**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**

Magmo Welfare Sanstha was established in the year 1994 by prominent doctors and other influencial persons in Nashik under leadership of Dr. Prakash Aher. It is registered organization under society and charitable trust act of Govt. of Maharashtra. NGO is working for various vulnerable and at risk populations in the district of Nashik. It has been undertaken and successfully implemented through various health centric programs such as (MSACS funded) PPTCT program, TB HIV coordination, Implementing link worker project since March 2010. Working in Migrant project since December 2008. Also has experienced in work of mobile ICTC cum STI clinic. NGO implemented and implementing program related to TB control. It includes outreach educator, IEC facilitator, ACSM, Sputum collection and transportation center, LT hiring scheme, urban slum scheme and TB HIV scheme in HRG.NGO having experience of working in other health program like sickle cell awareness, Health awareness campaign, base line survey in NRHM and training. NGO is having very efficient network of sister organizations form social, co-op, corporate, FHO, CBO, Govt; and union base organization of medical officer and nurses. NGO is closely associated with IMA and NIMA. NGO is member of executive council of NGO FORUM Nashik and is founder NGO of forum. Thus, NGO is working in social field of Nashik for community development.

In the year of 2012, on behalf of organization Dr. Prakash H Aher (Secretary) contested election of INDIA-CCM and elected from HIV AIDS constituency. INDIA CCM is national body working for GFATM. Today NGO is standing member of India CCM.

Trustees and members of NGO are prominent people from Nashik district. It includes doctors, social workers, agriculturist, advocates and other professionals. They are also attached to other social, economical and cooperative organization. It helps NGO to work in coordination with others. Due to this all efforts, NGO is having very good and productive relationship with stakeholders in district including Govt. officers and set up.

MAGMO welfare Sanstha is Registered NGO as Society Act Registration No: Maharashtra 3472/94, Nashik23/3/1994 Trust Act Registration No: Trust Act 1950 No. F-3413, Nashik 13/7/1994. **NGO is working for various vulnerable and on high risk populations in the district of Nashik.** It has been undertaken and successfully implemented projects related to health, education, community development and SHG group movement. **NGO is working for various vulnerable and on high risk populations in the district of Nashik.**

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

3, NDA Tower, Untwadi Road, Sambhaji Chowk, Nashik, Maharastra

Office ph no: 0253-2312265 Alternate no: 9689009995

E-mail: magmowelfaresanstha@gmail.com

* ***Chief Functionary:*** Dr Prakash H Aher (M B B S) He is a Retired Officer from Dist. Health officer Cadre. (Govt of Maharashtra) He is a Prominent Social activist in Maharashtra in field of health. He has served as a medical officer, Dist. TB officer & District Program officer of HIV Aids. He also is a CCM Member for 2012-2015 of (National level body governing global fund GFATM) He is the Founder member President of Maharashtra Gazetted Medical office Association for Maharashtra Unit. He is a Founder and present trustee of NGO forum Nashik.
* ***Year of establishment:***  1994
* ***Year and month of project initiation:***  1st December 2008
* ***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

15,000

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

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

The TI has covered a population of 18615 (M-17888+F-727) and all of them are registered in the last one year is 18615. No logic in reporting all the migrants in last year were not available in this year.

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

Male: 17888 and Female: 727

The sites include Industrial worker-3521, construction site workers-1639, Hotel workers-395 and daily wages workers757 with the major number of migrants and with some less number of HRG with other sites also like daily wagers. The category wise population was available only for newly registered 6870 and could not get for total active population

* ***Target Area***

MIDC-Satpur, Gangapur road, Trambak road, Anandvalli.

***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 Project Director Dr. Prakash Aher was available full time in the office. He is the retired medical officer from the District TB officer (medical). The MAGMO Welfare Sanstha was established with the vision of Dr. Aher and the full form of the MAGMO is Maharashtra Association of gazetted Medical Officers. The name itself includes that the body member’s majority are medical practitioners.

The NGO do not have to spend on the STI drugs as all the kits for STI are donated by the body members. (Checked and verified the expiry dates. All kits were found perfect.) Ms. Madhuri B. Bhamre traeasurer of the Organisation was also supporting the project and ready to support the evaluation team.

The organisation is very much experienced in working with for TI in the same area for last 8 years. They need to start thinking of shifting the office nearer to the target sites and place where HRGs are living more. Moreover it was found that they are running minimum of three projects (LWS,Migrants and Truckers) from the same office and it was suggested to find alternates.

**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 as PM-1, Counsellor-1, ORWs – 8, accountant cum ME-1. Three of the female ORWs are female. It was observed that some of the ORWs are very less educated but trained in HIV/AIDS. All the vacant positions have been filled within 10 days’ time. The office bearer has not paid the salary to the staff for last 5 months. Since they are implementing the same TI for last 8 years so the perspective is obvious in community is commendable. The PD attended all the 12 monthly meetings conducted. PM is visiting the field twice in a week and it is mentioned in his diary.

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

All staffs have undergone induction trainings by MSACS as well as in house trainings. M&E attended training on documentation and counsellor attended training on counselling. Apart from these they have conducted trainings internally facilitated by the Manager and TSU-PO. Documents for Training conducted are available but there were no detailed reports on them. No impact assessment has been done.

**3. Infrastructure of the organization**

The office had the assets which were budgeted in the migrant project. 3 computers, Audio- video equipments, cupboards, wooden partition (which was parting PD’s office, digital weighing scale and other medical equipments found in place with the proper code and at the expected places. Other assets were also verified with the help of the asset register.

**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.

MAGMO staff maintained documents and registers as per MSACS protocol. The evaluation team could verify some of the registers: Attendance register, counselling Register, Health camp register, ORWs daily dairy, Planning meeting register, Referral slips, HRGs line list and CMIS report file and meeting minutes, etc. 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.

***III. Program Deliverables Outreach***

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

The line listing has been verified and found updated. Unique id code has been maintained.

The total line listed of 18615 was verified as computerised and up to date.

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

It has been reported as all the new 18615 HRGs were registered through either DIC, Clinic or counselling. However, 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 is in place and all the ORWs were able to explain what micro planning was. The micro planning charts and documents verified as updated. The manager, M&E and counsellor do not maintain diary and don’t have work plan either.

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

Total coverage of population is reportedly 18615 and regular contacts reached with all the services are 6197.

***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 18615 HRG = 1:494. They have 7 PEs in addition to the target of 13 to improve the reach.

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 5760. 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***

PEs are not maintaining diaries but they could explain with required information. ORWs are maintaining daily diary register not field level rough diary. No PE documentation available except the tracking sheets.

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

They have appointed most of the PEs from the destination state. During the field visit and interaction with PEs and HRGs, PEs are having knowledge on HIV mode of spread, prevention and ICTC testing. Not enough STI knowledge observed in the community. Condoms are available with PEs and in DIC and IEC materials found in DIC. Condom demonstration skill of PEs is to be improved. 2 PL have demonstrated condom in the field.

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 slips. However there was no suggestions by PD/PM available for further follow up action.

**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 provide STI drugs at the camp sites with kits donated by the five donor doctors. The community met in the field said that they are satisfied with the services. Dr. Aher is being involved in the camps. They need to start referring cases to government STI clinics to increase the treatment adherence. The TI has not been found properly following up the STI cases in the field and did drug monitoring etc.

No. of camps conducted in the last year: 146 No. of STI suspects referred: 6946 (this is not symptomatic but clinic attendance), No. of STI cases treated: 541. No. of STI cases followed in the field: 213

The above data of STI referral pretends to be considered as referred to all available services but these 6946 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.***

The clinics are mostly conducted in the DICs and the visited 2 DICs are equipped with enough facilities and having private space for examinations. No STI drugs stock out so far. The camps are conducted with enough drugs and this has been verified with the doctor visiting the clinics.

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.***

The drugs were purchased initially from the revolving fund provided by SACS and TI is collecting the cost of the drugs provided to the community from the construction company. Now they do not use the revolving fund for drug purchase and using the whole money for condoms alone. However they have 5 doctors as donating all required STI kits and they have enough stocks as well.

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 but follow up of STI cases to be improved in terms of quality as they are only in documents. . Drug monitoring is not used a follow up mechanism. They don’t have referrals to government clinics for STI screening and treatment. They conduct ICTC testing at camps only with the support for ICTC counsellor. There were no private referrals to ICTC from TI. 12 new PLHIV were registered with the ART. 2 sputum positive HRGs were registered with DOTS and getting treatment at present.

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 and follow up cards found. The follow up details were not able to observe from ORW diaries.

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

The availability of condoms was verified in the construction sites as PEs were found with condoms stock and all DICs have condoms and all of them are accessible to the community and frequently the stock is replenished by the ORWs. They have 63 non-traditional condom outlets available at sites and they were verified as to be promoted further in terms of all HRGs knowing the outlets in the area.

1. ***No. of condoms distributed*** - No. of condoms distributed through different channels/regular contacts.
2. The total number of social marketing of condoms distributed so far in the last one year is 27300.

Condoms are distributed through PE, ORW, DIC and other outlets.

***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 efforts have been made to identify TB suspects and 2 were referred to DOTS. They have good rapport with ICTC, ART counsellor and MOs.

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

There do refer HRGs who are alcoholics for rehabilitation other than 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 and one PE is a member of the street theatre as an actor. They do not carry out film shows.

**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 with ART, TB clinics etc.

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

ICTC tested – 3894 and the total referrals could not be culled out. This is low and need to be increased. They have to try to work for the best result rather than working just for the target. Since 541 STIs were treated and 13 PLHIV were found positive, they have to increase the ICTC testing for higher identification of HIV positive.

***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 security services. No support groups available to support the TI activities.

***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 in tally software.

Stock book is available condom or stationary.

Pass for payment stamps is available on bills or PD sign on vouchers

Supportive document attached properly

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.M.

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***

Quotation process is not properly maintained (Quotations were not signed by Accountant, P.M, PD)

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 maintained

Audit Reports are available last 3 years

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

Condom Registers in not maintain properly (like as received from company name, bills no.

Cash or bank book was not sign by authority

Stationary stock book is not properly maintained without sign authority sign

Original Rent contract file was not available in NGO. Only Xerox copy is available

**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.

Ms. Manisha Naware is a young M.S.W. educated lady from the local place who studied her masters from Nashik itself who is serving as Project Manager. She has worked in Astha project before joining MAGMO. Her competency as a team leader seems to be very low. She needs more experience and training to be a team leader. It was observed that it was very difficult to manage the stress. She was trained by the MSACS. She is loyal the organisation as she had been serving the same since 2011. She is very much impressed with the PD.

***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

Ms. Shital Bhalerao has been serving for the post of counsellor since November 2014. She had studied her B.A. in psychology at Nashik. She has got induction training with this NGO from MSACS. She is young and enthusiast. She maintains counselling records and condom stock registers. All the registers are maintained properly. It seems all her good qualities make her a good counsellor. She is an asset to the NGO.

***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 8 ORWs appointed. There was one ORW who left the NGO in June 2015 but immediately the vacant position was filled by Annuruddha Bhosle. Who is the newest one and only one with the in house training. He is very young studied upto 12th std. He got introduction of HIV/AIDS from DOTS samajik Sanstha and from there he joined MAGMO recently.

Other ORWs Mr. Mahendra, Pradip and Chotulal are of well experienced. Chotulal had education up to 12th and was working in Industrial areas. His thrust for social service gave him call for this service. Mr. Mahendra also is was the teacher previously but just love for Social work called them here. They are the oldest ORW in the project.

There are three lady ORWs in migrant project. They are with this project since 2015 but have previous experience with the HIV/AIDS as well as the community through the other projects. They are not highly qualified or even graduates but their field experience and frank behaviour with the community members makes them one of the very good ORWs.

All the ORWs visit their PE regularly and provide them condoms as well as needed support. They visit the 50% of the IPC done by the PE as they know that this is the target.

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.

Out of 20, 14 PEs were from Maharastra. All the PEs are trained in IPC by the ORWs at the NGO level. They all are good in explaining the concept of HIV/AIDS and condom usage. PEs named Samadhan Jagtap, Yogesh Bhamre, Ysuf Khan and Ajay Jaware were met at in the PE group meeting and were excellent in expressing theri knowledge.

They do not maintain the PE diery. ORW write for them.

They reported that they provide condoms regularly, motivating the community to go for ICTC and STI services and providing BCC. 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 knowledge on STI is good but they need to emphasise more on STI than HIV.

***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.

Ms. Shraddha Funge is Master degree holder and serving at MAGMO as M&E officer cum accountant. She is with the project since June 2014 and is trained for the same. She maintains the data as well as all the other required data.

***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. 960 sessions were done by ORWs of 5200 sessions conducted by PEs. 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 a low level in all activities like planning, mid media activities and camps. The community members are part of only advocacy committee In PMC no HRG was found available.

**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 from PHS. 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 and asked them to involve community members in the same.

**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 observed.

***Other suggestions:***

* A bakery site visited was found with no inputs to the new employees and the same happened in another site of metal company
* All the staffs should maintain and update diaries.
* STI referrals to govt. and PPP clinics to be started again
* PM, M&E and Counsellors should start maintaining diaries as per monthly plans.
* The office of the TI is being used for 4 projects
* Field Sessions are reportedly conducted exactly as per budget every month as 10+20 for the past 2 years looks unrealistic.