**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**

The Godavari Foundation, Non Governmental Organization was established in 1993, Under Trust Act, Mumbai the Registration No. is F-2246(Jalgaon) and register under foreign contribution (Regulation) Act, 1976, NO-083840010. Basically, Godavari Foundation mainly works on Education and runs many collages in Jalgaon district. Godavari Foundation also implements health projects like National Mobile Medical Unit Project, Medical collage & Hospital having capacity of 500 beds, nursing collage and Physiotherapy College. Ministry of health and family welfare of India recognizes Godavari Hospital as a Mini Lap and MTP training centre which used to provide training to Government medical officers. The organization also have PPP Mobile ICTC and HIV test for ANC and suspected patients.

Godavari TI CC (MSM) Project Jalgaon was started as Godavari Mukta Project funded by Pathfinder International Pune in 2005 for FSWs only, and in 2007 Project starts working with MSMs. In Jalgaon, Udaan Trust was working on MSMs population, they started to provide Outreach services only and Mukta Project was providing Clinical services for them. In Feb.2008, Udaan Trust handed over the project to Mukta Project and then Mukta started STI, Outreach and all services for MSMs. In 1st November 2009, Pathfinder Handed over the Mukta Project to MSACS, Mumbai and since 1st November 2009 Project was separated for MSM community as Godavari TI MSM Project Jalgaon and in 1st April 2014 Project changed TI MSM to TI CC Project Jalgaon.

* **Name and address of the Organization**

Godawari Foundation (CC TI Project)

**Head office :**

Godawri Hospital Building, M J College Road,

Bhasker Market,

Jalgaon (Maharashtra)

**Project Office :**

19-20, 3rd Floor, Lunkad Tower,

Pande Chowk,

Jalgaon (Maharashtra)

* **Chief Functionary :** Dr. Ulhas Patil, President
* **Year of Establishment :** 1993
* **Year of month of project initiation** : November 2009
* **Evaluation Team**

Mr. Dinesh Prajapati - Team Leader

Mr. Shailesh Machhi - Co-Evaluator

Mr. Mahozzim khan - Finance Evaluator

* Time Frame : 1st April 2014 to 31st March 2016

**Profile of TI**

(Information to be captured)

* **Target Population Profile:** MSM & TG
* **Type of Project:** Core Composite
* **Size of Target Group(s)**

Total 868 (726 MSM + 142 TG) covered against target of 800 (700 MSM + 100 TG)

* **Sub-Groups and their Size :**

Kothi : 410

Panthi :138

DD : 178

TG : 142

Total :868

* Target Area :

Jalgaon (21 hotspots) of Jalgaon District (Maharashtra)

Bhusaval (7 Hotspots) of Jalgaon District (Maharashtra)

Chalisgaon (6 hotspots) of Jalgaon District (Maharashtra)

Key findings and recommendation on Various Project Components

1. **Organizational support to the programme -:**

The organisation provides support to the TI project. The President of the organisation, NGO coordinator and Dr. Dilip (Dy Dean of Medical College) are involved in the project for monitoring, training and support and understands the projects and its deliverables. However, it was found that PD was present in most of the monthly review meeting but qualitative and action based review and planning was missing at TI level. It appeared that strict monitoring is required by the PD and organisation to ensure smooth implementation of TI and its activities.

The organization head has initiated advocacy related activities, HRGs of TI avail free medical services from its health project. The organization is well-known NGO and implements many projects, it looks financially strong but the NGO has not provided any loan / financial support to TI in case of grant delay from MSACS.

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

Present TI has 1 PM, 1 M&E office cum Account Assistant, 1 Counselor, 4 ORWs and 14 Peer Educators. Majority of staff are more than Two years old except M&E officer and One ORW. The post of M&E officer cum accountant was vacant from April 2015 to 15 July 2015 (3.5 months). Monthly review meeting with staff is being conducted at TI level by Project Director and Project Manager. The project witnessed limited staff turnover during the year, but replacement of vacant post was not done within 2 months time limit and no attempt was made by the organization to fill up vacant post. Appointment letters were issued to all the staffs with roles and responsibilities attached. Attendance register is maintained and daily entry is done. An updated leave application file was in place at TI.

1. **Capacity building:**

During the year 3 trainings were conducted for TI staff. 2 were organized by DIVA project (Humsafar trust) for Counselor and PM; and One was conducted by TI NGO for orientation of newly recruited ORW. Newly recruited Peer Educators were not provided any orientation or basic training on HIV/AIDS. Documentation of training was not up to the marks and All peers, M&E office and 2 ORWs needs orientation and refresher training.

1. **Infrastructure of the organization**

The TI has set up project office at Jalgaon and DIC is attached with the project office. Apart from this, TI has DIC in Bhusaval. All required infrastructure and equipments are available at project office. The organization is having adequate infrastructure, which includes, chairs, tables, computers, printer, phone, internet etc required for the project. Overall the requisite infrastructure is in place for the project, but TI NGO needs to have spacious office and DIC which is currently not having enough space.All the assets have been codified.

1. **Documentation and Reporting:**

The organization is maintaining all the required documents of the project as per the formats provided by MSACS. The project has been submitting CMIS reports to MSACS in time. The field feedbacks are not shared and reviewed during staff meetings

1. **Programme Deliverables**

**Outreach**

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

894 (including 16 new HRGs) HRGs were registered, 25 were drop out and 869 HRGs are current active population.

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

Not Applicable for CC TI

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

Not Applicable for CC TI

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

ORW wise micro plan is available & the same micro plan was used by ORWs for delivery of services as per need and demand but Peer Educators were not aware about that plan, and it was not used by Peer Educators. Similarly, HRGs tracking for clinical services was also available with the counselor but same is not available with ORW for tracking of non-clinical services. Moreover, All ORWs were clear about risk assessment barring some confusion in understanding vulnerability.

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

TI has 869 active populations till date.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Kothi | Panthi | DD | TG | Total No of HRG |
| 410 | 138 | 178 | 143 | 869 |

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

Outreach planning tools were used for the designing the outreach activities. Monthly plan for all the staff is made. The field visit of the ORWs is limited to 2-3 times in a particular hotspot. The peers are provided with supportive supervision by the ORWs and other staff members. Participation of newly registered HRGs in DIC/ Hotspot meeting was not focused at TI level.

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

868 is active population and 14 Peer Educators are appointed, ratio is 1 : 62 HRGs.

1. **Regular contacts**

As per records and data available with TI, 825 (94%) HRGs are contacted once with any one project service against active population of 869. 762 HRGs are contacted twice in a month in gap of 10-15 days and provided project services (87%). During the field visit, we could not met more HRGs and during meeting with PEs, All Peer Educators were asked to write name of HRGs who are in regular contact, and only 2 out of 11 interacted can write 10 names of their HRGs, this is again raise questions about regular contacts of the HRGs.

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

Peer Educators are not able to fill form B, They do not have understating of prioritization of hotspots / HRGs and use of outreach tools. Overall, documentation of Peer Educators are poor and what available at TI office is maintained and updated by TI staff.

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

Majority (72%) of peer educators (10 out of 14) are above 30 years age. All Peer Educators were asked to write name of HRGs who are in regular contact, and only 2 out of 11 interacted can write 10 names of their HRGs, this is again raise questions about regular contacts of the HRGs. During interaction with the community members it was observed that majority of the HRGs have basic information on HIV/AIDS/STI transmission and its symptoms. They were aware of some of the programme activities – like receiving condoms and getting HIV testing done at civil hospital. However, they showed ignorance about why they have to get tested for HIV and VDRL. It is inferred that MSM are not using condom with their regular partners.

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

PM supervises the project through field visits and through monthly review meeting at TI level. The ORWs supervise the work of the Peers through field visits and one to one contact with the HRGs. ORWs needs to monitor the work of peer educators. Follow-up plan is weak and needs to be strengthened.

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

Five PPP Doctors are indentified for clinical and STI service. 1 is MBBS and other 4 are BAMS, 2 BAMS Doctors are untrained. Apart from PPP doctors, linkages with government hospital are also developed.

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

On visit to PPP clinic, it was observed that the clinic is fairly equipped. It has examination table and basics equipment. Discussion with the doctor revealed that HRGs visit her clinic from the project. 133 STI cases were identified and treated at TI.

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.

**No applicable for CC project**

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.**

Though three out of Five doctors appointed, are not yet oriented on Syndromic treatment protocol but they are following the same. HRGs are referred for ICTC/syphilis screening at Government hospital and around 95% got tested. It was observed from the available data that only 50% of the newly registered received PT in the project. During interaction with the community members it was found that their understanding related to STI is fair but Quality counseling to the HRGs must be done.

1. **Documentation :**

All the documents related to Clinical/STI Management and referrals are maintained by the project. Counselling register is maintained for all the HRGs who have been counselled. A patient sheet/network clinic format and daily summary sheet is also maintained by the counsellor. Stock registers and formats for STI drugs, condom are maintained. Referral slips are maintained for all the referrals- ICTC and VDRL.

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

An only free condom was distributed through 32 outlets, 14 Peers, 2 DICs and 4 ORWs. Condom demand was calculated after gap analysis. Outlets are developed at tea stall, Pan wala, toilets, Watchman, garden security guard, Brothel owner (yes in MSM also) etc.

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

178792 was yearly demand and 104974 (59%) was distribution through various channels. Condom was stock out from September 2015 to December 2015. In July August 2015 also there was low stock of condoms due to delay in supply from SACS level.

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

Not Applicable foe CC TI

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

|  |  |  |
| --- | --- | --- |
| Sr.No. | Name of Place | Type of Linkages |
| 1 | Civil Hospital ICTC - I | ICTC |
| 2 | Civil Hospital ICTC - II | ICTC |
| 3 | Shahu Maharaj ICTC (MCH) | ICTC |
| 4 | Chetanadas Mehta Jalgaon ICTC | ICTC |
| 5 | Bhusawal Municipal Hospital | ICTC |
| 6 | Chalisgaon RH | ICTC |
| 7 | Varangaon RH | ICTC |
| 8 | Civil Hospital DSRC | DSRC |
| 9 | Dr. Ashok G. Raverkar Jalgaon | PPP Doctor |
| 10 | Dr. Yogesh K. Baser Jalgaon | PPP Doctor |
| 11 | Dr. Prakash K. Mahajan Jalgaon | PPP Doctor |
| 12 | Dr. Vivek Arkadi Chalisgaon | PPP Doctor |
| 13 | Dr. Girish Patil Bhusawal | PPP Doctor |
| 14 | Mr. Nandedkar Jalgaon | DOTS (But No referrals) |
| 15 | Advocate Vijay Mahajan Raver | Advocacy, Crisis help |

1. **Referrals and follows up.**

In randomly verification of register, it is observed that in October to December 2015, November 2015, 43 STIs were treated, and follow up of 18 (41%) HRGs were done. TI counselor has lack of clarity in follow up and met HRGs (who treated with STIs) after 15 days.

No follow up was done for PLHIV. As per data observed, in December 2015, 50 PLHIV’s CD4 test date was due.

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

CBO "Sarvoday Foundation" was formed in 2012 and now after death of founder, CBO is dissolved from 2013. No SHGs were formed at all.

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

1 Event was conducted in Dec 2015; Only 25 HRGs were participated in the events. i.e. only 3% HRGs were participated. 3 Committees were formed i.e. Project Management committee, DIC committee and Crises committee involving 27 members in these 3 committees. Crises committee was formed and 1 case was address, as inferred from interaction with peers, many crises happens in field but that are not reported or addressed at TI level. It is observed that participation of community seen at records level only and community participation was not visible at field level, specially community participation from Bhusaval and Chalisgaon is NIL and the component is neglected as no planning and action was seen at TI level.

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

TI has 3 major sites for target intervention. Jalgaon, Bhusaval and Chalisgaon. In jalgaon, there are 4 ICTC, 3 PPP Doctors, In Bhusaval, there are 2 ICTC, 1 PPP Doctors, In Chalisgain, there are 1 ICTC, 1 PPP Doctors. No linkages found for TB.

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

2604 referrals were done to ICTC for HIV testing and 1341 testing were done

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

TWO stake holders were interacted and both were involved in supporting service delivery and project implementation. During the field visit it was seen that stakeholders were aware of the project and support in identification of new HRGs. However, their role in planning and service delivery was not visible. TI needs to identify field based stake holders who have direct influence on target group and target area.

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

Budget guideline is available as issued by MSACS Mumbai. Expenditure and Payments are made as per budget sheet.

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.**

Printed voucher is available with serialized numbers, Stock book available for condom and stationary. Bill are approved by PM, with stamps on bills & signature of PM, Accountant and PD. Supportive document were attach properly. Authority approval note-sheet or document is shown.

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.**

NGO has not purchased any Medicines or Condom during financial year.

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

Bank accounts separately available maintained by jointly signatories. Bank reconciliation is done. Audit Reports are available last 3 years. F.Y. 2014-2015 Audit compliance report is submitted by NGO to the MSACS. Cash or bank book was sign by authority. Ledger Prints out is available. Stationary stock book is available. Cheque issue register is available. Rent contract file was sign & available

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

**VII a. Project Manager**

Mr. Sachin Narkhede is Project Manager at TI, has done his MBA and associated with this TI since its inception i.e. 1st November 2009. However, he is not from social science background, his knowledge on project proposal, project indicators, planning, financial management and data management is sound and good. He conducts monthly review meetings but quality of the meeting needs to improve implementing various monitoring tools of the TI.

**VIII b. ANM/Counselor**

Mr. Vishwanath is Counselor and he has done MSW. He has also joined this TI from its inception i.e. 1st November 2009. Earlier he was working as ORWs and later promoted as Counselor. Counselor has Clarity on risk assessment and risk reduction and provided counseling on all 7 types. He has good knowledge on basic counseling, symptoms of STIs and HIV. He is able to maintain all clinic related data and registers.

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

Not Applicable foe CC TI

**VIII d. ORW**

The TI has 4 Out Reach Workers and 3 are from MSM community, Out of 4 appointed 2 are graduated; one is MSW and rest one has passed 12th. 3 ORWs are working since more than 2 years; One has recently joined in March 2016. Out of 4, only 2 ORWs are familiar with their project indicators, outreach plan, hotspot analysis, STI symptoms, importance of RMC and ICTC Testing etc. Rest Two are at learning stage and need training on outreach tools and clinical services.

**VIII e. Peer educators**

Majority of Peer educators do not have clarity on role and responsibility of Peer Educators. They are also not aware about due and overdue and Prioritization of hotspot. During interaction with PE, There were not aware about week they have done in last week of current month. Out of 14, only 11 were present during the meeting and 1 was interacted during field interaction. Peer Educators have fair knowledge regarding STI and HIV. All peer Educators have not provided any orientation or refresher training.

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

Not Applicable foe CC TI

**VIII g. Peer educators in Migrant Projects.**

Not Applicable foe CC TI

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

Not Applicable foe CC TI

**VIII j. M&E Officer**

M&E officer is B. Com passed and he has also done computer course. He has joined this TI in July 2015. However, having work experience of 1.5 years at this TI, he is still at learning stage and dependent on PM for data and records. He is not able to provide analytical information about Outreach and service uptake to the project staff.

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

As per the records and documents outreach activities were undertaken on regular basis. On an average 95% of the HRGs are covered in a month with one to one or one to group services besides condom promotion. However, the reflection of the same was fair but not good in the field. The staffs need to focus on the quality of BCC and dissemination of knowledge. The understanding of the essence of the need to provide services by the project was missing.

**IX b. Outreach activity in Truckers and Migrant Project**

Not Applicable foe CC TI

1. **Services**

It was observed in the project that most of the referral services like ICTC and Syphilis testing are satisfactory. However, the number of RMC done is high but it has to be ensured with proper internal checkups. Similarly, the counselor needs to focus on STIs issues, as all 7 types counseling was not provided to HRGs as observed from counseling data. Similarly, Free condom, SM condom and lubes needs to provide to HRGs as per their demand.

1. **Community involvement**

Community participation in this TI is up to the Peer educators and some HRGs (27 HRGs including Peer Educators) are members of the various Committees. Community Participation in planning and delivering project activities are NIL.

1. **Commodities**

Mainly free condoms were distributed. Condom Gap analysis was done on quarterly based as per guideline. Social Marketing of condom was not done in current year from April 2015 to March 2016. LUBE (Jelly) was not available and during field interaction and Peer Meeting, most of the HRGs demanded for the LUBE. In STI Drugs, mainly KIT 1 was available and in case of need of other KIT, HRGs were referred to District hospital for treatment.

1. **Enabling environment**

12 Advocacy meetings were conducted on need based, In TWO meeting reports we found date of 18.11.2016 and 17.10.2016. Follow up action was neither planned nor done after advocacy. Date of Advocacy does not match with movement register. As observed only Community ORWs and few PEs are participated in advocacy. Crises committee was formed and 1 case was address, as inferred from interaction with peers, many crises happens in field but that are not reported or addressed at TI level. 1 Event was conducted in Dec 2015; Only 25 HRGs were participated in the events. i.e. only 3% HRGs were participated

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

TI has worked and provided benefit of social protection schemes to HRGs in year 2013. During current year, no such activities noted at TI level. TI team claimed to process for 3 application forms which are in process at government office.

**XV. Best Practices if any.**

**None**

**Annexure C**

**Confidential Reporting form C**

**EXECUTIVE SUMMARY OF THE EVALUATION**

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

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

|  |  |
| --- | --- |
| **Name of the evaluators** | **Contact Details with phone no.** |
| **Mr. Dinesh Prajapati (Team Leader)** | 721-722, Kanan Society, Rajan Nagar,  Valsad Pardi Road, Abrama,  Valsad – 396001, Gujarat – India  M : +91 9408333476  **Email:** [dinesh\_bsw@yahoo.com](mailto:dinesh_bsw@yahoo.com) |
| **Mr. Shailesh Machhi (Co-evaluator)** | A-16, Vasanji Park,Dharmpur Road,Abrama,Valsad-396001.  Mo:+91 94294 50535  **Email:** profshai@yahoo.co.in |
| **Mr. Mahozzim khan (Finance Evaluator)** | +91 8007084900 |
| **Officials from SACS/TSU (as facilitator)** | Mr. Sanjay Pahurkar  (DAPCU Jalgaon) |

|  |  |
| --- | --- |
| **Name of the NGO:** | Godawari Foundation CC Project |
| **Typology of the target population:** | CC Project (MSM & TG) |
| **Total population being covered against target:** | 868 covered against target of 800 |
| **Dates of Visit:** | 25 – 26 April 2016 |
| **Place of Visit:** | Jalgaon, Bhusaval of Jalgaon District (Maharashtra) |

Overall Rating based programme delivery score:

|  |  |  |  |
| --- | --- | --- | --- |
| **Total Score Obtained (in %)** | **Category** | **Rating** | **Recommendations** |
| **61%-80% (62.1%)** | **B** | **Good** | **Recommended for continuation with specific recommendation.** |

**Specific Recommendations:**

|  |
| --- |
| * Though the PD is part of all the review meetings it was observed that internal review system is weak. Strict and regular monitoring by PD is required in order to improve the performance of the TI project. * All PE needs to fill form B and Prioritization of HRGs and hotspots. * All new HRGs are needs to ne covered in hotspot / DIC meetings. * Internal induction/refresher trainings should be organized by the organization on regular basis to upgrade the skills of the staff/Peers and their conceptual clarity. Computerization of the all records to be done. * The outreach part in the project needs focus. Outreach/micro planning and tracking of each HRGs for delivery of services must be ensured. * Advocacy meetings to be planned at all levels but follow up action required after advocacy and followed up by the project. Documentation to be done properly. Similarly, active participation of stakeholders to be ensured for enabling environment in the project. * Organization must fill vacant posts in due timeline, replacement of vacant post needs to be done within maximum 2 months. * All Doctors shall be provided training on syndromic management. * Free condom were not available, SM condom were not procured, these make many encounters unsafe and this results in high STI and HIV prevalence rate, TI needs to make micro-plan for condom management. * Community mobilization activities, functional of crises management team and committees needs to be focused at from NGO PD level. * Follow up of STIs and PLHIV are neglected at TI level, this is serious concern at TI level as we left HRGs to spread HIV deliberately. All HRGs treated with STIs and all PLHIV must be followed in due time line. * DOT refferal is not initiated and TI team has lack of clarity on importance of DOT refferal. * TI is more than five year TI and needs to initiate community mobilization activities, TI team * Crises committe was formed and 1 case was address, as inffered from interaction with peers, many crises happens in field but that are not reported or addressed at TI level. |

**Name of the Evaluators Signature**

|  |  |
| --- | --- |
|  |  |
| **Mr. Dinesh Prajapati** |  |
| **Mr. Shailesh Machhi** |  |
| **Mr. Mahozzim khan** |  |