***Annexure: B***

**Reporting Format-B**

**Structure of the Detailed Reporting format**

**(To be submitted by Evaluators to SACS for DIA evaluated with a copy to NACO)**

**Introduction**

* **Background of Scheme and Organization**

Presentation Society – Jeevan Jyothi Social Center is a registered Society under Bombay public act in 1958 and re-registration was done in 2001. They work on health, education and livelihood.

The organization conducted baseline survey in the year 2000 on health awareness and realised that there is urgent need to address the health hazardous of migrants. Hence taken a step forward towards prevention and care of HIV/AIDS and educating families on one to one specially living in the vicinity of slums about the causes of HIV and how it can be prevented from. Some of the issues like HIV/AIDS, family planning, early marriage, STIs, adult education, program for women and school drop outs have been addressed through different activities and education.

* **Name and address of the Organization**

**Presentation Society- Jeevan Jyothi Social Center, Mangor Hill, Vasco da Gama, Goa**

* **Chief Functionary:**

1. Sr. Rajpushpa - President
2. Sr. Nilfa D’cruz – V. President
3. Sr. Thecla – Treasurer
4. Sr. Dipti - Member
5. Sr. Mariazina - Member
6. Sr. Mercy - Member
7. Sr. Sheila - Member

* **Year of establishment**

It was established in Ireland in 1775 and in India in 1840.

* **Year and month of Project initiation:**

October 2008

* **Evaluation team**

Snehlata Bhatia – Evaluator

Archana Doshi – Goa SACS Representative

Sabina Godinho – Finance Assistant, Goa SACS

* **Time frame (dates of evaluation)**

2nd March and 3rd March 2016

**Profile of TI**

* Target Population Profile: MIGRANTS
* Type of Project: Bridge population
* Size of Target Group(s) :

Estimated population of 15 sites is 29,200

* Sub-Groups and their Size: NA
* Target Area: Azadnagar, Birla, Zuarinagar, Motidonger, Khareband, Betul jetty, Kharewada jetty, Baina, Construction sites, Ramnagar, Jai Ramnagar, Mobor jetty, Gogol area, Mangor

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

1. **Organizational support to the program**

Meeting was held with Project Director and one of the sisters. TI program is in line with their objectives. They are supportive and help in community mobilization advocacy with stakeholder. The Project Director also takes the program update during the monthly review meetings. Project Director is supportive and present during any major events conducted in the field.

The project staff presented their achievement of April 2015 to Dec 2015 to the evaluator. Role and responsibilities are known to the project team.

1. **Organizational Capacity**
2. **Human resources:**

Staffing is maintained as per the guidelines. The reporting structure and hierarchy is maintained. The roles and responsibilities of each staff and cadre are known to them. The staffs conduct the activities and adhere to them as per the guidelines. The staff is sensitive towards the target community and effectively handles the situation with confidentiality.

1. **Capacity building:**

Most of the staff are old and are trained by SACS, TSU. Formal trainings and in-house trainings are conducted by Goa SACS/TSU during evaluation period. In-house training is given by PM to the newly joined ORW.

Check list should be available for the induction training.

1. **Infrastructure of the organization**

The project office is established at the rented place in Vasco, South Goa, which is centrally located and sufficiently accessible. The current infrastructure houses the Jyothi project for Adolescents and youth, Jeevan: Adult care project, Nai Rista: Compassionate Partnership, Anjali: Nutritional Project, Swasthya: Health Project, Butterfly clubs for play and TI. The project office space is spacious and sufficient with proper infrastructure and assets including chairs, tables, computers and cupboards.

1. **Documentation and Reporting**:

Monthly reporting to Goa SACS is done by the TI project. Registers and records are maintained at the office level as per the required formats. Monthly review meetings are held at office level and by TSU/SACS at State level. Feedbacks shared during the review are followed up by project staff. SIMS is submitted to NACO.

1. **Program Deliverables**

**a. Outreach**

1. Line listing of the HRG by category.

Master register is maintained in computer.

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

Registration of migrants is done through 3 service sources and also in the field by ORWs.

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

NA

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

Micro planning is developed and maintained in the office. Visit plans are in place and documented at office level. ORWs with other team members develop monthly and weekly plan which is followed up but it is done mechanically. Same targets and events are planned even during 2 months when fishing jetties are closed.

5. Coverage of target population:

Bridge population: Target for 9 months is 9000 and registration is done of 7677.

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

Outreach planning is done but documentation is weak. Observation of PEs skills, messages are not mentioned anywhere. PEs and ORWs reported that they conduct sessions but is not reflected in PEs daily dairies. PEs diaries have name of 20 people in each month. ORWs and PEs are not using IPC tools.

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

PE ratio is maintained but due to budget constrains 10 PEs are active out of 14.

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

NA

9. **Documentation of the peer education**

Peer educators have notebook but work done is not recorded properly.

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

During evaluation could interact with 4 PEs. All of them need a lot of capacity building. During session they use word of *“galat kam karte hai”.* One of the female PE said she never talks about condom. Most of the community members are illiterate and listen to whatever PEs said. They don’t raise any question.

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

ORWs are daily in the fields. Weekly once they meet each PE. Data is collected from PE. Counsellor is in the field during health camp, events and counseling purpose. PM is in the field as and when required. M & E is present during events.

Counsellor said he does follow up of STI cases but record is not found. HIV positive are followed up, no mechanism for the HIV positive who have migrated. MSDS is developed by SACS but data entry started from Jan ’16.

**IV. Services**

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

Health camps are organized as per guidelines i.e. 60 hours in a month. Holidays like Sundays and feast days whole day health camps are organized.

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

NA

1. 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 doctor is qualified and very enthusiastic towards his work. He gives STI drugs

free of cost received by him as sample drugs. So STI drugs are not purchased by the TI.

Health camps are organized at congregation points, at residence of migrants and

workplace of migrants.

1. 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.

STI patients are treated as per symptoms. All STI treated are referred to ICTC. Counsellor said he does the follow up but records not found. Importance of partner treatment is not observed. HIV positive are registered at ART.

1. 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.

Treatment register, referral slips are available. Follow up card or follow up date in the

register is not recorded. STI drugs are not purchased.

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

Condom scarcity is observed due to fund constrains. Out of 50 condom depots 12

are active depots. It is observed that there are shops where condoms are available. The TI should guide the migrant HRB for condom purchase. They should also visit the shops and keep records of condom sold in the area.

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

Condom demand is 30700 for 9 months but condoms are sold 2700.

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

NA

1. **Information on linkages for ICTC, DOT, ART, STI clinics.**

Linkages with ICTC, DoT, ART, STI clinics are established.

1. **Referrals and follows up**

During 9 months 3000 are referred to ICTC and 2127 are tested. Over 5 years they have 58 people who are HIV positive from which 6 have died, 35 are in contact which are registered at ART.

**V. Community participation**

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

Groups as such are not formed.

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

Community participation is not observed.

**VI. Linkages**

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

Referral slips of ICTC are verified randomly and found records.

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

During 9 months 3000 are referred to ICTC and 2127 are tested. 70.9 % have been tested so 29.1 % is gap.

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

Stakeholders like contractors, supervisors are supportive but no contacts are made

with Builders of construction sites. Small children from 1 year to 5 years are around the

construction site left on their own while their parents are at work. Support could be

sought from the builders to build a shed for the children’s recreation as the labourers are

there for almost 3 years.

**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.

Financial planning as per SACS/NACO guidelines and expenditure is made accordingly

1. Systems of payments- Existence and adherence of payments endorsed by SACS/NACO,

All transaction above Rs.5000/- are through bank, cash transactions are for petty work below Rs.5000/-

1. 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.

Yes the NGO is using printed, serialized vouchers, vouchers are approved, bills are enclosed to the respective vouchers, stock and assets registers are maintained. No advance is given by the NGO.

1. 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.

Normally medicines are issued by the SACS. Procurement of assets was made initially at the time of starting of the project i.e. 2008, however the files were not available for verification.

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

Yes separate bank account is maintained operated jointly, bank reconciliation is carried monthly upto 29th Feb 2016 the books are reconciled. Audit observations are complied.

**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.

Shaista Sheik is with TI from Jan ’11. She is Bachelor of Sociology and Physiology. She has clear understanding of the program. She is very competent. She has knowledge about proposal. Quarterly, monthly and weekly planning are available. Data entry is going on from Jan ’16. Review meetings are conducted regularly. Minutes are available. Field monitoring are done. Advocacies are conducted. She need to observe IPC sessions and conduct field training. She needs to observe messages given by project team and feedback should be given.

**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

Parsuram Harijan is with TI from Jan 2010. He is 12th pass. The counselor has knowledge but it missed out at implementation. No record is found on ongoing counselling of HIV positive. Family counseling of HIV positive is not done. Follow up of STI patients are not seen. Partner notification is missed out. Field visits are done for health camp. It seems work is done mechanically.

**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 5 ORWs. Aarati Gupta is with TI from June ’11, she is 7th pass. Kiran Jain is from Oct ’12, she is 8th pass. Suresh Chawan is from Oct ’13, he is 12th pass. Pushpa Sakhpal is from Feb ’13, she is 12th pass and Bindiya Sakhalkar is from Feb ’16, she is 10th pass. Bindiya is in training phase. The 4 ORWs are trained and experienced. The ORWs have knowledge of the components but needs to be up-dated. Group sessions are conducted but IPC tools are not used. During session in the field it is observed that ORW uses word like “galat kam karte hai” and “if HIV positive woman is pregnant then she has to go for scissoring“ “65 % children are saved from getting HIV from HIV positive mother” “HIV positive mother should not breastfeed her new born baby at all” etc. IPC tools are not used by ORWs.

**IX 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.

I could interact with 3 peers from 10 active peers and 1 from non active peers. One of the peer educators conducted session in the field also used word “galat kam karte hai” like ORW. Record keeping is poor. One of the peers had list of 20 names in each month. They say they conduct session but is not recorded anywhere. IPC tools are not used by the Peers. They are aware of STI, ICTC, DoT services availability.

**X .h. 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.

Ms. Reena is M&E cum Accountant. She is Bachelor of Arts. She is with TI from Oct. 2008. Master register is maintained in the computer. MSDS data entry started from Jan ’16. She provided information about various indicators of TIs. She analysis data and feedback is given.

**X. 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.

**NA**

**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.

The ORWs and PEs are aware of the migrant’s availability and accordingly they are in the field. Quality of sessions conducted is poor and IPC tools are not used. Counselling is done 3662 against target 2850. I could not observe the quality of counseling. Clinic footfall is 3219 against target 2850.

**X. Services**

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

Condom promotion is very poor. Health camps are organized as per availability of migrants.

**XI. Community involvement**

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

Community is not involved in planning, implementation, advocacy or monitoring.

**XII. Commodities**

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

NA

**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.**

No committee is formed for project management.

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

Not done.

**XV. Best Practices if any**

Not observed or reported by the team

**Annexure C**

**Confidential**

**Reporting form C**

**EXECUTIVE SUMMARY OF THE EVALUATION**

**(Submitted to SACS for each TI evaluated with a copy to DAC)**

**Profile of the evaluator(s):**

|  |  |
| --- | --- |
| **Name of the evaluators** | **Contact Details with phone no.** |
| **Snehlata Bhatia** | **B-2 City Light Apartment, City Light, Parle Point, Surat, Gujarat 395 007**  **Phone: 9879517651** |
| **Finance Evaluator:** | **Sabina Godinho** |
|  |  |
| **Officials from SACS/TSU (as facilitator)** | **Archana Doshi,** |

|  |  |
| --- | --- |
| **Name of the NGO:** |  |
| **Typology of the target population:** | Bridge population |
| **Total population being covered against target:** | 7677 against 9000 |
| **Dates of Visit:** | 02/03/16 and 03/03/16 |
| **Place of Visit:** | Office cum DIC, Umiya Construction site, ICTC and STI clinic at Chikalim Cottage Hospital, Kharewada Fishing jetty, Baina area |

**Overall Rating based programme delivery score:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Total Score Obtained (in %)** | **Category** | **Rating** | **Recommendations** |
| Below 40% | D | Poor | Recommended for |
| **41%-60%** | C | Average | Recommended for |
| **61%-80%** | **B** | **Good** | **Recommended for continuation** |
| **>80%**  **(82.80)** | **A** | **Very Good** | **Recommended for continuation** |

**Specific Recommendations:**

|  |
| --- |
| * Counsellor, ORWs and Peer Educators need capacity building in message delivery, IPC tools, record keeping and documentation. * Micro planning is done but at implementation is routinely done. Eg. Same target is set when Fishing jetties are closed for two months. * Follow up of STI patient is needed. * Family counselling of HIV positive is missed out. * Migrants should be guided to the stores of the areas where condoms are available. * The team need clarity on who are the stakeholders and their involvement. |

**Name of the evaluators Signature**

|  |  |
| --- | --- |
| Snehlata Bhatia |  |
| Sabina Godinho |  |
| Archana Doshi |  |