

# **TI-Evaluation Report of Astitva Mahila Bahuuddeshiya Sanstha**

***Evaluation Team:***

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***Submitted to:***

**Maharashtra State AIDS Prevention & Control Society,  
Mumbai**

**April 2016**

## 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 NACO)**

##### **Introduction**

- **Background of Project and Organisation:**

Astitva Mahila Bahuuddeshiya Sanstha (AMBS) is one of the non-governmental organizations (NGOs) of Maharashtra state working on spectrum of topics pertaining to the social welfare and women centric activities are at the core of the organization and through various programmes mainstreaming marginalized populations like female sex workers (FSW). NGO has given vocational training to some of the HRGs who were looking forward to establish their own businesses. Some of the women have made Lord Ganesha's idols and marketed the same. As per the interaction with board members, AMBS is of the view that sustainable educational management is very much needed to accomplish livelihood opportunities and secured health and this leads to healthy, self-reliant and self-governed community. And, with this vision AMBS is doing study, analysis and execution. AMBS has become partner of Maharashtra State AIDS Control Society (MSACS) since August 2013 for intervening female sex workers (FSW) and men having sex with men (MSM) in Deulgaon Raja, Buldhana (Maharashtra).

- **Name and address of the Organization:** Astitva Mahila Bahuuddeshiya Sanstha (AMBS), Deulgaon Raja, Buldhana (Maharashtra).
- **Chief Functionary:** Ms. Premrata Wagh-Sonone (President of the organization & Project Director-TI)
- **Year of establishment:** 2007
- **Year and month of project initiation:** August 2013
- **Evaluation team:** Dr. Anil Pratap Singh (Team Leader & External Evaluator), Mr. Tushar Dey (External Evaluator), Mr. Bhagwat Eknath Kavhale (Finance Evaluator)
- **Time frame:** 18<sup>th</sup> April 2016 to 19<sup>th</sup> April 2016

##### **Profile of TI**

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

- Target Population Profile: FSW / MSM / IDU / TG/TRUCKERS / MIGRANTS: FSW
- Type of Project: Core/ Core Composite / Bridge population: Core
- Size of Target Group(s): Allocated Target for FSW HRGs is 600 while ever registered 799 but currently 779 FSWs are active. In MSM component 200 MSM
- Sub-Groups and their Size: All the registered target of FSWs are Home Based (HB)
- Target Area: TIs' hotspots stretched in 70 kms.

- **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...

For our interactions, Project Director of TI who is President of the organization as well as Secretary of AMBS were present who rather knew the project, but still lot more is yet to be done in order to support the community, making advocacy efforts, monitoring the project. During the entire span of the assessment period, the Project Director had attended majority of the staff-review meetings at monthly intervals. Casual advocacy efforts were made by the TI with identified stakeholders. For making the strong voices identification and motivation of stakeholders, visible efforts could have been undertaken in order to enhance the utilization of services and create a sustainable impact among their peers living either in high risks or vulnerabilities as well as for having more and more benefits through entitlements of various schemes.

## **II. Organizational Capacity**

- 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:**

Evaluators were not able to meet all the project staffs and all the PEs because of their absence.

### **Staff Details:**

S. N.	Name of the staff	Designation	Qualification
1	Premlata Prakash Sonone	Project Director	MA.MSW
2	Kishor Uttamrao Ubarhande	Project Manager	MA, MSW.
3	Kishor Salok	Counselor	MSW
4	Yogesh Chondekar	MEO & Accountant	B Com, Tally
5	Shilpa Jadhao	ORW 1 (FSW)	H.S.C.
6	Sashikala More	ORW 2(FSW)	S.S.C.
7	Archna Jadhao	ORW-3 (FSW)	S.S.C.
8	<i>DETAILS UNAVAILABLE</i>	<i>ORW-4 (MSM)</i>	<i>DETAILS UNAVAILABLE</i>

N.B.: MSM-ORW related documents were neither available nor anyone present as MSM-ORW during evaluations. Seven out of thirteen PEs (as sanctioned) could have been met and in absence of relevant records, ORW-wise PE-profile shabbily not being provided.

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

The TI had no records available on trainings. However, hand-holding/mentoring of the team was tried to be done by the concerned Programme Officer (PO) of the Technical Support Unit (TSU) and based on the

key observations/suggestions of the PO visits, TI in repeated PO-visits shown its reluctances in complying various suggestions as were received at the end of PO-TSU. Moreover, there were plenty of PO-visit comments regarding non-availability of a number of staffs/PEs during his consecutive trips to the TI. Also, most of the required documents were either unavailable or incomplete in each of his visit.

#### **Infrastructure of the organization:**

Deficiently there is limited space for TI-office/DIC. All assets codified as record in fixed-assets register

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

Documentations were extremely poor in capturing requisite information and majority of NACO formats were yet to be taken in use. There was plenty of scope to improve these documents for quality. Most of the required documents were either unavailable or incomplete. The relevance of documents with different hierarchical positions properly needs to be understood in order to maintain uniformity or symmetry. TI has to ensure availability of Form-A for registering HRGs which is the base of every documentations as well as planning and execution of the intervention. Various meeting minutes documented and a few of the NACO-formats were rather asymmetrical.

### **III. Program Deliverables**

#### **Outreach**

1. Line listing of the HRG by category.
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.
4. Micro planning in place and the same is reflected in Quality and documentation.
5. Coverage of target population (sub-group wise): Target / regular contacts only in HRGs
6. Outreach planning - quality, documentation and reflection in implementation
7. PE: HRG ratio, PE: migrants/truckers
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
9. Documentation of the peer education
10. Quality of peer education- messages, skills and reflection in the community
11. Supervision- mechanism, process, follow-up in action taken etc

#### **Line Listing of HRG by category:**

TI has yet to ensure proper availability of Form-A with requisite/complete information of HRGs for registering them because it is the base of every documentations as well as planning and execution of the intervention. However, as per the MIS, intervention has been made for 779 FSWs (active population) against the allocated targets of 600 while absolutely saturated allocated target of 200 MSM. In absence of information of HRGs (through Form-A of NACO) it is easier said than done, how TI could ascertain any line-listed framework for HRGs. In such a scenario, it is hard to establish data and figures for regular contacts during the assessment period.

***Coverage of target population (sub-group wise): Estimated / regular contacts***

As per the MIS, intervention has been made for 779 FSWs (active population) against the allocated targets of 600 while absolutely saturated allocated target of 200 MSM. In absence of information of HRGs (through Form-A of NACO) it is easier said than done, how TI could ascertain any line-listed framework for HRGs. In such a scenario, it is hard to establish data and figures for regular contacts during the assessment period.

***Outreach planning***

Outreach planning still to be properly understood by the team in making implementation plans for achieving indicator-based performances at vertical positions.

***Peer Education***

During in depth discussions on the nature of their work, it was observed that their roles in the community and their knowledge in context of communication skills for message delivery were found below average in terms of project requirements. PEs was yet to have their proper micro-plan in the line with ORW. Further, few of the PEs were relying on ORW for their planning e.g. ICTC, referrals/testing, Syphilis screening, Regular Medical Check Ups (RMC), etc.

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

PM is new to the project still to understand project's protocol and has also to understand essence of the intervention. Counselor knows nothing about the project. Both of these two upper hierarchy positioned staffs were unable to supervise rest of the staffs. Written feed-backs/action taken still not practiced between the vertical positions.

**IV. Services**

1. Availability of STI services - mode of delivery, adequacy to the needs of the community.
2. Quality of the services- infrastructure (clinic, equipment etc.), location of the clinic, availability of STI drugs and maintenance of privacy etc.
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.
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.
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.
6. Availability of Condoms- Type of distribution channel, accessibility, adequacy etc.
7. No. of condoms distributed- No. of condoms distributed through different channels/regular contacts.
8. No. of Needles / Syringes distributed through outreach / DIC.
9. Information on linkages for ICTC, DOT, ART, STI clinics.
10. Referrals and follows up

***Availability of STI services:***

STI services are catered mainly through PPP model three male-doctors but they have yet to receive training and also need to be oriented for filling-in network clinic forms.

**Availability of STI drugs:**

There is no proper document on availability of STI drugs.

**Quality of the services and treatment in the service provisioning:**

Service provisioning in context of STI treatment was observed being done through PPP model (male) doctors. Follow-up practice is yet to be there properly till complete treatment.

**Documentation**

Documentation done but there had lot of scope for improvement. However, counseling register and referral register, STD register, STI drug stock register, network clinic form, etc. found maintained and kept at the TI. Despite of having these registers, the same were still to be ally with NACO formats and yet to be symmetrical.

**Availability of Condoms- Type of distribution channel, accessibility, adequacy, No of condoms distributed etc:**

Outreach workers and peer educators distribute condoms randomly. The same was also told to us by all the met peer educators and HRGs interacted. The main channel of condom distribution was through PEs. Condom balance as on date was 28178.

**V. Community participation**

1. Collectivization activities: No. of SHGs/Community groups/CBOs formed since inception, perspectives of these groups towards the project activities.
2. Community participation in project activities- level and extent of participation, reflection of the same in the activities and documents

The TI observed yet to initiate collectivization of the community. However, community events were convened.

**VI. Linkages**

1. Assess the linkages established with the various services providers like STI, ICTC, TB clinics etc...
2. Percentages of HRGs tested in ICTC and gap between referred and tested.
3. Support system developed with various stakeholders and involvement of various stakeholders in the project.

**Linkages (for ICTC/VDRL/TB etc.) as being used by the TI:**

- 1 Rural Hospital, Deulgaon Raja
- 2 Rural Hospital, Lonar
- 3 Rural Hospital, Lonar

N.B.: For ART District Hospital Buldhana (100kms)& Jalna (25 kms)

Counselor does know nothing about the project and records were scattered/irrelevant. Data projected were not feasible but records shows the counseling happened. Below 70% RMCs but records are scattered. Records were missing on PT but a few incidences were there. Records were missing but a few incidences were there when RPR happened. Records were missing but a few incidences were there from linkages where extremely less ICTC tests happened. ART records are not there. Random/casual distributions happened and gaps were there.

## 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.

In absence of various requisite documents, it is hard to comment on system of planning. Adherence to SACS/NACO protocol is hardly visible.

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.

TI has tally-generated Vouchers are in place.

-All the payments were yet to be approved by the competent authority.

-Quotations were yet to be invited.

-Most of the vouchers' supporting are missing but some of the vouchers were supported with required evidences.

-NGO is not properly maintaining Stock and Issue register.

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.

-NGO is procuring medicines as per the guidelines.

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

-Joint Bank Account is maintained by the NGO.

-Bank Reconciliation Statement (BRS) was not presented before us.

-Cash book maintained in tally.

-Manual ledger is not in place.

### *Lapses in financial system:*

It was observed that syphilis screening kits were purchased but the same has got expired prior to its use, as per the inferences after having review of the stock book.

## 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.**

PM is new to the project still to understand project's protocol and has also to understand essence of the intervention. Written feed-backs/action taken still not practiced between the vertical positions.

### 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**

Counselor knows nothing about the project. So far as maintenance and updating of data and registers, the limited efforts have been made but NACO formats were yet to be used properly in order to track for direct service deliveries.

### 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.**

The project's ORWs still need to be versed properly about target on various indicators for his PEs. Outreach plan required yet to be there.

### 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.**

PEs were unable to fill-in their diaries. Proper prioritization of risk and vulnerability data still to be done after getting relevant information (as per Form-A of the NACO) and the same also need to be properly understood by PEs. Some of the FSW-PEs knew, in limited way, importance of RMC and ICTC testing, condom demonstration, communication skill, symptoms of STI and also knowing service facilities available in the city's periphery.

### 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 for this TI as evaluated.

#### 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 prioritize 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 for this TI as evaluated.

#### 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.

Not applicable for this TI as evaluated.

#### 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.**

Exclusive M&E position was sanctioned but the he was not present during the evaluations.

#### 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.

Limited outreach activities were observed being implemented rather in absence of proper planning which affected in properly ensuring the service uptake by the TI. Hotspot wise micro plan was yet to be properly in existence especially for STI services, linkages to ICTC/ ART center etc. and need to be further checked for having accuracies.

#### 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.

Not applicable for this TI as evaluated.

#### **X. Services**

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

Service uptake through the project was rather visible to limited extent. Only 5 HRGs from FSW component could have been met even after visiting various hotspots by us. Moreover, after repeat requests, TI could not show any of its hotspots. Hence it is our limitation to attain requisite percentile for FGD. Three of the met HRGs were satisfied but two were not very sure about the project's deliverables. Three out of five were getting as per their responses. Stakeholders' involvement is rather invisible. Past Counselor was known by three of the respondents and they were rather satisfied.

#### **XI. Community involvement**

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

None of the staffs were from the community. The roles community members were observed limited in planning/implementing/advocating/monitoring the project.

#### **XII. Commodities**

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

The project level planning for commodity distribution as per Demand Vs Distribution still need to be properly understood by the TI as per the protocol where data rectification was required essentially taken into consideration. Condoms were the main commodities being given which included free-distributions. Female condoms were neither procured nor provisioned through any TI-networks.

#### **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.**

There is gesture of limited need based advocacy. Crisis management team is there but addressal's essence is yet to be conceptualized properly. Crises also left to be noticed from the field.

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

The project had yet to provide various social protection schemes/ welfare schemes/social entitlements.

#### **XV. Best Practices if any**

None of the practice(s) could have been identified as good practice.