**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 DAC)**

**Introduction**

* ***Background of Project and Organization***

**Gunvant Shikshan** Sanstha is a social service organization registered under the Trust Registration No F/2886/Akola Dated:28/4/1993 & Society Act No Mah/3698/Akola Dated; 5/2/1993 By Charity Commissioner of Akola.

* Pioneer in the District for Implementing HIV/AIDS Project
* Govt Civil Hospital, Coordination Committee Member
* Truckers Targeted Intervention Under MSACS from 2004 to 2006
* 36 Positive Pregnant Mother Delivery Done in the Govt Hospital for

Providing NVP through NGO Outreach & 14 New born children follow up done under Prevention of Parent to child transmission Project in 2009-2010

* Working Under Swadhar 38 employee for the Rehabilitation Purpose
* Festival HIV/AIDS Awareness Program in 2007 & 2008
* NAVJEVAN PREVENTION OF PARENT TO CHILD TRANSMISSION PROJECT FUNDED UNDER MSACS (PPTCT)
* SAHARA TRUCKERS INTERVENTION PROJECT
* SWADHAR RESIDENTIAL HOME FOR GIRLS
* PRIME MINISTER ROJGAR YOGNA TRAINING PROGRAMME
* PROGRAMME ON ENVIRONMENT AWARENESS
* ROAD SAFTY PROGRAMME
* SHG TRAINING
* MICRO PLANING
* ANIMAL CARE PROJECT
* BAL HAKK ABHIYAN
* BEAUTY PARLOUR TRAINING PROGRAMME
* PLWHA MEETING
* DISABILITY COUNSELLING CENTRE
* MICRO PLANING
* SAMAJ SHALA
* REFRESHER TRAINING FOR DRIVERS
* VYAYAM SHALA
* FASION DESIGNING
* WELFARE OF OLDER PEOPLE
* BAL HAKKA ABHIYAAN
* ANIMAL SHELTER & CARE
* Awards- 100% Girls Admission in Swadhar Centre
* Innovative approach -
* DEVELOP OWN MANAGING COMMITTEE EMPLOYEE

RULES & REGULATION MANUAL

* Financial Management Manual
* Staff Appraisal System
* Advisory Committee
* Monitoring System
* In Process to Prepared Gender Policy
* Interactive activities- SHG Formation &Community Development Committee formation.
* Other- Organisation registered with Road Saftry Dept & Social Welfare Dept, Mantalaya.

|  |  |
| --- | --- |
| The organisation is working in grass root level under different programs with involvement of Key stakeholders. | We have a good rapport with the grass root level & village level Committee, which will easily help us understand the village level Leader & Source. |
| Trained, qualified & experienced staff & Consultant | Commitment will be there, & good understanding for Technically implementing Various Project |
| Board & Staff members are good trainers & having experience & Qualified Doctored, Engineer, to implement MSACS & Govt &Social Welfar, HIV/AIDS Project | The New Project staff will get good guidance & training from these members. |
| Good Financial condition & Documentation | Run Project on Own when funds not available |
| Experience in Implementing MSACS TI & PPTCT Project, Social Welfare, Road Safty, Jilha Parishad Dept Project | Experience used to Coordination & Networking with Govt and Private funding agency to implement Project |
| Specialized exp in PHC/Village Wise Peer identification & Appointment & village level worker in Akola | Utilize for Village Level Peer will be identify for the project |

Ngo involves all the community members in the Program such as Cultural troop, Stakeholders Association, Truckers/cleaners and Partners & stakeholders, Pan Stall owner, Guest House Owner, STD booth owner, Health dept , BMC officers, Police officers, RTO, NGO, Pvt Hospital & Doctors and DLN.

* **Name and address of the Organization:**

***Gunavanth Shikshan Sanstha, Digamber Tower, opp. Shrisat Market, Ranpise Nagar, Akola-444005, Maharashtra.***

* ***Chief Functionary***

***Ms. Arunthati Shrisat, Secretary***

* ***Year of Establishment***

***1993***

* ***Year of month of project initiation***

***February 2012***

* ***Evaluation Team***

***Mathivanan R, Imithiaz Ahmmed and Gajanan (Finance)***

* ***Time Frame***

***11, 12 and 13 April 2016.***

**Profile of TI**

(Information to be captured)

* ***Target Population Profile: MSM&TG***

***Target is 500 and active population as on today: 668***

* ***Type of Project: Core Composite***
* ***Size of Target Group(s): 500 and 668 active***
* ***Sub-Groups and their Size: MSM-584 and TG-85***
* ***Target Area***

***Akola, Akot, Murthijapur areas of Akola district.***

**Key findings and recommendation on Various Project Components**

1. **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…

Ms. Arunthati Shirsat, the president of the NGO and Mr. Vijay Taranath Shrisat, Secretary have been interacted on their perspective of these project activities. Both of them told that they were planning to implement HIV prevention programme among their community as they felt that HIV was a threat to the society and it is mixed with moral values of the community. The President is an elected member of corporation and she said that they had witnessed many affected by HIV in their community locally and hence they decided to implement some project and applied MSACS. The secretary is serving as PD and he has been observed with complete involvement the way he explained his role. Both of them were available throughout the evaluation process that showed their involvement. The staffs expressed their complete satisfaction on their support whenever required and they were encouraging the staffs and President has initiated many social entitlement schemes to the community. The president has been available. They have the vision of promoting both MSM and FSW CBOs as capable of addressing all the needs of the community in future. Overall it has been very much apparent that they are very much involved in the project both in field level and management.

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

All the contracted staffs were found available as 1 PM, Counsellor-1, M&E cum accountant-1, ORW-2 and PD during evaluation. PM is monitoring the whole project activities and he provides support supervision in the field to ORW. Both the ORWs have been replaced in the last 12 months and trained by the CBO, not MSACS. The PM is primarily monitoring all the activities and reporting to SACS. He provides support to all staffs. Five ORWs are monitoring and supporting the PEs. PD also is visiting the field whenever required. All staff members attend the review meeting and plan for the coming month. PD attended 11 out of 12 meetings in the last year. Since all the staffs are from the community the commitment of office bearers and staffs found excellent through the way they have described their roles and responsibilities. The best part of the TI found was no complaints about anything or anybody (within themselves, towards SACS, DPO and TSU-PO). The staff turnover is a major concern as all the two ORWs are new and none represents the community. They need to appoint one ORW from the community.

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

Training register has been available for verification but impact assessment has not been done. The newly inducted ORW has to be trained further on project components. Proper and recommended materials need to be used in the trainings. This has been evident among both ORWs who were discussed on their knowledge on HIV and programme implementation part and they could explain the components and indicators but need more role clarity. Though they work hard they need more attention in proper documentation and his diary was found with errors and mismatches. No impact assessment has been done as per document but during monitoring the office bearers are assessing the staffs’ capacity in implementation and reflection of the same in impact at overall TI implementation level.

1. ***Infrastructure of the organization***

The office of the organization is located in heart of the city and HRGs could use it often, equipped with all furniture, computers and enough space to conduct internal trainings. Many of the HRGs were using the office for resting and sharing purposes. The office is attached with the DIC and the clinic is two KM away from the TI.

1. ***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.***

TI is maintaining all required documents such as From A, B, C, C1 ,D, ORWs tracking Sheets, HRG line list, Syphilis register, Drug Register, Condom Stock register, Event Register, referral slips, Monthly meeting register Movement Register, Micro plan, daily dairy and action plan.

However form B and C are maintained by ORWs with the support of PEs and form B and C were found maintained together in one format. They are conducting weekly & monthly review meetings regularly. They are collecting data from ORWs during the meeting and reporting to MSACS. The PD attended 10 of the 12 monthly meetings conducted. The documents are maintained mainly by the Counsellor and M&E officer. PM requires being involved more in document.

They maintain counselling Register, STI clinic register, ORWs daily dairy, Master register, HRGs line list and CMIS report file and meeting minutes. They don’t have any feedback mechanism other than shared during the weekly and monthly meetings. M& E is entering all collected reports in system. The gap analysis system is practiced. The manager also has work plan/action plan and maintain diary. The manager needs to sign in the diaries of ORWs during his field visit. Monthly review meeting was found with action plan but need to be properly maintained with gaps analysed towards each staff and suggestions by PM&PD and follow up action taken points.

1. **Programme Deliverables**

**Outreach**

1. ***Line listing of the HRG by category***

A total number of 668 currently have been line listed against the target of 500. Category wise population is MSM-583 and TG-85

1. ***Registration of migrants from 3 service sources i.e.STI Clinics, DIC and Counseling.***

***Not Applicable***

1. ***Registration of truckers from 2 service sources i.e.STI Clinics and Counseling.***

***Not applicable***

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

Site wise /PE wise Micro plan has been found in place and the same has been verified with achievements as matching and the reports were documented properly. All the staffs were aware of the micro plan and data.

1. ***Coverage of target population (sub-group wise); Target/Regular Contacts only in HRGs***

A total number of 668 have been line listed against the target of 500. Category wise population is MSM: 583, TG: 85. The regular contacts are 504 in total.

1. ***Outreach planning-quality, documentation and reflection in implementation.***

Outreach planning needs to be done systematically as the PEs providing the gaps in delivery of services to the ORW every week in weekly meeting and planning for the next week but no suggestions and action taken points mentioned. The ORWs have form B and C together and discussing the other service deliveries such as referrals to STI, ICTC, sessions and condom estimation. The quality of the document has been verified good as the B&C forms were cross verified with diaries and C1. The planned activities have been carried out and the same is reflecting in their fields verified. It is suggested to follow properly based on the review gaps and follow up actions.

1. ***PF: HRG ratio, PE: migrants/truckers.***

***Not applicable***

1. ***Regular contacts (as contacting the community members by the outreach workers/Peers***

***at least twice a month and providing services as 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.***

504 HRGs have been regularly contacted with the project services at least twice a month and providing condom, STI, ICTC and IPC services. The understanding of the project staffs has been very good and they could explain their responsibilities and the importance of the services. Though their condom distribution level and usage in the community reportedly good, social marketing of condom has not yet been started is a big gap. As the community expressed the need, they have to explore the possibilities of supplying jelly along with the condoms regularly.

1. ***Documentation of the peer education.***
2. Quality of peer education-messages, skills and reflection in the community.

The peer education document has been noticed that PEs are maintaining diaries and ORWs are filling up the forms. Form B is maintained by the ORW with the complete inputs of PE. It has been suggested to document on how many members are regularly using condoms, how many of them are found with risk perception and increased health seeking behaviour etc. All the met 12 PEs were able to tell what they do as peer educators. It was observed that they had been well trained and having knowledge on how HIV spreads through, prevention, STI symptoms, ICTC, PT, Syphilis test, condom demand calculation and condom usage. All the 12 PEs could demonstrate condoms. All the met 16 members have explained all the services and they know the clinic places. All of them found with condoms and thye said that they couldn’t use condoms always with their regular partner/lover.

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

The supervision mechanism has been found available as ORWs supervise the PEs and PM is supervising the ORWs and PE. As the PM has been promoted from ORW level he has a good level of contact with PEs. Every month they conduct review meetings and discuss the gaps and plan to address them. The monthly review meeting minutes were verified and action taken points were available in all the meetings. It was reported that PD is supervising all the staff members in the field and it was observed that PD is highly committed and complete understanding of the project. However no follow up in action has been documented but it has been found done during discussion and course of evaluation.

1. **Services**
2. Availability of STI services-mode of delivery, adequacy to the needs of the community.
3. Quality of the services-infrastructure (clinic, equipment etc), location of the clinic, availability of STI drugs and maintenance of privacy etc.
4. 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 the use of revolving funds.
5. ***Quality of treatment in the service provision-adherence to syndromic treatment protocol, follow up mechanism and adherence, referrals to VCTC, ART, DOTS centre and community care centres.***

* TI is maintains healthy rapport with all ICTC’s for smooth honoring of HIV testing referrals.
* Records have shown that 18 active HIV positive HRG in TI, but there seems to be some lacking in follow-up to adherence of ART.3 HRGs are in LFU.
* The documentation of their current status with regard to ART registration, drug adherence, CD4 is maintaining by TI.
* The project manager needs to monitor and update the records regularly.
* The ORW and PEs are having very good linkages with the community and service providers of the every site.
* During visit of ICTC it was observed that the TI is sending the referrals to 2 hospitals in its working area and we were visited KG hospital and DHW-Akola. The counsellor expressed that the TI is sending referrals regularly to the ICTC and ICTC counsellor is attending the health camps on regular basis.
* TI referrals were matched at ICTC and ART centres.
* There were no TB clients at TI level.

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 officials documents in this regard.***

* The TI maintains a separate register for every component.
* The clinical cards are maintained month wise.
* Regarding referral slips the clinic ANM/Counselor is maintaining the month wise referral slips in file.
* Stock register was also verified, it’s also maintained in as per the MOU.
* Condom stock register as well as distribution register is available.
* The TI budget is not utilized for drugs procurement.

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

* The free condoms supplied by MSACS directly to the TI on their demand.
* There was adequate condom availability at the project office.
* The main channels of distribution of condoms are 1to1, 1to groups and clinic only. The DIC register was not reflected the condom distribution.
* During counseling the condom being used for Demo and Re demonstration of condom usage.
* Social marketing condoms also done by TI, but it is very minimal

1. ***No. of condoms distributed through outreach/DIC.***

* 94118 free and 2700 social marketing condoms distributed in current year.
* There was 4 months no condoms available at TI level.
* The social marketing of condom has been started in this TI last one year the field team sold 2700 condoms to HRGs.
* Social marketing of condoms needs to be improve.

1. ***No. of Needles/Syringes Distributed through outreach/DIC.***

***Not applicable:***

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

* TI is maintains healthy rapport with all ICTC’s for smooth honoring of HIV testing referrals.
* There were only 2 repeat STI infections found.
* There were no TB cases at project level.
* PLHAs are receiving ART services without any disturbances because the NGO done the advocacy with the service providers on regular basis and also maintain the healthy rapport.
* The counsellor of DSRC of DHW hospital is very committed and innovative, she discharged the services to every client in kind manner.

The community is very interested to avail the services at DSRC centre.

1. ***Referrals and follows up.***

* Referral mechanism is good
* They are maintaining separate file for referral slips.
* The referral slips are being maintained month wise.
* Follow up mechanism needs to improve at all levels of TI.
* Follow up register also maintained.

1. **Community participation:**
2. ***Collectivization activities: No. of SHGs/Community groups/CBO’s formed since inception, perspectives of these groups towards the project activities.***

Community collectivisation has been planned as PD said that they were planning to form a CBO among the TG. At present there is no SHG or support group formed among the HRG. Since this TI has started three years before and this is the first evaluation we have strongly suggested concentrating on this.

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

Community participation was evident in terms of DIC meetings, participating in events and clinic visit. All of them could be verified with the concerned documents and scored well in assessment tool in this too.

1. **Linkages**

**VI. Linkages**

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

TI is linked to all the health service providers and have good rapport with them.

|  |  |  |  |
| --- | --- | --- | --- |
| S.No. | ICTC-Centres | ART- centres | DSRC- Centres |
| 1 | KG Hospital |  |  |
| 2 | DHW-Akola | DHW-Akola | DHW-Akola |
| 3 | District Hospital-Akola | District Hospital-Akola | District Hospital-Akola |
| 4 | Area Hospilta-Alkot |  |  |

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

* Total HRGs are 660 among them 476 HRGs underwent for HIV test in above mentioned ICTC centres.
* 72% of HRGs tested for HIV and 28% yet to go for HIV test
* Still balance 184 HRGs yet to be tested for HIV.
* The TI need to prepare concrete strategic plant to cover all HRG to go for HIV test.

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

* With the continuous support of the NGO the TI developed very good linkages with al service providers as well as stake holders of the project.
* We met two stake holders of the project they are having very good public relation in the local city.
* The stake holders are also coming to TI on their free time and providing information regarding social entitlements to the community.
* The TI is putting efforts a lot to find out good stakeholders and involve them in TI programme activities.
* With support of stake holders the TI was planned a AADHAR registration counter at TG areas.
* The Office bearer MRs.Arundhathi is planning to bring some free land pattas to community this is under process and at the table of District Collector for approval.
* The TI and stake holder are giving more support to the community to get some subsided loans for community for economical sustain.

1. **Financial system and procedures**
2. ***System of planning: Existence and adherence to NGO-CBO guidelines/any approved systems endorse by SACS/NACO-supporting officials communication.***

* Financial Planning within the project is done as per approved budget line items. All activities are planned as per the time line item in the proposal .Financial planning is done in accordance with these to meet the implementation requirement.

1. ***Systems of payments - Existence and adherence of payments endorsed by SACS/NACO, availability and practice of using printed and serialized vouchers, stock and issues registers, practice of setting of advances before making further payments.***

* Vouchers are printed and serially numbered and are maintained in proper order. There are some vouchers found                         without supportive documents (i.e Health Camp Expenditure, Crisis Response Expenses, Consolation fees for                         doctor).. With regard to the payments made in the project, it is found that there are some vouchers which are not supported by appropriate bills. There are some cash payments( MSM Project Office Rent, & Peers Honorarium). Stock Register is not updated.

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.***

* Procurement system is in place.
* Organization has obtained permission from MSACS whenever purchases had to be made for the project.
* With regard to medicines for the project, they are provided from MSACS/NACO therefore, medicines were not bought from the local market.

1. **Competency of the project staff.**

**VII 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.

**Mr. Mahesh Pajai**, done his MSW and working as PM in this project for the past one year and he was promoted to PM from ORW position. He served as ORW for one year. He was found with sound knowledge on HIV, STI and programme components and many of the indicators. He explained how he had been collecting the data, supporting ORWs in the field. He said that he was responsible for review meeting, advocacy and crises management, stakeholders meeting and condom programming. He reportedly visits the field 12-13 days a month. He established rapport linkages with ICTC and ART centres. He is visiting ICTC and ART centres at least 2 times every month and once at DAPCU meeting. He has undergone 2 trainings from SCAS. He has good attitude towards the work and community that was established in the field as HRGs were mentioning about his visits and support in terms of advocacy and crises management. He is still doing a sufficient work even without getting full salary. However he is conducting review meeting with discussion and collecting data. He needs to discuss the gaps and prioritising the components to be achieved, suggestions to staffs and action taken points.

**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.

Mr. Gunal Belsare, is a 26 years old young MSW is working as counsellor in this project since November 2014. He was found with good knowledge on HIV, STI, risk assessment, basic counselling skills etc. He maintains the documents of counselling register, STI tracking, RMC and clinic register. He said that he was visiting field 8 days a month. It was verified with the community but few could not tell his name.

**VIII c. ANM/Counsellor in IDU TI**

Clarity on risk assessment and risk reduction, knowledge on basic counselling and HIV, symptoms of STIs, maintenance and updating of data and registers. Working knowledge about local drug abuse scenario, drug related counselling 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.

**Mr. Gopal Phuse:** Educated up to 12th standard and he has joined 7 months before and attended training from SACS. He was able to explain his role as ORW at his area level and he mentioned hotspot based programme. He was found with maintaining form B and C together in a single format. He could tell about the importance of ICTC, RMC and condom programming. He was found with involved in advocacy and crises management programmes. However he needs to prioritise his work based on hotspot meetings outcome. He also is not getting salary and getting a meagre amount of advance and working as much as he can. He was found with recently filled daily diary and he accepted that he lost his diary and rewritten the same with the reference of Form C and review meeting minutes. Some of the dates are not matching with plan and attendance.

**Mr. Gajanan Gahale** has completed BCCA and working in the project for the past 3 months and reportedly trained by NGO. He has adequate knowledge on HIV, risk assessment, condom programming, weekly meeting at hot spot level and importance of RMC, ICTC and STI. He could provide support to PEs at hotspot level but he needs to be properly trained further on project indicators and STI education.

**VIII e. Peer educators**

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

The team met only 06 PEs out of 08. All the met 6 PEs are well informed on prioritisation of hotspots, importance of PT, RMC and HIV testing. They have enough knowledge on HIV and symptoms of STI and syndromic case management. They were able to demonstrate condom usage. All PEs are having contact with registered HRGs and many of them could explain about importance of RMC, ICTC and DIC meetings. They are conducting weekly basis hotspot meetings. Weekly four times ORWs are providing supports to them at field level. All Peer educators are trained on outreach activities at TI level. Peer educators are well aware about facilities and services available at TI level. They could contact the PLHIV in providing moral support and giving education.

**VIII f. Peer educators in IDU TI**

Prioritization of Prioritization of hotspot, importance of RMC and ICTC testing, condom demonstration skill, 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.**

***Not applicable***

**VIII h. peer educator in Truckers Project**

***Not applicable***

**VIII j. M&E Officer**

Whether the M&E officer (FSW & 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. Kiran Borakhade** is working as M&E officer since December 2014 and having good knowledge on the project activities and data analysis. She could provide all the details required for evaluation. She was found active in collecting and providing data and could send the reports with the help of counsellor and PM. She needs to develop herself on presentation skills. She is also visiting the field on her own interest and helping the team during events, advocacy, motivation to clinic etc. She has to be motivated and trained further.

**Ix a. Outreach activity in core TI project**

Interact with all PEs (FSW, MSM and IDU) interact with all ORW’s 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.

Hotspot wise micro plan was not found available at TI. As per weekly and monthly plan, outreach activities have been done. The service uptake among the community has been evident. Total HRGs line listed is 668. They have 573 HRGs regular contacts. 579 HRGs have taken RMC services at least two times a month. 476=72% HRGs are ICTC tested. Last one year 05 HRGs were found positive and all of them were referred to ART. 561 reportedly visited the clinics at least once in the last one year. 398 HRGs were syphilis tested. Condom demand was 222198 and supplied 91658 due to no supply from SACS for four months.The role and activities clarity are there among both ORWs and PEs.

**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 services uptake that is whether enough clinic footfall, counselling 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.

***Not applicable***

1. **Services**

Overall services in the project, quality of services and service delivery, satisfactory level of HRG’s.

The STI services were made available through DIC level STI clinics and few got from govt. STI facilities. The clinic doctor was discussed and he expressed his satisfaction on clinic attendance and follow up. He has been found committed towards the community. It was impressive that an MBBS with such a good attitude towards sexual minority. All the community members told that they were happy with the STI services and made available at any time they require through clinics, referrals and taking them to the services etc.

1. **Community involvement**

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

The community has been involved in addressing advocacy issues and at DIC level. The PEs are participating in planning and no other participation of the community. There is a possibility to involve TGs who are experienced in planning and monitoring in a better way.

1. **Commodities**

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

They are calculating the condom demand against average sexual encounters per week per KP. The distribution channel is mainly through the PE and ORW. Condom depots need to be created for MSM at hotspot level. It has been observed as necessary in Maharana Park hotspot during field visit.

**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.

Since the office bearer and current leader of the NGO Ms. Arunthati is a corporation councillor, a good level of linkage found with local PRI members and other stake holders like police department. Two have been met in the field. 06 crises were reported and resolved within 24 hours. They were providing Adhaar card registration and photographing during evaluation to all HRGs as camp with the support of government officials and PRI members. Community response to project level advocacy is very good. It is suggested to start forming support groups among community and contact local opinion leaders to get support.

They have to strengthen their linkage with network of positive people and possibly promote a MSM network as they report inconvenience in participating the general network of positive people.

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

Adhaar cards were provided to majority of the HRGs. The leader of the NGO has initiated free land provision and subsidised loans to HRG and it is in the process was verified as at the collector office.

**XV. Best Practices if any.**

Ensured Aadhaar cards to all HRGs through the rapport with elected members.