**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:

Muslim Samaj Prabodhan Va Shikshan Sanstha (M.S.P.S.S) is a socio-cultural, apolitical, secular autonomous registered voluntary social work organization established in the year 1983, registered under the Foreign Contribution Regulation Act (FCRA) vide registration number 083860031.

The NGO was started with the mission of working for social awakening and education of Muslim communities, offering vocational courses and free legal aid services for destitute, orphans and divorcees. It also has the objective of running a hostel with provision for educational opportunities for the offspring of destitute, divorcees and poor / weaker sections of the society.

In the early stages the organization mainly focused on Muslim divorcee women. In course of time, the ground experiences motivated the organization to plan and act scientifically for inspiring change in the knowledge, attitude and behavior among women, child in all the sections of the society building up awareness on their situation and needs and the resources available to satisfy the needs through collective efforts thereby achieving a dignified life.

**Projects Implemented by the MSPSS:**

* Community Kitchen ( Bhaji Bhakari Kendra)
* A training cum production center 1989- 2004
* Sanstha had started in 1989 a project i.e. Community kitchen “Bhaji Bhakari Kendra” is was training cum production center. Which gives employment and training of how to run a mess. Sanstha has established sales outlets in the city.
* Vocational Training Center
* In the year 1998-99 Sanstha started vocational training center for divorcee and destitute women and their drop out children. Project was funded by Functional Vocational Board, Bangalore. Following training programs were carried out by the sanstha in collaboration with Shramik Vidayapeeth which was affiliated to Shivaji University, Kolhapur. The center offered training on Paper file making, Computer education, Domestic Electric Fitting, T.V/Tape servicing, Pickles, Papad and Spices making
* *Mahatma Phule Shikshan Hami Yojana., Funded by Municipal Corporation, Kolhapur.*
* This is non formal education project. Children between age group of 6 to 14 yrs are covered under the project. The school was situated near Unchagaon Octroi Post, Kolhapur. The students are basically from Chittodiya tribal community. 25 students are been given non-formal education within the school.
* Name and address of the Organization:

C/O: Sammesar Medical,Station Road,

Ichalkaranji-416115

Dist: Kolhapur

* Chief Functionary: Mr. I.N. Baig
* Year of Establishment: 1983
* Year of month of project initiation: August 2013
* Evaluation Team: M. Omega Jyotsna, RajaBabu, Manisha
* Time Frame: 20th April to 22nd April 2106

**Profile of TI**

(Information to be captured)

* Target Population Profile: FSW/MSM/TG/
* Type of Project: Core Composite
* Size of Target Group(s) – FSW – 238, MSM – 875, TG - 85
* Sub-Groups and their Size: FSW Home based – 238, Kothi – 291, Panthi – 271, DD – 75, TG - 85
* Target Area: S.t.Stand, Bhagatsingh Bagh, Rani Bagh, Shahu Putala, Kurundwad, Awale Petrol, Guru Talkies

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…

* Interaction was held with the Project Director and Associate. They had a positive perspective towards the Project. The appreciated the Project staff that though there had the financial crunch yet they had continued to do the work. They were proud that they had a committed staff working for the Project.
* As per their mission statement, they informed that they would continue to strive to work for the downtrodden and marginalized community. Their major focus would be to ensure to create a respectable status for the Community in the Society and ensure that they receive all services from the Project.

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 staffing pattern in the Organization is as per the laid down structure of the NACO Protocol. The Project Manager of the Project is supported by an M&E officer, four Outreach workers. There are 18 PE’s on the Project. The M&E and the ORW report to the PM about the Project activities. The PE’s report to the ORW about the Progress of their activities. The supportive supervision in term of the Project components is minimal. Guidance is given only with reference to dues of the RMC and HIV testing.
* The Staff are committed to working with the community. The staff is aware of their roles yet they need to improvise on reaching out to the community in terms of BCC of all Project service components. Turnover has been observed with reference to hindrance in funds flow from SACS.

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

* One external training has been conducted by the Humsafar trust for the ORW.
* In-house capacity building programmes have been held with the support of the STRC personnel. The recently recruited PE’s and ORW need to be capacitated on Outreach planning, knowledge about the mobility of the sex workers, Micro planning etc.

1. Infrastructure of the organization:

* The staff of the Organization has faced problems with the earlier office premises. They were forced to vacate the premises abruptly due to some conflict situations. Currently they have shifted to a single room premises. There is just enough space for the Staff to be seated.

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.

* The Documentation and reporting is as per the SACS Protocol.
* The PM has joined recently therefore the ORW and other staff who have been working past 8 years at times surpass the commands, yet within control.
* All the Documents as per the SACS Protocol are maintained. No mismatch has been found amongst the registers such as daily diary, movement register and activities held.
* However there is insufficient planning for conducting DIC, Hotspot and demand generation meetings in the action plan as well as in the review meeting registers.
* No documentation is maintained in the Clinic, PPP ICTC facility, hence the team could not ascertain the actual number of cases accessing these services. There was a mismatch in the number reported by PE and the actual found in the register. 15 HRG received PT in the month of December. But that is not mentioned in the register.
* About 90% of random checks done informed that all HRG were receiving three month RMC without fail an without delay

1. **Programme Deliverables**

**Outreach**

1. Line listing of the HRG by category:

* The total target population is 1120, against which 960 have been registered. A formats for al the registered HRG are duly filed in with all the relevant data which classifies them as being high risk, medium risk and low risk.

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

* The PM joined in January 2015, yet he has minimal information about the Project and other activities. He has no knowledge about Micro planning and the same is reflected in the staff.
* The Outreach workers too, though they have been working since long time, they have no idea about micro planing. The Outreach planning, dues for RMC, HIV testing and Syphilis testing is done through the line listing data with the ORW and the same information is given to the PE’s.

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

* More than 60% of the population have been provided with all project services ie condom, STI, ICTC and syphilis. As per the records, all are being contacted and being provided. When randomly checked for RMC 30 of 30 cases had three month RMC with no change in the month for the past one year such as Jan, April, July etc. In the field interactions the Kothi mentioned that they attend regularly more than the mentioned frequency, where as the frequency of the Panthi differed.
* The sex workers in the field are contacted by the ORW only, the ORW keeps in constant contact with the FSW HRG through Phone.
* In the MSM field, since there are about 7 PE’s in one site, though they are under different ORW, all of them know each of the HRG, henceforth is appeared that all PE’s are in contact with all the HRG’s in the site.

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

* Outreach planning is primarily done for pursuing the dues of the RMC, HIV, Syphilis testing’s. The risk and vulnerability issues, hot spot prioritization etc are not being given much focus.
* The same is reflected in the field.
* In the Outreach planning, during interactions with very few FSWHRG it was observed that one was street based, two were high way based, one was lodge based, one was home based. But where as in the records it is written as all are home based, hence forth contacts are more phone based. If the HRG is available, ORW contacts her, otherwise they speak over phone. There is minimal space for the PE’s.

1. PF: HRG ratio

* The PE HRG ratio is maintained as per the protocol of SACS.

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.

* As per the records all are being contacted and given condoms once in every two weeks. There is no difference n outreach for High risk HRG except for the number of condoms.
* Referral services are being provided on a regular basis, On records and during random checks done in any month, al HRG are receiving RMC every three months on a regular basis, there are no changes in the months even such as one month late etc.
* The records numbers differed to the responses by the HRG . The visits of the Kothi’s, few high way based and street based, lodge based etc access services on a were more frequent,

1. Documentation of the peer education.

* Minimal Documentation by the PE’s. Nil documentation by illiterate PE’s

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

* The Quality of Peer education messages is good. The message intake was observed to be more amongst the Kothi’s, than the Panthi’s. The Kothi’s were more aware of the risk factors than the Panthi’s even the risk behavior also significantly differed.
* The capacities of few needs to be built up regarding risk of HIV transmission between female to male and male to male.

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

* During the field interactions it was observed that the ORW had more hold over the sites than the PE’s.
* Three ORW’s in their work profile mentioned the same roles and responsibilities as PE’s.
* The delineation of HRG in the sites to each of the PE’s is also questionable due to their collective activity in one site, high mobility patterns amongst hotspots and sites.
* In one site the HRG were more aware of the ORW than the PE. The FSW HRG knew only their ORW. They also informed that they access condoms from the ORW.
* In lieu of the above, it can be said that there lacunae in overall supervision and mentoring.

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

* The mode of STI Service delivery is through PPP clinics. The number attending the DSRC is very minimal and negligent.
* There are 6 PPP clinics located very close to the Hot spots and the HRG attend very regularly as per the records.
* The Community is satisfied with the services of the PPP clinics.
* The Community responded that they visit only two PPP service Providers most often i.e. is Dr. Malage, and Dr. Kadam.
* Dr. Kadam informed that about only about 30 – 40 cases attend his clinic, and it has been about 3 – 4 months since he has attended the DIC.

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

* All the STI services are given through the PPP mode. The Doctors have two Proctoscopies and one Speculum. In instances when there are more than 10 HRG’s it is a difficult task to do RMC for all of them, as they have to follow the sterilization process.
* Kits are available, the NGO accesses them from the DDAPCU and issues to the respective PPP provider.
* For HIV testing, they have a PPP service, the Lab technician tests tge HRG. He mentioned that report is given to the HRG but could not be verified. The balance stock matched. IN April though tests have been done no data maintained.
* Syphilis is also done through PPP service.
* No records for Syphilis and HIV except for the HIV and Syphilis register.

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.

* The HRG have mentioned that the services provided to them are good, they are satisfied. The Kothi’s and FSW insist on internal examination and the same is provided to them by the service providers.

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.

* Al Documents are registers are maintained as per SACS protocol. All have been updated till March.
* No data available for April except for Clinic sheets.

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

* The Current balance is 53 condoms.
* Condoms are distributed as per the risk factors.
* All HRG reported their satisfaction about the condoms being provided.

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

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| --- | --- | --- | --- | --- |
| **S.No.** | **Performance Indicator** | **During April 2014 to March 2015** | **During Ap. 2015 to March.2016** | **Total** |
| 1. | Total demand for Free condoms as per CAG | 188000 | 190471 | 378471 |
| 3. | Total Distribution as per CAG | 186411 | 156349 | 342760 |
| 4. | Distribution through PEs and ORWs | 173211 | 145634 | 318845 |
| 5. | Distribution Through other outlets | 9520 | 6015 | 15535 |
| 6. | Total demand for SM condoms as per NACO guide lines | 37600 | 38094 | 75694 |
| 7. | Total distribution of SM condoms | 3680 | 4700 | 8380 |

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

* The ORW have complete information about ICTC and ART services. As their attendance to DSRC is minimal, they are not aware of the services.
* The PE’s knowledge about the other service centers except for PPP’s is very inadequate.

1. Referrals and follows up.

* The referrals and follow up regarding the RMC and ICTC is very efficient.
* ART follow up and updation of data is not being followed. On a random check – Pre- ART: 1410 – regular, 1287 has not turned up after 8th march 2015, 3761 not registered with IGM, 9039- not registration.
* ART: 3722 – not registered with IGM, 2433 – regular, two numbers 4867, 8590 are not registered with IGM. However the information provided is that they have been registered with IGM.

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

* Earlier the NGO received funds for CBO activities, the CBO then formed was vibrant with activities, since the funding has stopped the CBO activities have declined.
* Community committees are existent in records, field data verification does not align with the same.

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

* The FSW community regularly attends all activities conducted by the NGO.
* The MSM community have their own cultural events. More than 60% of the population attend the events.
* The HRG are joyous about their events.

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

* Linkages are very good with the PPP service providers.
* ICTC and ART linkages need to be strengthened so as to access their services on regular basis.

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

|  |  |  |  |
| --- | --- | --- | --- |
| HRGs tested for HIV | Referred – 1599  Tested - 1599 | Refered – 1749  Tested - 1749 | 3348 |

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

* Good Support System has been developed with all the stake holders.
* The Key stakeholders are shopkeepers who resolve crisis issues at the hot spots from any goondas and holigans. They also protect them the Police.
* Few advocacy sessions have been held with the Police too.

1. **Financial system and procedures**

* System of planning:

Every Financial term to be followed on the guideline. Expenditure and Payment were Charged to the Correct Head wise.

* Systems of payments –

All the Transaction which are more than Rs.2000 are paid by through Cheque. Cash Register is maintained. Vouchers are printed and Machine numbered. Details of Specific Quantity and Rate of Snacks not Mentioned of Bill.

* Systems of procurement –

Quotation Process is followed for Purchase of Fixed Asset, Clinical Material and Drugs during the Period.

* System of documentation-

Registers related to Finance are maintained. Register of Lubes and Syphilis Kit Details are not Written Properly (eg. Batch No.Expiry & Mfg Date ,Bill Amount.). Bank Reconciliation Statement Maintained every Month.

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

**VII a. Project Manager**

* MR. Ajit Vadde MSW; is the project manager in this TI project working since January 2015. Even though he is sincere at work he needs to be good at Computer and data management. He has to be a good team leader. He needs to plan for advocacies properly and document the same in an authentic manner. He is good at book keeping and supporting his crew in all aspects. His prior experience was with a similar NGO. His commitment to NGO is applaud able. He needs to be in field for more time as the field is the mirror in which the quantitave efforts reflect that magnifies the glory of the NGO’s efforts. He has to be proactive by all means as he is a good sports man as seen in his curriculum vitae.

**VIII b. ANM/Counselor**

* Mahesh ravel MA; B; Ed, who grown up from the gross route level to a crucial position i.e. From PE to counselor, is committed and sincere at his work. He is good at book keeping and filing the patient cards but needs to be more familiar with his job specific responsibilities. He needs to be clearer with risk and vulnerability to counsel the targeted community towards risk reduction. His linkages with various service providers and stake holders are really good.

**VIII d. ORW**

* There are 4 Outreach workers on board namely Dattatreya Ambekar, Ishmael Sheik, Mahadev and Sumitra Lahre. Except Mahadev who is SSC by qualification all are well qualified having 2 to 4 years of experience in this TI with core population. All are good at supporting their PEs in all aspects regarding performance indicators. Their documentation with regard to referrals, respective formats, action plan, movement, daily diaries and etc. are undoubtedly up to the mark. Their linkages with various stake holders are also good. However their efforts are to be well reflected in the field. Micro plan need to be in place for prioritization of HRGs towards services.

**VIII e. Peer educators**

* This CC Target intervention comprises 18 Peer educators. They are knowledgeable regarding HIV/AIDS and STIs and good at condom demonstration. However, the over aged Peer educators are to be replaced with immediate effect. Site and hotspot wise micro plans need to be prepared and the PEs need to be well versed with the same to prioritize and track the HRGs towards needed and available services

**VIII j. M&E Officer**

* Mr. Rahul Lipare B.Com; is the M&E cum accountant working in this organization since November 2014. He is well versed with advanced computer accounting and project related data management. H e is very supportive to his co staff members and has good knowledge about project performance indicators. It was observed that he is a crucial person in this target intervention. However, he needs to make his prescribed no. of field visits for the purpose of cross verifying the data provided by the OR staff and PEs

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

* The outreach activity in the project functional area is being carried out by the Peer educators being supportively supervised by their respective ORWS. The entire outreach activities are being monitored by the Project Manager. The outreach plan needs to be interlinked with well prepared micro plan so as to ensure site and hotspot wise prioritization of HRGs towards essential services. Quantitative efforts need to be matched with qualitative efforts.

1. **Services**

The main service available in the TI is supply of commodities such as free and SM condoms along with lubricants for the MSM community, against the demand based on condom gap analysis. The other services are counseling and referrals to service centers like ICTC, ART, Syphilis, TB (DOT) and PLHA networks. The PPP mode of STI services available in the TI need to be so authentic and the community need to be referred to ICTC also for HIV tests as the organization has been utilizing only the services of a private lab technician for the same. The identified 36 positives are linked to ART. Out of 36 FSWs are 13, MSMs are 21 and 2 TGs and out of 2 + TGs one is connected to link ART.

1. **Community involvement**

* No signs of community involvement in planning and implementation are observed. As MSPSS fostered a CBO and the same CBO is handling a TI on its own, the Community’s involvement in all spheres of TI has to be ascended to audible heights. Some committees like Crises, advocacy, Clinic are in place. There is a CBO established separately for MSM community titled Maître HIV/AIDS sanghatan in which the ORWs in TI are holding governing positions in the said CBO. This was established in the year 2007 bearing the reg. no. M4 2350.

1. **Commodities**

* Supply of commodities like free and social marketing condoms and lubricants for MSM community is happening in the Target intervention based on project and hotspot wise condom gap analysis. Buffer stock to be maintained as the Evaluation team found only 53 free condoms during stock verification. The stock of lubricants is adequately maintained.

**XIII. Enabling environment**

The advocacy efforts of the NGO with various stakeholders such as watchmen of parks in the town, pan shop owners in RTC bus stand and etc. are okay. Proper and strategic plan need to be made before conducting informal or formal advocacies and authentic documentation need to be in place. Crises management team is in place. The staff has good rapport with various stakeholders.

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

**XV. Best Practices if any**

**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.** |
| **M. Omega Jyotsna** | **9866159993** |
| **Raja Babu** | **7396325050** |
| **Officials from SACS/TSU (as facilitator) Mr. Niranjan Desai** | **827557117** |

|  |  |
| --- | --- |
| **Name of the NGO:** | **MSPSS Icchalkaranj** |
| **Typology of the target population:** | **MSM, FSW, TG** |
| **Total population being covered against target:** | **960/1100** |
| **Dates of Visit:** | **20th April to 22nd April 2106** |
| **Place of Visit:** | **Icchalkaranj** |

Overall Rating based programme delivery score:

|  |  |  |  |
| --- | --- | --- | --- |
| **Total Score Obtained (in %)** | **Category** | **Rating** | **Recommendations** |
| **Below 40%** | **D** | **Poor** | **Recommended for** |
| **41%-60%** | **C** | **Average** | **Recommended for** |
| **61%-80% - 71.3%** | **B** | **Good** | **Recommended for Continuation with Specific Inputs** |
| **>80%** | **A** | **Very Good** | **Recommended for continuation with specific focus for developing learning sites.** |

**Specific Recommendations:**

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| --- |
| * The Staff need immediate capacity building on Micro planning. * Individual focused outreach planning is very much required and the same must be reflected in the field. * In the ST stand, the population can be divided for two outreach workers, as the population is about 420 instead of 4 outreach workers. There is greater mobility, hence forth; a thorough mapping needs to be done. Few Kothi’s also reported that there could be about 25 – 50 Kothi’s in ST stand, but more Panthi’s in the Stand. * Mobility within the sites needs to be monitored as expressed by few Panthis that Kothi’s are present in different sites at different timings. * 70% of the HRG’s are undergoing tests RMC regularly for every three months. The same response was received from the site from Panthi’s even so from few FSW. Hence forth a reality check needs to be done. If it is really happening, then it goes on a for a model site. * ART data needs to be checked, updated and regular follow up is required. |

**Name of the Evaluators Signature**

|  |  |
| --- | --- |
| M. Omega Jyotsna |  |
| Raja Babu |  |
| Manisha |  |
|  |  |