TI Evaluation

Kaira Social Service Society

Truckers

State : Gujarat

Ahmedabad

Dates : 03 – 05 July, 2015

Evaluation Team :

Dr. Rajat Kumar Das - TL

Dr. Vaibhavi Patel – Programme

Mr. Kunal Dhandharia - Finance

**Annexure: B**

**Reporting Format-B**

**Structure of the Detailed Reporting format**

**(To be submitted by Evaluators to SACS for each TI evaluated with a copy to Ahmedabad SACS)**

**Introduction**

oBackground of Project and Organisation : ( **Kaira Social Service Society – Truckers** )

The organization was initiated in 1967 under the Diocesan Social Service with a focus on women empowerment through self help groups, farmers improvement and several minority development project. It has currently about 17 projects natural resources conservation, control of pollution, awareness generation on non conventional energy sources etc. It has received support from Governmental agencies such as NABARD and CAPART. There has also been HIV AIDS projects centred around children which was followed by carrying out HIV AIDS programme for truckers in the current operational area.

oName and address of the Organization : **Kaira Social Service Society**

Main office : St. Xavier’s School Campus, Sardarnagar – Hansol. Ahmedabad – 382 475, Gujarat Tel ; +91 – 79 – 22861216; e-mail : [kairasss@gmail.com](mailto:kairasss@gmail.com) and website : [www.kairasociety.org](http://www.kairasociety.org)

Project Office : Viswakarma Complex, Near Asapala Hotel, Narol Circle, Sarkhej Highway, Ahmedabad

oChief Functionary: Father Jagdish Makwan supported by Fr. Joseph Appavoo +91 9825953865

oYear of establishment : March, 1967

oYear and month of project initiation: March 2013

oEvaluation team : Dr. Rajat Kumar Das ( Team Leader ), Dr. Vaibhavi Patel ( Program Evaluator ), Mr. Kunal Dhandharia ( Finance Evaluator ). Facilitator – Ms. Monali Shah : Ahmedabad SACS

oTime frame 03 July – 05 July, 2015

**Profile of TI**

(Information to be captured)

oTarget Population Profile: FSW / MSM / IDU / TG/TRUCKERS / MIGRANTS :

Truckers

oType of Project: Core/ Core Composite / Bridge population : Bridge Population

Bridge Population

oSize of Target Group(s) : 30,000 – Thirty thousand

oSub-Groups and their Size : It was reported that about 35 % are from Rajasthan, 15 % is from Maharashtra, 20 % from the Southern states and the other major groups are from North India – Punjab, Haryana and Delhi etc.

oTarget Area : Narol to Sarkhej Highway, Narol to Aslahi Circle, Aslahi Circle to Bagrol Road, Aslahi Circle to Vinjol Road. Major Halt Points are – Naya Parking, Gurukrupa Parking, Karur Parking, Patel Parking, White House, Batwa Parking, Tirupati Parking, Jai Jagannath, Arvind Carrier and Sainad Parking are the main sites of this project coverage.

**Key Findings and recommendations on Various Project Components**

**I. Organizational support to the programme**

Interaction with key office bearers, 2-3, of the implementing NGO/CBO to see their vision about the project, support to the community, initiation of advocacy activities, monitoring the project etc…

There is a Project Director – who is also the Chief Functionary and is responsible for this project and other projects suoervision. He is providing project oversight. The team has experience and insights into the project issues.

**II. Organizational Capacity**

1. Human resources: Staffing pattern, laid down reporting and supervision structure and adherence, role and commitment to the project, perspective of the office bearers towards the community at a large staff turnover

Most of the office bearers are local and the team is led by two females who are the Project Manager and Counselor both of them having been associated with this project since inception. The M&E officer has just left since the last week of the previous month. The team has developed access to the target community and stakeholders. The organization has developed human resource policy since the last three years and the project senior team has also undergone human resource training last April 2015. For the regular long term staff of the organization norms of the Diocesan is followed.

2. Capacity building: nature of training conducted, contents and quality of training materials used, documentation of training, impact assessment if any.

The capacity building aspects have been done to some extent during this project on subjects such as monitoring & documentation, finance, advocacy and earlier on STI. The Project Manager, M & E officer. There has been induction training too of the team. However, there has not been any formal training of the Counselor under this project but she is qualified. PEs have also received some training.

3. Infrastructure of the organization

The organization has a large building with residential facilities for around 100 training participants. Apart from this there are other associated activities carried out in the centre. The project office is located in a good roadside position on the highway near the Narol Circle and has adequate space and furniture. In the project office, the organization has a computer and printer too and both are functional.

4. Documentation and Reporting: Mechanism and adherence to SACS protocols, availability of documents, mechanism of review and action taken if any, timeliness of reporting and feedback mechanism, dissemination and sharing of the reports and documents for technical inputs if any.

The project has a computerized asset list which is adequately detailed and printout is available in the Asset Register. Other documentation are maintained as per norms such as reporting formats, planning documents, registers as well as soft data which is stored in the project computer. When checked it it was seen that the documentation of daily medicine use was relatively good but could be further improved to save time and avoid errors. Also the counselor register has elaborate information but several key information such as from which halt point or area is missing and analysis not undertaken.

**III. Program Deliverables**

**Outreach**

1. Line listing of the HRG by category.

A few long distance truckers have made repeat visits during a year while the rest are one time project beneficiaries.

2. Registration of migrants from 3 service sources i.e. STI clinics, DIC and Counseling. :

3. Registration of truckers from 2 service sources i.e. STI clinics and counseling.

STI clinics in the form of health camps are done on an average of 20 to 22 per month which is more than the number planned and registrations are done there. Categorization of the truckers with regard to source – destination have been done but time of halt and frequency of visits not used adequately for micro planning.

4. Micro planning in place and the same is reflected in Quality and documentation. :

Micro planning is in place and there is required documentation maintained as per norm. Quite a few micro plans with maps are displayed on the project office walls. However, planning is more activity based and apportionment is done on the basis of targets rather than site based needs.

5. Coverage of target population (sub-group wise): Target / regular contacts only in HRGs

The staff team have developed rapport with the target groups with assistance of transport agencies and brokers and are able to reach out to a substantial portion. However, high risk follow up is weak owing to reasons of service facilities located at quite a distance.

6. Outreach planning – quality, documentation and reflection in implementation

The ORW team and PEs have developed rapport with the target groups and outreach planning is being done focused on the halt sites and health camps have been timed with location specific needs.

7. PE: HRG ratio, PE: migrants/truckers

There was maintenance of PE : Truckers ratio with mostly being ex truckers and helpers and currently there has been a drop with 7 out of the 20 just leaving recently. There are no trucker PEs.

8. Regular contacts ( as contacting the community members by the outreach workers / Peers at least twice a month and providing services such as condoms and other referral services for FSW and MSM, TG and 20 days in a month and providing Needle and Syringes) - understanding among the project staff, reflection in impact among the community members

The project staff are able to maintain regular contacts with some of the truck drivers only those who frequent the halt sites as repeat visits in a year.

9. Documentation of the peer education

The PEs do not maintain any diaries and thus documentation of essential information may not be factually recorded.

10. Quality of peer education- messages, skills and reflection in the community

The PEs are aware of the basic messages and condom demonstration skills. However recent departure of a sizeable portion of the PEs have reduced field inputs. Along with this the fund flow problem has caused reduced mobility of the ORWs which is hampering the support to the PEs.

11. Supervision- mechanism, process, follow-up in action taken etc

There is oversight by the organization’s senior management either by the Project Director or the organization’s Finance person and at mid level by the Project Manager through project meetings and regular supervision and monitoring.

**IV. Services**

1. Availability of STI services – mode of delivery, adequacy to the needs of the community.

The STI services are carried out through health camps organized at a frequency of 20 to 22 camps per month. The health camps are held in the morning hours from Monday to Thursday for about 3 hours or more based on the number of truckers and counseling is also carried out during these camps. On Fridays and Saturdays the health camps are done in the late afternoons to the evenings from about 5 to 8 PM. The clinic sites are the halt points including Parking sites where covered rooms are mostly available.

2. Quality of the services- infrastructure (clinic, equipment etc.), location of the clinic, availability of STI drugs and maintenance of privacy etc.

In the health camps there is reasonable space with both audio and visual privacy for the Doctor and partial audio privacy for the lady Counselor as these camps are held in rooms available at the Parking sites. The room has a sub room in the front which is used by the Counselor. There has been no stock outs and there is availability of STI drugs. General medicines are often supplied by the organization and these are sometimes not available.

3. In case of migrants and truckers the STI drugs are to be purchased by the target population, whether there is a system of procurement and availability of quality drugs with use of revolving funds.

The issue of selling STI drugs and the revolving fund has reportedly caused clients to question the need to purchase STI drugs which has led to the organization diverting clients to Government treatment centres. During our visit to the health camp at Patel Parking on the 4th of July, 2015, one client returned the medicines after being told that he would have to pay about Rs. 30 /- for the same.

4. Quality of treatment in the service provisioning- adherence to syndromic treatment protocol, follow up mechanism and adherence, referrals to VCTC,ART, DOTS centre and Community care centres.

There is a qualified local physician who is also experienced and has a clinic in the operational area. The doctor has received training on Syndromic management and practices the same as reported. The organization sometimes refers clients to his clinic as he is willing to treat them there. However, fund flow to the organization is creating difficulties for him too.

5. Documentation- Availability of treatment registers, referral slips, follow up cards (as applicable- mentioned in the proposal), stock register for medicines, documents reflecting presence of system for procurement of medicines as endorsed by NACO/SACS and the supporting official documents in this regard.

Records are available as per norms. The registers are up to date. However, there is ove3r documentation with a day sheet for medicines usage which can be done away with if the existing exel sheet uses summation for cumulative usage to enable the user to be more efficient and less time consuming.

6. Availability of Condoms- Type of distribution channel, accessibility, adequacy etc.

There is availability of condoms in most of the various outlets visited and the project had planned 80 outlets of which currently 60 are functional. Out of the 60 only two are traditional. The supply chain is planned for replenishment through either PE channel or telephonic from the outlets.

7. No. of condoms distributed- No. of condoms distributed through different channels/regular contacts.

The project target was to do social marketing of 10 lakhs and 08 thousand condoms during 2014-15 along with support from PSI and the project team was able to do 40,796 during the same period taking into consideration that PSI data is not available. PSI after two bouts did not come and do any refilling or follow up. The FSW and MSM / IDU core group projects also overlap in operational area terms causing difficulty for condom social marketing. The revolving fund is Rs. 10,000 /-. It is apparent that the target is unrealistic and the PSI support is not workable. Recently the target has been revised to 84, 000 which is more realistic.

8. No. of Needles / Syringes distributed through outreach / DIC.

Not applicable.

9. Information on linkages for ICTC, DOT, ART, STI clinics.

The local ICTC is located at Darlimra Urban health centre which is about 5 kilometers away. There is good linkage with the local ICTC centre but the costs are prohibitive owing to auto rickshaw costs. Regarding reports the Urban Health Centre is proactive and gives priority to truckers reports and the ORW often waits to collects these reports. However, the other ICTC centres which are nearer to some of the project sites and heavy workloads and thus reporting is delayed. Regarding DOTS there is a Rajasthan based NGO Ajeevika which is working on TB close by and the project receives substantial support including the mobile van for migrants. During the last month one DOTS case was positive in the Urban Health centre.

10. Referrals and follows up

Referrals were 4,833 in the 2014-15 with an average of 400 per month and out of that and follow up appears moderate with 1,773 tested during the same period and 13 cases were found to be positive. Out of these 13 only 5 were linked to the ART centre. DOTS referrals of positives have been done.

**V. Community participation**

1. Collectivization activities: No. of SHGs/Community groups/CBOs formed since inception, perspectives of these groups towards the project activities.

Collectivization efforts have not yet been attempted.

2. Community participation in project activities- level and extent of participation, reflection of the same in the activities and documents

Community participation is restricted to support in hosting health camps and there is acceptance of the staff.

**VI. Linkages**

1. Assess the linkages established with the various services providers like STI, ICTC, TB clinics etc…

Linkages have been established with the ICTC, STI testing facilities and DOTS. One problem is delayed reporting in some of the related ICTC centres which discourages the truckers.

2. Percentages of HRGs tested in ICTC and gap between referred and tested.

High risk mapping and identification is not well taken up. The gap between referrals is that 4,833 were referred out of which 1,773 were tested.

3. Support system developed with various stakeholders and involvement of various stakeholders in the project.

There is good rapport developed with the different stakeholders including the Transport companies and the Parking sites where the halt spots are located.

**VII. Financial systems and procedures**

1. Systems of planning: Existence and adherence to NGO-CBO guidelines/ any approved systems endorsed by SACS/NACO- supporting official communication.

No Deviations Recorded.

2. Systems of payments- Existence and adherence of payments endorsed by SACS/NACO, availability and practice of using printed and serialized vouchers, approval systems and norms, verification of documents with minutes, quotations, bills, vouchers, stock and issue registers, practice of settling of advances before making further payments.

The cash balance of the NGO is frequently above Rs 5000/- which needs to be taken into consideration.

3. Systems of procurement- Existence and adherence of systems and mechanism of procurement as endorsed by SACS/NACO, adherence of WHO-GMP practices for procurement of medicines, systems of quality checking.

No Deviations Recorded.

4. Systems of documentation- Availability of bank accounts(maintained jointly, reconciliation made monthly basis), audit reports

Audit Report For the year 2014-15 not yet finalized and is under process.

**VIII. Competency of the project staff**

VIII a. Project Manager

Educational qualification & Experience as per norm, knowledge about the proposal, Quarterly and monthly plan in place, financial management, computerization and management of data, knowledge about program performance indicators, conduct review meetings and action taken based on the minutes, mentoring and field visit & advocacy initiatives etc.

The Project Manager is experienced and has MA in Home Science qualification and has HIV AIDS project experience of about 9 years and is currently satisfied with the organization and thus does not want to leave. She has been associated with the project since inception and independently handles this project with good knowledge of issues.

VIII b. ANM/Counselor

Clarity on risk assessment and risk reduction, knowledge on basic counseling and HIV, symptoms of STIs, maintenance and updating of data and registers, field visits and initiation of linkages etc

The Counselor is a female who is very qualified with a MA in Pshycology and Diploma in Counseling and has considerable experience and skills on Counseling. Although she is a femalre, it appears that there has been no problems in reaching out to the target community.

VIII c. ANM/Counselor in IDU TI

Clarity on risk assessment and risk reduction, knowledge on basic counseling and HIV, symptoms of STIs, maintenance and updating of data and registers. Working knowledge about local drug abuse scenario, drug-related counseling techniques (MET, RP, etc.), drug-related laws and drug abuse treatments.

For ANM, adequate abscess management skills.

Not applicable.

VIII d. ORW

Knowledge about target on various indicators for their PEs, outreach plan, hotspot analysis, STI symptoms, importance of RMC and ICTC testing, support to PEs, field level action based on review meetings etc..

There are 8 ORWs of which 2 are females. All of them are well experienced and have received induction training. The ORWs are well versed with project issues, STI symptoms and ICTC testing. However, location specific data collection is one of the weak areas.

VIII e. Peer educators

Prioritization of hotspots, importance of RMC and ICTC testing, condom demonstration skill, knowledge about condom depot, symptoms of STI, knowledge about service facilities etc.

There has recently been a deluge of majority of PEs leaving their positions owing to fund issues. The existing PEs are able to demonstrate the required skills.

VIII f. Peer educators in IDU TI

Prioritization of hotspots, condom demonstration, importance of RMC and ICTC testing, knowledge about condom depot, symptoms of STI, working knowledge about abscess management, local drug abuse scenario, de-addiction facilities etc.

Not Applicable.

VIII g. Peer Educators in Migrant Projects

Whether the Peers represent the source States from where maximum migrants of the area belong to, whether they are able to prioritise the networks/locations where migrants work/reside/access high risk activities, whether the peers are able demonstrate condoms, able to plan their outreach, able to manage the DICs/ health camps, working knowledge about symptoms of STI, issues related to treatment of TB, services in ICTC & ART.

Not applicable.

VIII h. Peer Educators in Truckers Project

Whether the peers represent ex-truckers, active truckers, representing other important stake holders, the knowledge about STI, HIV, and ART.Condom demonstration skills, able to plan their outreach along with mid-media activity, STI clinics.

Majority of the Peer Educators are well experienced and have been around for more than two years. They have good skills as evidenced from their communication drills. However, owing to lack of documentation their services are not adequately recorded.

VIII i. M&E officer

Whether the M&E officer ( FSW and MSM/TG TIs with more than 800 population and all migrant TIs are eligible for separate M&E officer) is able to provide analytical information about the gaps in outreach, service uptake to the project staff. Whether able to provide key information about various indicators reported in TI and STI CMIS reports.

The M & E officer has recently left the project and joined elsewhere. Data storage and maintaining of registers is up to date.

**IX. a. Outreach activity in Core TI project**

Interact with all PEs (FSW, MSM and IDU), interact with all ORWs. Outreach activities should reflect in the service uptake. Evidence based outreach plan, outreach monitoring, hotspot wise micro plan and its clarity to staff and PEs etc.

Not Applicable.

**IX. b. Outreach activity in Truckers and Migrant Project**

Interact with all PEs and ORWs to understand whether the number of outreach sessions conducted by the team is reflecting in service uptake that is whether enough clinic footfalls, Counseling is happening. Whether the stake holders are aware of the outreach sessions. Whether the timings of the outreach sessions are convenient / appropriate for the truckers/migrants when they can be approached etc.

Outreach services are done accordingly as the truckers halt time varies from 1 or 2 days and the staff team have good rapport with the transport agencies, parking sites and brokers.

**X. Services**

Overall service uptake in the project, quality of services and service delivery, satisfactory level of HRGs,

There is development of rapport by the staff amongst the target groups. HRG assessment appears to be weak areas.

**XI. Community involvement**

How the TI has positioned the community participation in the TI, role of community in planning, implementation, Advocacy, monitoring etc

Communities appreciate the staff work as well as project contribution. There is good involvement of the Parking site owners as they not only offer their infrastructure but also their audio visual aids such as the television sets for BCC activities.

**XII. Commodities**

Hotspot / project level planning for condoms, needles and syringes. Method of demand calculation, Female condom programme if any,

The number of condom outlets is about 80 % of the planned target. Supply planning is found to be adequate with no stock outs noted. There is availability of STI drugs but the organization is now facing budgetary constraints. However, elementary demand estimation is weak.

**XIII. Enabling environment**

Systematic plan for advocacy, involvement of community in the advocacy, clarity on advocacy , networks and linkages, community response of project level advocacy and linkages with other services etc. **In case of migrants (project management committee) and truckers (local advisory committee) are formed and they are aware of their role, whether they are engaging in the programme.**

The organization has not set up a local advisory committee.

**XIV. Social protection schemes / innovation at project level HRG availed welfare schemes, social entitlements etc.**

None

**XV. Best Practices if any**

Not significant. However, the organization follows 30 % women amongst staff with the project leadership i.e. Project Manager and Counselor being females.