**Annexure: B**

**Reporting Format- B**

**Structure of the Detailed Reporting Format**

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

**Introduction**

* **Background of Project and Organization: Lo Parishad Unit 1**

Lok Parishad is a registered non-profit organization working for women and child in the area of health and Education. Lok Parishad has made its presence noticeable in Panvel region by conducting several programs for the mentioned target audience. Many under privileged children in this area was helped by this organization for school enrolment. While touching and conducting small programs, the need was arise to cater the vulnerable section (female sex workers) of this area and hence this project on HIV/AIDS was implemented with the support from MSACS.

* **Chief Functionary:** Ashok Gaikwad

**Year of Establishment:** February 2000

GBBSD-160F21986 14/02/2000 15/05/2000

* Year of month of project initiation: April 2014
* NGO address: Narmada Complex, Gala No. 42, Behind S.T. stand, Railway station road. Old. Panvel, Raigad- 410206
* Evaluation Team: Ms. Riji Nair

Ms. Rohini Gorey

Mr. Ravindra Kadam (DAPCU- Accountant)

* Time Frame: 11th to 13th March 2016

**Profile of TI**

(Information to be captured)

Lok Parishad is a registered non-profit organization working for women and child in the area of health and Education. Lok Parishad has made its presence noticeable in Panvel region by conducting several programs for the mentioned target audience. Many under privileged children in this area was helped by this organization for school enrolment. While touching and conducting small programs, the need was arise to cater the vulnerable section (female sex workers) of this area and hence this project on HIV/AIDS was implemented with the support from MSACS since 2008.

1. **Organizational support to the programme -:**

The evaluation team visited office of Lok Parishad Unit I at Panvel Narmada complex. The DIC and Clinic are in the same premises. The staff is recruited as per guidelines of MSACS.

The posts at present filled are as given below:

1. Project Director: 01
2. Program manager:01
3. ORW: 01
4. ANM:01
5. M & E cum accountant:01
6. Peer educators: 19
7. **Organizational Capacity:**
8. **Human resource:**

As sanctioned the project has PM, M & E cum accountant, of 5 ORW one is in place, 1 Counselor, 1 Doctor and 19 Pes in place of the sanctioned 20.

1. **Capacity building:**

The project is initiating HIV/AIDS program in 19 Bars of Panvel and its closest area and through which they are covering more than 1200 bar girls.

Training from MSACS for them has not yet conducted. The project needs to conduct internal training at regular intervals as most of them are still lacking the skill to perform condom demonstration. Training register is maintained but it is not updated. The Peer Educators appointed lacks the program delivering skills and none of the Peers maintain their field activity report.

It was observed that no inputs from PO in context of training and skill building of staff is given as all the Pes or ORW are still hesitating to perform oral condom demonstration. The staff is committed and motivated and needs qualitative training, monitoring and proper hand holding.

1. **Infrastructure of the organization**

The project has Drop in Center, Clinic and project office near Panvel station area as it is convenient for the team to reach the bar sites from this place. Though the foot fall of KPs at the DIC is less, the project office doesn’t have enough place for counseling. However the PD said with the limited funding from SACS they can only manage this much.

There is no clinical setting or privacy given for the kps who come for clinical service.

**Documentation and Reporting:**

The project manager tries to maintain all the required registers and dairies given by MSACS. However few registers/formats (advocacy, training, clinic forms, event register, and stock register) are yet to be received from MSACS. The team is trying to document the same in their own way. The project manager does multitasking with the minimum team effort as only 1 ORW in place. Other team members are also planning to quit soon because of no fund disbursement from MSACS.

At present the project has 19 Peer Educators in place, appointment letter for them is not given neither the Pes document their daily project activity details. The peer appointed in this project are illiterate and hence they don’t maintain any document. It was very difficult to get the Old and new Peer educator data as no attendance register, appointment letter, PE monthly activity plan are maintained.

The supervisory reports and monthly meeting minutes are maintained but action to be taken by the PE/ORW is not maintained. The project doctor need to mention the clinical finding or observation in the clinic encounter form and the follow-up mechanism for tracking the STI patients.

**Programme Deliverables**

**Outreach**

1. Category wise line listing is carried out by the project staff. A total of 2045 is ever registered in this project through its inception and the active population is 1250 KPs.
2. Of the 5 sanctioned Outreach workers the project has 1 in place covering the active 1250 targeted population. From last few months the project surviving with 1 ORW as the staff had to quit because of no funding by MSACS. The ORW is doing whatever work is assigned but it’s not impacting the project deliverables. Of the total STIs in the project not even 50% are met for follow-up. ORW is not mentioning the ICTC and VDRL services undertaken by KPs in few of the ITS.
3. The project have outreach wise micro plan but it’s not updated and one or two PE micro plan is only mounted. However the project has 19 active PES and the same need to be done for all. The Peer educator’s main activity is to distribute condoms and the same they report to the outreach worker.
4. More than 15500 free condoms and 7100 social marketing condoms are distributed by the team in a year. The team need to conduct condom gap analysis as it was observed that only 10% condom are distributed against the need.
5. Condom social marketing is carried out but not in all project sites. The team itself feel that the KPs are used to the free condoms so they won’t buy. There are instances of less lubricant and tear off issues of the free condom which is provided by MSACS.
6. Importance of ORW supervising the Peer Educators work area is not done and documented properly.
7. As there is no proper planning and monthly assessment done in this project by the PM/PO, the project lacks STI follow up numbers and ICTC testing services. The data doesn’t match at referral linkages center. The data shared by Panvel Rural hospital ICTC center and the ngo counselor there are discrepancies of few referral (7 to 9) and VDRL numbers. The data of VDRL and ICTC referral slips re not properly maintained.
8. PM has established nice rapport with the ICTC counselor however the NGO counselor need to develop the same and verify the referral data on monthly basis.
9. The monitoring and supervision mechanism need to be strengthened at each level (ORW/PM/PO). The PM maintain the visit report but the next visit impact on the previous observation is not mentioned. The PO need to visit all site at regular interval as the KPs from few bars are still practicing double condom usage. Of the total positive cases almost 6 positive cases are from one bar. The reason for more positive cases in this bar is because the girls working in this bar goes on contract with the customers. Hence it was observed that the team need to have strong advocacy with them as the girls need to adopt safe sex practices.
10. The Outreach worker need to monitor the quality of condom demonstration conducted by the Pes as they doesn’t carry out condom demonstration regularly on site.
11. Movement register is maintained and matched.
12. Peer appointment letters or attendance register are not maintained, hence it was difficult to understand how may Peer Educators are on board and how many were drop out.
13. **Services**
14. **Basic services:-**

Of the 5 sanctioned Outreach workers the project has 1 in place covering the 1200 targeted population (Bar based). It is observed that the team (ORW & Pes) through its regular one to one and group the team is able to reach approximately 1100 kps in a month. The Peer activity is not documented. The report is taken by the Outreach worker during their visit at the PE site. From OCT 2015 no mid-media activity like street play, poster exhibition, etc.. Undertaken as there was no fund availability. Due to no fund disbursement from MSACS the staff turnover was noticeable. The District Programme Officer shared that the project suffered because they were no consumable supply from MSACS to DAPCU (Consumable shortage like no testing kits, STI drugs, lab forms, condoms, etc..) .

1. **Clinical services:-**

The project office has STI static clinic in its project office however no privacy is maintained. The project director need to look into this mater as no section for counselling or checkup is demarcated. The organization has another project office next to Unit 1 office and there they have place for clinical setting so the Unit 1 kps are treated there. The footfall of kps at static clinic is less so the project conducts 6 to 8 health camps in a month at the bar site. Only 44 kps with STI were followed-up of the total 103 in a year. . The data of VDRL and ICTC referral slips re not properly maintained.

The counselor conducts more than 3800 counseling session in a year however only 1487 ICTC testing is done against the target of testing twice a year. Of the said counselling session, only 260 times condom demonstration was showed by the counselor. The counselor has not received training from MSACS, however during the PO visit the training was provided.

The project has a PPP set-up for which DAPCU and the organization has an agreement. The kps undergone testing, their reports are given by Peers in hand. The data of HIV positive is reported wrongly to MSACS in year 2014-15 and 2015-16. The total no of HIV positive is 47 till date and reported are 12. The counselor need to fill the PLHIV data accurately and PO need to guide them properly as the counselor mention drop out and drop in frequently.

1. **Commodities**

Condom Social Marketing (CSM) depots list are not updated. More than 15500 free condoms and 7100 social marketing condoms are distributed by the team in a year. The team need to conduct condom gap analysis as it was observed that only 10% condoms are distributed against the need. It was observed that Condom social marketing is still not initiated by the team in many of the bars. The project had shortage of free condoms from MSACS for more than a quarter. The kps are facing issues with this condom as it’s less lubricative.

In our field visit to one of the bar site, it was noticed that the Kps are ready to purchase condom but still the project team is focusing on free distribution.

1. **Community participation:**

It was observed that the community participation in DIC is very poor as their project area of intervention in vast. (Panvel , kalamboli). The team with the help of DAPCU has helped more than 104 KPs to get their Aadhar card, Naukar nama. Few KPs children were helped for hostel boarding. The project has formed various committees (DIC, Clinic, Condom, Advcacy, etc). However, registers for each committee need to be maintained separately. The Peers or KPs are not involved much in the committee. The project team has not made any effort to involve the project related stakeholders in Project Management committee. Need based advocacy is not carried out in the project as the Peers and KP involvement in the project is not much. The team has developed good rapport with the bar owners however it need to be channelized properly for the project. The team need to conduct bar owners/ managers meet biannually as most of the condom depots, girls’ identity card (Naukar nama), health camps, etc.. need to be discussed.

1. **Linkages**

The team has developed linkages with ICTC & ART centers. They refer to Panvel Rural hospital ICTC center and from Jan 2016, the project with DAPCU initiative have started a PPP (FICTC) model for covering all KPs for testing. The project counselor plays a role of ANM and after counseling she withdraw blood sample for testing and positive KPs are then referred for confirm test result at Panvel rural ICTC center. The data of HIV positive is reported wrongly to SACS in year 2014-15 and 2015-16. The total no of HIV positive is 47 till date and reported are 12. This happened because the team was unclear on how to fill the PLHIV register (drop outs noted are many).

On ART and pre ART cases are registered at Dhirubhai Ambani Hospital. The team says the Counselor at this center (Ms.tara) is not sensitive towards the KPs and many kps have reported the same to them. Few have also left from this center and connected to Jyotish Care (CC) Kalamboli for ART services.

1. **Financial system and procedures**
2. **Systems of Planning :**

Existence & adherence of SACS guidelines & any approved systems endorsed by official communications.

1. **Systems of Payments :**

Printed & Serialized vouchers, approval systems & norms, bills, stock & issue registers practice of setting of advances & then payments.

1. **Systems of Procurement :**

Existence & adherence of systems and mechanism of procurement as endorsed by SACS.

1. **Systems of documentation :**

Availability of bank accounts (maintained jointly, reconciliation made monthly basis), audit reports available, Asset’s register, cash book, bank book, ledger book, payment register is maintain regularly.

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

**VII a. Project Manager**

The PM appointed in this project has done her BA in Sociology and is associated in since inception. The PM is doing multi-tasking but lacks direction too. She need to be trained on management skills as the team knows she is cooperative and multi-tasking so most of the work is been done by her.

**VIII b. ANM/Counselor**

Counselor position is filled and she is in this project from last 2 years. She has not received any training from MSACS and hene most of the documents like referral lip of VDRL and testing is not maintained properly.

**VIII d. ORW**

Of the sanctioned 5 Outreach workers, the project has 1 in place and the PM shared that MSACS have not disbursed the fund properly last one year and hence the project service suffers because of less or no Outreach workers in place. At present the project has only 1 ORW in place.

**VIII e. Peer educators**

The project at present have 19 Peer Educators in place of the sanctioned 20 and all are from the community. However capacity building of these Pes need to be done at regular intervals as they lack certain project related information and were unable to perform condom demostration. They also don’t do oral condom demonstration at field even though most of the KPs complain of doing oral sex.

**VIII f. M&E Officer cum Accountant**

The project have M & E cu accountant who is thorough with the excel data that she share with MSACS. With regards to account knowledge many SOE vouchers were not in place with proper PD approval.

1. **Services**
2. Of the 5 sanctioned Outreach workers the project has 1 in place covering the 1200 targeted population. It is observed that the team (ORW & Pes) through their regular one to one and group session is covering more than 1100 kps in a month. However the Peer activity is not documented.
3. The counselor conducts more than 3800 counseling session in a year however only 1487 ICTC testing is done against the target of testing twice a year. Of the said counselling session, only 260 times condom demonstration was showed by the counselor. The counselor has not received training from MSACS, however during the PO visit the training was provided.
4. STI screening is done for more than 5850 kps in a year. A matter of concern is there is no privacy given in most of the bars for STI screening and counseling but still the project team manages to cover 80% of the monthly STI clinic target. Condom social marketing is carried out but not in all project sites. The team itself feel that the KPs are used to the free condoms so they won’t buy.
5. More than 15500 free condoms and 7100 social marketing condoms are distributed by the team in a year. The team need to conduct condom gap analysis as it was observed that only 10% condoms are distributed against the need.
6. Micro plan for ORW sites was displayed but Peer Educator wise map is not mounted.
7. A total of 5050 RMC is done in a year which means more than 3 RMCs is done per KP.
8. The team claims that they have not detected any TB cases in their project area.
9. More than 2300 KPs in a year undergo Syphillis/RPR examination and none are reactive.
10. **Community involvement**

It was observed that the 19 bars are spread across the area of Panvel and kalamboli. The team covers more than 1100 kps in a month however the kps involvement in project is less. The kps are not involved in any of the formed committee (DIC, Clinic, Condom, advocacy, Project management). The Peer involvement in project is not much as their daily activity are not documented. However the project need to have capacity building training of their project team mates as most of them are still not carrying out condom demonstration effectively.

1. **Commodities**

Condom Social Marketing (CSM) depots list are not updated. More than 15500 free condoms and 7100 social marketing condoms are distributed by the team in a year. The team need to conduct condom gap analysis as it was observed that only 10% condoms are distributed against the need. It was observed that Condom social marketing is still not initiated by the team in many of the bars. The project had shortage of free condoms from MSACS for more than a quarter. The kps are facing issues with this condom as it’s less lubricative.

In last financial year the project faced shortage of most of the consumable like STI drugs, lab form, HIV test kit, condoms etc... The project team has requested and informed DAPCU about the same at various intervals however the reply received by them was MSACS has not delivered.

1. **XIII. Enabling environment**

The project have formed various committee but KPs are not involved much in it. The Peer Educators too are not involved in any committee. It was observed that the community participation in DIC is very poor as their project area of intervention in vast. (Panvel , kalamboli). The team with the help of DAPCU has helped more than 104 KPs to get their Aadhar card, Naukar nama. Few KPs children were helped for hostel boarding. The project has formed various committees (DIC, Clinic, Condom, Advcacy, etc). However, registers for each committee need to be maintained separately. The Peers or KPs are not involved much in the committee. The project team has not made any effort to involve the project related stakeholders in Project Management committee. Need based advocacy is not carried out in the project as the Peers and KP involvement in the project is not much. The team has developed good rapport with the bar owners however it need to be channelized properly for the project. The team need to conduct bar owners/ managers meet biannually as most of the condom depots, girls’ identity card (Naukar nama), health camps, etc.. need to be discussed.

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

The project team has helped more than 100 kps to get their Aadhar card and naukar nama identity card in bars.

**XV. Best Practices if any.**

The project team is very supportive and helpful. They believe in team work. The project team has helped more than 100 kps to get their Aadhar card and naukar nama identity card in bars.

**Annexure C**

**Confidential Reporting form C**

**EXECUTIVE SUMMARY OF THE EVALUATION**

**(Submitted to SACS for each TI evaluated with a copy to DAC)**

**Profile of the evaluator(s):**

|  |  |
| --- | --- |
| **Name of the evaluators** | **Contact Details with phone no.** |
| **Riji Nair** | **9819102146** |
| **Ms. Rohini Gorey** | **9819904452** |
| **Mr. Ravindra Kadam** | **9527029249** |
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| --- | --- |
| **Name of the NGO:** | **Lok Parishad (Unit 1)** |
| **Typology of the target population:** | **Female Sex workers bar girls** |
| **Total population being covered against target:** | **1200** |
| **Dates of Visit:** | **11th to 13th April 2016** |
| **Place of Visit:** | **Panvel** |

Overall Rating based programme delivery score:

|  |  |  |  |
| --- | --- | --- | --- |
| **Total Score Obtained (in %)** | **Category** | **Rating** | **Recommendations** |
| **Below 40%** | **D** | **Poor** |  |
| **41%-60%** | **C** | **Average** | **average** |
| **61%-80%** | **B** | **Good** |  |
| **>80%** | **A** | **Very Good** |  |

**Specific Recommendations:**

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| --- |
| 1. The team lack support from DAPCU- PO as we didn’t see any visit recommendation given to the tem in their visit register. 2. The team is good and need motivation on regular basis by the project head and PO- TSU 3. The PO need to train the Peers and ORW on condom demonstration and the typology they are providing service do indulge in Oral sex. 4. Project director need to involve KPs in project activities by forming self-help groups or skill building activity for them. |

**Name of the Evaluators Signature**

|  |  |
| --- | --- |
| Ms. Riji Nair |  |
| Ms. Rohini Gorey |  |
| Mr. Ravindra Kadam |  |
|  |  |