

# **TI-Evaluation Report of Matribhumi Multipurpose Foundation**

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***Submitted to:***

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**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:**

*Matribhumi Multipurpose Foundation* is a not-for-profit, voluntary organization was founded in 2001 under Societies Registration Act 1860, and Bombay Public Trust Act 1950. The genesis of the Trust is a culmination of promotional efforts for improving the “quality of life” of rural and tribal people, who were engulfed in poverty, disease and squalor in the drought prone district of Akola, Maharashtra. The initial 15 private clinics, school volunteers and Gram Panchayatis has been tie-up, in 2001 as part of participatory and comprehensive tribal health care model. Organization has worked in under nutrition children of two talukas of the district Jalgaon Jamod and Sangrampur respectively. As a part of tribal and rural health programme networking, organisation has developed linkages with various social organisations. Organisation have a vast network of technical expertise with Akhil Bhartiya Sarvodaya Mandal, SEARCH Gadchiroli, and various social activist Dr. Abhay Bung, Smt. Medha Patkar, Dr. Sujan Barant, Shrikant Narvear, Shankar Hari Bagade, Justice Chandrashekhar Dharmadhikari, Thakurdasjee Bung etc. Organization is very much involved tribal health development in the past few years; the focus of the organisation was on establishing and strengthening local committees of community members who gradually assumed responsibility to implement health project activities at the local level. Formal and informal interactions by village and other volunteers from the community, and focused outreach in terms of understanding risks and vulnerabilities of each community member through micro-planning village volunteers’ level were key outreach strategies. A clear-cut advocacy plan was implemented with the help of the project’s Advocacy Officer. Advocacy Committees comprised of members from the tribal community took the lead in procuring social entitlements for community members. As part of the project’s heavy focus on access and utilization of quality health services by tribal community, these services were made available through a combination of, outreach medical visits, collaborations with community-preferred healthcare providers and linkages with government hospitals. The project has networked with the existing government healthcare infrastructure. Special focus was given to the health issues of adolescent girls belonging from tribal community by conducting health sessions under the Young Girl’s Initiative (YGI). Matrubhumi is being implementing various activities .Health Literacy Project in tribal area of Jalgaon Jamod and Sangrampur Taluks, State level Youth developing programs, Water Policy Awareness Campaign to Understanding the importance of water management & make people aware of it. Understanding social problems of different sections of society. Understanding various environmental problems. Collection information about rehabilitation of people affected due to contraction of big dams, earthquakes, etc collect. Matrubhumi Multipurpose Foundation is implementing rainwater harvesting project in rural Buldana work begin with recharging of wells, nala bundings. Organization is a part of Sant Gadge Baba Gram Swachata Abhiyan as a Key Resources Agency. Matrubhumi Multipurpose Foundation was involved as a partner of CAPART for Nodal NGO Project. Organization is also involved in strengthening the network of poor farmers to avoiding suicides attempts through conducting training on developing alternative income sources. Forming SHGs for collectivization of the affected farmer’s families. Promoting organic farming for healthy food.

Matrubhumi Multipurpose Foundation being implementing the HIV prevention project through Targeted intervention with High Risk Group (HRG) Like Female Sex Worker and Men who having sex with men as

well as organization is working other vulnerable population including HRG through Link Worker Project in 100 Vulnerable villages based on mapping data.

- **Name and address of the Organization:** Suvarna Nagar, Near Datta Mandir, Buldana-443001.
- **Chief Functionary:** Mr. Harshvardhan Sapkal (Project Director-TI)
- **Year of establishment:** 2001
- **Year and month of project initiation:** October 2010
- **Evaluation team:** Dr. Anil Pratap Singh (Team Leader & External Evaluator), Mr. Tushar Dey (External Evaluator), Mr. Bhagwat Eknath Kavhale (Finance Evaluator)
- **Time frame:** 22<sup>nd</sup> April 2016 to 23<sup>rd</sup> April 2016

#### **Profile of TI**

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

- Target Population Profile: FSW / MSM / IDU / TG/TRUCKERS / MIGRANTS: MSM
- Type of Project: Core/ Core Composite / Bridge population: Core composite
- Size of Target Group(s): Allocated Target of MSM 500 (while registered 613 but 505 active)
- Sub-Groups and their Size: 505 MSM (*Panthi-145, DD-80, Kothi-280*)
- Target Area: TI's intervening spots spread over 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...**

Three of the key office bearers were interacted in order to understand their vision about the project, support to the community, advocacy efforts, monitoring the project TI project etc. The Organization has preferred Assistant Project Director (APD) to hold staff-review meetings at monthly intervals. But, critically, the honorarium of Project Director (PD)-TI transacted to the account of PD instead APD who actually giving his time and attending TI's staff meetings. APD is contributing for the TI without any honorarium. During April 2014 to March 2015, the Assistant Project Director had attended majority of the staff-review meetings. Review mechanism is existed within the system and programme deliverables have rather been taken into considerations. The TI had formulated various committees and the representation from the community was observed limited. Management was also observed keen in extending its support so that benefits through entitlements of various schemes could be given to line-listed HRGs.

##### **II. Organizational Capacity**

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

Evaluators were able to meet all the project staffs and peer-educators currently working for the project. Staffs were given with appointment letters wherein roles and responsibilities were spelled-out. Following are the staff allocated whose educational status/experience being given underneath:

##### **Staff Details:**

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Matribhumi Multipurpose Foundation, Buldhana (Maharashtra): MSM-TI

S. N.	Name of the staff	Designation	Qualification	Working Since (with name of month)
1	Harshwadhan Sapkal	Project Director	B.Com BPed	oct-11 to Till date
2	Akash Mohite	Project Manager	MSW	Oct-15 to Till Date
3	Sakharam Bhilala	ANM/Counselor	MSW	Nov-15 to Till Date
4	Prasad Deshpande	MEO & Accountant	B.A.	Aug-14 to Till Date
5	Sk. Asif Sk. Ashfaq	O.R.W. 1	B.E. 1 <sup>st</sup> Year	April-14 to Till Date
6	Panjabrao Khare	O.R.W. 2	11 <sup>th</sup>	July-15 to Till Date

ORW-wise PE-profile is also being given underneath which were working at present:

**1. Outreach Worker-1**

Sl. No	Name of PE	Age in years	Qualification	Target	Date of Joining	Intervening area
1.	Harish Kambale	35	10 <sup>th</sup>	82	01-12-14	State Bank, Buldana
2.	Baban Sapkal	48	2 <sup>nd</sup>	85	01-10-11	Near Shahu Eng. Collage, Buldana
3.	Sunil Khandare	31	10 <sup>th</sup>	79	01-12-14	Near Collector Bangalow, Buldana

**2 Outreach Worker-2**

Sl. No	Name of PE	Age in years	Qualification	Target	Date of Joining	Intervening area
1.	Firoj Khan	30	7 <sup>th</sup>	65	01-10-11	Bus stand, Chikhali
2.	Juglesh	23	7 <sup>th</sup>	67	01-12-12	Weekly Market, Chikhali
3.	Rafique	31	4 <sup>th</sup>	60	01-10-11	Near Janta Collage, Mehkar

4.	Sadik	26	10 <sup>th</sup>	62	01-12-11	Near Kanchan Mahal, Mehkar
5.	Vivek More	22	10 <sup>th</sup>	5	01-03-16	Behind Bus Stand, Mehkar

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

Most of the project staffs are old ones who have got various trainings both formal-trainings and in-house/on-site mentoring by TSU-POs. The staffs had received induction and other trainings. However, training reports could have been there especially for managerial purposes/project-strengthening if staffs were to be instructed to write what they have learnt from these trainings and accordingly to be ensured quality availability of Form-L of NACO. Through documents on various training it is hard to comment on the quality of the content/training materials used. Furthermore, the impact of these capacity building efforts rather reflected in the practice to some extent. The involvement of TSU for technically supporting the TI was visible through various minute reports.

Given below are the details of training as happened for TI-staffs and PEs:

**Training Details (SACS):**

Sl.No	Name of staff/ Designation	Training given by	Content	Dates of Training
1	Sagar Bonde, PM	SACS, STRC (SOSVA)	Induction	03-11-14 to 06-11-14
2	Sakharam Bhilala	SACS, STRC (SOSVA)	Induction	24-11-14 to 26-11-14
3	Suraj Kharat	SACS, STRC (SOSVA)	Induction	15-12-14 to 18-12-14
4	Sk. Asif Sk. Ashfaque	SACS, STRC (SOSVA)	Induction	15-12-14 to 18-12-14
5	Sakharam Bhilala	SACS By. Ashiyana Foundation	Capacity Building Treatment literacy	21-12-15 to 22-12-15
6	Akash Mohite	SACS, Humsafar	Capacity Building	25-02-2016

**2. Infrastructure of the organization:**

TI-Office cum DIC has space constraints. Only Counseling room is ideal as per the protocol (where confidentiality issue could have been care-of). No separate DIC is available. TI-office/DIC is limited to two rooms only. One room is there which is being used both as TI-office for working of PM, MEO cum Accountant as well as documentation by ORWs. Designated DIC is prime need at Buldhana because majority of line-listed project beneficiaries belonged to this place. Also, for ease at work of the staff, it is required to provide proper legroom at the project office. Intervention sites at Chikhli and

Mehkar are at distant locations i.e. 35km and 80km respectively. There is a working DIC (regularly good attendances of project beneficiaries). DIC was equipped with IEC -pictorial/text mostly in *Marathi* language (and a few in English & Hindi) addressing core topics pertaining to HIV/AIDS (in relation to sex-work) and other relevant IEC materials. Free condom, service-map, target vs. achievement details, TI-team details, service directory (based on available referral and linkages) were also there. Commodity storage place is not available at TI cum DIC office which is being stored at another project's office of the organization. Assets' records were available and coded as well but the same was still to be verified periodically.

**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.**

TI adhered to SACS protocols for its documents. Some of the NACO formats were in use but individual tracking mechanism need to be properly in existence. The relevance of documents with different hierarchical positions rather needs to be properly understood and maintained for uniformity/symmetry. TI has followed stipulated timeline for report submission. Two-way written feed-backs still to be visible wherein lower positioned staff could have to receive suggestion/directive from upper ones for obligatory compliances. However, as per the available records timeliness was followed for submission of MIS but sometimes delayed in complying PO's suggestions at various occasions. Manual entries were still to be computerized for various NACO formats. Documents pertaining to counseling like referral register, counseling registers, etc. were available.

**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:** Line Listing of HRGs (MSM) was present with the Unique ID number but requires rectifications/additions. TI has been allocated target of MSM 500 while registered 613 but 505 active.

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

As per the MIS, intervention has been made for 505 MSM against the allocated targets of

500. PE diaries were observed in limited use. Over 60% allocated targets were in regular contacts during the assessment period as per the available records.

### ***Outreach planning***

Line-listed HRGs' risk assessment was done in the month of December 2015. There were outreach plans available (being revised at quarterly intervals for line-listed information and on monthly/weekly basis for programme execution). In outreach plans information were given on condom requirement; analyses on high/medium/low risk; days & time of meeting STI; condom negotiations etc. But at the same time there was scope to revise the data flown/used from PM, Counselor & M&E for transferring the same to ORWs & respective PEs. Further, peer-wise site map need to be available properly with all of them given with requisite information including commodity requirements, dues of RMC/ICTC/STI-follow-ups as well as referral and linkages in the access of the community. Besides having done these planning exercises, the condom demand vs. distribution gap was observed and the same need to be analyzed in order to bridge the gap on commodity distribution.

### ***Peer Education***

The range of PEs to HRGs was observed as per prescribed norms. A total of eight PEs' position sanctioned. Four out of eight PEs were beyond 30 years of their age i.e. 50% belonged to the age group of 30 years. 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 average to below average in terms of project requirements. PEs had their bags wherein condoms, IEC in *Marathi*, penis model, were placed. Micro-plan has gaps because in several months, no plan is there for dues/over-dues for linkages and other programme deliverables. Further, PEs were relying on ORWs for their planning to achieve various targets within the time frame of the project tenure, e.g. ICTC, referrals/testing, Syphilis screening, Regular Medical Check Ups (RMC), etc.

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

PM and Counselor has above average understanding of the TI and they disseminated the data-flow for outreach as well as peer-education. Written feed-back required to be given at the end of PM for documentation/field along with some extent of feed-back has also need to be recorded. Likewise, two-way communication between rest of the team-mates essentially taken into considerations.

## **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 ICTC,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 three PPP-doctors whose details are as underneath:

**PPP Doctor's details:**

Sl. No.	Name of the Doctor	Allopath/non-allopath	Received training on Syndromic Management from SACS/TSU	Letter of Understanding (LoU) signed: Yes/No	Working since
1	Dr. P.P. Pamparkar	Allopath	SACS	Yes	01-10-11
2	Dr. Irshad Khan	Allopath	SACS	Yes	01-02-15
3	Dr. S. S. Shinde	Allopath	SACS	Yes	01-04-13

***STI-drugs' availability:***

STI-Kit No. 1 is balance with quantity of 100 kits and 20 kits of STI-Kit No. 4

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

STI medicines were intermittently procured by the TI from MSACS. The TI had faced problems of stock-outs. It was also felt feasible to calculate demand as per the prevailing ailments to avoid situations of having these medicines stocked-out and also to maintain buffer stock.

***Documentation***

Availability of treatment registers, referral slips, documents reflected presence of system as endorsed by NACO/SACS and considerable amount of the supporting official documents in this regard. Counseling register and referral register were maintained. STD register, STI drug stock register, network clinic form, etc. maintained to keep information on STI services being given. TI has empanelled three male PPP doctors. PPP doctors need to be versed properly on filling-up of the network clinic form (Form-F).

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

Outreach workers and peer educators distribute condoms as per the demands. 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. The TI has freely distributed 144042. Condom balance as on date (23<sup>rd</sup> April 2016) was 31500. Condom gap analyses were done which need to be revised for authenticity. Distributions' variances against demand were also noticed.

**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 was not observed collectivizing the rest of the community but included HRGs in Advocacy Committee and Crisis Management Committee (CMC). Hence, community considerations were taken to some extent for planning and executing the project. Through review of meeting minutes, there reflected community's inclination towards success of the intervention. As per the interactions made and documents reviewed the community was getting services as provisioned through the project ranging from BCC, availing commodities/ required medical facilities due to being at most risk/referrals and linkages for RMC/STI, ICTC, ART (if sero-positive), DOT etc. Regular foot-fall at the DIC was observed less which might be due to the fact that designated DIC yet to be there separately. Rather considerable number of HRGs' participation was observed in various demand generation meetings and the same were also reported through MIS. Random cross-checks of these meeting registers with both the ORWs were found in the symmetry with MIS-reports. During field-visits quality reflection of activities was observed after having interactions in FDGs. Moreover community events were also organized but participation of HRGs were less in numbers.

**Community event details:**

<i>S.N.</i>	<i>Date of Community event</i>	<i>Main activities</i>	<i>Total No. of HRGs participated</i>
1	13.12.14	Awareness about HIV	26
2	29.10.15	Importance of health	27

**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/ART/TB etc.) as being used by the TI:**

1. Rural Hospital, Chikhali & Mehekar: For ICTC, VDRL & TB
2. District Hospital, Buldhana: For ICTC, Syphilis-screening, TB & ART

During the course of evaluation, following linkages were visited, which were observed being used by the TI:

**1) At District Hospital, Buldhana:**

- a) At District Hospital Buldhana, there are two ICTCs, adjacent to each other, which are said to be ICTC-1 & ICTC-2
  - i) ICTC-1: There are one counselor and one lab technician working at ICTC-1. Average client load is around 700 per month. Laboratory for pathological examinations at ICTC-1 is in another room (in front of counseling room) but there is no supply of water in this room and Lab Technician (LT) bring water from elsewhere in plastic container for his use as and when required by him.
  - ii) ICTC-2: There are two counselors and one Lab Technician at ICTC-1. Average client load is around 800 per month. There is space constraint in ICTC-2 for working of the staffs because two counselors (one male and the other is female) as well as one Lab Technician (LT) doing their respective duties in this small internment. Also, medical/bio-hazardous wastes kept there until and unless the same had been taken by

sweepers of local health administration who are supposed to finally dispose it off. As per the interfaces, none of the agency (-ies) got engrossed for disposing this waste being highly infectious in nature. Even, water supply is not there inside. There observed gaps in proper waste disposal mechanisms in context of disinfection and final disposal which need to be done as per the NACO guidelines.

As per the interaction with staffs at the aforesaid ICTCs, HRGs have been enjoying single-prick facility for twin-tests (-ICTC as well as Rapid Plasma Reagin Test). However, supply/procurement of Rapid Plasma Reagin (RPR) kits were intermittent for one-two months in the year 2015.

- b) Suraksha Clinic: One counselor is working at Suraksha clinic where currently a doctor who has got specialization in venereal disease is working.
- c) ART Centre: ART centre at District Hospital, Buldhana got fully functional since January 2010. At ART Centre there are three counselors along with one Pharmacist, one Data Manager and one Lab Technician are working who were being headed by one Senior Medical Officer (SMO). ORWs belonging to the project Vihan are also got space for sitting at ART centre who mainly help catering LFU cases both for general/ANC/ HRGs' whose sero-statuses are positive. Further, relying on interactions with pharmacist at ART, medicines to patients are being dispensed out for one month. But, recently there were shortage of ZL and a few of the patients were shifted to TLE after having got medical advice/prescription of the doctor. Besides, she (-Pharmacist) also shown her concern over excessive number of NVP tablets (to be expired in September 2017) which she notion need to be shuffled elsewhere in order to avoid losses from being expired because the same seemed disproportionate as per the current trend of requirements in coming months.

## 2) Rural Hospital, Chikhli:

- a) ICTC: One Counselor and one Lab Technician (LT) observed working there at Rural Hospital, Chikhli. Both of them observed highly inclined for their job's-assignments. They also extend outreach camps for ICTC/VDRL-testing for HRGs of TI.

## 3) Rural Hospital, Mehekar: Rural Hospital, Mehkar (located at approximately 80 kms. away from Buldhana district headquarter) is designated ICTC and also functional as Link-ART. As per the interaction with Counselors (-one male and the other female), there are 140 +ve patients linked to this ART centre, as of now. Counselors told that there are 6 LFU cases from amongst these linked patients and outreaches are regular. Further, monthly dispenses of medicines is being possible from this centre, to the patients, and the stocks are persistently kept in buffer during recent months.

**DAPCU's Involvements:** DAPCU representatives are regularly visiting the TI, generally at monthly intervals, and given quality allusion especially on augmenting linkages' services and observed keen in linking project beneficiaries with citizen benefits.

**DATA TRIANGULATION:** Data triangulation practices observed adopted, at monthly intervals, especially between linkages as well as TIs (and other HIV programmes of the district), on ICTC/DSRC/RNTCP issues and DAPCU, Buldhana strategically playing an instrumental role in this regard towards maintaining symmetrical data from these entities. Though, the amounts of efforts are significant but left some scope for tactically carrying out the same. Indicator-based coordination-sheet could also be developed for the ease at work in data-triangulation meets.

At a glance, linkage-wise services (along with certain relevant indicators) could be given as follows:

Indicator	Period April 2014 to March 2015
Direct Condom Distribution (MSM)	144042
Condom balance as on date	31500
No. of non-traditional outlets	-

Regular Contact (MSM)	4739
Total new registrations (MSM)	133
PT (MSM)	133
RMC-MSM (Qtly. basis 1 <sup>st</sup> qtr.)	330
RMC-MSM (Qtly. basis 2 <sup>nd</sup> qtr.)	415
RMC-MSM (Qtly. basis 3 <sup>rd</sup> qtr.)	454
RMC-MSM (Qtly. basis 4 <sup>th</sup> qtr.)	416
TOTAL RMC- MSM	1605
Syphilis screening-MSM (1 <sup>st</sup> time)	347
Syphilis screening-MSM (2 <sup>nd</sup> time)	72
No. of STI cases diagnosed	38
No. of STI cases treated	38
No. of STI cases counseled	1223
No. of STI cases followed-up	38
ICTC-MSM (referral, 1 <sup>st</sup> time/ 2 <sup>nd</sup> time referrals)	700
ICTC-MSM (tested, 1 <sup>st</sup> time/ 2 <sup>nd</sup> time tests)	700
Cumulative +ves (MSM)	3
Cumulative LFU (MSM)	0
Cumulative Died (MSM)	0
Cumulative +ves alive (MSM)	3
Cumulative +ves Migrated (MSM)	0
Cumulative +ves Drop out (MSM)	0
Cumulative Linked to ART (MSM)	1
Eligible for ART/on ART (MSM)	1
New +ves (MSM)	0
New +ves Linked to ART (MSM)	0
TB referral/on DOT	0

## 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.

- The NGO is adhering to the NGO-CBO Guidelines and other systems endorsed by SACS/NACO

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

- The NGO is using Pre printed and serialized Vouchers.
- All the payments were yet to be approved by the competent authority.
- Quotations were invited for purchases made above Rs.2000.
- All the vouchers were supported with required evidence.

-NGO is 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 medicine as per the guidelines.

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

-A Joint Bank Account is maintained by the NGO.

- Bank Reconciliation Statement is maintained on quarterly basis which need to be monthly.

- Cash book not maintained on daily basis and not signed monthly by the concerned authority as well.

- Manual ledger register is in place.

## **VIII. Competency of the project staff**

### **VIII a. Project Manager**

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

The Project Manager is MSW degree holder. He has joined this TI at *Matribhumi Multipurpose Foundation* in October 2015. He has yet be properly versed with the project's protocol in order to understand essence of the intervention. He rather knew the proposal contents. But, the planning exercises were yet to be reframed in terms of delivering services in order to authentically tracking the individual HRGs for the ease of his lower hierarchal team-mates. He is doing quarterly and monthly plan exercises but financial management according to indent of programme activities yet to be properly undertaken by him. Computerizations of certain formats were yet to be done and he had still to understand managing the data properly. Also he has need to be versed with many programme performance indicators as per the protocol. Review meetings being convened regularly but action taken based on the minutes yet to be incorporated. There was also reflection of her field visits (PM diary) but mentoring of field staffs was rather invisible in outreach documents. He had undertaken advocacy initiatives but the advocacies were not planned ones and follow-up after the meeting is missing.

### **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 has joined in the month of November 2015. During the interaction as well as documentation by Counselor, it was observed that his clarity on risk assessment and risk reduction, knowledge on basic counseling and HIV, symptoms of STIs etc. are rather above average to cater for the intervention. So far as maintenance and updating of data and registers the efforts had yet to be made properly to borrow the data belonging to PEs and respective ORWs to track on direct service deliveries. Counselor visits the field (as per the projects-beneficiaries' interactions/documentation) and started making his rapport with the linkage/beneficiaries as visited by the evaluation team.

#### 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.**

Two ORWs are currently working for the project one is old, joined the project in April 2014 and the other one has joined in July 2015. Mention in documents reflected common as adopted by horizontal team-mates (-ORWs). They rather having knowledge about target on various indicators for their PEs, outreach plan, STI symptoms, RMC and ICTC testing, support to PEs, field level action based on review meetings etc. Despite of that micro-plan has gaps because in several months, no plan is there for dues/over-dues for linkages and other programme deliverables. Weekly summary sheet Form-D also not observed filled-in. However, there were certain amount of outreach plans available with ORWs and risk assessments were revised at quarterly intervals for line-listed information for programme execution. The same were in symmetry with their respective peer educators. In outreach plans information were given mainly on condom requirement; certain amount of analyses on high/medium/low risk; days & time of meeting STI; condom negotiations etc. Peer-wise site map was yet to be available in proper way. By interviewing respondents at various fields, it was reflected that ORWs got their rapport.

#### 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 not properly familiar in filling their diaries and observed highly dependent on ORWs. There was ample scope for improvement in doing proper prioritization. All the met peer educators had average understanding on the project. Majority of PEs knew importance of RMC and ICTC testing, having average condom demonstration skills, communication skill, symptoms of STI and also known to

service facilities available in the TI'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 cum Accountant position was sanctioned and currently working M&E cum Accountant is graduated in Arts, joined the project in April 2014. Analytical information were rather available to the project towards identifying gaps in outreach service uptake as well as key information as were required for various reporting systems. He, at some extent, was able to provide key information about various indicators as were reported through MIS'.

**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.

Outreach activities were observed being implemented by planning the activity and same were also recorded for activities done; and thereby ensuring the service uptake by the TI. Micro plan is properly not in existence. As per the interaction with the team along with

peer educators/ORWs as well as review of their documents it was apparent that service uptakes were still need to be proper. Evidence based outreach plans were need to be available there and frequent visits/monitoring visits were made.

#### **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 and documentarily evident uptakes as well as the level of satisfaction of beneficiaries but as per the contract with MSACS performance not happen to that extent. Regular Medical Check Ups (RMCs), ICTC, Syphilis Screening, etc. were done by the project. ART follow-ups were yet to be seriously undertaken.

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

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

One of the staffs (ORW) is from within the community. Nonetheless, peer educators as well as a few of the HRGs were included in various committees as formulated (described elsewhere in the report). The roles community members were observed at some degree 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,**

Condom gap analyses were done which need to be revised for authenticity. Distributions' variances against demand were also noticed. Free condom distributions being done but CSM could not happen.

#### **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.**

TI identified some of its stakeholders and advocacies were ensuing. However TI still needs to understand the importance and essence of doing advocacies with potential stakeholders. Advocacies were need-based ones and still to be followed-up properly



after the meeting.

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

The project is yet to properly link its line-listed beneficiaries with various social protection schemes.

**XV. Best Practices if any**

Yet to be identified.