**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***

**Brief description:-**

RTM SAP MANDAL is situated in Maharashtra State’s Amravati district, Teosa block and village Gurukunj-Mozari, India. We are inspired by our national saint ‘Tukdoji Maharaj’ and upon his very name the organization has been registered. We emulate his combination of devotion and action to uplift the backward, marginalized and vulnerable people of our region through various IEC programs and specific targeted interventions. Our IEC focus has been on TB, HIV, AIDS, Malaria, STDs, RTIs, sickle cell anemia and generating awareness among the rural masses about the available government schemes and services. Our targeted interventions with truck drivers, FSWs, pregnant women have helped to halt HIV among these vulnerable groups. We have link workers, outreach workers and volunteers trained in HIV-AIDS, gender, sexuality, women, youth and adolescent health who are linked to provide services to difficult to reach sub-populations to access health care services. Our FSW project in rural and urban Amravati as well in Bhandara districts is working to halt and reverse the prevalence of HIV/AIDS among the female se workers and to provide quality services for their sexual health needs. Through PMTCT, we provide quality services to ANCs and this has strengthened the service delivery system. Through LWS project we are reaching out to HRGs and vulnerable men and women in rural areas with information, knowledge, skills on STIs and HIV prevention and risk reduction. Project ‘Axshya’ is promoting a new dimension to TB control by focusing on ACSM for strengthening the RNTCP and halting further spread of TB in Amravati district. The orphanage (Balgruha) is supported by WCD, GoM. This year 60 single/double orphan children in the age group of 6 – 16 are taken care of and linked to the village school for their education and other in-house facilities are provided for their holistic development. Through ‘Vasundhara’ project, capacities of SHGs and UGs are being developed in integrated watershed management. Inclusion of people with different type of disabilities including deafblind, MSI and mentally health, life skills to adolescent girls, gender justice, natural resource management, livelihood sustainability are our future concerns. We wish to receive support from organizations who share our goals and objectives.

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

Rashtrasant Tukdoji Maharaj Sikshan & Argya Prasarak Mandal,

Radha Nagar, Amravati-444603

* ***Chief Functionary:***

**Dr. Wadegar**

* ***Year of Establishment:* 2007**
* ***Year of month of project initiation: February 2012***
* ***Evaluation Team***

***Mathivanan R, Imithiaz Ahmed and Pravin Mhasal-Finance***

* ***Time Frame: 20,21 & 24 April 2016***

***Profile of TI***

***(Information to be captured)***

* ***Target Population Profile: FSW***
* ***Type of Project: Core***
* ***Size of Target Group(s): 800 and active against the target is 797***
* ***Sub-Groups and their Size: Home Based:-642, Street Based-154***
* ***Target Area: Area covered: Amravati rural***

**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…

The president and secretary were discussed and both of their outlook on HIV prevention required for Amravati district and they have started working on HIV prevention much before they got support from MDACS. They have been implementing two TI, one LWS and PPTCT. The secretary is working as PD and he showed his involvement in project activities such as advocacy and monitoring. He is regularly attending all monthly meetings and most of the weekly review meetings to provide his guidance. The team discussed with the secretary and he has been involved in HIV prevention for the past 8 years primarily conducted awareness on their own and started doing prevention among truckers for the past four years. With his influence with government office he could support the community by ensuring they all get the basic identities and employment to some. He could explain how HIV prevention is major health challenge in communicable disease control. The NGO is running an orphanage for CLHIV too.

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.***

The contracted staffs were found available at the time of evaluation, as PM-1, Counsellor-1, M&E-1, ORW-3 and 15 PEs. The PM is primarily monitoring all the activities and reporting to SACS. He provides support to all staffs. Four 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 commitment of office bearers were found evident through the staffs could explain their support and PD was available throughput the evaluation period.

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

All the staffs were working from inception except the M&E and all of them were trained well both at TI level and by SACS. Training register has been available for verification but impact assessment has been done. All 3 ORWs were found field that they work hard they need more attention in proper documentation and their diary was found with errors and mismatches. 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. Though the PM is visiting the field and he was found with low level of commitment the way he could deliver the data and details required for evaluation. Since the organization is doing well with other committed staffs the replacement of manager could be considered within their staffs of other projects because all of them were working in their other projects related to HIV.

1. **Infrastructure of the organization**

TI office is located in highway 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 8 PPPs clinics were very much at implementation area.

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.

They are 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 are maintained by ORWs with the support of PEs and properly documented. They are conducting weekly & monthly review meetings regularly. They are collecting data from ORWs during the meeting and reporting to MSACS. The PD attended 11 of the 12 monthly meetings conducted. The documents are maintained mainly by the M&E officer and PM. M&E 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 has to maintain a daily diary. The manager needs to sign in the diaries of ORWs during his field visit. Monthly review meeting was found with action plan and action taken points but need to be properly maintained with gaps analyzed towards each staff and suggestions by PM&PD and follow up.

1. **Programme Deliverables**

**Outreach**

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

A total number of 837 totally registered and 797 active currently have been line listed against the target of 800. Category wise population is HB:-642 SB:-154

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 837 have been line listed against the target of 800. Category wise population is. The regular contacts are 796 in total, which is good achievement.

Outreach planning has been carried out as per guidelines. Outreach planning is 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. It is suggested to follow properly based on the review gaps and follow up actions. All the staffs have monthly action plans. PM has to sign in the ORWs daily diary whenever she visits the field.

The ORWs have been maintaining both 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.

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.

796 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. They have distributed 2120 SMC in the last one year and need to be done on regular basis based on the actual requirement.

1. ***Documentation of the peer education.***

It has been noticed that peer education document of 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 behavior etc.

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

13 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 11 PEs could demonstrate condoms. All the met 13 members have explained all the services and they know the clinic places. All of them found with condoms and they 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 3 ORWs supervise the 13 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. M&E is supposed to supervise the documentation and she needs to start the same.

1. **Services**
2. ***Availability of STI services-mode of delivery, adequacy to the needs of the community.***

* *The project has set up the 8 PPP clinics at project implementing area in Amaravati and providing the STI clinic services to all the FSW community as per their health needs.*
* *The PPP Clinics were established in the areas of slums where the FSW community is more.*
* *The clinic is in adequate place, separate counseling room also maintained at PPP clinic.*
* *The doctor is experienced and associated with this TI since inception.*
* *The PE and ORWs are accompanying with the FSW community to the PPP clinic.*
* *Some FSWs are visiting by themselves and utilizing the services from PPP clinic because the clinics are located at nearest areas.*
* *The DIC is at office with all equipment.*
* *FSWs are regularly visiting the clinic and taking the services.*

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

* *Project has been providing STI, RMC and condom services to HRG’s.*
* *8 PPP clinic is at the project implementing and it is flexible to access services by community.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Sl | Site Name | Doctor Name | Qualification | SCM Training |
| 01 | TIosa, | R.B.Wadekar | B.A.M.S, MD | Trained-2011 |
| 02 | Morsi | Girish Dhote | BAMS | Not -Trained |
| 03 | Dariyapur | Deep Lakshmi Barwat | BAMS | Not -Trained |
| 04 | Nangaokhandeshwar | R.B.Wadekar | BAMS,MD | Trained |
| 05 | Chandur Bazar | Kalpana Nimbhorkar | BAMS | Not -Trained |
| 06 | Varud | Poonam Aahake | bams | Not -Trained |
| Madhuri. | BAMS | Not -Trained |
| 07 | Anjan gaon | Tarun Patel | BAMS | Not -Trained |
| 08 | Acchal Pur | Roshni Patil | BAMS | Not -Trained |

* *The PD of this project is also a professionally doctor and he was trained under SCM by MSACS in Amravati. In the year of 2011.*
* *For new doctors the PD had put request to DAPCU to be train all new MO of the PPP clinic, but due to various reasons the DAPCU was not conducted any training to MOs.*
* *The Project Director took initiate and given training to all new MOs on Syndromic Case Management (SCM)*
* *For the further clarifications the doctor will take the support of the PD as well as senior and only trained medical officer of the entire district.*
* *Separate counseling room is at clinic for counseling.*
* *ANM/counselor is perusing her MSW, she knows about the counseling types very well and she spent time for community to provide qualitative counseling in DIC.*
* *She is having sufficient knowledge to provide the counseling services.*
* *It is observed that internal examinations are conducting in PPP clinic, this information shared by FSW community during our field visit.*
* *The Speculums are available at clinics with sterilization.*
* *All symptomatic STIs are being treated with loose medicines, the medical officer given the prescription to all STI HRGs to purchase from the pharmacy due to non supply of the drugs.*

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 the use of revolving funds.***

***Not applicable***

1. ***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 centers.***

* *TI is maintains healthy rapport with all ICTC’s for smooth honoring of HIV testing referrals.*
* *Records have shown that 10 active HIV positive HRG in TI. Among them 05 are in Pre ART and 05 are on ART and one is died.*
* *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 3 hospitals in its working area and we were visited KG hospital and DHW-Akola. The counselor expressed that the TI is sending referrals regularly to the ICTC and ICTC counselor is attending the health camps on regular basis.*
* *Ti referrals were matched at ICTC and ART centers.*
* *Monthly tested consolidation sheets are taking from every government service providers.*
* *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.*
* *The TI maintains referrals slips ORW wise also.*
* *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 of condoms also done by TI but it is very minimal.*

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

* 339704 free condoms distributed in current year.
* *There was 4 months no condoms available at TI level but they were able to mnage to provide the required condoms though PHCs and other government health facilities.*
* *The social marketing of condom has been started in this TI last one year the field team sold very minimum condoms to HRGs.*
* *Social marketing of condoms needs to be improved*

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 was no 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 counselor 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.***

* *They maintain separate file for referral slips.*
* *There was no repeat STIs in TI.*
* *The referral slips are being maintained month wise.*
* *Follow up mechanism need 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 participation was found very meager except the participation in events and functions. A very few HRGs were part of committees and no support group system has been started yet. No SHGs were formed so far and no CBO initiation.

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.

**VI. Linkages**

* *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.*
* *The PD of this project is a secretary of the organization, he also a member of District hospital Ethics committee.*
* *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.*
* *There was a private school is running by the NGO secretary and he is giving free education to HRGs children on free.*
* *The stake holders of the project are having regularly touch with the community and preparing a economic sustainable plans for HRGs like income generation programmes for their behavioral change.*

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

NGO Not using manual Book keeping policy, account maintained in Tally. SOE- UC submitted on quarterly basis.

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.***

Payments were made as per guideline. No transaction maid by cash above Rs. 5000. Stock and issues registers in place. No advances before making further payments.

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 done as per guideline. But no proper approval taken form SACS.

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

Separate joint Bank Account maintained. Reconciliation made monthly basis. Audit for 2015-16 till to be done. NGO Not using manual Book keeping policy, account maintained in Tally.

**Recommendations – Finance : Accountant need orientation.**

* Need to be training to project accountant, to send exposure to DAPCU.

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

**VII a. Project Manager**

**Ashok:**

He has done his MBA and working as PM in this project since Sep 2013.He has been working as PM in another TI that was closed. He could explain his role in support monitoring to ORWs and PEs. He has been initiating advocacy meetings and crises. He is conducting weekly review meetings but not able to present the gap analysis system and feedback mechanism. Hough he attended trainings in TI and SACS he needs to be further developed or replaced.

**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

**Rutuja:**

She is pursuing her MSW second year and she is working as counsellor since Sep 2014. She said that she is providing the required information but could not explain on what counselling meant. She requires training on basic, STI, pre and post-test counselling. She could narrate the documents she was maintaining and how. She could tell risk assessment, risk reduction, STI and RMC services provided to KPs. She is maintaining all the required registers at TI level and made available for verification.

**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.

**ORWs:**

**Madhuri Shirsagar:**

She is pursuing B.A second year and working as ORW in this TI since August 2013 and she could explain all the details of her work at hotspot level and at weekly review meeting. She worked in SHGs with another NGO for four years. She could do the risk assessment and plan the work based on the same. She said that she is visiting the PE and supporting them in the field at least five times a week. She explained how she involving herself in crises management and advocacy. She is motivating the PE to bring KPs for ICTC, STI and RMC services. She has 5 peer educators and 9 hotspots in 3 blocks. She is conducting DGA meeting properly. She started 5 SHGs among KPs and linked with government services.

**Seema:**

She completed 12th standard and is working as ORW since August 2015. She could explain the basic services and all her documents were verified as updated and she too could explain what support she provides to PE at hotspot level. However she could develop the knowledge on basic information to be given to STI and PLHIV at community level.

**Savitha** studied up to 12th standard and working as ORW in this TI since October 2013. She worked as ORW in LWS and PPTCT for several years. She needs to be trained on programme indicators. She has been delivering the service to KPs through PE was found very well without missing any component.

**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.

All the met 13 PEs were well informed on prioritization of hotspots, importance of PT, RMC and HIV testing. They have enough knowledge on HIV and symptoms of STI and syndromic case management. 13 PEs out of 13 were available at TI level FGD. 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. 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. 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.

**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.**

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

***Not applicable***

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

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

***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.

**M&E: Monali Langewar:**

She is a B.Com graduate and working as M&E in this project since June 2015. She was working as support staff to management in LWS project of the same NGO. She was able to provide all the data required for evaluation. It was observed that she is collecting data from ORW and manager and does not cross verify the same with their documents. Since there is no proper monthly review meeting, her role is limited to collect the data and sending CMIS report. She further needs to be trained on data analysis and document maintenance by SACS

**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 updated 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 837 and active are 797. They have 797 HRGs regular contacts. ***It is surprising that all the HRGs except one attended once RMC and 796 HRGs have taken RMC services at least two times a month. 1046=97% HRGs are ICTC tested. Last one year none of the HRGs were found. All 756 reportedly visited the clinics at least once in the last one year. All 756 HRGs were syphilis tested. Condom demand was* 359656 *and supplied* 339704*=94%% though in the situation of 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, 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.

***Not applicable:***

1. **Services**

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

8 PPP level STI clinic and few got from govt. STI facilities. Two clinic doctors were discussed and she expressed his satisfaction on clinic attendance and follow up. He has been found committed towards the community. 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 need to involve HRGs at large level in the programme planning and implementation.

1. **Commodities**

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

Condom demand calculation and supply 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 street based FSWs at hotspot level.

**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.

A good level of linkage was found with local elected and members and other stake holders like police department. Two have been met in the field. 13 crises and 20 advocacies were reported. They have conducted 20 advocacy meetings with proper follow up documentation. 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 CBO of FSW 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.**

Social Entitlement

1. Voter Cards :50
2. Ration Cards :12

**XV. Best Practices if any.**

No typical best practices found at TI level except the leader prepared an IEC material approved by SACS and participating in GIPA meeting initiated by DAPCU.