

TI-Evaluation Report of Setu Charitable Trust (SCT)

Evaluation Team:

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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 Organisation:**

The *Setu Charitable Trust (SCT)* was founded in 1994. The organization had implemented a UNICEF-project meant for rehabilitation of children working in slaughter houses during 2002-2005 in the districts of Nanded, Jalana and Aurangabad of Maharashtra. The SCT also had been partnered with the National Child Labor Project under which Health Awareness activities done for children and the same was open to the parents of these children. In these activities, sexually transmitted infections of participating parents identified by the NGO which later shared to the Maharashtra State AIDS Control Society (MSACS). Relying on the information provided by the SCT, MSACS granted the NGO TI-project. The organization has some other programmes like Consumer Club for awareness generation amongst school children on various aspects of the consumer information. Income generating activities were also taken by the NGO along with non-formal education etc.

- **Name and address of the Organization:** TI-Office Address: Beside Maulana Azad Library 1st floor of Dhumale Complex Dhumale building Apna Corner Parbhani-431401
- **Chief Functionary:** Mr. S V Chavhan (Project Director-TI)
- **Year of establishment:** 1994
- **Year and month of project initiation:** August 2008
- **Evaluation team:** Dr. Anil Pratap Singh (Team Leader & External Evaluator), Mr. Tushar Dey (External Evaluator), Mr. Sandeep V. Ghode (Finance Evaluator)
- **Time frame:** 27th April 2016 to 28th April 2016

Profile of TI

(Information to be captured)

- Target Population Profile: FSW / MSM / IDU / TG/TRUCKERS / MIGRANTS: FSW
- Type of Project: Core/ Core Composite / Bridge population: Core
- Size of Target Group(s): Allocated Target of FSWs 900 while 985 are active as of now. However, 1052 FSWs were ever registered by the TI.
- Sub-Groups and their Size: Amongst 985 active FSWs, 610 are brothel-based (BB), 197 home-based (HB) and rest 178 line-listed as Tamasha based.
- Target Area: TI's sites stretched within approx. 20 kilometers periphery from the TI office.

- **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...

Though none of the official from the NGO management present for our interactions, but inclination was visible through review of various records. PD-TI observed supporting the community, making advocacy efforts and evolved internal monitoring system for reviewing the project as per the performance indicators and proceeded with statistical considerations, in the past, by thorough discussions on target vs. achievement and thereby identified gaps if any to fulfill the same. Written feed-backs were given by PD with specified deadlines and staffs complied in time. In the assessment period, the Project Director of the TI had attended majority of the staff-review meetings at monthly intervals. Further, rigorous advocacy efforts have been made but with stakeholders who were positive ones, largely neglecting those who might have negative stake(s) as there was reflection of crises (in available Form-K). Since identified stakeholders' list was exclusively of positive stakeholders (even at the PD-TI & NGO-management) hence there was rather limited scope for possible analyses of stakeholders on the level of their support and thereby prioritizing advocacies. However, strong voices of (positive) stakeholders were visible and efforts have been made by themselves in order to enhance the utilization of services and created a sustainable impact among their peers living either in high risks or vulnerabilities. Management was keen in extending their support for project-audiences so that they could avail benefits through entitlements of various schemes.

II. Organizational Capacity

- 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:**

Evaluators were able to meet all the project staffs and PEs for interaction/review of their records/field visits. Staffs were given with appointment letters wherein roles and responsibilities were spelled-out. Given below are the staff details:

Staff Details:

S. N.	Name of the staff	Designation	Qualification	Working Since (with name of month)	Experience
1	S.V.CHAVHAN	Project Director	B.A	Aug-08	Different field 5 year
2	RAFIQUR REHMAN KHAN	Project Manager	B.Sc.; B.Ed.	Aug-08	13 year experience in HIV/AIDS
3	SHAIKH ABDUL RAHIM	Counselor	B.A.	Feb-16	Promoted from ORW to Counselor
4	ABDUL HAMED KHAN	MEO & Accountant	M.C.A	Nov-15	NCLP 2 year experience
5	GANESH UPHADE	O.R.W. 1	B.A.; B. Ed.	May-09	NCLP 1 year experience

6	RAJU LANDGE	O.R.W. 2	M.A.; B.P.Ed.	Apr-10	In TI 8 year experience
7	RAMESH PANDAVVIR	O.R.W. 3	B.A.	Apr-10	In TI 6 year experience
8	S.V.WAGHMARE	O.R.W.4	B.A.	Mar-16	NCLP 1 year experience

ORW-wise PE-profile is also being given underneath which were working at present:

1. Outreach Worker-1

Sl. No	Name of PE	Age in years	Qualification	Target	Date of Joining	Intervening area
1.	Vimal Desai	40	3rd Standard	69	Apr-12	KHANDUBA BAZAR
2.	SHARDA BAI	36	4 th Standard	72	Oct-14	SAKLA PLOAT
3.	Vimal Waghmare	38	5 th Standard	65	Aug-08	BUS STOP
4.	Jaya Bai	35	5 th Standard	60	Apr-10	SAI CORNER

2 Outreach Worker-2

Sl. No	Name of PE	Age in years	Qualification	Target	Date of Joining	Intervening area
1.	ShobhaGaikwad	34	3 rd Standard	69	Aug-08	MARATHWADA PLOAT
2.	Tarabai More	35	4 th Standard	71	Apr-08	MADINA NAGAR
3.	AshaPadulkar	28	5 th Standard	69	Apr-12	BUS STOP

3 Outreach Worker-3:

Sl. No	Name of PE	Age in years	Qualification	Target	Date of Joining	Intervening area
1.	Kamal Kulthe	26	5 th Standard	65	Aug-08	BARVA PARISAR

2	Jyoti Kuril	24	5 th Standard	62	Apr-10	KHANDUBA BAZAR
3	Vimal Desai	38	3 rd Standard	62	Apr-12	GURUBABA NAGAR
4	Indubai	33	4 th Standard	67	Apr-13	DHAR ROAD WANGI ROAD

4 Outreach Worker-4:

Sl. No	Name of PE	Age in years	Qualification	Target	Date of Joining	Intervening area
1.	Sharda Bai	35	4 th Standard	56	Oct-14	MARATHWADA PLOAT
2.	Usha Desai	36	5 th Standard	74	Aug-08	KHADAN UPPER AREA
3.	RadhabaiKorde	28	3 rd Standard	59	Apr-13	KHADAN VIBHAG
4.	Kashibai	40	4 th Standard	65	Apr-08	MARATHWADA PLOAT

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

Most of the project staffs are old ones who have got various trainings both formal-trainings and in-house/on-site mentoring by TSU-PO. The staffs had received induction and other trainings. However, training reports could have been there especially for managerial purposes/project-strengthening if staffs were to be instructed to write what they have learnt from these trainings and accordingly to be ensured quality availability of Form-L of NACO. Through documents on various training it is hard to comment on the quality of the content/training materials used. Furthermore, the impact of these capacity building efforts rather reflected in the practice to some extent. The involvement of TSU for technically supporting the TI was visible through various minute reports. DAPCU representatives are also regularly visiting the TI, generally at monthly intervals, and given quality allusion especially on augmenting linkages' services and observed keen in linking project beneficiaries with citizen benefits.

Followings trainings were happened:

a) Training Details (MSACS):

S.No.	Name of staff/ Designation	Training	Content	Dates of Training
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		given by		
1	Rafiqur Raheman Khan (programm manager)	SACS	Programm financial delivery	Nov 2014
2	Jay Shree Patre (Counsoler)	SACS	Conselling IC management STI	Jan 15
3	Sk.Rahim ORW	SACS	Field work documentatio n	Feb 15
4	RajuLandge ORW	SACS	Field work documentatio n	Feb 15
5	Ramesh Pandavir ORW	SACS	Field work documentatio n	Feb 15
6	Ganesh Uphade ORW	SACS	Field work documentatio n	Feb 15
7	Imran Abdul Raheman (M&E)	SACS	Monitoring Document	Mar 15

b) In-house training by NGO:

S.N.	Name of staff/ Designation	Training given by	Content	Dates of Training
1	RafiqurRaheman Khan (programm manager)	NGO	Capacity build Advocacy	April 14 jan 15 July 14 to oct 15
2	Jay Shree Patre (consoler)	NGO	Counseling risk assessment linkages	April 14 jan 15 July 14 to oct 15
3	Sk.Rahim (ORW)	NGO	All format form field work linkages	April 14 jan 15 July 14 to oct 15
4	RajuLandge (ORW)	NGO	PE content RMC ICTC linkages	April 14 jan 15

				July 14 to oct 15
5	Ramesh Pandavir (ORW)	NGO	PE content RMC ICTC linkages	April 14 jan 15 July 14 to oct 15
6	Ganesh Uphade (ORW)	NGO	PE content RMC ICTC linkages	April 14 jan 15 July 14 to oct 15
7	Imran Abdul Raheman (M&E)	NGO	PE content RMC ICTC linkages	April 14 jan 15 July 14 to oct 15

Infrastructure of the organization:

The TI-office cum DIC is at: Beside Maulana Azad Library, 1st floor of Dhumale Complex, Dhumale Building Apna Corner, Parbhani (Maharashtra). Looking at geo-mapping of hot-spots, TI-office cum DIC could have been located at rather centralized place in terms of beneficiaries' numbers/sites. The organization has one big hall in the main junction on the commercial area. The organization uses its central space for DIC. The counselor sits in extreme corner of the hall and for audio-visual privacy fenced by three almirah. The computer is placed at another corner of the hall. For working of the rest of the staffs, hall is being shared in common. The condom stocks are also kept in this hall. The office has minimum furniture, almirah, computer and printer, telephone, and racks for keeping files and registers. However, the office is some restraints for the ease of working of staffs. For DIC of project beneficiaries, the space is equipped with IEC -pictorial/text in *Marathi & Hindi* languages on core topics pertaining to HIV/AIDS (in relation to sex-work), free condom, service-map, target vs. achievement details, TI-team details, service directory (based on available referral and linkages). DIC was suitable for the community and safe (as per the beneficiaries' interactions). Assets' records were available and duly coded.

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

TI adhered to SACS protocols for its documents. Majority of the NACO formats were in use and individual tracking mechanism was in well existence. Most of the documents qualitatively captured relevant information. However mechanism of review through review meetings as well as staff meetings is in practice. The relevance of documents with different hierarchical positions rather understood and maintained uniformity/symmetry. TI has followed stipulated timeline for report submissions. There was vigil for ensuring authenticity of documents at the level of PEs both by their respective ORWs as well as upper hierarchy staffs. Two-way written feed-backs also visible to some extent when lower staff positioned (TI) team-mates received suggestion/directive from upper ones and complied as well. Majority

of documents were computerized by the TI and M&E cum Accountant was observed keenly involved in doing so. As per the available records timeliness was followed for submission of MIS and other reports. Updated line-list (last up-dation done in December 2015) was available (which had been revised at the interval of three months, as per the information of Form-A) and accordingly estimations done for Form-B (PE-diaries). Though PEs were unable to fill-in their diaries by own, but they knew its content well and having help of their respective ORWs for authentic mention of requisite information. Manual entries were computerized for various NACO formats as well as other records. Documents pertaining to counseling like referral register, counseling registers, etc. were available and counselor observed well acquainted in having his clarity for the records, he maintained. It is worthwhile to mention that past counselor (who now left the project after having another job) was also present during the entire span of project evaluations. The past Counselor was also well acquainted with project-protocols. Various meeting minutes documented and NACO-formats were symmetrical in relation to staffs and PEs on board which largely correlated with each other.

III. Program Deliverables

Outreach

1. Line listing of the HRG by category.
2. Registration of migrants from 3 service sources i.e. STI clinics, DIC and Counseling.
3. Registration of truckers from 2 service sources i.e. STI clinics and counseling.
4. Micro planning in place and the same is reflected in Quality and documentation.
5. Coverage of target population (sub-group wise): Target / regular contacts only in HRGs
6. Outreach planning - quality, documentation and reflection in implementation
7. PE: HRG ratio, PE: migrants/truckers
8. 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
9. Documentation of the peer education
10. Quality of peer education- messages, skills and reflection in the community
11. Supervision- mechanism, process, follow-up in action taken etc

Line Listing of HRG by category: Line Listing of HRGs was present in a single excel-sheet in soft copy with the Unique ID number. A total of 985 HRGs were active (against allocated target of 900).

Coverage of target population (sub-group wise): Estimated / regular contacts

As per the MIS, intervention has been made for 985 FSWs against the allocated targets of 900. PE diaries were observed in use. Over 90% active HRGs reached during last one year and who were in regular contacts during the assessment period.

Outreach planning

ORWs visited the respective PEs five days a week. Line-listed HRGs' risk assessment was compiled in the month of December 2015. There were effective outreach-plans available with all the four ORWs (being revised at quarterly intervals for line-listed information and on monthly/weekly basis for programme execution). Peer-wise site map was available with all of them given with requisite information including commodity requirements, dues of RMC/ICTC/STI-follow-ups as well as referral and linkages in the access of the community. Planning exercises on condom demand vs. distribution was done significantly and taken into planning-considerations. Also, rest of the target (on ICTC/Syphilis-screening/RMC etc.) vs.

planning done at considerable extent and observed carried forward in next-planning if the same was undone due to any reason.

Peer Education

During in depth discussions on the nature of their work, it was observed that their roles in the community and their knowledge in context of communication skills for message delivery were found effective in terms of project requirements. PEs had their bags wherein condoms, IEC in *Marathi* and *Hindi*, penis model, condoms were placed. Plan Vs Achievement well understood by majority of them. PEs were having rather proper micro-plan in the line with ORWs. Further, few of the PEs were relying on ORWs for their planning to achieve various targets within the time frame of the project tenure, e.g. ICTC, referrals/testing, Syphilis screening, Regular Medical Check Ups (RMC), etc. thereby further planning were done and strategized towards gaining requisite achievements.

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

PM knew the proposal contents and the properly framing out planning-exercises and providing requisite supervision to his TI-team mates, in order to deliver services by authentically tracking the individual HRGs. He made yearly/ quarterly/monthly plans for managerial purposes. Review meetings being convened regularly as per performance indicators and action taken based on the minutes were well incorporated. There was also reflection of his field visits (PM diary) wherein mentoring of field staffs was visible in outreach documents. Also, Counselor understands the TI who documented supervision/follow-up as was visible enough. Moreover, the past counselor (who now left the project after having another job) was also present during the entire span of project evaluations. The past Counselor was also well acquainted with project-protocols. Both of these two upper hierarchy positioned staffs as well as M&E cum Accountant were observed able to supervise rest of the staffs. Written feed-backs/action taken practiced between the vertical staffs' positions and also between ORWs & PEs of the gamut of TI.

IV. Services

1. Availability of STI services - mode of delivery, adequacy to the needs of the community.
2. Quality of the services- infrastructure (clinic, equipment etc.), location of the clinic, availability of STI drugs and maintenance of privacy etc.
3. 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.
4. 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.
5. 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.
6. Availability of Condoms- Type of distribution channel, accessibility, adequacy etc.
7. No. of condoms distributed- No. of condoms distributed through different channels/regular contacts.
8. No. of Needles / Syringes distributed through outreach / DIC.
9. Information on linkages for ICTC, DOT, ART, STI clinics.
10. Referrals and follows up

Availability of STI services:

STI services are catered mainly through two PPP (female) doctor (BAMS). Following are the details of the doctor:

PPP Doctor's details:

Sl. No	Name of the Doctor	Allopath /non-allopath	Received training on Syndromic Management from SACS/TSU	Letter of Understanding (LoU) signed: Yes/No	Working since
1	Dr.Deepali Sudhir Kakde	B.A.M.S.	Yes	Yes	August 2008
2	Dr.Pratibha Patil	B.A.M.S.	Yes	Yes	April 2010

Doctor is filling-in network clinic forms of NACO with mention of findings. STI cases were observed properly followed-up as reflected from document as well as relevant interaction with Counselor and the doctor. Presumptive Treatments (PTs) were given to the newly registered or those who met after the gap of six months. During April 2014 to March 2015, amongst 52 new registrations 24 were also suffering from venereal disease who had got the same medicine as meant for PT and rest of the 28 cases had received PT, as such.

TI has projected 915, 934, 942 and 948 Regular Medical Check-up (RMC) at quarterly intervals of our assessment period (April. '14-March. '15).

Availability of STI Kits & loose STI drugs:

STI-Kit No. 1 was balanced with 37 kits (to be expired in January 2017) while STI-kit No. 6 is balanced with 32 kits only, to be expired in January 2017. And, rest of the other STI-kits, remained 'zero'. Loose STI-drugs of NACO e.g. Azithromycin (1g) Cefixime (400 mg) Fluconazole (150 mg) Doxycycline (100 mg) Metronidazole (400 mg) etc. were yet to be procured. Doctors, prescribed medicines in the event of stock-outs.

Quality of the services and treatment in the service provisioning:

Service provisioning in context of STI treatment was observed above average in all respect.

Documentation

Documentation done was rather proper. Counseling register and referral register, STD register, STI drug stock register, network clinic form, etc. found maintained and kept at the TI.

Availability of Condoms- Type of distribution channel, accessibility, adequacy, No of condoms distributed etc:

Outreach workers and peer educators distribute condoms as per the demands. By reviewing the condom stock-register it was observed that condoms were given to ORWs for direct distributions by their respective PEs. Each of the ORWs had further maintaining their condom registers where recorded weekly-issuances/ monthly- returns of condom for their PEs as per the demand/distributions. Condom gap analysis has also been done.

V. Community participation

1. Collectivization activities: No. of SHGs/Community groups/CBOs formed since inception, perspectives of these groups towards the project activities.
2. Community participation in project activities- level and extent of participation, reflection of the same in the activities and documents

The TI was observed collectivizing the community. Certain SHGs are established. TI-staffs motivated the PEs during their review meetings to formulate the SHGs in order to make its project audiences' self-reliant. Resource personnel from TI, Banks, supply office, medicos/ para-medicos, SMO etc. who had given Income Generation Activity (IGA) trainings as well. These SHGs were now taking shapes as support groups rather being limited to micro-finance. SHG named "*Navkiran Mahila Mandal*" (brothel-based) got registered at Charity Commissioner (vide registration No. MH/509/2015) while "*Freedom Mahila Mandal*" (tamasha and brothel base) also registered here (vide registration No. MH/453/2011). These collectivization efforts had impacts in making difference.

Community participation was rather also reflected by reviewing various records and relevant interactions. However, regular foot-fall at the DIC was observed around ten HRGs daily and 15-20 HRGs in DIC level meetings. Rather considerable number of HRGs' participation was observed in various demand generation meetings and the same were also reported through MIS. Random cross-checks of these meeting registers with all the ORWs were found in the symmetry with their MIS-reports. Community events were also convened by the TI. During hotspot-visits, quality reflection of these done activities witnessed by having interactions with HRGs in FDGs. In addition to these community events were also convened.

Community event details:

S.N.	Date of Community event	Main activities	Total No. of HRGs participated
1	08/04/2014	International Women Day	380
2	06/12/2014	World AIDS Day, Mahilamelava	530
3	10/04/2015	World's Health Day and Women day	430
4	03/12/2015	Mahilamelava	680

VI. Linkages

1. Assess the linkages established with the various services providers like STI, ICTC, TB clinics etc...
2. Percentages of HRGs tested in ICTC and gap between referred and tested.
3. Support system developed with various stakeholders and involvement of various stakeholders in the project.

The TI was observed using services of following linkage located in the periphery of T:

a) Civil Hospital, Parbhani being used for STI/ICTC/TB/ART.

1st time referral for ICTC was 937 while for 2nd time it was 951 and 1st time tests were 870 and 910 undergone 2nd time ICTC-tests. It is worthwhile to mention that when we tried to get and collate certain data from linkages, symmetrical statistics were obtained. TI understands essence of DOT referrals. HIV positive cases were linked to ART and properly followed up by confidentially maintaining relevant record.

At a glance, linkage-wise services (along with certain relevant indicators) could be given as follows:

Indicator	Period April 2014 to March 2015
Direct Condom Distribution (FSW)	722770
Condom Distribution (Non-traditional-outlet)	13350
TOTAL CONDOM DISTRIBUTION	736120
Condom balance as on date	12768
No. of non-traditional outlets	19
Regular Contact (FSW)	11175
Total new registrations (FSW)	52
PT (FSW)	28 (N.B.: Amongst 52 new registrations 24 were also suffering from venereal disease who had got the same medicine as meant for PT)
RMC-FSW (Qtly. basis 1 st qtr.)	915
RMC-FSW (Qtly. basis 2 nd qtr.)	934
RMC-FSW (Qtly. basis 3 rd qtr.)	942
RMC-FSW (Qtly. basis 4 th qtr.)	948
TOTAL RMC- FSW	3739
Syphilis screening-FSW (1 st time)	666
Syphilis screening-FSW (2 nd time)	551
No. of STI cases diagnosed	34
No. of STI cases treated	34
No. of STI cases counseled	34
No. of STI cases followed-up	34
ICTC-FSW (referral, 1 st time/ 2 nd time referrals)	937/951
ICTC-FSW (tested, 1 st time/ 2 nd time tests)	870/910
ICTC-FSW detected positive	4
FSW-Linked to ART	4
Cumulative +ves (FSW)	62
Cumulative LFU (FSW)	12
Cumulative Died (FSW)	6
Cumulative Linked to ART (FSW)	39
Eligible for ART/on ART (FSW)	39
TB referral/on DOT	62/ ON DOT 3

CD4 Statues of Sero-positive HRGs:

Case No.	Base CD4 Count	Last two CD4 Counts	
		Previous with date	Latest with date
1.	182 CD4 09/11/10	510 CD4 15/05/15	688 CD4 22/02/16
2.	290 CD4	360 CD4	490 CD4

	21/11/10	05/04/15	20/12/16
3.	95 CD4 22/10/11	210 CD4 15/04/15	390 CD4 01/04/15
4.	120 CD4 08/10/11	350 CD4 05/05/15	390 CD4 13/12/15
5.	390 CD4 10/12/12	385 CD4 05/01/15	498 CD4 10/11/15
6.	190 CD4 25/11/11	280 CD4 01/03/15	410 CD4 1/11/15
7.	305 CD4 10/08/12	325 CD4 10/03/15	307 CD4 05/09/15
8.	188 CD4 15/10/13	290 CD4 15/03/15	390 CD4 20/10/15
9.	350 CD4 10/11/13	360 CD4 10/02/15	410 CD4 10/12/15
10.	221 CD4 20/10/08	390 CD4 01/07/15	403 CD4 03/05/16
11.	305 CD4 05/03/09	380 CD4 03/03/15	405 CD4 10/11/15
12.	350 CD4 05/04/12	370 CD4 05/01/15	450 CD4 10/11/15
13.	105 CD4 20/10/11	405 CD4 02/02/15	480 CD4 11/12/15
14.	220 CD4 10/05/12	290 CD4 03/03/15	490 CD4 03/03/16
15.	320 CD4 05/06/13	380 CD4 05/02/15	405 CD4 03/09/15
16.	180 CD4 05/11/2012	290 03/02/2015	413 CD4 15/09/2015
17.	310 CD4 15/05/2010	350 CD4 10/01/2015	410 CD4 07/08/2015
18.	309 CD4 14/08/2010	340 CD4 18/03/2015	400 14/09/2015
19.	320 CD4 03/06/2010	370 CD4 03/01/2015	410 CD4 03/10/2015
20.	340 CD4 07/04/2012	370 CD4 22/11/2015	415 CD4 03/01/2016
21.	85 CD4 07/03/2011	200 CD4 11/10/2014	360 CD4 03/05/2015
22.	110 CD4 25/06/2011	300 CD4 09/01/2015	380 CD4 11/06/2015
23.	90 CD4 07/02/2011	180 CD4 02/09/2015	370 CD4 08/02/2016
24.	120 CD4 14/03/2012	200 CD4 18/10/2015	380 CD4 03/02/2016
25.	100 CD4 08/04/2012	180 CD4 28/11/2015	395 CD4 04/03/2016
26.	90 CD4	170 CD4	510 CD4

	09/03/2012	25/10/2014	21/07/2015
27.	118 CD4 01/04/2010	190 CD4 20/11/2014	475 CD4 28/01/2015
28.	240 CD4 27/07/2008	400 CD4 15/02/2015	570 CD4 12/01/2016
29.	310 CD4 09/03/2008	390 CD4 13/09/2014	540 CD4 02/01/2016
30.	180 CD4 02/01/2009	400 CD4 12/08/2015	609 CD4 18/01/2016
31.	94 CD4 08/02/2009	308 CD4 11/09/15	690 CD4 08/04/16
32.	110 CD4 16/08/13	440 CD4 04/01/15	580 CD4 03/04/16
33.	85 CD4 30/07/11	392 CD4 02/03/15	555 CD4 09/01/16
34.	210 CD4 06/12/10	270 CD4 15/07/15	568 CD4 09/11/15
35.	292 CD4 24/09/10	398 CD4 17/09/15	570 CD4 24/03/16
36.	192 CD4 11/04/09	370 CD4 16/07/15	594 CD4 24/01/16
37.	95 CD4 17/05/2008	368 CD4 24/08/2015	613 CD4 21/01/16
38.	110 CD4 19/07/10	390 CD4 22/03/15	448 CD4 19/08/15
39.	308 CD4 26/03/11	398 CD4 19/11/14	455 CD4 04/02/15
40.	227 CD4 24/01/10	467 CD4 28/1/14	497 CD4 01/01/15
41.	308 CD4 03/03/12	410 CD4 05/04/15	425 CD4 6/10/15
42.	125 CD4 05/04/13	305 CD4 10/01/15	390 CD4 15/08/15
43.	350 CD4 08/08/08	309 CD4 05/02/15	480 CD4 20/09/15
44.	192 CD4 25/07/11	358 CD4 30/04/15	410 CD4 05/11/15
45.	290 CD4 20/08/11	320 CD4 30/06/15	510 CD4 31/03/16
46.	410 CD4 28/08/08	430 CD4 01/05/15	490 CD4 30/12/15
47.	310 CD4 20/04/13	410 CD4 01/04/15	580 CD4 01/01/16
48.	211 CD4 22/12/14	310 CD4 05/05/15	480 CD4 10/12/15
49.	320 CD4	390 CD4	450 CD4

	01/08/08	10/04/15	07/12/15
50.	180 CD4 05/08/2011	350 CD4 06/08/15	430 CD4 01/02/016
51.	80 CD4 20/02/10	192 CD4 28/09/15	490 CD4 07/02/16
52.	98 CD4 02/01/10	375 CD4 20/10/15	573 CD4 21/02/16
53.	173 CD4 13/06/2010	412 CD4 19/03/15	499 CD4 27/03/16
54.	262 CD4 03/10/11	420 CD4 08/08/15	540 CD4 15/01/16
55.	312 CD4 28/07/12	468 CD4 10/05/15	609 CD4 14/01/16
56.	187 CD4 21/05/12	510 CD4 03/04/15	627 CD4 18/11/15
57.	174 CD4 03/10/13	477 CD4 24/07/15	568 CD4 28/03/16
58.	75 CD4 9/06/13	591 CD4 10/07/15	633 CD4 05/12/15
59.	195 CD4 02/04/13	210 CD4 11/02/15	543 CD4 09/08/15
60.	229 CD4 24/07/14	498 CD4 30/01/15	650 CD4 22/03/11
61.	300 CD4 14/01/14	490 CD4 15/08/15	600 CD4 25/04/16
62.			

N.B.: Analyses of above mentioned cases revealed that majority of them had their CD4 counts at increasing drift if comparing with base/previous counts. However, there were prevailed delays in consecutive tests as evidenced through the review of +ve HRGs' records. Furthermore, several cases are still either due or over-due for getting tested for CD4 count. It is worthwhile to mention that CD4 count, if timely available, for consecutive tests, at six months' intervals, might have given proper picture on trends, wherein decreasing drifts could have been witnessed, if any, for focused and prioritized counseling of such case(s). Proper follow-up mechanism is also need to be evolved for the positives cases as they were prominently important to be intervened under programme delivery.

VII. Financial systems and procedures

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

-All Expenses are done with grants guideline.

- 2. 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, practice of settling of advances before making further payments.

- Vouchers are printed with serial numbered. Meeting minutes reg. seen with presently. Quotations of Tent, stationery & Refreshments are seen. Bills are certified. Stock of medicine & condom reg. seen. All advances are settled by NGO.

- 3. Systems of procurement-** Existence and adherence of systems and mechanism of procurement as endorsed by SACS/NACO, adherence of WHO-GMP practices for procurement of medicines, systems of quality checking.

No any procurement of Medicine are made by NGO during Fianance year.

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

- Bank Account is separate maintain by NGO with 2 specimen sign. Bank Reconciliation made on monthly basis. Audit reports send MSACS.

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.

Project Manager having B.Sc. & B.Ed. degrees working project inception, observed well versed and acclimatized with the project. He knew the proposal contents and the properly framing out planning-exercises in order to deliver services by authentically tracking the individual HRGs. He made yearly/ quarterly/monthly plans for managerial purposes. Computerizations of certain formats were done by him and data effectively taken-up for managing the same for proper execution also in future course of activities. Review meetings being convened regularly as per performance indicators and action taken based on the minutes were well incorporated. There was also reflection of his field visits (PM diary) wherein mentoring of field staffs was visible in outreach documents. Advocacy initiatives were undertaken in the line of needs of the community but missing to properly consider negative stakeholders.

VIII b. ANM/Counselor

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

Counselor does understand the TI and having his clarity on risk assessment and risk reduction, knowledge on basic counseling and HIV, symptoms of STIs etc. So far as maintenance and updating of data and registers, the efforts have been made to all the requisite records. He has got her good rapport at linkages.

VIII c. ANM/Counselor in IDU TI

Clarity on risk assessment and risk reduction, knowledge on basic counseling and HIV, symptoms of STIs, maintenance and updating of data and registers. Working knowledge about local drug abuse scenario, drug-related counseling techniques (MET, RP, etc.), drug-related laws and drug abuse treatments. For ANM, adequate abscess management skills.

Not applicable

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.

ORWs were preparing their documents. All the four project's ORWs were versed properly about target on various indicators for their PEs, outreach plan, STI symptoms, RMC and ICTC testing, support to PEs, field level action based on review meetings etc. They were using updated line-list (last up-dation done in December

2015) was available (which had been revised at the interval of three months, as per the information of Form-A) and accordingly estimations done for Form-B (PE-diaries). They fill their weekly summary sheet Form-D and target vs. achievements were discussed and gaps were analyzed. There were outreach plans available with all of the ORWs and risk assessments were tried to revise at quarterly intervals for line-listed information in order to execute outreach. In outreach plans information were given mainly on condom requirement; analyses on high/medium/low risk; days & time of meeting STI; condom negotiations etc. Peer-wise site map was also available with all of them given with requisite information including commodity requirements, dues of RMC/ICTC/STI-follow-ups as well as referral and linkages in the access of the community. The site-maps were also given to the peer educators. By interviewing respondents at various hotspots, it was reflected that ORWs have got their quality rapport.

VIII e. Peer educators

Prioritization of hotspots, importance of RMC and ICTC testing, condom demonstration skill, knowledge about condom depot, symptoms of STI, knowledge about service facilities etc.

Prioritization has been done for those whose services were due/over-due and PEs are aware of these requisite protocols. Written feed-backs were given by upper hierarchy staffs (PM, Counselor) to ORWs while ORWs given verbal feed-backs to less literate PEs and well documented along with relevant data. Peer educators met during evaluations who knew their project better conceptualized the same and having proper communication skills as well. As per the interaction with staff and PEs, the TI has exercised for quarterly risk-assessment and currently PE diaries were given to PEs, based on information got in the month of December 2015. Majority of the PEs knew importance of RMC and ICTC testing, condom demonstration, communication skill, symptoms of STI and also knowing service facilities available in the city's periphery.

VIII f. Peer educators in IDU TI

Prioritization of hotspots, condom demonstration, importance of RMC and ICTC testing, knowledge about condom depot, symptoms of STI, working knowledge about abscess management, local drug abuse scenario, de-addiction facilities etc.

Not applicable for this TI as evaluated.

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 prioritize 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 for this TI as evaluated.

VIII h. Peer Educators in Truckers Project

Whether the peers represent ex-truckers, active truckers, representing other

important stake holders, the knowledge about STI, HIV, and ART. Condom demonstration skills, able to plan their outreach along with mid-media activity, STI clinics.

Not applicable for this TI as evaluated.

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.

Exclusive M&E cum Accountant position was sanctioned and the TI has appointed female staff for this position who is well qualified i.e. having MCA. He was able to provide analytical information about the gaps in outreach, service uptake to the project staff. Moreover, he is competent in providing key information about various indicators reported in TI as well as STI-MIS reports.

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.

ORWs are well doing their documentation at their ends. They were authentically summing up Form-B of their respective PEs and highlighting dues/over-dues in next plan of action depending upon weekly feed-backs from PEs in especially in review-meetings.

Outreach activities were observed being implemented by planning the activity and same were also recorded for activities done; and thereby ensuring the service uptake by the TI. Hotspot wise micro-plan was observed in existence especially for STI services, linkages to ICTC/ ART center etc. As per the interaction with the team along with peer educators with ORWs as well as review of their documents it was apparent that service uptakes were proper. Evidence based outreach-plans also observed wherein frequent visits/monitoring visits have properly been reflected. Demand generation meetings observed being held *as per the norms of revised TI-costing guidelines (2014)*, preferably at hotspots and captured project relevant demand of the beneficiaries. In these meetings, minutes were having attendance-signatures/thumb-impressions but UID/names as per line-list could have been provided properly for ease in estimating number of new HRGs attending these events.

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, Counseling 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.

Not applicable for this TI as evaluated.

X. Services

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

Service uptake through the project was rather visible and evidenced through documents/interaction with HRGs, at the level of satisfaction of beneficiaries. During FGD, majority of the interacted HRGs screened for syphilis/ICTC tested and underwent RMCs. They were also aware of their DIC, Counselor etc. and had project services. So far as commodity distribution, HRGs observed satisfied. In case of STI, they were able to have free medicines (but sometimes prescriptions, depending upon drugs' availability) from the project especially for venereal-diseases (symptomatic/ asymptomatic). Moreover, general medicines also being dispensed whenever HRGs suffered from other ailments as told by PPP doctors who give them the same without charging money.

XI. Community involvement

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

Two of the ORWs were from the community who had got their promotion from peer educators. Peer educators as well as some of the HRGs were included in the list of various committees. Through these committees, community has decisive roles in planning, implementation, advocacy initiatives as well as monitoring the pace of on-going project activities and extended efforts for HRGs' citizen benefits/collectivization.

XII. Commodities

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

Free condoms were given to HRGs as per demand. TI also managed to have free condoms even during shortages of supplies at the end of SACS. And, PEs & HRGs were trained on *Femidom*. The project level planning for commodity distribution as per Demand Vs Distribution well understood by the TI as per the protocol. Condoms were the main commodities being given as per the data available with ORWs/PEs.

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.

TI had identified its stakeholders but positive ones and regular advocacies were happened. During PEs'-interactions as well as FGDs with HRGs, the project's audiences had due attention whenever crises experienced by themselves. The TI was still need to understand the importance of doing analyses of stakeholder at whatsoever extent they were supporting or else. One of the noteworthy advocacies included advocacy as conducted in past with District Civil Supplies (DCS) Officer who convinced for provisioning separate ration shop for FSWs which has been visited by us as in its full-fledged working structure being run by the Community Based Organization of FSWs. Thus, a few of the SHGs now getting shapes of CBOs and making base for community owned intervention in time to come.

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

TI has made its efforts in linking all its +ve HRGs with nutritional support, Sanjay Gandhi Yojna also helped them in making their *Adhar Card*, *BPL Card* as well as opening bank accounts.

TI also had made tremendous efforts for its project beneficiaries in order to availing various entitlements. Noteworthy amongst these were:

Details of Social Entitlement:

Sr. No.	Social Entitlement/protection schemes/citizen benefits	No. of beneficiaries
1	Ration card	985
2	Adhaar Card	1930
3	Voter Id	970
4	Bank Account	985
4	Gas connection	510
5	Nutrition support for PLHIV	68
6	Accidental insurance	12
7	Education Support	180
8	Got vocational training from state's Women and Child Department	310
9	SHGs constituted	22
10	SHGs registered under Societies Registration Act	05
11	Other	
12	Widow Pension	210
13	BimaYojna(RashtarpatiSwasthabimaYojna/ P.M. SurakshaBimayojna)	590
14	Life Skill Dev. For Children	310
15	Linkage with Any Other Social Entitlement Scheme	1050
16	Conducted any special medical checkup/Camp	1290
17	Other / pan card	200
18	JandhanYojna Bank account	804
19	Sanjay Gandhi NiradharYojna	65
20	Rajiv Gandhi JivandaiYojna	300
21	AntodayYojna	48

22	Nutritional support from ICDS for children of HRG	98
23	BalsangopanYojna	98
24	Member SHG (HRG)	280
25	Honorarium to <i>tamasha</i> artist	180
26	Providing support by enrolling FSW children in crèche	60
27	Providing support by enrolling FSW girls in Kasturba Gandhi BalikaVidhalay	52
28	Enrolling name of HRG social economic survey those having left this survey	398

XV. Best Practices if any

1. Dispensing General Medicines to HRGs’:-

The TI mobilized its PPP doctors who by themselves willing to provide general medicines to HRGs during RMC visits.

2. Female Condom:

Counselor provided proper knowledge about female condom to HRG and demo also conducted.

3. Mainstreaming from being marginalized:

Coordinated approach of work-culture both for service deliverables and aspects involved in social welfare as well as for mainstreaming beneficiaries from being marginalized.