**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**

DOTS Samajik Sanstha was established in 2005. Our organisation is working in various sector ( like as health, environment, Sport and culture etc). We were arranged Kala-Mohatsav in Igatpuri tehsil Dist. Nashik for tribal artists, new poets. On 1st Dec 2008 DOTS Samajik Sanstha got TI project from MSACS for migrant people in Nashik district.

All members of this organization are well qualified in various fields like Social Welfare, management & paramedical, management & commerce Statistical & Economics.

Since 2008 DOTS Samajik Sanstha is implementing Migrant, PPTCT, ACSM and TB Program at Nasik District .

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In 1st Dec 2008 we got TI project from MSACS for migrant people in Nashik district.

Our all members are well qualified in various field. Four member from Master Of Social Welfare, One from management & paramedical, One from management & commerce and One from Statistical & Economics.

Onward 2008 – 2016 our NGO is implementing Migrant PPTCT ACSM TB Programe Nasik District .

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

DOTS Samajik Sanstha,

Banglow # 1, Shri Pooja Row Houses, Opp. Hanuman Garden, Prashant Nagar Road, Pathardi Phata, Nashik-10

E-mail: [dotssanstha@yahoo.com.in](mailto:dotssanstha@yahoo.com.in), phone # 0253-2382955

* ***Chief Functionary:*** Mr. Sunil Shankar Kadam
* ***Year of establishment:***  2005
* ***Year and month of project initiation:***  1st December 2008
* ***Evaluation team:*** Mathivanan R, Purvi Trivedi and Shailesh Patil (finance)
* ***Time frame:*** 25-26 April 2016

**Profile of TI**

(Information to be captured)

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

15,000

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

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

The TI has covered a population of 16808 (M-15930+F-878) and newly registered in the last one year is 9788.

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

Male: 15,930 and Female: 878

The sites include Industrial worker-11535, construction site workers-3338, Hotel workers-1387 and Dairy workers-184 with the major number of migrants and with some less number of HRG with other sites also like daily wagers, mine workers and quarry etc.

* ***Target Area***

MIDC Ambad.

***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…

The office bearers are available at the Project office. PD is Mr. Vilas Narayan Khairnar is a very simple and any time available to the project staff as and when they need him without any interference and with full support. He is the Vice President of the NGO also and well educated. The NGO’s vision and mission includes HIV prevention. The PD was available as and when the staff needed them and it was observed in the meeting minutes register that the PD attains the most of the meetings held at monthly basis with the TI staff.

The other Board members were also available to meet the evaluation team. During the evaluation period of two days we could manage to see the Treasurer Mr. Hemant Pardesi who is equally active in the project details. The best part was that when the MSACS grant delayed, this is the NGO who never stopped the salary of the staff. It was observed that the Board members are supportive to the TI project team and never interfere in the very operational issues. The PM was observed to be very free from the pressures of the PD or any other board members. This leads to the better results of the project.

**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

All the required staffs are in place. PM-1, Counsellor-1, ORWs – 8, accountant cum ME-1. One of the ORWs has been promoted to the post of counsellor. All the vacant positions have been filled within 10 days’ time. The office bearers are treating the staffs by providing proper salary. Since they are implementing many development projects as well, their perspective on community is commendable. The PD attended all the monthly meetings conducted. PM is visiting the field twice in a week and it is mentioned in his diary. The documents are maintained mainly by the PM and M&E officer. The counsellor is also very well equipped with the records as well as community interactions.

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

All the staffs are trained but the trainings done by the PM himself and not by MSACS or TSU. The training register was seen and observed that the PM gave training to all the newly recruited staff just for two hours.

All the ORWs accept one or two needs detail training by the expert. The content and quality of the trainings were not being used prescribed materials as they were done by the PM alone. The trainings were reportedly done at TI level but there was no impact assessment done or reflected with the PE either.

**3. Infrastructure of the organization**

The TI is located in a main part of the Nashik city and fully equipped with computer, table and chairs and has enough space for conducting meetings and trainings. The office however was not apparently used by HRGs as this also is working as a paid DIC. It doesn’t have any recreation facility a DIC should have.

**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.

The master register and line listing were available from 2014 year wise for verification. They are maintaining documents and registers as per SACS protocol. They maintain counselling Register, Health camp register, Training registers, planning registers, ORWs daily dairy, HRGs line list and CMIS report file and meeting minutes. It was observed that during the weekly & monthly meeting ORWs’ reports are reviewed and planned for the coming months by PM. 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. The M&E was found less efficient as she has not trained enough to carry out the responsibilities. They were sharing all the reports and documents for the purpose of evaluation.

***III. Program Deliverables Outreach***

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

The line listing has been verified and found updated and they are maintaining the master register and line listing year wise from 2014. The TI has covered a population of 16808 (M-15930+F-878) and newly registered in the last one year is 9788.

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

During the discussion and verification they told that registration done through ORWs’ field visits and individual contacts. It has been observed that they have new HRG registration system through DIC services, STI clinics, counselling and congregation points supportive documents are available to substantiate this.

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

***Not applicable***

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

Micro planning has been done and not updated properly and they need to be trained on how to maintain microplanning.

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

Total coverage of population is 18,808 and newly registered is 9788 regular contacts reached with all the services are 4861.

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

Outreach planning is available with all the ORWs and PM. They collectively decide the target and achievement to be done with a proper outreach plan. During the staff meeting they are preparing action plans and ORWs have copy of action plans available with them.

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

20 PEs against 16,808 HRG = 1:840.

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 Repeated migrants contact in last one year is 4861. 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***

No PE diaries were seen for verification during evaluation and ORWs told that they couldn’t maintain diary and it would affect the relationship if they ask them to do so. However all the met 10 PE were well educated and holding good positions in the industry.

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

The Project has appointed majority of the PEs from the source state as reported. The all are very well equipped with the knowledge and skills as most of them are working with them since inception. Some of them are more experienced than the ORWs. During the field visit and interaction with PEs and HRGs, PEs are having knowledge on HIV mode of spread, prevention and ICTC testing. Condoms are available with PEs and in DIC and IEC materials found with the Pes.

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

Project manager and project director are frequently visiting the field. ORWs told that follow-up is being done. PD and PM also visit the field for advocacy issues. The ORWs are supervising PEs, ORWs and counsellors are supervised by PM both in the field and data analysis. Follow up action taken points are available in monthly review meeting register. ORWs are maintaining movement register and daily diary register. However the monthly review meetings should be conducted as mentioning the data collected from ORW and suggestions by PM and PD and follow up action taken against them.

**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. They were referring the cases to PPP and Govt. STI facilities. Dr….. is the PP who gives his services. This NGO do not purchase the STI drugs at all. The PPP just prescribe and rest is followed up.

No. of camps conducted in the last year: 135 No. of STI suspects referred: 4861, No. of STI cases treated: 547. No. of STI cases followed in the field was not available in documentation and could not be met in the field.

The above data of STI referral pretends to be considered as referred to all available services but these 4861 STI referrals referred to health camps alone by ORWs and PEs without referral slips and could not be considered as proper referral.

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.***

There is no clinic of the Ngo but they just conduct temporary health camps at the places provided by their stake holders and gatekeepers. Most of the Dairy owners and Hotel owners allow using their premises to conduct the camp. They don’t purchase the STI drugs. PP just prescribes.

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.***

This NGO do not purchase any drugs. They need to discuss to make sure the STI patients getting proper treatment by the camps.

1. ***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.

Throughout all the STI cases are receiving Syndromic case management. The treatment protocol is being maintained. The follow up is being done systematically by the PE, ORW and Counsellor. Counsellor has the list of STI cases and visiting field for follow up and counselling. They do refer the community for testing to govt. ICTC and testing all the members visiting the camps with the support of Govt. technicians. ICTC referrals: 3510, tested: 3464

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.

There are no free condoms to distribute. Total number of 36,900 socially marketed Deluxe condoms has been reported.

The availability of condoms was verified at the different condom depot as well as at the sites as PEs were found with condoms stock and all DICs have condoms and all of them are accessible to the stock is replenished by the ORWs.

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

Socially marketed Delux condoms distributed are 36,900.All these condoms are distributed through PE, ORW, DIC and other 124 outlets and 5 of them were verified during the field visit. The condoms distribution is apparently very low against the population and risk associated with their lifestyle. And 124 reported outlets is not logically matching with the reported 3000 condoms supplied per month.

***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 was found intact and counsellors and DS – DAPCU could explain the same. They have a very good linkage with DOTS as they are working for RNTCP support service also with CHAI. Since the very purpose of the NGO establishment is TB the TB related services are reaching the community. Since they have a very few number of STI referrals to government clinics the linkage is limited. They need to start referring STI cases to government set up as the clinic/camp practice is just prescribing the STI drugs. The practice of purchasing drugs also not there.

***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.

No collectivisation activities have been carried out.

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

It was observed that in all activities like events and mid media activities of street theatres, organising camps, advocacy activities and advisory committee the community members are involved and consulted. The documents showed the same.

**VI. Linkages**

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

The linkages with STI and ICTC are apparent and linkage with ART, TB clinics etc. Also observed as this NGO started their first project with the TB work, it was primarily practiced.

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

Referred: 3510 and Tested –3464. Since the rapport and availability of the community is higher than other places (visited 2 sites), there are possibilities to increase the testing. The fact that very less no of PLHIV, only 6 identified so far and pushes to increase the ICTC.

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

The support system developed is through the community participation in advisory and advocacy committees and mid media activities. They have created a very good rapport with the site owners and construction companies and Dairy owners.

***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 not in tally software or written by manually.

Stock book available condom, or stationary .

All payment made by cheques

serialized vouchers are available

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

No STI Drug/medicine is purchased by NGO

No stock is available of STI Drug

1. 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 2 years (2012-13, 2013-14 )

Audit Reports is not available last 1 years (2014 - 2015 )

F.Y. 2014-2015 Audit compliance report is submitted by NGO to the MSACS

Condom Registers in not maintain properly ( Whitener used by NGO )

Ledger Prints out is not available

In the bank book salary paid by NGO wrongly enter y posted

Observations - On All Salary voucher net salary paid amount is mentioned but Professional tax credit amount in not mentioned . At the end of year NGO deposit Professional tax in bank but professional tax credit entry is not taken by NGO

But the correct entry is

Gross salary amount Debit

Professional Tax amount credit

Bank account Net amount Credit

**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 Mr. Dattatray Dangat**, is a Masters in Social work from Pune University. He has been working in this migrant project for 3 years and worked at Yashda NGO also before joining DOTS S.S. He has got knowledge on HIV/AIDS and TB. He is capable of conducting monthly planning meetings very effectively observed from the documents and interaction. He is regularly visiting the field and reportedly good in motivation. He also regularly conducts the weekly review meetings with staff which are seen in the meeting minute’s registers. He is a clam person and a good team leader but need more clarity and training on TI and proper documentation. He expressed his satisfaction in this job and willingness to work continuously.

***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. Chandan Khare** has been elevated from ORW to the post of counsellor. He is with DOTS S.S since 2010.He has studied B.A. psychology and holds Diploma in Journalism. He had worked as a journalist in leading newspaper of Nashik. Then he stared feeling his thurst for social work and Joind this NGO as an ORW in February 2010. He was promoted as a counsellor looking at his cometenceies and educational qualifications in January 2015. He has attended the training conducted byMSACS. He is maintaining counselling records and condom stock registers. The condom stock register is not maintained properly. In this regards he needs regular supervision from PM or PD. Overall his natural qualities makes him a good counsellor. He is loyal to the organisation.

***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..

Among 8 ORWs working in the project, two (Swati Modak and Archana) are newly joined i.e. on 1/02/2016. They were provided with only two hours training from PM which is not sufficient. Although both have experience of working in the field of HIV/AIDS, their educational qualification do not allow this much less training and start working as ORW in the field ( Swati is 10th pass and Archan is 12th pass). They need to be trained with immediate effect and the PM assured that training will be given within this currant month.

**Mr. Devidas Chaudhari** is the only ORW who is Graduate in Arts as well as has been working as an ORW since February 2009 with the same organisation. This could be seen in his work in the field as well as in his Peer educators’s competency.He has very thoro knowledge of HIV?AIDS and the linkages facilityes asd so is with his Peers. He has succeffully maintain relations with the stake holders and gatekeepers. Although he had been trained by MSACS, then also he needs formal training on records maintaining and documentations.

**ORWS- Mr. Telangi shree ram and Mr. Vishal Khandabahal** are the middle aged gentle man with no back ground of HIV or TI. Their work experience is in banking and   
BMC. This creates question on their joining as ORW and sudden 360 degree change in the career with this much less money at the age when a person expect the settled down in his career with good salary.

**ORWs- Akash, Vishal, Kiran and Harishchandra** are just one year old in this TI project with lest knowledge and competency on working in field and HIV/AIDs. Their training was also done only for two hours that too by PM only wich is not sufficient to train on all the documents making and services to be provided in field by the projects and to PEs. This is the serious issue of training the staff.

All the ORWs maintain good rapport within the team and good in executing the overall activities. They are not maintaining their diaries regularly which may lead to insufficient information and erred documentation.

***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.

The evaluation team could manage to meet the as many as 8 Peers at the NGO office for the meeting. Their dedication towards the program was appreciated as all of them spent as much time as we asked to. Some of them were very young (aged from 20 to 24). They all had very deep knowledge of HIV/AIDS and need of condom, supply, STI, treatments and ICTC.

17 out of 20 PEs were representing the source state, i.e from other states but technically all of them are from source states and providing services to people from their own states. We could meet 4 PEs in the field were observed with great commitment in services. They reported that they provide condoms regularly, motivating the community to go for ICTC and STI services and providing BCC. The DIC was well maintained with all information displayed and condoms stored for supply. ORWs are reportedly helping them to prepare the outreach plan. The met PEs told that they were helping in organising camps and events. They are able to demonstrate condom. The PEs and the community were easy with the lady ORWs. The knowledge on STI is good but they need to emphasise more on STI than HIV and follow up of the ART with the infected population.

***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.

M&E officer Ms. Pallavi Ware is working as M& E since 1/06/2015. She is serving M&E cum Accountant. Before her joining there was Mr. Vignesh was working till who was trained from MSACS. But Ms. Pallavi is also showed her competency although she had not gone through any other training but the in house training only. All the reports were found in place.

***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.

***Not applicable***

***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, Counselling 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.

During interaction with PEs and ORWs it was reflected that the number of sessions conducted were adequate and important information on HIV and STI were provided. It has been reported that they conducted 5491 sessions by ORWs and PE separately and only 7% of the PE sessions were supervised by ORWs. It has been asked to all the staffs separately and they said that they were supposed to attend 10% of the sessions of PE instead of 50%. The timings of the sessions are discussed and decided by the PEs and ORWs. The met stake holders said that they were aware of all sessions conducted so far.

**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 involved in all activities like planning, mid media activities and camps. The community members are part of advocacy committee. There is no PMC was available at TI level.

**XII. Commodities**

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

During the monthly review meeting they plan for condom requirement and procure the same. However demand calculation is not there as they feel not feasible to do with migrants.

**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 and other linkages. They have project management committee in the name of advisory committee and asked them to change the title.

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

No social protection schemes are provided

**XV. Best Practices if any**

No typical best practices were found.

**Visited sites and met stakeholders and condom outlets:**

Site name: Harsh construction: Stakeholder: Mr. More-Safety officer and 7 migrants.

DIC: Datta Nagar, 5 migrants. Unpaid DIC: Thambre Chal

Bharat Dairy: 10 HRG,

Hotel white lily, Avinash Nikam-Stakeholder

Depots -5

Shapthanik hotel- 07 new migrants

***Other suggestions:***

* Condom supply and visibility could be improved by creating outlets in surrounding places of the sites.
* STI referrals to govt. and PPP clinics to be started
* All the staffs should maintain and update diaries.
* M&E and Counsellor should be trained further
* Newly inducted ORWs should be properly trained by SACS