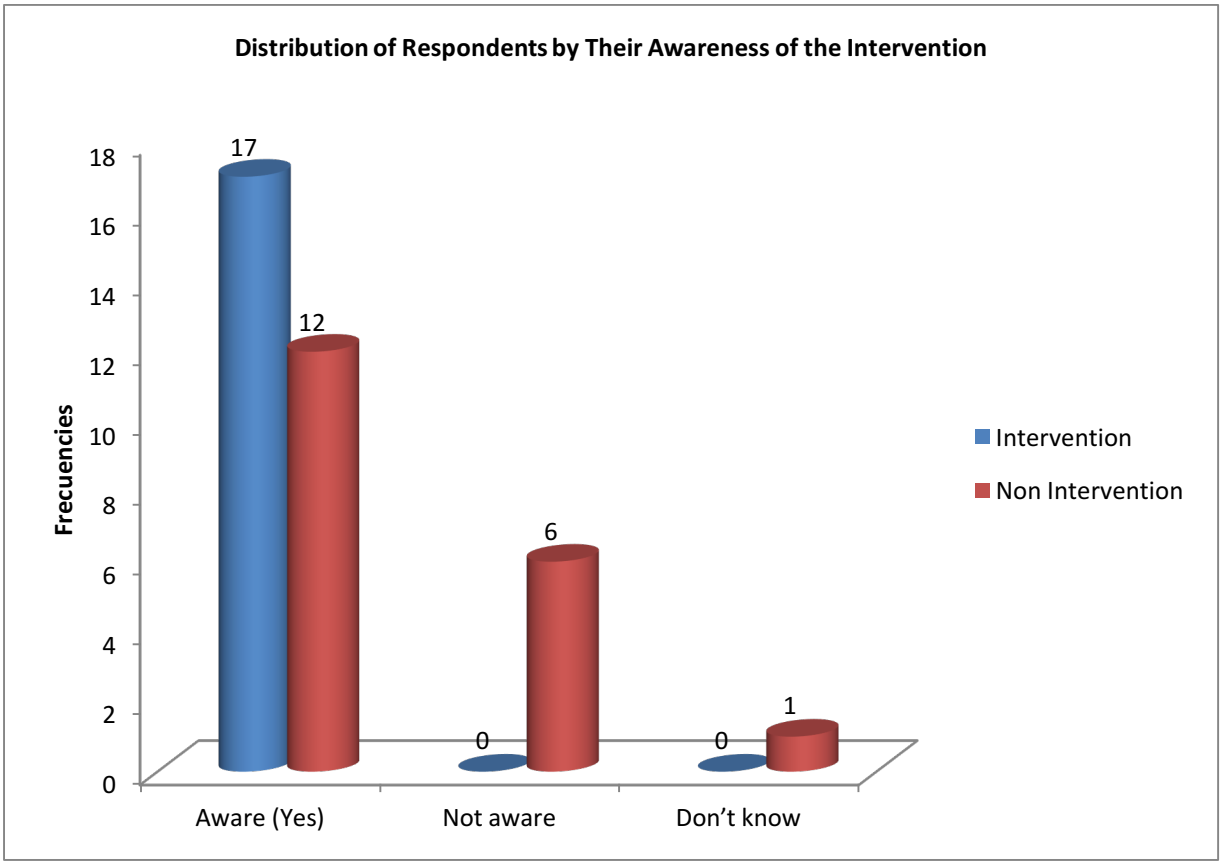
Age group	Intervention	Non-Intervention
≤20 years	5(29.4%)	6(31.6%)
21-30 years	12(70.6%)	13(68.4%)
Total	17(100%)	19(100%)



In the study population, if we see the distribution of respondents by age, under age group 21-30 years the distribution of respondents were 70.6 per cent in intervention area and 68.4 per cent in non-intervention area. Under age group less than equal to 20 years, the distribution of respondents were 29.4 per cent in intervention area and 31.6 per cent in non-intervention area.

Table 3: Distribution of respondents based on their awareness on the intervention:

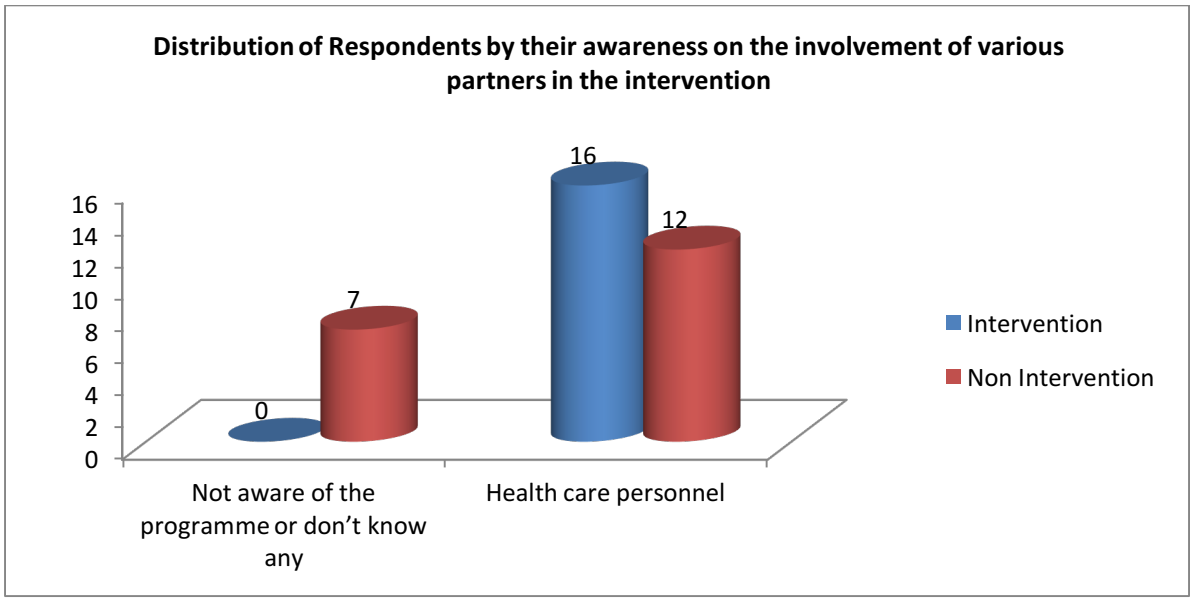
	Intervention	Non-Intervention
Aware (Yes)	17 (100%)	12(63.2%)
Not aware	0	6(31.6%)
Don't know	0	1(5.3%)
Total	17(100%)	19(100%)



In this study, we found that all of respondents (100 percent) in the intervention area are aware about the intervention. Meanwhile in the non-intervention area majority of the respondents (63.2 percent) are aware about the intervention, followed by 31.6 percent of respondents who were not aware about the intervention.

Table 4: Distribution of respondents based on their awareness on the involvement of various partners in the intervention

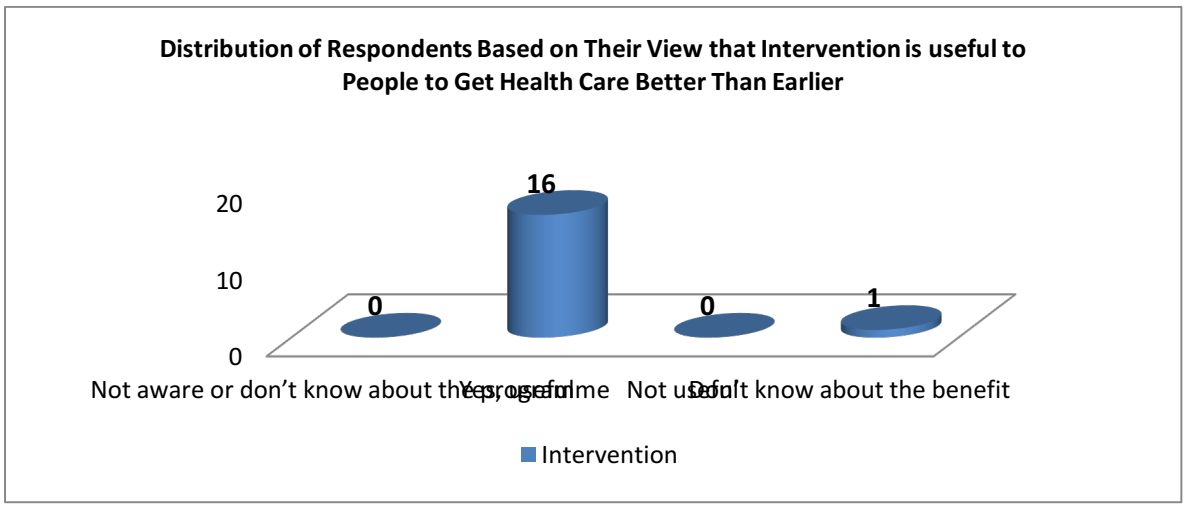
	Number-Intervention (%)#*	**Number-Non-Intervention(%)#***
Not aware of the programme or don't know any	0	7(36.8%)
Health care personnel	16(94%)	12(63.2%)
NGOs	16(94%)	0



It is a multiple response answer; if we see the distribution of awareness of involvement of various partners in order to make government facilities accessible, 94 percent respondents (N=17) in the intervention area responded positively that they are aware about the health care personnel (Doctors, ANM, outreach workers and ASHA) as well as NGOs who come in their locality. On the other hand, only 63.2 percent respondents in non-intervention area are aware about the health personnel visiting them.

Table 5: Distribution of respondents based on their view that intervention is useful to people to get health care better than earlier

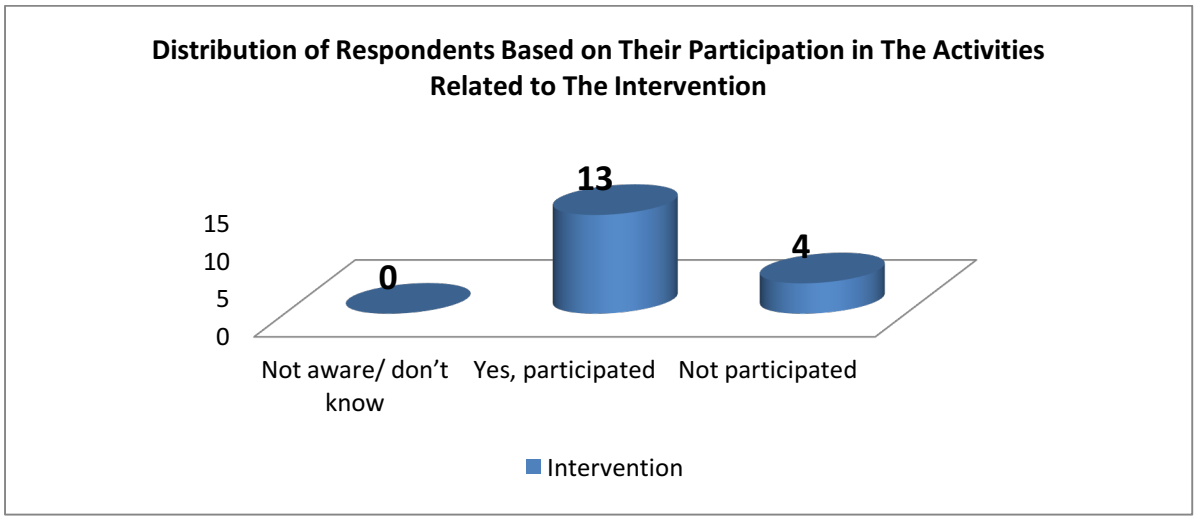
	Number (%)
Not aware of the programme or don't know about the programme/intervention	0
Yes, useful to improve health care	16(94%)
No, Not useful	0
Don't know about the benefit to the programme	1(6%)



In the study population, majority of the respondents (94 percent, N=17) found the intervention activities useful for them, While 6 percent of the respondents did not knew about the benefits.

Table 6: Distribution of respondents based on their participation in the activities related to the intervention

	Number (%)
Not aware of the programme or don't know about the programme/intervention	0
Yes, participated	13(76%)
No, not participated	4(24%)



If we see the distribution of participation in the intervention activities 76 percent of the respondents (N=17) participated actively, while 24 percent did not participate in any activity.

Table 7: Distribution of respondents based on their role in/contribution to the intervention

Activity/Role	Number (%)#
Executed/participated in community mobilization activities	13(100%)

In the study population, cent percent of the respondents (N=17) participated in executing community mobilization activities.

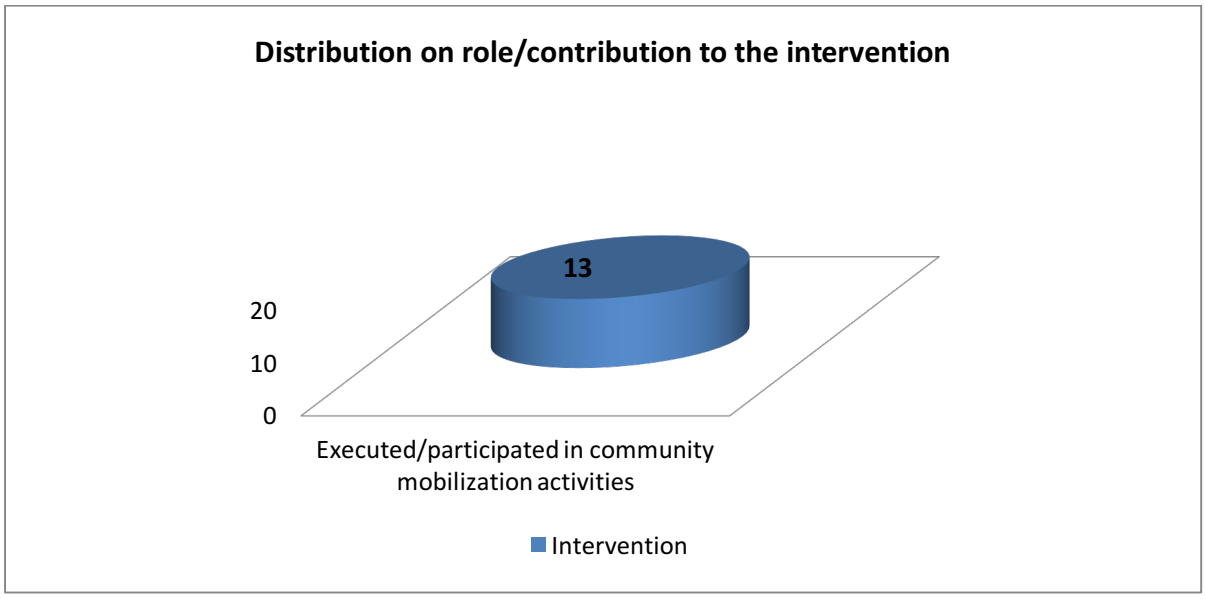


Table 8: Distribution of respondents by her stay in the present locality:

Duration of migration	Number of Women (%)
1-2 years	9(52.9%)
2-4 years	6(35.3%)
4-6 years	2(11.8%)
Total	17(100%)

In the study population, it was found that in majority of the respondents (52.9 percent) in intervention area migrated at the destination point for 1-2 years, followed by stay between two to four years (35.3 percent). Around 11.8 percent of the respondents have migrated for duration of 8 to 10 years.

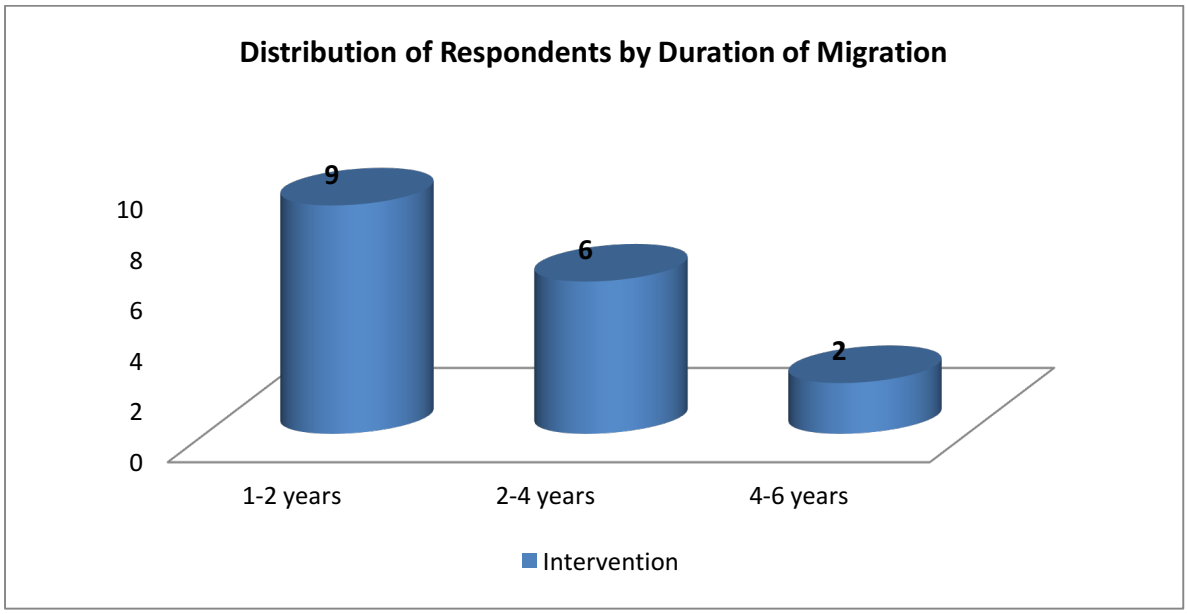
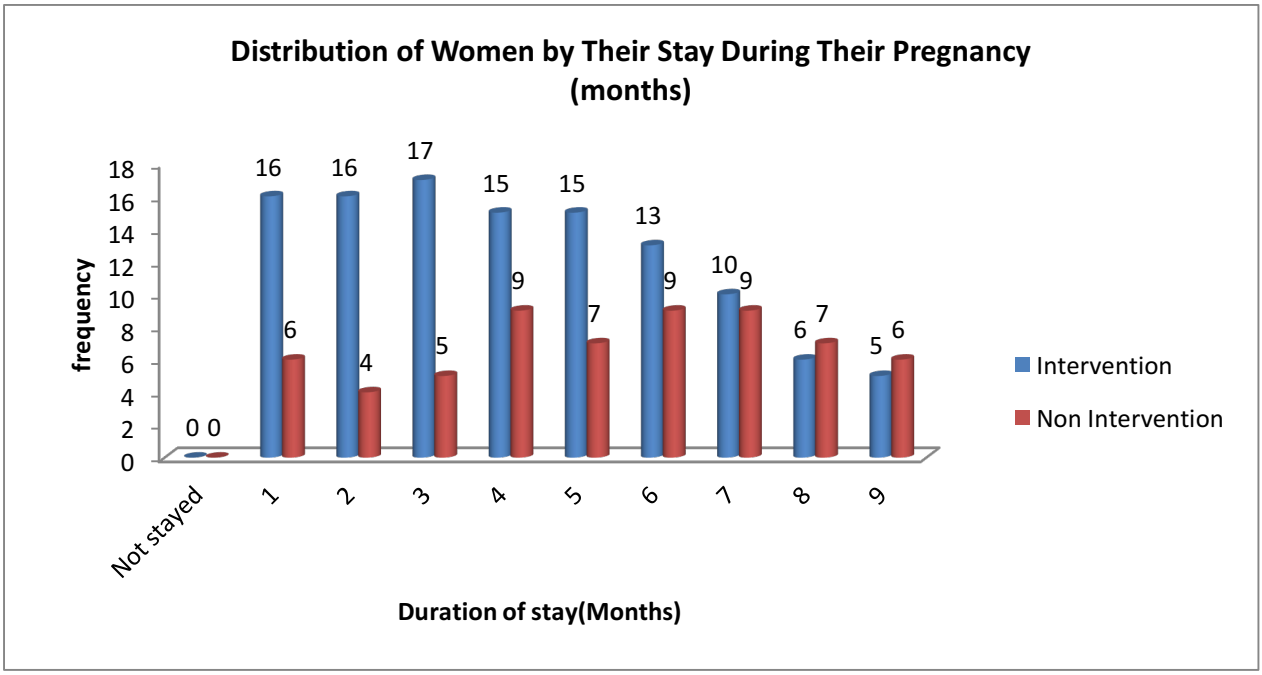


Table 9: Distribution of women based on their stay during their pregnancy (month-wise)

	Intervention clusters **Number (%)#**	**Control clusters** **Number (%)#**
Pre-intervention data (No variables present in the formative phase questionnaire regarding this)		
Not stayed in the present locality		
1st month	**N/A**	
2nd month	**N/A**	
3rd month	**N/A**	
4th month	**N/A**	
5th month	**N/A**	
6th month	**N/A**	
7th month	**N/A**	

8th month	**N/A**	
9th month	**N/A**	
Post-intervention data		
Not stayed in the present locality		
1st month	**16(94.1%)**	**6(31.6%)**
2nd month	**16(94.1%)**	**4(21.1%)**
3rd month	**17(100%)**	**5(26.3%)**
4th month	**15(88.2%)**	**9(47.4%)**
5th month	**15(88.2%)**	**7(36.8%)**
6th month	**13(76.5%)**	**9(47.4)**
7th month	**10(58.8%)**	**9(47.4)**
8th month	**6(35.3%)**	**7(36.8%)**
9th month	**5(29.4%)**	**6(31.6%)**

Pre-intervention data not available for the variables mentioned above. In the post intervention data, if we compare the distribution of women based on the stay during their pregnancy, all the women in intervention and non-intervention area stayed in the migrant site at some point of time during their pregnancy.



In the non-intervention area, majority of the respondents (47.4 per cent) stayed in the migrant site during 4th, 6th and 7th month of the pregnancy. Only 21.1 per cent respondent stayed during 2nd month of pregnancy.

In the intervention area, all the respondents stayed in the migrant site during the 3rd month of the pregnancy. In the 1st and 2nd month 94.1 per cent of the respondents stayed in the migrant site. The distribution of respondents stay decreases on the 8thand 9th month of the pregnancy were only 35.3 and 29.4 per cent respondent stayed in the intervention area.

Table 10: Distribution of women based on their stay during their pregnancy (month-wise)

	Intervention clusters **Number (%)#**	**Control clusters** **Number (%)#**
Pre-intervention data (No variables present in the formative phase questionnaire regarding this)		
Not stayed in the present locality	**(N/A)**	
1st trimester	**(N/A)**	
2nd trimester	**(N/A)**	
3rd trimester	**(N/A)**	
Post-intervention data		
Not stayed in the present locality	**0**	**0**
1st trimester	**65(382.4%)**	**24(126.3%)**
2nd trimester	**43(252.9%)**	**25(131.6%)**
3rd trimester	**21(123.5%)**	**22 (115.8%)**

Pre-intervention data not available for the variables mentioned above. In the post intervention data, if we compare the distribution of women based on the stay during their pregnancy (trimester-wise), under 1st trimester the percentage distribution in intervention area (382.4 per

cent) is almost 3 times than non-intervention area (126.3 per cent). In 2nd trimester the percentage distribution in intervention area (252.9 per cent) is almost two times than non-intervention area (131.6 per cent). Findings in the 3rd trimester are almost similar in both clusters.

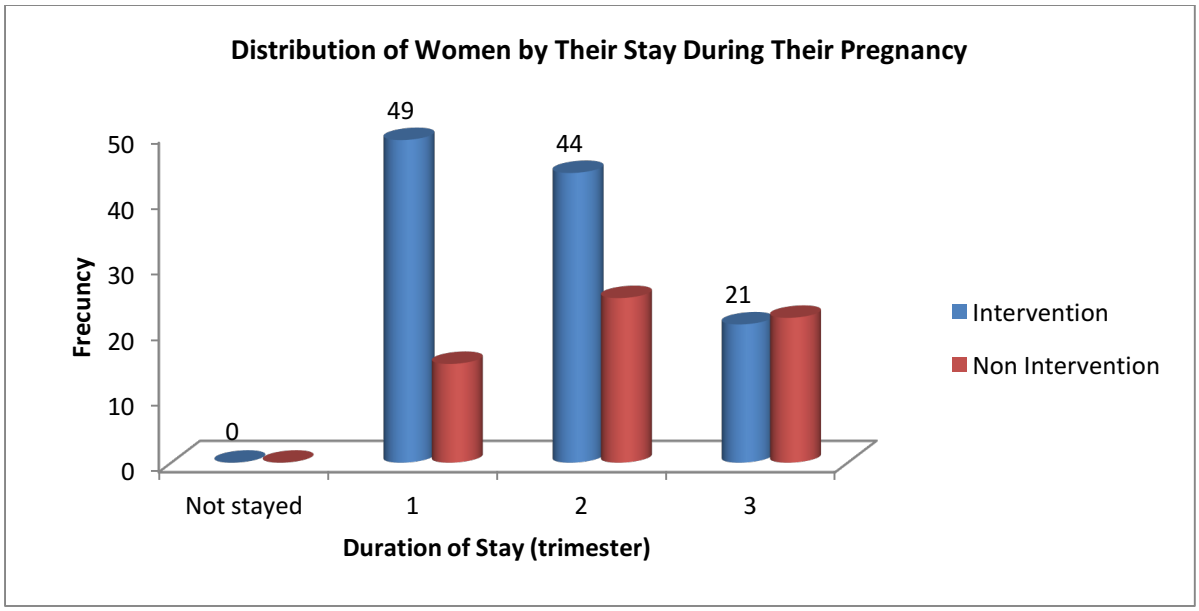
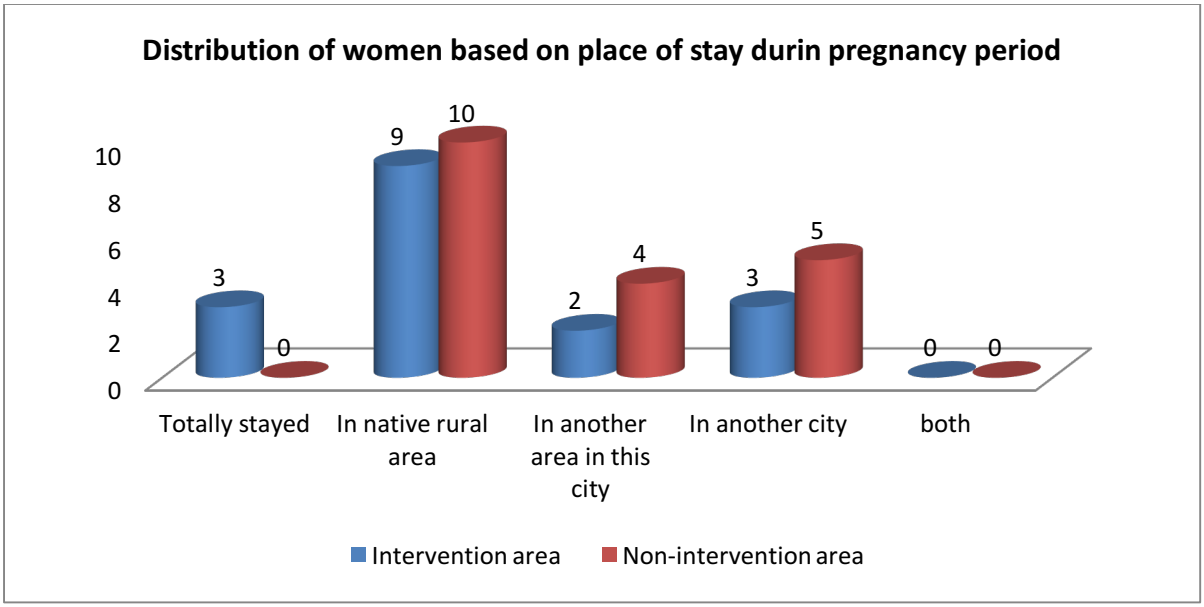


Table 11: Distribution of women based on their stay during the period other than that in which they stayed in the present location

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Totally stayed in the present location	**87(29.3%)**	
In native rural area	**203(68.4%)**	
Both	**7(2.4%)**	
Post-intervention data		
Totally stayed in the present location	**3(17.6%)**	**0**
In native rural area	**9(52.9%)**	**10(52.6%)**
In another area in this city	**2(11.8%)**	**4(21.1%)**
In another city	**3(17.6%)**	**5(26.3%)**

If we see the distribution of women based on the location of stay, in the pre-intervention data 68.4 per cent respondents stayed in their native rural area. While 29.3 per cent totally stayed in the present location.

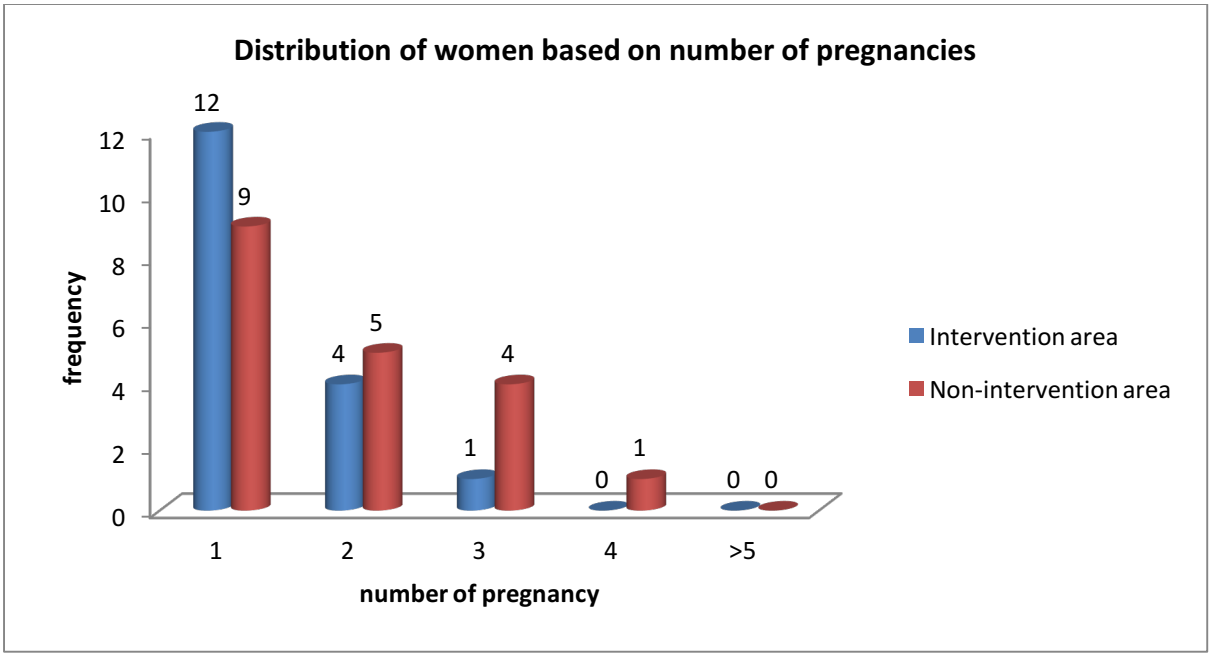


In post-intervention data, majority of respondents (52.9 percent and 52.6 percent) stayed in native rural area in intervention area and non-intervention area respectively during their pregnancy period, followed by 17.6 per cent and 26.3 per cent of respondents stayed in another city during their period in intervention area and non-intervention area respectively.

Table 12: Distribution of women based on the total number of pregnancies

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data		
One	**165(55%)**	
Two	**83(27.7%)**	
Three	**37(12.3%)**	
Four	**14(4.7%)**	
Five and more	**1(0.3%)**	
Post-intervention data		
One	**12(70.6%)**	**9(47.4%)**
Two	**4(23.5%)**	**5(26.3%)**
Three	**1(5.9%)**	**4(21.1%)**
Four	**0**	**1(5.3%)**
Five and more	**0**	**0**

In the pre-intervention data, for the distribution of women based on number of pregnancy it was found that majority of the women (55 per cent) had their 1st pregnancy followed by 27.7 per cent women with two pregnancies. 5 per cent of the women had 5 or more number of pregnancies.

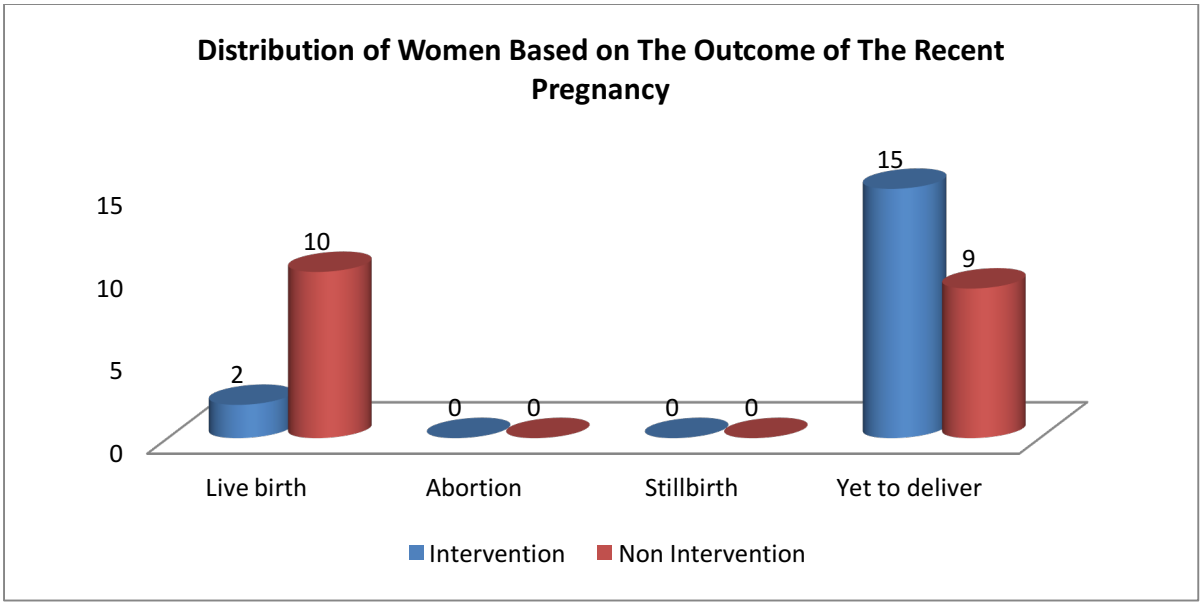


In the post intervention data, majority of migrants (70.6 per cent and 47.4 per cent) had only one pregnancy in intervention area and non-intervention area respectively, followed by 23.5 per cent and 26.3 per cent women with two pregnancies in intervention area and non-intervention area respectively.

Table 13: Distribution of women based on the outcome of the recent pregnancy:

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data		
Live birth	**188(96.7%)**	
Abortion	**6(3%)**	
Stillbirth	**2(0.3%)**	
Yet to deliver	**0**	
Post-intervention data		
Live birth	**2(11.8%)**	**10(52.6%)**
Abortion	**0**	**0**
Stillbirth	**0**	**0**
Yet to deliver	**15(88.2%)**	**9(47.4%)**

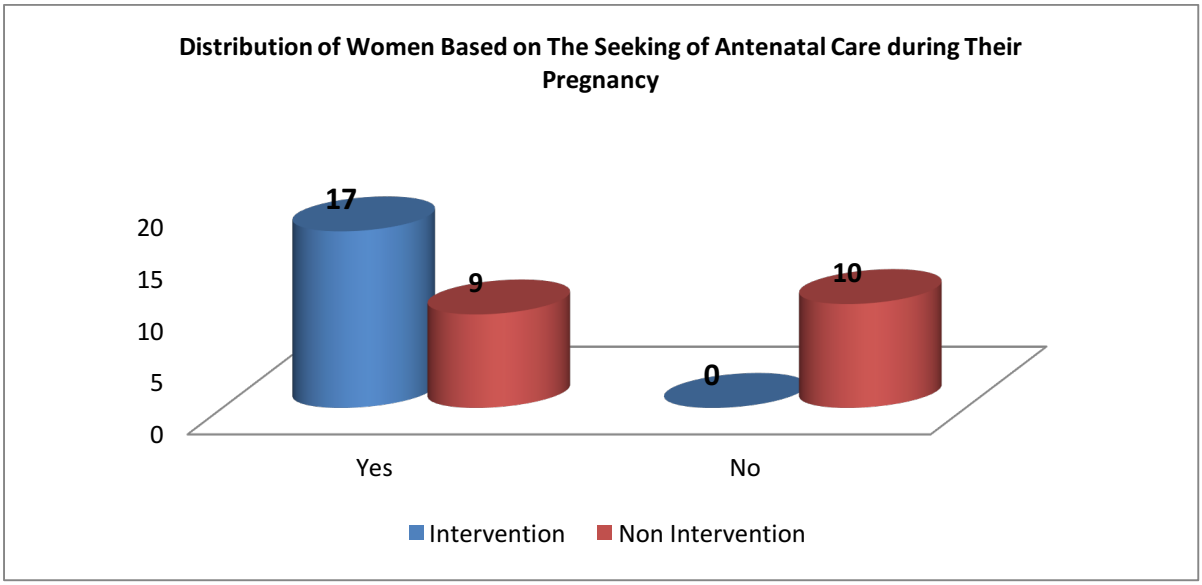
In the pre-intervention data, for the distribution of women based on outcome of pregnancy it was found that majority of the women (96.7 per cent) had live births. 3 per cent women had abortions.



Meanwhile in post intervention data majority of the women (88.2 per cent) in intervention area were yet to deliver for the outcome of their recent pregnancy, followed by 11.8 per cent of women who had live birth for the outcome of their pregnancy. In the non-intervention area around 52.6 per cent women had live birth for the outcome of their recent pregnancy, followed by 47.4 per cent women who were yet to deliver for the outcome of their recent pregnancy.

Table 14: Distribution of women based on the seeking of antenatal care (ANC) during their recent pregnancy

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Yes	**268(89.6%)**	
No	**31(10.4%)**	
Post-intervention data		
Yes	**17(100%)**	**9(47.4%)**
No	**0**	**10(52.6%)**



In pre intervention data, majority of the women (89.6 per cent) were seeking for antenatal care (ANC) during their pregnancy. Meanwhile in post intervention data, all the women respondents (100 per cent) were seeking antenatal care (ANC) during their pregnancy in intervention area, while only 47.4 per cent women said that they had availed antenatal care (ANC) during their pregnancy in the non-intervention area.

Table 15: Distribution of women based on the reason for not seeking ANC:

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data		
1. can't say	**2(6.5%)**	
2. family did not allow	**4(12.9%)**	
3. felt unnecessary	**11(35.5%)**	
money problem	**4(12.9%)**	
Health facility is far	**10(32.3%)**	
Post-intervention data		
1. not aware	**0**	**8 (80%)**
2. family did not allow	**0**	**0**
3. felt unnecessary	**0**	**2 (20%)**
4. money problem	**0**	**0**
5. Health facility is far	**0**	**0**

In the pre-intervention data, if we see the distribution of women based on the reason for not seeking ANC, it was found that 35.5 per cent women did not felt ANC services necessary. 32.3 per cent women said that health facility was far, while 12.9 per cent women each either had money problem or family did not allow them.

In pre intervention data, in intervention area all the women had availed ANC services, meanwhile in non-intervention area majority migrants (80 percent) were not aware about antenatal care (ANC) and followed by 20 percent migrants felt that antenatal care is unnecessary thing.

Table 16: Distribution of women based on the source of ANC they sought:

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data		
Sought ANC	**267**	
Nearby govt. health facility	**140(52.4%)**	
Mobile clinic	**3(1.1%)**	
Health worker	**32(12%)**	
Maternity hospital	**39(14.6%)**	
Qualified private practitioner	**19(7.1%)**	
Tertiary/specialised hospital	**24(9%)**	
Unqualified local practitioner	**1(0.4%)**	
NGO/Trust hospital	**6(2.2%)**	
Dai	**1(0.4%)**	
Others	**2(0.7%)**	
Post-intervention data		
Sought ANC	**17**	**8**
Nearby govt. health facility	**4(23.5%)**	**6(75%)**
Mobile clinic	**0**	**0**
Health worker	**2(11.8%)**	**1(12.5%)**
Maternity hospital	**0**	**1(12.5%)**
Qualified private practitioner	**11(64.7%)**	**0**
Tertiary/specialised hospital	**0**	**0**
Unqualified local practitioner	**0**	**0**
NGO/Trust hospital	**0**	**0**
Dai	**0**	**0**
Others	**0**	**0**

In pre-intervention data, out of 267 women seeking ANC services it was found that 52.4 per cent women sought services from nearby government health facility. 14.6 per cent women availed it from maternity hospital, while 9 per cent women took it from tertiary/ specialized hospitals. Around 7 per cent women sought ANC services from qualified private practitioners.

In post-intervention data, out of 17 and 8 women who sought ANC services in Intervention and non-intervention area respectively it was found that, majority of the women (23.5 per cent and 75 per cent respectively) were went to government health facility nearby as the source of ANC they sought in intervention area and non-intervention area respectively.

Table 17: Distribution of women based on the first visit for ANC (month-wise):

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Not sought ANC	**31(10.3%)**	
1st month	**4(1.3%)**	
2nd month	**115(38.3%)**	
3rd month	**98(32.6%)**	
4th month	**10(3.3%)**	
5th month	**31(10.3%)**	
6th month	**1(0.3%)**	
7th month	**7(2.3%)**	
8th month	**0**	
9th month	**3(1%)**	
Post-intervention data		
Not sought ANC	**0**	**10(52.6%)**
1st month	**3(17.6%)**	**2(10.5%)**
2nd month	**6(35.3%)**	**2(10.5%)**
3rd month	**6(35.3%)**	**2(10.5%)**
4th month	**1(5.9%)**	**2(10.5%)**
5th month	**1(5.9%)**	**1(5.3%)**
6th month	**0**	**0**
7th month	**0**	**0**
8th month	**0**	**0**
9th month	**0**	**0**

If we seethe distribution of women based on the first visit for ANC (month-wise), in pre-intervention data 38 per cent of the women visited for 1st time for ANC in the 2nd month of pregnancy followed by 32.8 per cent women who visited in the 3rd month of the pregnancy. 10.3 per cent of the women did not seek ANC services during pregnancy.

In post-intervention data, out of 17 and 19 women who were interviewed in Intervention and non-intervention area respectively it was found that, in intervention area majority of the women (35.3 per cent each) seek ANC for the 1st time in 2nd and 3rd month of the pregnancy. In non-intervention area the responses are distributed evenly from 1st to 4th month (10.5 per cent each), while 52 per cent women did not seek ANC services and only 5.3 per cent of migrants in the non-intervention area did the first visit to antenatal care in the fifth month.

Table 18: Distribution of women based on the first visit for ANC (trimester-wise)

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Not sought ANC	**31**	
1st trimester	**217(80.7%)**	
2nd trimester	**42(15.6%)**	
3rd trimester	**10(3.7%)**	
Post-intervention data		
Not sought ANC	**0**	**10(52.6%)**
1st trimester	**15(88.2%)**	**6(31.6%)**
2nd trimester	**2(11.8%)**	**2(15.8%)**
3rd trimester	**0**	**0**

If we seethe distribution of women based on the first visit for ANC (trimester-wise), in pre-intervention data 80 per cent of the women visited for 1st time for ANC in the 1st trimester followed by 15.6 per cent women who visited in the 2nd trimester.

In post-intervention data it was found that, in intervention area majority of the women (88.2 per cent) seek ANC for the 1st time in 1st trimester followed by 11.8 per cent women in 2nd trimester. In non-intervention area, 31.6 per cent women visited for the 1st time foe ANC in 1st trimester followed by 15.8 per cent women who visited in 2nd trimester.

Table 19: Distribution of women based on the number of visits for ANC during the current pregnancy:

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data		
Not sought ANC	**31(10.3%)**	
Once	**13(4.3%)**	
Twice	**22(7.3%)**	
Thrice	**83(27.7%)**	
Four times	**60(20%)**	
Five times	**16(5.3%)**	
6 and more times	**75(25%)**	
Post-intervention data		
Not sought ANC	**0**	**10(52.6%)**
Once	**2(11.8%)**	**1(5.3%)**
Twice	**8(47.1%)**	**4(21.1%)**
Thrice	**5(29.4%)**	**3(15.8%)**
Four times	**2(11.8%)**	**1(5.3%)**
Five times	**0**	**0**
6 and more times	**0**	**0**

In the pre intervention data, it was found that 27.7 percent of respondents visited the antenatal care for three times during the current pregnancy, followed by 25 percent of respondents visited the antenatal care for more than 6 times during the current pregnancy. Meanwhile in the post intervention study, majority of the respondents (47.1 per cent and 21.1 per cent) visited the antenatal care twice during the current pregnancy in the intervention area and non-intervention area respectively.

Table 20: Distribution of women based on the person advised them to go for ANC:

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Not sought ANC	**31(10.3%)**	
None/Self	**28(9.3%)**	
Husband	**131(43.7%)**	
Other family members	**50(16.7%)**	
Health worker	**49(16.3%)**	
Anganwadi worker	**11(3.7%)**	
Others	**0**	
Post-intervention data		
Not sought ANC	**0**	**10**
None/Self	**15(48.4%)**	**1(10%)**
Husband	**4(12.9%)**	**1(10%)**
Other family members	**3(9.7%)**	**3(30%)**
Health worker	**6(19.4%)**	**2(20%)**
Anganwadi worker	**3(9.7%)**	**3(30%)**
Others	**0**	**0**

Based on the pre intervention data, it was found that majority of the respondents (43.7 per cent) were advised by their husband to go for an antenatal care (ANC), followed by 16.7 per cent migrants were advised by another family member to go for an antenatal care (ANC).
16.3 per cent of the respondents were advised by health workers for ANC check-up and 3.7
Per cent women were advised by Anganwadi workers.

Meanwhile in the post intervention study, in the intervention area around 48.4 per cent were advised by none and they themselves went for an antenatal care (ANC). 19.4 per cent women were advised by health workers and 9.7 per cent by anganwadi workers.

In non-intervention area out of 19 respondents 10 did not sought for ANC check-ups. Out of 9 women 3 each were advised by other family member and anganwadi worker respectively.

Table 21: Distribution of women based on whether a health worker or any other health personnel visited them (by health workers themselves) during pregnancy

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Yes, health worker visited	**41(13.7%)**	
Not Visited	**259(86.3%)**	
Post-intervention data		
Yes, health worker visited	**13(76.5%)**	**5(26.3%)**
Not Visited	**4(23.5%)**	**14(73.7%)**

In the pre-intervention data, only 13.7 per cent women were visited by health personnel during pregnancy. While in post intervention data, in intervention area 76.5 women were visited by health personnel during pregnancy. In non-intervention area only 26.3 women were visited.

Table 22: Distribution of women based on the first visit of health worker/health personnel (month-wise):

	Intervention clusters Number (%)	Control clusters Number (%)
Pre-intervention data		
No health worker visited	**259(86.3%)**	
Visited during 1st month	**8(2.7%)**	
Visited during 2nd month	**14(4.7%)**	
Visited during 3rd month	**10(3.3%)**	
Visited during 4th month	**4(1.3%)**	
Visited during 5th month	**2(0.7%)**	
Visited during 6th month	**2(0.7%)**	
Visited during 7th month	**1(0.3%)**	
Visited during 8th month	**0**	
Visited during 9th month	**0**	
Post-intervention data		
No health worker visited	**4(23.5%)**	**14(73.6%)**
Visited during 1st month	**0**	**1(5.3%)**
Visited during 2nd month	**5(29.4%)**	**1(5.3%)**
Visited during 3rd month	**5(29.4%)**	**2(10.5%)**
Visited during 4th month	**1(5.9%)**	**1(5.3%)**
Visited during 5th month	**1(5.9%)**	**0**
Visited during 6th month	**0**	**0**
Visited during 7th month	**1(5.9%)**	**0**
Visited during 8th month	**0**	**0**
Visited during 9th month	**0**	**0**

Based on the pre intervention data, it was found that around 4.7 percent respondents were visited by health worker until second month, followed by 3.3 per cent women who were visited in 3rd month.. It is to be noted that 86.3 per cent of the women were not visited by health worker.

Meanwhile in the post intervention data, in intervention area around 29.4 per cent respondents each were visited by health worker until the second and the third month. In non-intervention area

around 10.5 percent were visited by health worker until the third month in the non-intervention area. It is to be noted that 73.6 per cent of the women were no visited by health worker in non-intervention area.

Table 23: Distribution of women based on the first visit of health worker/health personnel (trimester-wise)

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data		
No health worker visited	**259(86.3%)**	
Visited during 1st trimester	**32(10.7%)**	
Visited during 2nd trimester	**8(2.7%)**	
Visited during 3rd trimester	**1(0.3%)**	
Post-intervention data		
No health worker visited	**4(23.5%)**	**14(73.6%)**
Visited during 1st trimester	**10(58.8%)**	**4(21.1%)**
Visited during 2nd trimester	**2(11.8%)**	**1(5.3%)**
Visited during 3rd trimester	**1(5.9%)**	**0**

In the pre intervention data, it was found that around 10.7 per cent respondents were visited by health worker during the 1st trimester, followed by 2.7 per cent women who were visited in 2nd trimester. It is to be noted that 86.3 per cent of the women were not visited by health worker.

Meanwhile in the post intervention data, in intervention area around 58.8 per cent respondents were visited by health worker in the 1st trimester followed by 11.8 per cent respondents who

were visited in 2nd trimester. In non-intervention area around 21.1 per cent were visited by health workers in the 1st trimester, while 5.3 per cent were visited during 2nd trimester.

Table 24: Distribution of women based on their reception of IFA tablets by government facility or personnel during their current pregnancy:

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Yes, IFC tabs received	**264(88%)**	
Not received	**36(12%)**	
Post-intervention data		
Yes, IFC tabs received	**17(100%)**	**10(52.6%)**
Not received	**0**	**9(47.4%)**

Inthe pre intervention data, majority of the respondents (88 per cent) were received the IFA Tablets during their current pregnancy. Meanwhile in the post intervention data, in intervention area cent per cent respondents received the IFA Tablets during their current pregnancy. In non-intervention area 52.6 per cent respondents received the IFA Tablets during their current pregnancy.

Table 25: Distribution of women based on their consumption of IFA tablets (that were given by government facility or personnel during their current pregnancy)

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Not received IFC tabs	**36(12%)**	
Consumed all tabs	**238(79.3%)**	
Consumed some tabs	**21(7%)**	
Not consumed any	**5(1.7%)**	
Post-intervention data		
Not received IFC tabs	**0**	**9(47.4%)**
Consumed all tabs	**8(47.1%)**	**4(21.1%)**
Consumed some tabs	**9(52.9%)**	**6(31.6%)**
Not consumed any	**0**	**0**

Inthe pre intervention data, majority of the respondents (79 per cent) consumed all IFA Tablets during their current pregnancy. 12 per cent respondents did not receive IFA tablets. Meanwhile in the post intervention data, in intervention area 47.1 per cent respondents consumed all IFA Tablets during their current pregnancy. 52.9 per cent respondents consumed some IFA tablets. In non-intervention area 21.1 per cent respondents consumed all IFA Tablets during their current pregnancy. It is to be noted that 47.4 per cent respondents did not receive IFA tablets.

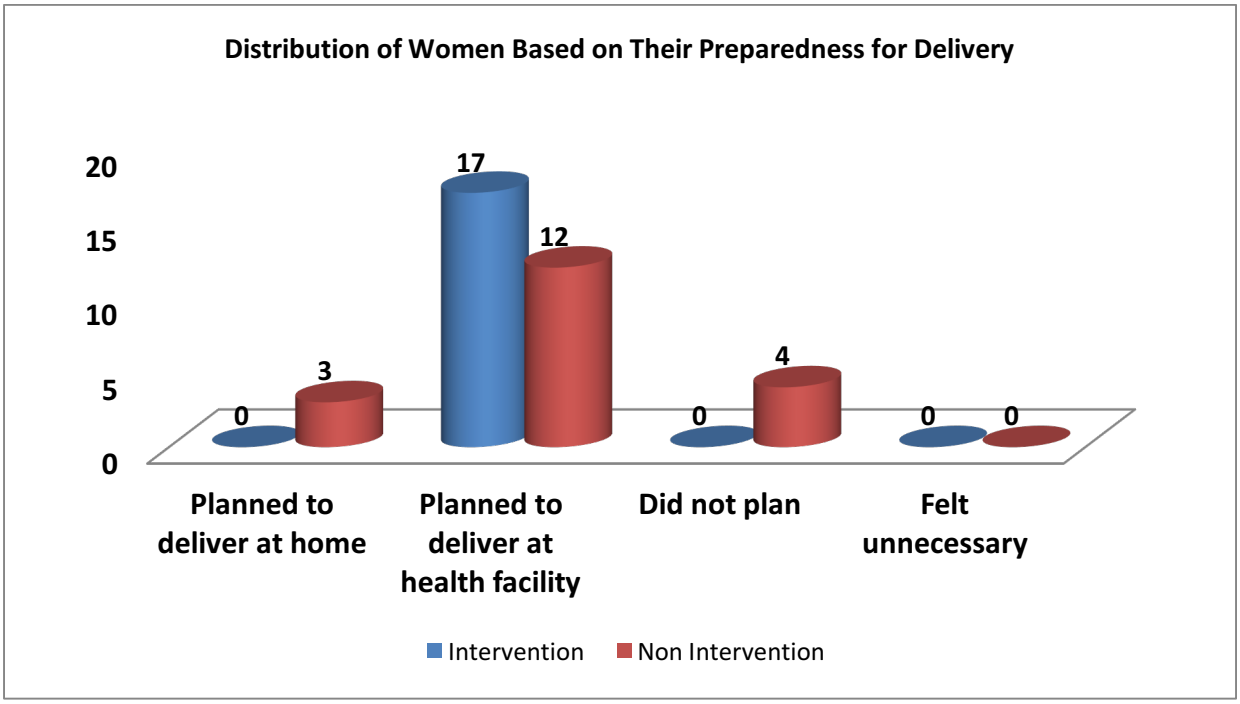
Table 26: Distribution of women based on their reception of TT injection during their current pregnancy:

	Intervention clusters No. (%)	**Control clusters No. (%)**
Pre-intervention data		
Yes, taken TT inj.	**272(90.7%)**	
Not taken	**28(9.3%)**	
Post-intervention data		
Yes, taken TT inj.	**17(100%)**	**8(42.1%)**
Not taken	**0**	**11(57.9%)**

Inthe pre intervention data, it was found that 90.7 per cent of the respondents had taken the TT Injection, while 9.3 per cent respondents did not take TT Injection. Meanwhile in the post intervention data, all of migrants (100 per cent) had taken the TT Injection in the intervention area as compared to 42.1 per cent of respondents in the non-intervention area

Table 27: Distribution of women based on their preparedness for delivery (planning in advance where to deliver the child):

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data(options mentioned are in the form of Yes and No)		
Planned to deliver at home	**N/A**	
Planned to deliver at health facility	**N/A**	
Did not plan	**N/A**	
Felt unnecessary	**N/A**	
Post-intervention data		
Planned to deliver at home	**0**	**3(15.8%)**
Planned to deliver at health facility	**17(100%)**	**12(63.2%)**
Did not plan	**0**	**4(21.1%)**
Felt unnecessary	**0**	**0**



Based on the study, it was found that cent per cent respondents planned to deliver at health facility in the intervention area. While only 63.2 per cent respondents in the non- intervention area planned to deliver at health facility.

Table 28: Distribution of women based on the type of delivery:

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Normal delivery	**289(96.3%)**	
Delivery by forceps	**1(0.3%)**	
Caesarean	**10(3.3%)**	
Currently pregnant	**0**	
Post-intervention data		
Normal delivery	**2(11.8%)**	**10(52.6%)**
Delivery by forceps	**0**	**0**
Caesarean	**0**	**0**
Currently pregnant	**15(88.2%)**	**9(47.3%)**

In the pre intervention study, it was found that majority of respondents (96.3 per cent) had a normal delivery; only 3.3 per cent respondents had caesarean delivery. In the post intervention data, around 88.2 per cent respondents were currently pregnant in the intervention area, while 11.8 per cent respondents had normal delivery. In non-intervention area 52.6 per cent respondents had a normal delivery, while 47.3 per cent respondents were currently pregnant.

Table 29: Distribution of women based on the place of delivery

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data		
Nearby health facility	**12(4%)**	
Govt. Hospital	**136(45.3%)**	
Private hospital	**41(13.7%)**	
Home	**109(36.3%)**	
NGO/trust hospital	**2(0.7%)**	
Currently pregnant	**0**	
Post-intervention data		
Nearby health facility	**0**	**1(5.3%)**
Govt. Hospital	**2(11.8%)**	**1(5.3%)**
Private hospital	**0**	**1(5.3%)**
Home	**0**	**7(36.8%)**
NGO/trust hospital	**0**	**0**
Currently pregnant	**15(88.2%)**	**9(47.4%)**

In the pre intervention data, around 45.3 per cent respondents were delivered at government hospital. 36.3 per cent respondents had home deliveries, while 13.7 respondents were delivered at private hospitals.

Meanwhile in the post intervention area, around 88.2 per cent and 47.4 per cent respondents were pregnant currently in the intervention area and non-intervention area respectively. 11.8 per cent respondents delivered at government hospital in intervention area. In non-intervention area 36.8 per cent respondents had home deliveries.

Table 30: Distribution of women based on the person assisted in home delivery:

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data(Total=109)		
Doctor	**1(0.9%)**	
Nurse/midwife/HW	**2(1.9%)**	
Dai	**38(34%)**	
Mother/mother-in-law	**66(62.3%)**	
elderly lady	**1(0.9%)**	
Others	**1(0.9%)**	
Post-intervention data		
Doctor	**0**	**0**
Nurse/midwife/HW	**0**	**0**
Dai	**0**	**5(71.4%)**
Mother/mother-in-law	**0**	**2(28.6%)**
elderly lady	**0**	**0**
Others	**0**	**0**

In the pre intervention data, it was found that 62.3 per cent respondents were assisted by mother or mother in law in home deliveries, followed by 34 per cent respondents who were assisted by dais.

Meanwhile in post intervention data, in intervention area no home deliveries took place. In non-intervention area, out of 7 home deliveries 5 deliveries were assisted by Dai and 2 by mother/mother-in-law.

Table 31: Distribution of women based on how they reached the health facility for delivery:

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Availed govt. ambulance	**3(1.6%)**	
Availed private ambulance	**1(0.5%)**	
Arranged taxi/auto rikshaw	**178(93.2%)**	
Others	**9(4.7%)**	
Post-intervention data		
Availed govt. ambulance	**0**	**0**
Availed private ambulance	**0**	**0**
Arranged taxi/auto rickshaw	**2(100%)**	**3(100%)**
Others	**0**	**0**

In the pre intervention data, it was found that 93.2 per cent respondents arranged taxi or auto rickshaw to reach health facility for deliver. Only 1.6 per cent respondents availed government ambulance.

Meanwhile in the post intervention data, out of 2 respondents in intervention area and 3 in non-intervention area all arranged taxi or auto rickshaw to reach a health facility for deliver.

Table 32: Distribution of women based on whether they received any money/incentive for delivering in health facility:

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Yes, received incentive	**92(30.7%)**	
Not received incentive	**208(69.3%)**	
Post-intervention data		
Yes, received incentive	**0**	**2(67%)**
Not received incentive	**2(100%)**	**1(33%)**

In the pre intervention data, 69.3 percent respondents did not receive money incentive for delivering in health facility. Meanwhile in the post intervention data, both the respondents in intervention area who delivered received incentives. While in non-intervention area, out of 3 respondents 2 received incentive while 1 did not.

Table 33: Distribution of women based on whether they were visited by health worker/health personnel after delivery within 42 days/6 weeks:

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Yes, HW visited	**47(15.7%)**	
Not visited	**253(84.3%)**	
Post-intervention data		
Yes, HW visited	**0**	**2(22.2%)**
Not visited	**2(100%)**	**7(77.8%)**

In the pre intervention data, 84.3 per cent of the respondents were not visited by the health worker after delivery within 6 weeks. In the post intervention study, in the intervention area both

the delivered respondent was visited by health worker. While in non-intervention area out of 9 deliveries 2 respondents were visited by health worker while the rest 7 respondents were not visited.

Table 34: Distribution of women based on whether they were advised by health worker/health personnel after delivery regarding family planning:

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Yes, advised on FP	**160(53.3%)**	
Not advised	**140(46.7%)**	
Post-intervention data		
Yes, advised on FP	**0**	**2(22.2%)**
Not advised	**2(100%)**	**7(77.8%)**

In the pre intervention data, it was found that 53.3 percent respondents were advised by the health worker regarding family planning. In the post intervention data, in intervention area both the respondents were advised on family planning. In non-intervention area, out of 9 deliveries 2 were advised while 7 respondents were not advised on family planning.

Table 35: Distribution of women based on whether they were advised by health worker/health personnel after delivery regarding breast feeding:

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Yes, advised on BF	**216(72%)**	
Not advised	**84(28%)**	
Post-intervention data		
Yes, advised on BF	**1(50%)**	**1(11.1%)**
Not advised	**1(50%)**	**8(88.9%)**

In the pre intervention data, it was found that 72 per cent respondents were advised by the health worker regarding breast feeding. In the post intervention data, in intervention area out of 2 deliveries only 1 was advised on breast feeding. In non-intervention area, out of 9 deliveries 1was advised while 8 respondents were not advised on breast feeding.

Table 36: Distribution of women based on whether they were advised by health worker/health personnel after delivery regarding immunization of the child:

	Intervention clusters **Number (%)**	**Control clusters** **Number (%)**
Pre-intervention data		
Yes, advised on child immunization	**226(75.3%)**	
Not advised	**74(24.7%)**	
Post-intervention data		
Yes, advised on child immunization	**2(100%)**	**3(33.3%)**
Not advised	**0**	**6(66.7%)**

In the pre intervention data, it was found that 75.3 per cent respondents were advised by the health worker on child immunization. In the post intervention data, in intervention area both the respondents were advised on child immunization. In non-intervention area, out of 9 deliveries 3 were advised while 7 respondents were not advised on child immunization.

Details on refusal:

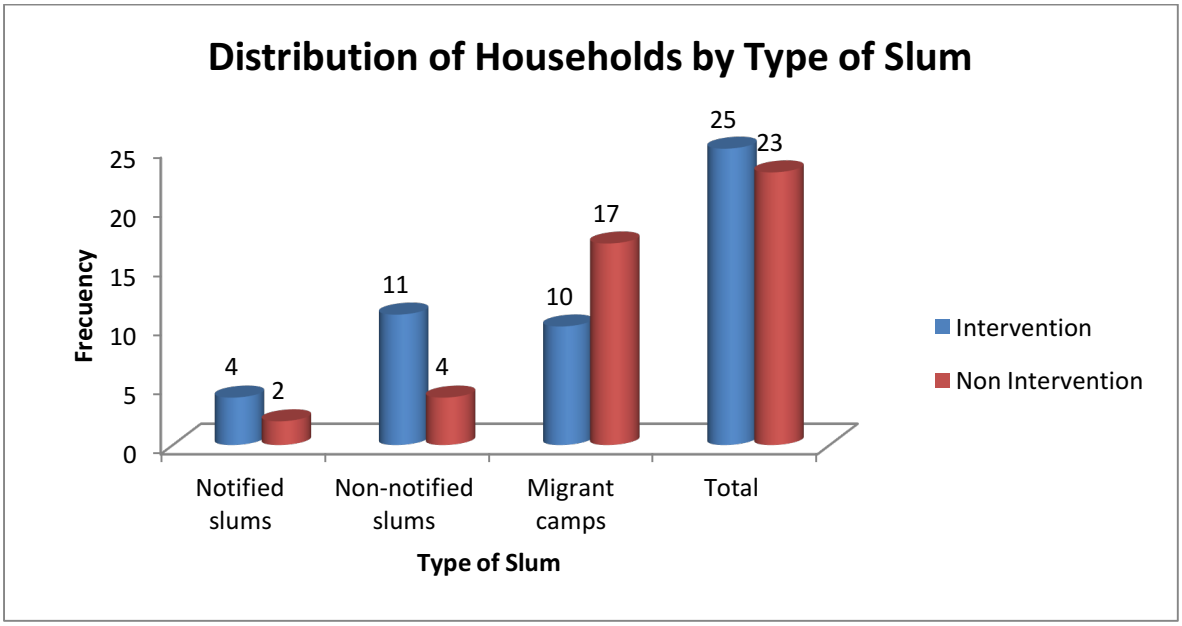
	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data		
Number - completed	**4006(99.9%)**	
- incomplete	**2(0.1%)**	
- refused	**0**	
Post-intervention data		
Number - completed	**17(100%)**	**19(100%)**
- Incomplete	**0**	**0**
- refused	**0**	**0**

In the pre intervention data 99.9 per cent of the respondents did not refused for the interview and were completed. While in post intervention data, in both intervention and non-intervention none of the respondents refused and all questionnaires were complete.

PART 3: REPORT ON IMMUNIZATION

Table 1: Distribution of households by type of slum

Duration of migration	Number of households (Intervention)	Number of households (Non-Intervention)
Notified slums	4(16%)	2(8.7%)
Non-notified slums	11(44%)	4(17.4%)
Migrant camps	10(40%)	17(73.9%)
Total	25(100%)	23(100%)



In the study population, if we see the distribution of households by type of slums, 44 percent of respondents in intervention area live in non-notified slum while its only 17.4 per cent in non-intervention area. Under slum type migrant camps, the percentage of respondents were 40 per cent in intervention area and 73.9 per cent in non-intervention area.

Table 2: Age and gender-wise distribution of reference children

Age group	Intervention			Non Intervention		
	Male children	Female children	Total children	Male children	Female children	Total children
< 1 month	1(4%)	0	1(4%)	1(4.3%)	0	1(4.3%)
2 months	0	0	0	0	0	0
3 months	0	0	0	1(4.3%)	0	1(4.3%)
4-6 months	2(8%)	4(16%)	6(24%)	2(8.7%)	3(13%)	5(21.7%)
7-9 months	1(4%)	6(24%)	7(28%)	2(8.7%)	5(21.7%)	7(30.4%)
10-12 months	6(24%)	5(20%)	11(44%)	4(17.4%)	5(21.7%)	9(39.1%)
Total	10(40%)	15(60%)	25(100%)	10(43.5%)	13(56.5%)	23(100%)

In the study population, if we see the distribution of respondents by age, it was found that around 24 percent male children in the intervention area were in 10 to 12 months age group, and followed by 8 percent male children were in 4 to 6 months age group. Then majority female (24 percent) children in the intervention area were in 7 to 9 months age group, followed by 20 per cent female children in 10 to 12 age group in the intervention area. Meanwhile in the non-intervention area there were around 17.4 per cent male child in the age group 10-12 months followed by 8.7 per cent each in age group 7to 9 months and 4 to 6 months respectively. For female children 21.7 per cent each were in age group 10 to 12 months and 7 to 9 months respectively.

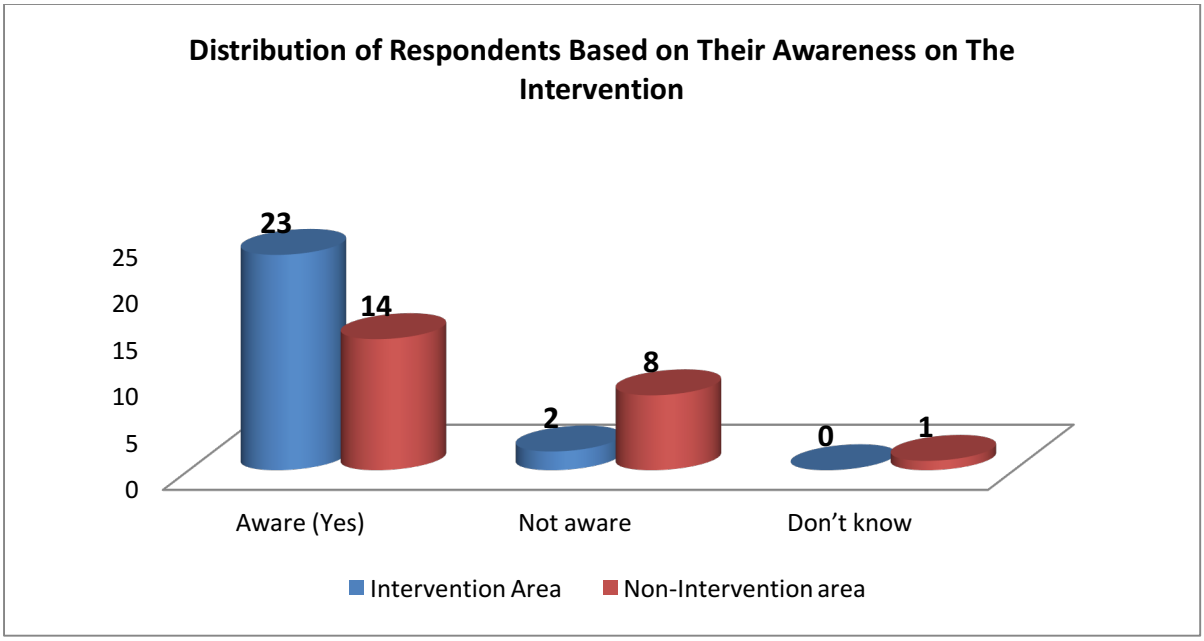
Table 3: Distribution of households by duration (number of years) of migration

Duration of migration	Intervention	Non-Intervention
< 1 year	2 (7.1%)	2 (8.6%)
1-2 years	9 (32.2%)	8 (34.7%)
2-4 years	4 (14.3%)	5 (21.7%)
4-6 years	0 (0.0%)	2 (8.7%)
6-8 years	1 (3.6%)	2 (8.6%)
8-10 years	6 (21.4%)	4 (17.4%)
>10 years	3 (12%)	0 (0.0%)
Total	25 (100.0%)	23 (100.0%)

In the study population, if we see the distribution of respondents by duration of migration, in intervention area around 32.2 percent respondents migrated since 1 to2 years ago in the intervention area, followed by 21.5 per cent respondents in category 8 to 10 years. Then in the non-intervention area most of respondents (34.7 percent) migrated since 1 to 2 years, followed by 21.7 percent who migrated since 2 to 4 years.

Table 4: Distribution of respondents based on their awareness on the intervention

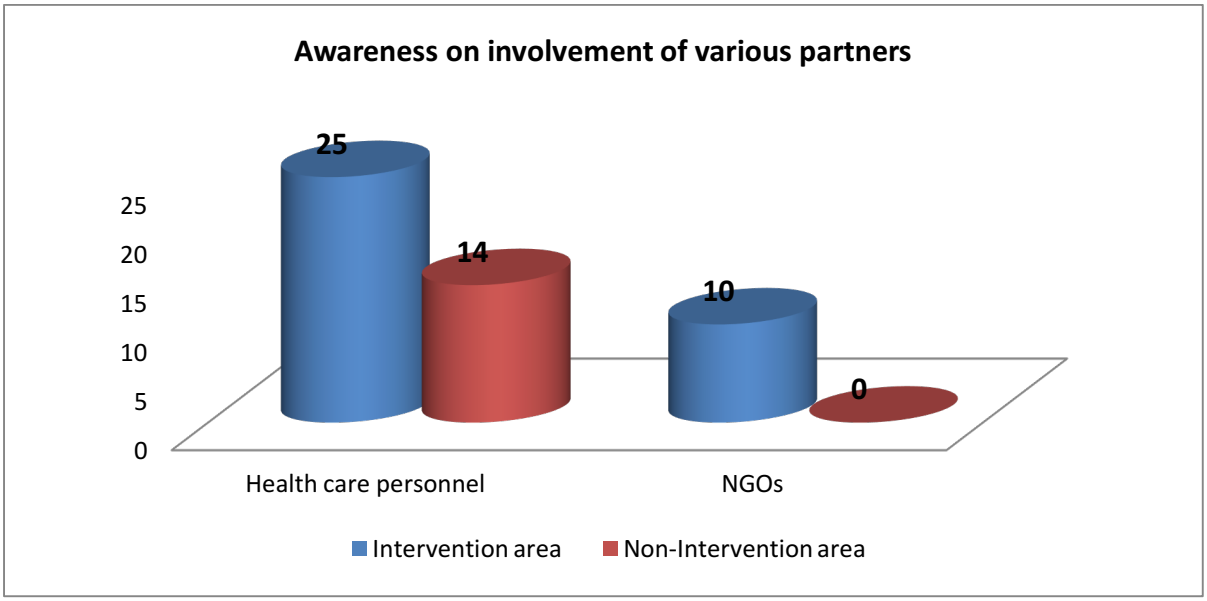
	Awareness of the Intervention (Intervention)	Awareness of the Intervention (Non-Intervention)
Aware (Yes)	23 (92%)	14 (60.9%)
Not aware	2 (8%)	8 (34.8%)
Don't know	0	1 (4.3%)



In this study, it was found that 82.1 percent in the intervention area are aware about the intervention. Meanwhile in the non-intervention area only 63.2 percent respondents are aware about the intervention, followed by 34.8 percent of respondents who were not aware about the activities.

Table 5: Distribution of respondents based on their awareness on the involvement of various partners in the intervention

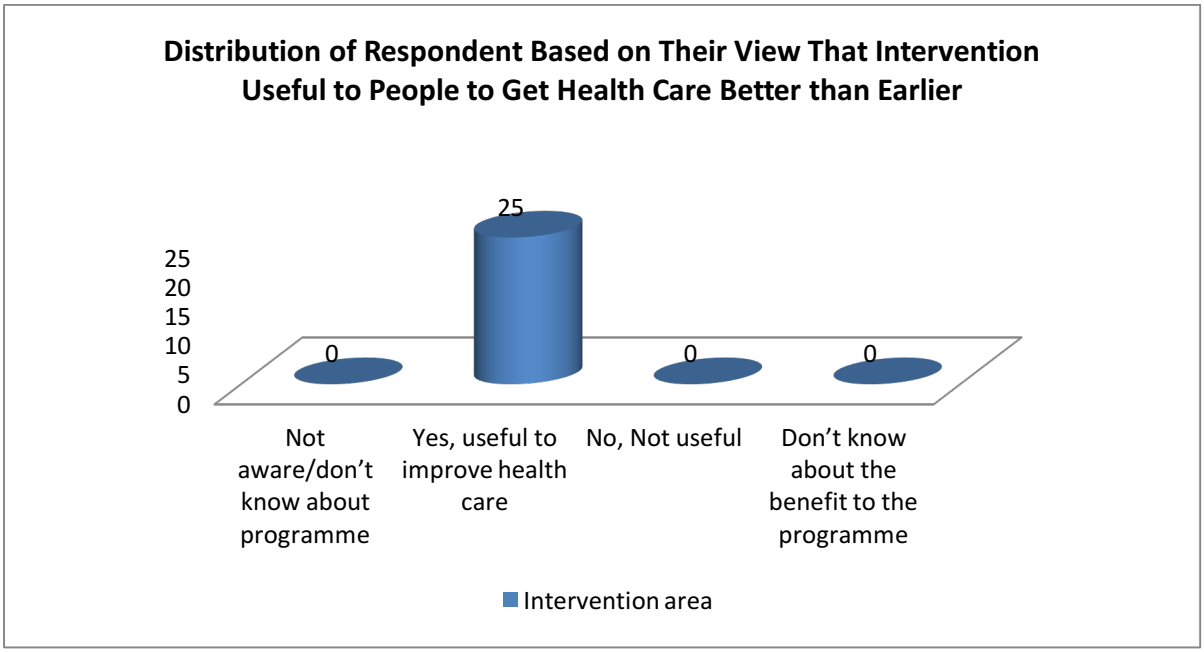
	Intervention	**Non-Intervention**
Not aware of the programme or don't know any	0 (0.0%)	0 (0.0%)
Community	0 (0.0%)	0 (0.0%)
Health care personnel	25 (100%)	14 (60%)
Researchers	0 (0.0%)	0 (0.0%)
NGOs	10 (40%)	0 (0.0%)
Others*	0 (0.0%)	0 (0.0%)



It is a multiple response answer. In the study population, it was found that in intervention area cent per cent were aware of health care personnel in the activities, while 40 per cent respondents were aware of the involvement of NGO staff.

Table 6: Distribution of respondents based on their view that intervention is useful to people to get health care better than earlier:

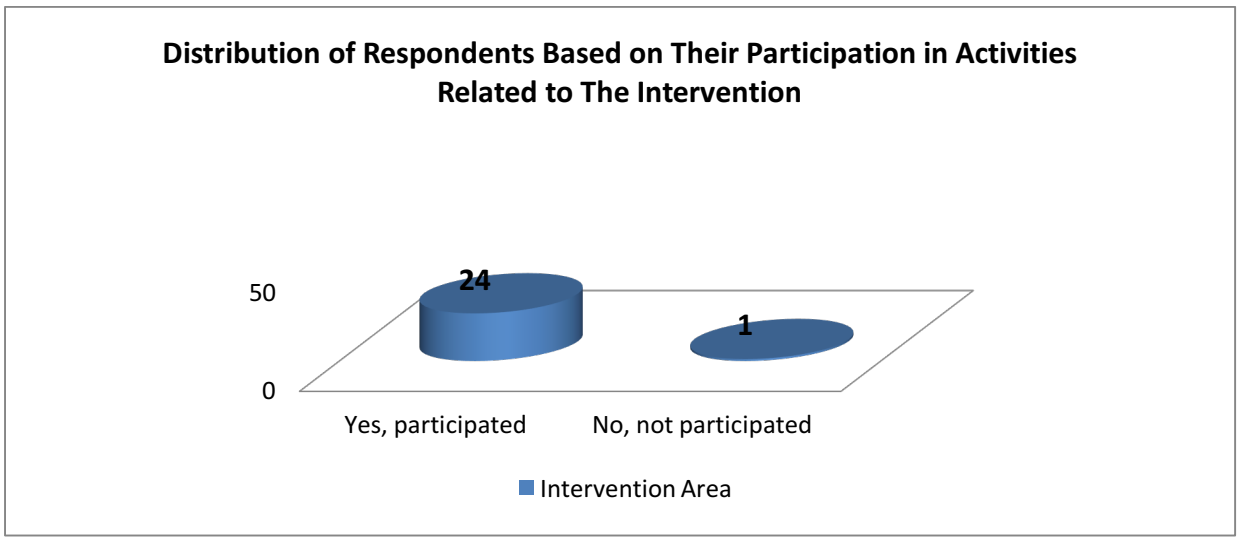
	intervention is useful to people to get health care better than earlier (Intervention)
Not aware of the programme or don't know about the programme/intervention	0
Yes, useful to improve health care	25 (89.3%)
No, Not useful	0
Don't know about the benefit to the programme	0



Based on the study in the intervention area, cent per cent of the respondents feels that intervention activities are useful to improve health care.

Table 7: Distribution of respondents based on their participation in the activities related to the intervention

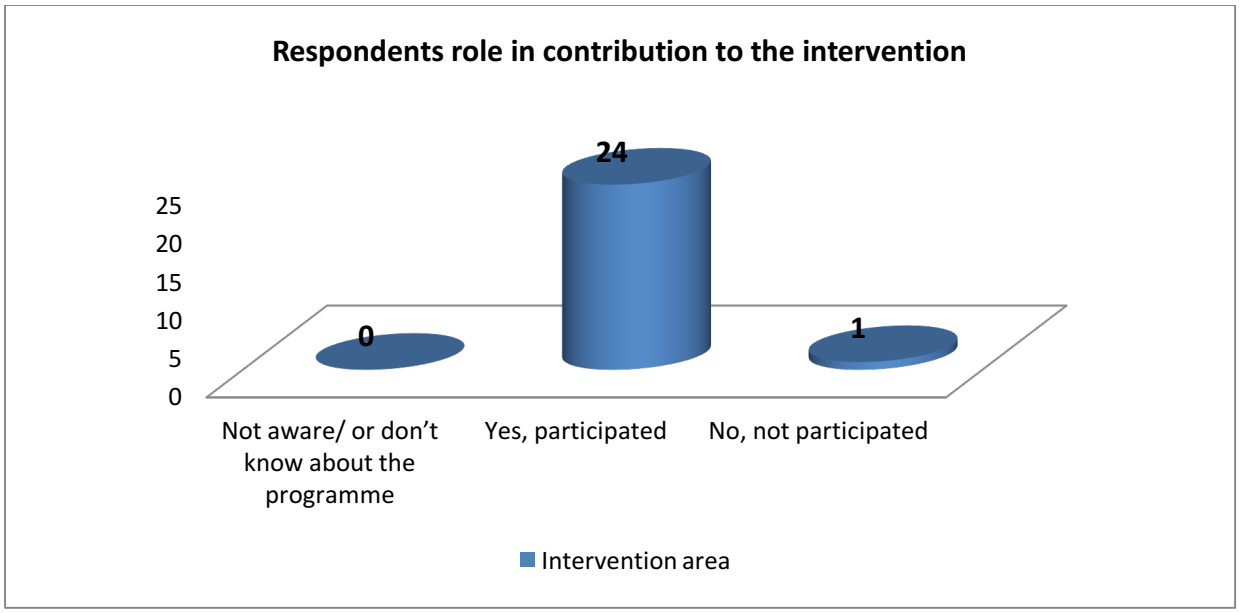
	participate in any of these activities (Intervention)
Not aware of the programme or don't know about the programme/intervention	0
Yes, participated	24 (96%)
No, not participated	1 (4%)



In the study population it was found that, 96 per cent of the respondents participated in activities related to intervention.

Table 8: Distribution of respondents based on their role in/contribution to the intervention:

Activity/Role	Number (%)#
Actively volunteered in intervention activities	3(12%)
Executed/participated in community mobilization activities	21(84%)
Not participated	1(4%)



In the intervention area, it was found that out of 25 respondents, 84 per cent participated in community mobilization activities while 12 per cent have actively volunteered for the intervention.

Table 9: Distribution of children by their stay in the present locality:

Duration of migration	Intervention	Non-Intervention
1st month	22 (88%)	18 (78.3%)
2nd month	22 (88%)	19 (82.6%)
3rd month	22 (88%)	20 (87%)
4th month	22 (88%)	21 (91%)
5th month	20 (80%)	20 (87%)
6th month	18 (72%)	19 (82.6%)
7th month	15 (60%)	17 (73.9%)
8th month	16 (64%)	16 (69.6%)
9th month	14 (56%)	14 (60.9%)
10th month	12 (48%)	14 (60.9%)
11th month	10 (40%)	13 (56.5%)
12th month	7 (28%)	12 (52.2%)

In the intervention area, majority of the children (88%) stayed in the migrant site during the 1st, 2n, 3rd& 4th months. The distribution of stay of the children decreases on the 10th, 11th and 12th month of the stay, the percentages were only 48, 40 and 28 per cent respectively.

In non-intervention area majority of the children (91 per cent) stayed in the migrant site during the 4th month. Followed by 3rd and 5th months were 87 per cent children stayed.

Table 10: Distribution of respondents based on the facility to which they approach for getting vaccines for their children:

	Intervention clusters Number (%)#	**Control clusters Number (%)#**
Pre-intervention data		
Nearby health facility	**97(48.5%)**	
Mobile clinic	**3(1.5%)**	
Health worker	**16(8%)**	
Qualified private practitioner	**18(9%)**	
Govt. hospital	**63(31.5%)**	
Local practitioner	**0**	
Dai	**0**	
Others	**3(1.5%)**	
Don't know/No response	**0**	
Post-intervention data		
Nearby health facility	**12 (48%)**	**5 (21.7%)**
Mobile clinic	**0 (0.0%)**	**0 (0.0%)**
Health worker	**1 (4%)**	**6 (26.1%)**
Qualified private practitioner	**0 (0.0%)**	**0 (0.0%)**
Govt. hospital	**8 (32%)**	**4 (17%)**
Local practitioner	**2 (8%)**	**0 (0.0%)**
Dai	**0 (0.0%)**	**1 (4.3%)**
Others	**0 (0.0%)**	**5 (21.7%)**
Don't know/No response	**6 (24%)**	**2 (8.7%)**

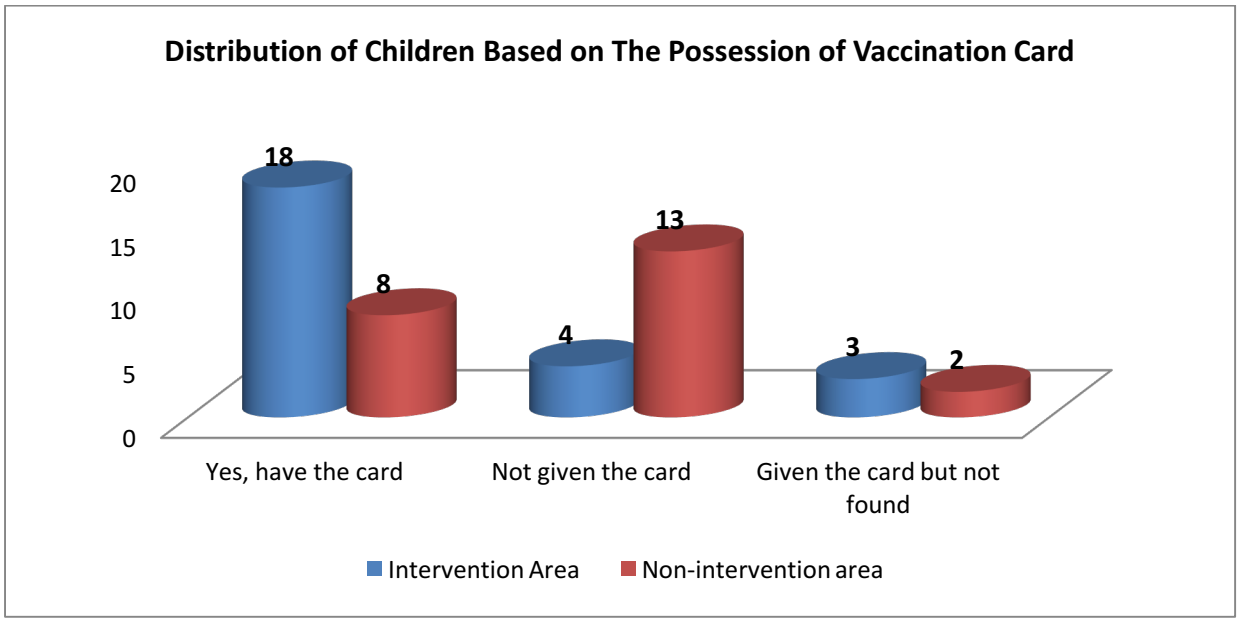
In the pre-intervention data, majority of the respondents (48.5 per cent) approached nearby health facility for getting vaccines to their children, followed by government hospitals were 31.5 per cent respondents went.

In the post intervention data, in intervention area majority respondents (48 per cent) went to health facility nearby to getting vaccines, and followed by 32 per cent went to government hospital to getting vaccines. Meanwhile in the non-intervention area, around 26 percent went to health worker to getting vaccines.

Table 11: Distribution of children based on the possession of vaccination card

	Vaccination Card (Intervention)	Vaccination Card (Non-Intervention)
Pre-intervention data		
Yes, have the card	**262(90.3%)**	
Not given the card	**21(7.2%)**	
Given the card but not found	**7(2.4%)**	
Post-intervention data		
Yes, have the card	**18 (64.3%)**	**8 (34.8%)**
Not given the card	**4 (14.3%)**	**13 (56.5%)**
Given the card but not found	**3 (10.7%)**	**2 (8.7%)**

In the pre-intervention data, 90.3 per cent of the respondents had vaccine cards, while for 2.4 per cent card was given but lost. In post-intervention data, in intervention area 64.3 per cent respondents had vaccine cards, while for 10.7 per cent card was given but not found.



In the non-intervention area, only 34.8 per cent respondents had vaccine cards, while for 8.7 per cent card was given but not found.

Table 12: Reception of various vaccines appropriate for age among the children by intervention status:

Time period/Vaccine		Intervention status					
		Pre Intervention		Post Intervention			
				Intervention		Non-Intervention	
		Yes	No	Yes	No	Yes	No
Vaccines to be received at birth for all children	BCG (0-1 month)	254(87.6%)	36 (12.4%)	22 (78.6%)	6 (21.4%)	11 (47.8)	12 (52.2%)
	OPV-0	254(87.6%)	36 (12.4%)	22 (78.6%)	6 (21.4%)	9 (39.1%)	14 (60.9%)
	Hepatitis B -0	253(87.2%)	37 (12.8%)	18 (64.3%)	10 (35.7%)	5 (21.7%)	18 (78.3)
Vaccines to be received at 6 weeks of age (1 ½ month)	DPT -1	264(91%)	26(9%)	18 (64.3%)	10 (35.7%)	7 (30.4%)	16 (69.6%)
	OPV – 1	263(90.7%)	27(9%)	19 (67.9%)	9 (32.1%)	11 (47.8%)	12 (52.2%)
	Hepatitis B - 1	264(91%)	26(9%)	18 (64.3%)	10 (35.7%)	7 (30.4%)	16 (69.6%)
Vaccines to be received at 10 weeks of age (2 ½ month)	DPT – 2	257(88.6%)	33(11.4%)	20 (71.4%)	8 (28.6%)	6 (26.1%)	17 (73.9%)
	OPV – 2	257(88.6%)	33(11.4%)	19 (67.9%)	9 (32.1%)	7 (30.4%)	16 (69.6%)
	Hepatitis B - 2	255(87.9%)	35(12.1%)	17 (60.7%)	11 (39.3%)	5 (21.7%)	18 (78.3%)

Vaccines to be received at 14 weeks of age (3 ½ month)	DPT – 3	246(84.8%)	44(15.2%)	19 (67.9%)	9 (32.1%)	3 (13.0%)	20 (87.0%)
	OPV – 3	245(84.5%)	45(15.5%)	16 (57.1%)	12 (42.8%)	6 (26.1%)	17 (73.9%)
	Hepatitis B – 3	242(83.4%)	48(16.6%)	17 (60.7%)	11 (39.3%)	5 (21.7%)	18 (78.2%)
Vaccines to be received at 9-12 months	Measles (9-12 months)	184(63.4%)	106(36.6%)	0	25 (100%)	2 (8.7%)	21 (91.3%)
	Vitamin – A	181(62.4%)	109(37.6%)	0	25 (100%)	2 (8.7%)	21 (91.3%)
Various vaccines to be received by 14 weeks of age	3 doses of DPT	N/A	N/A	N/A	N/A	N/A	N/A
	3 doses OPV	N/A	N/A	N/A	N/A	N/A	N/A
	3 doses of Hep-B	N/A	N/A	N/A	N/A	N/A	N/A
Any other vaccine		0	0	0	25 (100%)	0	23 (100.0%)

Note: The category "*Various vaccines to be received by 14 weeks of age" is not applicable as in the inclusion criteria of the sample age of the child was less than 1 year".

If we summarize the whole table, for the vaccines received at birth for all children in the pre-intervention data around 87 per cent of the children received all the vaccines (BCG, OPV-0 & Hep-0). In post intervention data, 78 per cent children received BCG and OPV-0 while 64 per cent children received Hep B-0. In non-intervention area, only 47 per cent children received BCG-0, followed by 39 per cent children who received OPV-0.

In the pre-intervention data, for the category vaccines to be given at 6 weeks of age (1 and half month), around 90 per cent of the children received all the vaccines (DPT-1, OPV-1 & Hep-1). In post intervention data, 64 per cent children received DPT-1 and Hep-1 while 67.9 per cent children received OPV-1. In non-intervention area, only 30.4 per cent children received DPT-1,

followed by 47.8 per cent children who received OPV-1. Only 30.4 per cent children received Hep B-1 vaccine.

In the pre-intervention data, for the category vaccines to be given at 10 weeks of age (2 and half month), around 88 per cent of the children received all the vaccines (DPT-2, OPV-2 & Hep-2). In post intervention data, 71.4 per cent children received DPT-2, 67.9 per cent received OPV-2, while 60.7 per cent children received Hep B-2. In non-intervention area, only 26.1 per cent children received DPT-2, followed by 30.4 per cent children who received OPV-2. Only 21.7 per cent children received Hep B-2 vaccine.

In the pre-intervention data, for the category vaccines to be given at 14 weeks of age (3 and half month), around 84 per cent of the children received all the vaccines (DPT-3, OPV-3 & Hep B-3-2). In post intervention data, 67.9 per cent children received DPT-3, 57.1 per cent received OPV-3, while 60.7 per cent children received Hep B-3. In non-intervention area, only 13 per cent children received DPT-3, followed by 26.1 per cent children who received OPV-3. Only 21.8 per cent children received Hep B-3 vaccine.

In the pre-intervention data, for the category vaccines to be given at 9 to 12 months, around 63 per cent of the children received all the vaccines (Measles and Vit-A). In post intervention data, in intervention area no child received measles and vit-A vaccines.

Table 13: Vaccination status of children by intervention status

Vaccination status	**Intervention status**					
Various vaccines to be received by 12 months / 1 year of age	Pre Intervention		Post Intervention			
			Intervention		Non-Intervention	
	Yes	No	Yes	No	Yes	No
Fully immunized against six VPDs (BCG, OPV, DPT, Measles)	162(54%)	138(46%)	3(12%)	22(88%)	2(8.7%)	21(91.3%)
Partially immunized against six VPDs (BCG OPV, DPT, Measles)	102(34%)	198(66%)	19(76%)	6(24%)	12(52.2%)	11(47.8%)
Did not receive any vaccine	32(10.7%)	268(89.3%)	3(12%)	22(88%)	9(39.1%)	14(60.9%)
Fully immunized against 7 VPDS BCG, OPV, DPT, Hep B, Measles	168(56%)	132(44%)	1(4%)	24(96%)	0	23(100%)
Partially immunized against 7 VPDS BCG, OPV, DPT, Hep B, Measles	96(32%)	204(68%)	21(84%)	4(16%)	14(60.9%)	9(39.1%)

Table 14: Reasons for not/partial immunization of children by intervention status

Reasons for not/partial immunization	**Intervention status**		
	Pre Intervention	Post Intervention	
		Intervention	Non Intervention
Not aware of		24 (96%)	21 (91.3%)

vaccination	11(3.8%)		
Don't know the immunization days	0	0 (0.0%)	1 (4.3%)
Child is ill	0	1 (4%)	0 (0.0%)
Don't take the child out before 1 month	9(3.1%)	0 (0.0%)	0 (0.0%)
Family related reasons	11(3.8%)	0 (0.0%)	0 (0.0%)
No time to go	259(89.3%)	0 (0.0%)	0 (0.0%)
Others	0	0 (0.0%)	1 (4.3%)

In the pre-intervention data, if we see the reasons for not/partial immunization of children by intervention area 89 per cent of the respondents had no time to go for vaccination, while 3.8 per cent each had family related problems and were not aware of vaccination.

In post-intervention area, majority of the respondents (96 per cent and 91.3 per cent) in intervention and non-intervention area respectively were not aware of fully immunization.

Details on refusal:

	Intervention clusters Number (%)	**Control clusters Number (%)**
Pre-intervention data		
Number - completed	**4006(99.1%)**	
- incomplete	**2(0.1%)**	
- Refused	**0**	
Post-intervention data		
Number - completed	**25 (100.0%)**	**23 (100.0%)**
- Incomplete	**0 (0.0%)**	**0 (0.0%)**
- Refused	**0 (0.0%)**	**0 (0.0%)**

In the pre intervention data 99.9 per cent of the respondents did not refused for the interview and questionnaires were completed. While in post intervention data, in both intervention and non-intervention none of the respondents refused and all questionnaires were complete.

B. Conclusions summarizing the achievements and indication of scope for future work:

A rigths based and integrated approach was adopted to achieve sustainable and long term success in this intervetnion. Migrant's empowerment for access to services was key component of the intervention. Peers were selected among migrant communities and trained to facilitate and demand access to health related services for their communities. These peers are actively playing role of facilitators for access to healt hcare for their communities and will continue even after end of the project.

Community awareness and mobilization was done for generating basic awareness on the disease morbidity. Regular feedbacks were taken to reassess the program and make changes as per the requirement of the community. Community meetings, lectures, street plays, film shows, were used during awareness programs. As per the language need and requirement of the communities IEC material were developed and dissemineted. Overall we received wholehearted particiaption of migrnts in the project.

Inclusive partnership was key strategy with health department officials (both state and local Municipal Corporation), employers of migrants (mainly for improving living conditions), and Non-government stakeholders to make most of the available resources. We could get remarkable successes of advocacy which was done with government stakeholders to provide health services at migrant locations, which were not covered earlier, such as work sites, open spaces or other halt points of migrants. ICDS, DOTS, Malaria and MCH division of Local Municipal Corporation, Red Cross Society, have done remarkable contribution in the whole process, including conducting health awareness, early screening and detection of the Malaria/TB. Sputum test were done on the intervention sites and suspected cases were instantly referred. Regular immunizations have started at migrants' locations with activesupport of employers. These departments have included these migrants' locations in their regular outreach planning, which assures sustainability of the project. To summarize the whole

intervention, the main objective of improving migrant's access and governments response to it has been achieved as now the migrant locations under intervention are in the list of the health department's action plan and are visited on regular basis. On the other hand the migrants are aware of their informed choices and able to access the health services as and when required.

The intervention has some success in galvanizing the administration such as developing health referral system with government health services, and creating pro-migrant response of central, state and local government to address health issues of migrants via regular outreach activities. But it is apparent that the administration will need pressure as well support while developing institutional framework for migrant inclusive programs till the mainstream of migration happens at larger scale in various health programs in India.

C. Abstract of project work

Public health foundation of India in collaboration with an NGO, Disha Foundation, supported by Indian council of medical research has implemented an intervention study on Migration, Poverty and Access to health care. The study was focussed on understaning health status and health care access of internal mobile migrant population in Nasik city, working in construction, agriculture and informal economy. The study shows that the poor living conditions of the migrants, along with absence of specific targeted strategies has left large number of migrants excluded from coverage of various health services inclduing mother and chidl health, infectious diseaes and occupational health. Other barriers such as a stigma for the migrants like language, social exclusion, fear, lack of awareness of the informed choices, low health-related spending capacity lead to delay in the access to health services for disease prevention and treament.

Based on above findings of formative phase, an intervention was developed to address mother and child health, Malaria and Tuberculosis and occupational health among migrants involving multi-stake holders (community, government and private institutions). A rigths based and integrated approach was adopted to achieve sustainable and long term success. Community awareness and mobilization was done for generating basic awareness on the disease morbidity. Regular feedbacks were taken to reassess the

program and make changes as per the requirement of the community. Community meetings, lectures, street plays, film shows, were used during awareness programs. As per the language need and requirement of the communities IEC material were developed and dissemineted. Migrant's empowerment for access to services was key component of the intervention. Peers were selected among migrant communities and trained to facilitate and demand access to health related services for their communities.

Inclusive partnership was initiated with health department officials (both state and local Municipal Corporation), employers of migrants (mainly for improving living conditions), and Non-government stakeholders to make most of the available resources. Advocacy was done with government stakeholders to provide health services at migrant locations, which were not covered earlier, such as work sites, open spaces or other halt points of migrants. ICDS, DOTS, Malaria and MCH division of Local Municipal Corporation, Red Cross Society, have done remarkable contribution in the whole process, including conducting health awareness, early screening and detection of the Malaria/TB. Sputum test were done on the intervention sites and suspected cases were instantly referred. Regular immunizations have started at migrants' locations with active support of employers. These departments have included these migrants' locations in their regular outreach planning, which assures sustainability of the project. To summarize the whole intervention, the main objective of improving migrant's access and governments response to it has been achieved as now the migrant locations under intervention are in the list of the health department's action plan and are visited on regular basis. On the other hand the migrants are aware of their informed choices and able to access the health services as and when required.