**Annexure: B**

**Reporting Format-B**

**Structure of the Detailed Reporting format**

**(To be submitted by Evaluators to SACS for each TI evaluated with a copy to NACO)**

**Introduction**

* **Background of Project and Organization**

Pravara Medical Trust was implementing the Targeted Intervention project since 2005 onwards with the technical and financial support of Pathfinder International. The project seeks to empower sex workers and MSMs to make informed choices and adopt behaviors that will reduce their vulnerability to STI/HIV/AIDS thus enabling them to improve and gain greater control over their lives. The TI project implemented by PMT in the districts was under the project named “Mukta”. Under this project a clinic and community based STI diagnosis and treatment, HIV education and prevention and behavior change programs were initiated. To facilitate service delivery a network of static and satellite clinics was established in brothel and non-brothel based areas; the project also focused its attention on training, supervision and support facilities to upgrade the existing PP working with vulnerable groups. Clinic based activities are complemented by community-based outreach activities with sex workers, clients of sex workers, MSMs, police, and madams. The project got transitioned to MSACS in April 2010.and CC TI Project in April 2014 Start to MSACS.

The project also seeks to create enabling environments for behaviour change to occur, as well as creating and building the capacity of associations of sex workers and MSMs to advocate for their rights and demand quality health and social services.

Pravara Medical Trust, Loni, in collaboration with Stina and Birgir Johanasson foundation, Linkoping, Sweden has started a project on HIV/AIDS & FAMILY LIFE EDUCATION for adolescent and youth population in the target area under Primary Health Centers Loni (Dadh), Kolhar, Rahata with the following long term objectives;

**Long Term Objectives**

* To change the attitude and behavior of the adolescent and youth of the target area by promoting the responsible behavior and healthy practices in respect to sex and its related behavioral problems.
* To prevent and control spread of STD/HIV/AIDS in general and the target area In particular.

Transition of the TI Project to NACO/MSACS was from 2011 onwards since then the project is exclusively supported and funded through MSACS.

Pravara Medical Trust is a known setup in Loni having their own “Pravara Institute of Medical Sciences (Deemed University). The social development activities were initiated and governed by “Centre for Social Medicine”.

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

Nityanand Bhavan, Shivajinagar, Behind Rotery eye club, Malegao camp, Malegao, Dist. Nashik

E-mail: [muktanashikmsm@gmail.com](mailto:muktanashikmsm@gmail.com)

* ***Chief Functionary:***

**PD Dr. K.V. Somsundaram is the chief functionary who is representing the Pravara Medical Trust**

* ***Year of establishment:***  1972
* ***Year and month of project initiation:***  1st April 2014
* ***Evaluation team:*** Mathivanan R, Purvi Trivedi and Shailesh Patil (finance)
* ***Time frame:*** 27-28 April 2016

**Profile of TI**

(Information to be captured)

* ***Target Population Profile***: FSW / MSM / ~~IDU~~ / TG/~~TRUCKERS / MIGRANTS~~

1250 (560 FSW, 540-MSM, 150- TG)

* ***Type of Project:*** ~~Core/~~ **Core Composite** / ~~Bridge population~~

* ***Size of Target Group(s)***

The TI has covered a population of 1520(MSM-591+FSW-858+TG-71) and newly registered in the year 2015-16 is 190 against the target of 1250 (MSM-540+FSW-560+TG-150).

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

(Currant Population)

MSM: Kothi-400, Panthi-159, DD-22, TG-71

FSW: Brothel based-214, Home based-160,

* ***Target Area***

Malegao Town and Manmad Town.

***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…

PD Dr. K.V.Somasundaram is the director of the Centre for Social Medicine of Pravara Institute of Medical Sciences (Deemed University). He was available at the beginning of the evaluation process. He admitted that he is too busy to attain the Wrap up meeting at the end of evaluations to know the feedback of the evaluation team. While interacting with him he clearly indicated that whether or not MSACS provide us funds we will continue with the TI. Later on during evaluation process we could found that the staffs of such big organisation have not been provided with the salary because of no grant from SACS. No other officials from the organisation were available for the meeting. PD attains bimonthly meetings with this particular TI as he has to attain the other TI (migrant, Malegao) also. There was no indication of organisational support to the TI either in monitoring or technical support provision. PD’s involvement was not observed in any manner and he was found with least bothered attitude of running this TI. As PD admitted they were not serious in continuing the TI.

**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

The evaluation team observed that all the required staffs’ positions were in filled as. PM-1, Counsellor-1, ORWs – 5, accountant cum ME-1. All the vacant positions have been filled within 10 days time. The documents are maintained mainly by the PM and M&E officer. ORWs also maintained the records of planning etc. There are total 17 PEs out of which MSM are older from the previous MSM projects. Still turnover was observed. FSW PEs is not found active. 5 ORWs are new out of sanctioned 6 except one from MSM community. The perspective of the office bearers was found nil as we already discussed.

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

All staffs underwent in house induction training. The ORWs got training by MSACS. PM training is not done. M&E attended training on documentation and counsellor attended training on counselling. Apart from these they have conducted trainings internally facilitated by TSU PO. Documents for Training conducted are available but there were no detailed reports on them. No impact assessment has been done.

The project team requires orientation and on-field training. The project team should be train on Advocacy, Networking and Community Mobilization.

The counsellor is the only one who has got training from SOSWA.

**3. Infrastructure of the organization**

The office is located in a main area of the city and with enough space for training and conducting meetings. They have all the required equipment required for TI but they need to make it more attractive with recreation facilities as the office is functioning as DIC too. The office had the assets which were budgeted in the previously funded MSM project. The recent budget had only budget for Rs. 6000 out of which chairs and tables for the DIC were bought. Computers, Audio- video equipment, cupboards etc. were found in place with the proper code and at the expected places.

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

They are maintaining documents and registers as per SACS protocol. They maintain counselling Register, Health camp register, ORWs daily dairy, Referral slips, HRGs line list and CMIS report file and meeting minutes. Project manager said that during the weekly & monthly meeting ORWs’ reports are reviewed and planned for the coming months. They don’t have any feedback mechanism other than shared during the weekly and monthly meetings. M& E is entering the all collected reports in system.

It was observed by the evaluation team that the FSW site is demolished by the Municipal Corporation for last 2 months. More than 250 FSWs are missing but it does not reflect anywhere in any of the records or reporting. *Thus the data found to be fabricated.*

***III. Program Deliverables Outreach***

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

The line listing has been done; verified and unique id code has been maintained. But again the question raises that those FSWs (Total 214 brothel based) who has gone underground for more than 1and half months are not given any services or contact than also it doesn’t reflect anywhere in the reporting.

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

**Not Applicable**

1. ***Registration of truckers from 2 service sources*** i.e. STI clinics and counselling. \

***Not applicable***

1. ***Micro planning***

Micro planning was available in the project.Area wise map of each ORW was available where PEs, Stakeholders, condom depot & ICTC were depicted in the map. Outreach plan is in place but not for each congregation point. Further to note, the TI project has maintained daily movement register. The project team, as mentioned during an interaction with them, maintained daily diary which was linked with monthly activity plan such as PE supervision or health camp, or ICTC camp or IPC session or FGDs or congregation events, counselling session, follow up and so. The micro planning charts and documents verified as updated. The manager is not maintaining diary and does not have work plan.

1. ***Coverage of target population (sub-group wise):*** Target / regular contacts only in HRGs

Total coverage of population is 1520 and regular contacts reached with all the services are 1012.

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

ORWs have developed their day to day plan which mention the date, place and time of the field activities of each ORW. They also have their area map. However the day to day plan should also reflect the activity they are going to perform i.e. organizing event, 1-1 interaction, 1-group interaction, health camps, street play etc. This would help in better planning & further focusing on the activity to be performed in the field. The TI should also attempt analysis on various indicators i.e. hotspot wise HRGs analysis etc. They need to work on condom demand analysis.

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

17 PEs against 1250 HRG Thus the PE ratio = 1:73.

1. ***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

The Regular contacts in last one year are with MSM 575 and FSW 369. They are contacting the HRGs by the outreach workers / Peers at least twice a month and providing services such as condoms and other referral services like ICTC and STI.

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

MSM PEs are educated still not maintaining any records or diary. FSW also don’t maintain any records. They need to maintain diaries but they are updated regularly with required information by ORWs.

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

FSW PE could not manage to show their KPs as home based KPs are not ready to talk or meet, Brothel was demolished one and half months ago as well as these PEs are not literate so couldn’t make their own documents They had skills in condom demo and HIV- STI. During the field visit to MSM sites, interaction with PEs and HRGs, it was observed that PEs are having knowledge on HIV mode of spread, prevention and ICTC testing. This clearly indicates that the MSM component is strong due to previous program and at present for last two years since the CC started it is failed to make any impact. Condoms are available with PEs and in DIC and IEC materials found in DIC. Condom demonstration skill of PEs is good. But they need to reach more population in field than on paper.

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

It is observed that the Project director having very busy schedules is not visiting the field at all. PM is not experienced or trained as a leader. His leadership qualities couldn’t be seen. They need to increase their frequency and quality supervision in the field. ORWs told that follow-up is being done. PD and PM should support the ORWs for the advocacy issues. The ORWs are supervising PEs, ORWs and counsellors are supervised by PM. Follow up action taken points are available in monthly review meeting register. ORWs are maintaining movement register. Still it is strongly recommended to provide quality supervision mechanism.

**IV. Services**

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

STI services made available through STI and ICTC camps. The PPP are arranged for the camps and Govt. STI facilities and ICTC counsellors are used for the same. Dr. Sandeep Khairnar and Dr. Sushant Nikam give their services to the MSM camps and Dr. Kalindi Nikam and Dr. Vanashree Palod provides their services to the FSW camps.

It is suggested to start referring to Govt. and PPPs by using referral slips in future. The STI referrals to health camps also should be provided with referral slips. This will ensure the missed cases follow up.

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

The clinics are mostly conducted in the DICs and the visited 2 DICs are equipped with enough facilities and having private space for examinations. STI drugs are not purchased.

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 use of revolving funds.***
2. ***Quality of treatment in the service provisioning***- adherence to syndromic treatment protocol, follow up mechanism and adherence, referrals to VCTC,ART, DOTS centre and Community care centres.

Total STI treated was 574 and only 75 out of then were followed up in the field for complete treatment and reinfection. Follow-up mechanism mechanisms needs to be improved a lot as it is very poor in the field due to the non-availability of community. Referral to government ICTC and STI services were not found available. STI referral details were not available and only the RMC showed as referrals. Adherence of PLHV is also found poor and one of them is getting treatment from private. 2 MSM and 2 TG were found positive in the last 2 years and they were registered with ART. Overall- FSW-19,MSM-16,TG-8 Total-41.

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 official documents in this regard.

All the registers are made available at the time of evaluation. Treatment registers and referral slips were verified but no follow up cards found. The follow up details were observed from Counselling register and ORW diaries.

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

The availability of condoms was verified at the pan stalls near Brothels and MSM sites. It was available at the Kohinoor talkies also at MSM site. MSM PEs was found with condoms stock. The distribution channels are through PE, depots and unmanned outlets in some MSM encounter points.

1. ***No. of condoms distributed*** - No. of condoms distributed through different channels/regular contacts.

Condoms free distribution: 368745 (120045 for MSM, 233555 for FSW and 15145 for TG) SM: 12030 (2306 for MSM, 9380 for FSW and 344 for TG). Social marketing is very low and done for the sake of providing. Among MSM the social marketing is going on good.

***8. No. of Needles / Syringes distributed through outreach / DIC***.

***Not Applicable***

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

The linkage with ICTC is intact as they refer and involve the ICTC lab technicians and sometimes counsellors in the health camps. However they don’t refer STI cases to govt. or PPP clinics and no efforts have been made to identify TB suspects and refer to DOTS. Since reportedly they don’t have any PLHIV in their project area, they have no contact with ART centres.

***10. Referrals and follows up***

There are no other referrals and follow up except STI and ICTC that has been already explained in the previous sections.

**V. Community participation**

1. ***Collectivization activities:*** No. of SHGs/Community groups/CBOs formed since inception, perspectives of these groups towards the project activities.

Previously a CBO formed by Pathfinder International at Nashik District level for FSW and MSM separately but the KPs at Malegao do not show their active participation in that as well as the NGO also do not seem to motivate this collectivisation. Now there is no initiation on formation of CBO or collectivisation. They seemed very frivolous on this.

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

Various events were organised and festivals were celebrated in DIC. But the MSM community seems to be more active in this program and hardly a few FSWs participation was found.

**VI. Linkages**

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

The linkages with STI and ICTC and a few (4 linkages with ART of MSMS and TG) is observed. No linkage with TB and DOTS were found.

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

The project needs to strengthen the ICTC component. Total STI screening done for 2582(MSM& FSW) and STI treated 574. 1605 tested for HIV. Most of the HRGs were tested approaching field testing along with health camps.

It is recommended to use ICTC centre for HIV testing. Maximum number of testing must be done at ICTC centre not at health camps.

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

This component is seriously missing. There was no serious stakeholder found for this TI. They have long way to go. This impression became stronger after visiting the Mosam pul brothel area. The total area was demolished overnight one and half months ago but still the project staff is not aware of the where about of those FSW. They could not do anything for their safety measures. MSM component is visible because of the previous project and no effects are seen during the CC period.

**VII. Financial systems and procedures (as given by the finance consultant)**

1. ***Systems of planning : Existence and adherence to NGO-CBO guidelines/ any approved systems endorsed by SACS/NACO -supporting official communication***

Budget guideline is available issued by MSACS Mumbai . Expenditure Payment 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, approval systems and norms, verification of documents with minutes, quotations, bills,vouchers, stock and issue registers of documents with minutes, quotations,bills,vouchers, stock and issue registers, practice of settling of advances before making further payments.***

* Printed voucher is available but manually writing not in tally software vouchers
* Stock book available condom, or stationary .
* No pass for payment stamps is available on bills or PD sign on vouchers
* Authority approval note sheet is not attach
* Bills are not certified by accountant or PM
* No Bulk Cash transaction is found
* Stock Registers was not sign by Accountant, P.M, PD
* On all Payment voucher No sign of P.D

1. ***Systems of procurements –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***
   * Syphilis kit purchase process is not properly maintain
   * Original Quotation file is not available in NGO
   * NO Guidelines or Sanction process is shown by NGO regarding Purchase
2. ***Systems of documentation- Availability of bank accounts ( maintained jointly, reconclitation made monthly basis),audit reports***

* Bank accounts separately available maintained by jointly signatories
* Bank reconciliation is maintain
* Audit Reports are available last 3 years
* F.Y. 2014-2015 Audit compliance report is submitted by NGO to the MSACS
* Condom Registers in maintained
* Cash or bank book was not sign by authority
* Stationary stock book is not Properly maintained without sign authority

**VIII. Competency of the project staff**

***VIII a. Project Manager***

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

PM Mr. Shatrughna Borse is very well educated young Project Manager. He has done his M.A. B.Ed. and PG in psychology. He is well experienced. He worked as a counsellor in mental hospital as well as in Migrant TI. From there he was promoted as project manager. He got training as counserllor in migrant TI. He presented like a very fresh one. There was no sharpness observed regarding program. His record says he is visiting the field twice in a week but we could make out that the FSW component was very poorly handled. He fails to present his maturity to handle such TI.

***VIII b. ANM/Counsellor***

Clarity on risk assessment and risk reduction, knowledge on basic counselling and HIV, symptoms   
of STIs, maintenance and updating of data and registers, field visits and initiation of linkages etc

Mr. Dilip Sonawane is having education till 12th std. But he knows his task very well. After schools he worked for NNP+ as PE. In 2010 he got chance to work with the migrant project as an ORW. This field jobs made him expert in the concept of HIV-STI prevention and usage of condom for the same. Being one of the community members he decided to dedicate his life in this field only. Then in2014 he was promoted to CC at Malegao as a counsellor. He was given training by Soswa and he got trained in TOT also. This makes him a capable counsellor. He maintains the majority of the documents and records. He maintains his diery which shows his regular visits to the field for the camps as well as follow up cases.

***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..

There are total 5 ORWs on staff for the population of 1250.

One of the ORWs Soyeb Saiyad has been promoted from Sathi to PE and now as ORW. Other ORWs Avinash and Vijaynath are less educated and got on job training in HIV/AIDS. Shahbaaz and Gyandev are master degree holder from commerce and Arts. They both also got no experience of HIV/AIDS and got onjob training. All the ORWs are very young and enthusiastic.

All the ORWs maintain good rapport within the team and good in executing the overall activities. They are maintaining their diaries regularly but the field reflects opposite scene. These young boys need serious guidance to work in the field through supervision. As making documents and understanding our own micro plan is not enough for this TI.

***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 prioritise 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

***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.

Kiran H. Khare, is a BA (CCCO) graduate trained in tally and he was found that he could collect the data and analyses the same for reporting. He could provide all the data required for evaluation. He is working since April 2015. He could explain on how he was attending the review meetings both weekly and monthly and collect the data ORW wise and from counsellor. He could not explain on how did he cross verify the data collected properly. He also said that he was visiting the field and supporting the clinic and other support services like advocacy and crises management but there was no document evidence for the same.

***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.

Micro plan was available in its ideal manner. All the ORWs were able to explain at their best which shows their understanding level. The problem was observed only when the evaluation team went to the field area. That time it was came out that the whole brothel based FSW areas Mosam pul in Malegao and Habib Nagar in Manmad is demolished one and half months ago. There were hardly ten KPs found all together. This contains at least 250 KPs. In the Population of 560 FSW is half of them are not found for more than one and a half months and still the project are documenting clinic records sounds fishy. This is a matter of very serious concern.

MSM sights were found working good with a good rapport but still not all PE work for their community. The NGO still could not make impact in their collectivisation efforts.

***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,

***NOT APPLICABLE***

**X. Services**

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

Various services have been delivered to the community members like sessions, distribution of condoms, ICTC, ART, and STI. Community members are happy with the project services. Gaps found and filled in follow-up testing like ICTC and STI. Through heath camps they are providing ICTC and STI services to the HRGs.

**XI. Community involvement**

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

Community is not involved in any programmatic activities like planning, mid media activities and camps. The community members are part of advocacy and Project management committee and crisis committee. But no evidence was found.

**XII. Commodities**

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

They do follow the practice condom demand calculation based on the sexual encounters per HRG per week. However they could not establish this with documents matching the field observation especially among FSW.

**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.

Advocacy meeting details are available in prescribed format with plan. PM, PD and ORWs have clarity on advocacy. The community members are involved in advocacy activities other but not much linkages related work has been documented.

The youthfulness is observed in as different festivals like Raksha bandhan Diwali, IWD, YUWA Divas, WAD, etc. were often celebrated as DIC programmes.

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

The KPs specially MSM and some FSW were supported in getting their ADHAR card, and PAN card. They said that they have started self-help group but not well established and they have started the cloth bank also in the DIC for the poor KPS and their kids.

**XV. Best Practices if any**

No typical best practices were observed but many key achievements noted and could be shared with other projects to improve the outcome of the project.