**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:**

Kranti Mahila Sangh community based organization-CBO established in 2008 with support of Niramay Arogya Dham under CORRODOR project which was supported but KHPT. With the help of K.H.P.T. & Niramay Arogya Dham Kranti Mahila Sangh is registered under “SOCIETY REGISTRATION ACT 1980” & “MUMBAI PUBLIC TRUST 1950 “on dated 20th Oct 2008 and membership of 1033 HRGs. CBO has their own Bank A/C & Pan card registered under 12A.

Kranti is working for rights, Health among sex worker community from last 2 year with support of C-FAR. Kranti is providing documents like Adhar Card, Ration Card, PAN Card to Sex work community and also for working to giving Social Schemes like Sanjay Gandhi Niradhar Yojana,Gharelu Kamgar Yojana,Sukanya Yojana,Bal-Sangopan Yojana at present ,Kranti is implementing Targeted Intervention Program me (HIV & STI Prevention Project),SWASTI (CBO Development Project ), Hasari Duniya (Empowering of HIV Affected & Infected Project).

As a CBO KMS enhanced capacities and started implementing activities independently. Maharshtra SACS acknowledge the services of KMS and awarded the TI Programme in 201. TI 2 progamme is implementing in 4 sites of solapur districts with 1132 HRGs.

**Name and Address of the Organization**

|  |  |
| --- | --- |
| Name and address of the Organization: | Kranti Mahila Sangh TI 2  Susang, Dr. Swami, V.S., E-3, Mantri Chandak Park, Vijapur Road, Solapur |
| Chief Functionary: | Smt. Kashibai Jadhav |
| Year of establishment: | 2008 |
| Year and month of project initiation: | 2012 |
| Evaluation team: | M. Ramesh-Team Leader  Dr. Manisha Gore – Evaluator  Surwase Vikrant (DAPCU Accountant) – Finance Evaluator |
| Time frame: | 14th to 16th April 2016 |

* **Profile of TI**

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

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

Size of Target Group(s): 1100 (FSW-1000 and MSM-100)

Target Area: Tembhurni, Barshi, Khurdwadi and Mohol of Solapur district

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of the Site** | **FSW** | | | | | **MSM** | | | | **Grant Total** |
|  | **BB** | **HB** | **TT** | **DB** | **Total** | **Koti** | **DD** | **TG** | **Total** |  |
| Barshi | 236 | 131 | 6 | 25 | 398 | 11 | 14 | 25 | 50 | 448 |
| Kurdhwadi | 14 | 16 | 0 | 0 | 30 | 4 | 0 | 13 | 17 | 47 |
| Mohol | 28 | 267 | 0 | 0 | 295 | 0 | 0 | 6 | 6 | 301 |
| Tembhurni | 10 | 131 | 118 | 69 | 328 | 0 | 0 | 8 | 8 | 336 |
| Grand Total | 288 | 545 | 124 | 94 | 1051 | 15 | 14 | 52 | 81 | 1132 |

**Key findings and recommendation on Various Project Components**

1. **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…**

CBO was started with the community empowerment and awarded with the TI programmes. It is appreciated that CBO is supporting financially in crisis which is helping to retain the staff and providing the services to HRGs.CBO has good expertise and experience in T programme implementation but not evidenced. CBO support is to the project is poor as project director involvement was not visible and advocacy activities were not planned and conducted. CBO body members monitoring is also poor.

1. **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

At the time of evaluation all the positions were filled as per the proposal except one peer educators. Huge staff and peer educators’ turnover was evidenced in all positions and replacement was not done in time. Experienced and energetic staffs are there in the project but they are not aware of their roles and responsibilities which were reflected in field implementation. The staff requires training in all components of TI and respective modules.

The appointment orders and JDs were not available at project level and not issued to project staff. The staff is not having clarity on their roles and responsibilities. The understanding level of project team and conceptual clarity regarding the project needs improvement. Monitoring and supervision in all levels is comparatively poor. Field visits of the project staff is not up to the mark and support to the field staff is very poor.

Field visit dairies maintenance is also poor and not documenting in detailed. The documentation at all levels need improvement such as recording the minutes of the meeting, reviewing, action taken report, future action plans, updating of micro plans with logical approach, filling of B forms. Only 1 Community member was positioned as ORW.

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

Project Manager, Counselor and ORWs are well qualified very much experienced but in practical it was not evidenced in the implementation. Moreover the project is implementing by the CBO which has vast experience but NACO guidelines are not following. Formal trainings were conducted during the contract period to any of the project staff. TI doesn’t have any proper structure for induction program for the project staff. The entire project team requires capacity building in especially on NACO guidelines, various areas, therefore it is recommended that training programmes need to be conducted on induction and respective modules. It is highly recommended to provide necessary trainings.

* 1. **Infrastructure of the organization**

Project is implementing in Barshi, Mohol, Tembhurni and Kurdwadi sites which are more than 70 km away from Sholapur but operating from Sholapur. KMS has 2 DICs each at Barshi which is having good infrastructure with sufficient space for the staff, clinic, DIC and moreover it’s not community friendly and 2nd one at Tembhurni which is having poor infrastructure. All the assets procured though grant fund was entered in to a separate stock book and identification codes were given to each of these items.

* 1. **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**.

Documentation and Report system is in place as per the protocols but quality of documentation is need to improvement. Master register is not available in soft copy and up dation is questionable. Review meetings are happening but project performance review and planning is not happening and support/feedback mechanism is poor. Monthly and weekly meetings are not happening regularly. Monitoring elements and Qualitative reporting system needs to be improved such as more information regarding the projects progress and lessons learned may be projected. Documentation training needs to be provided to project team. Field level monitoring system needs to be strengthened. Feedback loop needs to be inbuilt in the project.

**Programme Deliverables**

**Outreach**

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

Line listing of the HRGs was done but majority of HRGs Form A are not available with the project. Also line list was not updated

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

Not Applicable

1. **Registration of truckers from 2 service sources i.e.STI Clinics and Counseling.**

Not Applicable

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

ORW wise micro planning is in place but Counselor is not maintaining. Micro planning is not reflecting in the in reaching the community as Outreach plan was not preparing. ORW has only monthly wise due list and mobilizing for the services in group instead of through outreach based on the prioritization of risk and vulnerability. Documentation is also poor as micro plan is not updating weekly.

1. **Coverage of target population (sub-group wise); Target/Regular Contacts only in HRGs**

As per the agreed contract the target of HRG is 1100 and project was able to reach out to 1213 HRG during the project period. As per the available records, the project was able to reach out 90% of HRG on regular basis at least two times in a month but quality is missing in outreach regular outreach is not happening by PEs and also support supervision by the ORWs. 181 new HRGs were registered during 2015-16

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

Outreach planning is not maintaining and ORWs were not able to plan for PEs which is affecting the quality of outreach. ORWs are not preparing any specific outreach plan based on the prioritization of High Risk, STI and ART follow up and just they are reaching the HRGs who they met. Though all the ORWs are visiting the hotspots for providing support to the PEs but in practice they are doing OR instead of PEs and the visits are not properly planned. Further Outreach plans may be prepared with logical approach prioritizing HRGs for service delivery.

1. **PE: HRG ratio:**

PE: HRG Ratio is maintaining as per the NACO guidelines and noticed huge variance in PE:HRG ratio and also in ORW:HRG ratio as follows. More than 25% of PEs has less than 1: 50 HRG ratio and more than 25% PEs has more than 1:80 HRGs

|  |  |  |  |
| --- | --- | --- | --- |
| **No.** | **Name of the Peer Educator** | **No. of HRGs** | **%** |
| 1 | HEENA SHAIKH | 70 | 116.67% |
| 2 | URMILA BHAKHARE | 96 | 160.00% |
| 3 | UMA MANE | 88 | 146.67% |
| 4 | ASHWININ GHODASE | 30 | 50.00% |
| 5 | RUKMINI SUTAR | 62 | 103.33% |
| 6 | JANNAT MUJAWAR | 75 | 125.00% |
| 7 | TARABAI DHUMAL | 54 | 90.00% |
| 8 | SULTANA SHAIKH | 49 | 81.67% |
| 9 | MANDA UGHADE | 39 | 65.00% |
| 10 | NEETA MOHAN KADAM | 74 | 123.33% |
| 11 | SHUBHANGI GAVADE | 63 | 105.00% |
| 12 | SHEETAL SALGAR | 119 | 198.33% |
| 13 | POOJA CHAVAN | 79 | 131.67% |
| 14 | MINAKSHI NAIK NANWARE | 75 | 125.00% |
| 15 | ASHA VIRAGE | 78 | 130.00% |
| 16 | DUTTA RANI KHANDAGALE | 81 | 135.00% |
|  |  | 1132 |  |

|  |  |  |
| --- | --- | --- |
| ORW | Coverage HRG No. | % |
| ORW1 | 166 | 66% |
| ORW2 | 358 | 143% |
| ORW3 | 295 | 118% |
| ORW4 | 232 | 93% |
| ORW5 | 81 | 32% |
|  | 1132 |  |

1. **Regular contacts (as contacting the community members by the outreach** **workers/Peers at least twice a month and providing services as 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.**

Regular contacts performance shown as more than 95% but ORWs/Peer educators’ field visit days are very less as 5 to 8 days in the month. ORWs/PE are not doing individual outreach and distributing condoms in group. The effectiveness of OR is poor as the project witnessed 7% of STI cases and 1 HIV positive cases during the contract period. As per the TI records syphilis positivity is zero. The key population met during the evaluation process and it was noticed that the quality of RMC and other services is compromising. Even though the majority of the key population among whom we could meet expressed satisfaction with the services provided by the PEs.

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

Majority of the PEs are illiterates and are not trained, their documentation is maintaining by ORWs but core elements of planning and achievements are missing in the B form. Majority of the Peer educators are illiterate and suggested to ensure the maintenance of B form by them.

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

Peer educators capacities need to strengthened as the knowledge and skills are poor. It is observed that majority of peer educators are not having clarity on roles and responsibilities and also not aware of their risk and vulnerability which is affecting the quality of peer education. The Education and key messages are not effective which is impacting on the HRGs knowledge, skills levels and on service delivery. The Peer education is not focusing on behavior change to create the demand for services but ORWs/PEs are bringing the HRGs who met in the field/office without the need and prioritization. It was noticed that condom negotiation skills of HRGs are very poor.

Presently project is having 16 peer educators on board and more than 10 PEs were not utilized RMC/ICTC/RPR services which indicate their behavior change which influence their peers. It was also noted that few of the Peer Educators are not able to demonstrate condom properly during the interaction. Review meetings are not happening regularly. Therefore project shall take a serious note of the same and provide necessary training to all PEs to handle the BCC sessions effectively and make it result oriented. Outreach team need to be equipped to assess the various behavior change barriers and condom usage barriers’ existing among the HRG and accordingly necessary knowledge, skill and support has to be provided to ensure sustained behavior change among the HRG.

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

Monitoring and Supervision in all levels is very poor. Project Managers, Counselors and ORWs field visits are very low which is affecting the support supervision and quality of the services. From the discussions with ORWs it was found that they are also giving same type of information to the HRG rather than monitoring and providing field level technical support to PEs. Therefore the project needs to concentrate more on supportive supervision and also shall document the same. The weekly meetings of PEs are not conducting which need to materialize. The quality is not visible in all the reviews and POs recommendations were also not implemented. All the monitoring meetings shall be taken seriously and as far as possible MECA, Project Manager and ANM present in these meetings shall provide data analysis and feed back to the OR team.

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

STI services are providing through the PPP/camp and Government health facilities. Dr. Susane is providing the services but he is not qualified (BAMS) and also not trained on SCM approach. During the interaction with Medical Officer, it is observed that the team (Medical officer, Counselor, ORW and PE) will travel together to Barshi, Timbhurni, Kurdwadi which are more 75 km from Sholapur. Clinics are conducted in the DICs and STI services are providing in the field through camp mode without basic essential requirements i.e. bed, speculums, privacy and etc. Medical officer said Internal examination is happening and used speculums are carrying to Sholapur for sterilization but it was observed that internal examination is not happening and noticed that un-sterilized speculums.

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

Clinics are conducted in the DICs and STI services are providing in the field through camp mode without basic essential requirements i.e. bed, speculums, privacy and etc. Medical officer said Internal examination is happening and used speculums are carrying to Sholapur for sterilization but it was observed that internal examination is not happening and noticed that un-sterilized speculums.

Kit 1, Kit4, and Kit6 drugs are available. RPR Kit stock is not matching with stock register as 226 stocks was there but physical stock was only 200 kits.

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 the use of revolving funds.**

Not Applicable

1. **Quality of treatment in the service provision-adherence to syndromic treatment protocol, follow up mechanism and adherence, referrals to VCTC, ART, DOTS centre and community care centers**.

Project is not adhering to syndromic case management protocol in PPP clinic as the doctor is not trained in SCM and also not qualified. Follow up of the STI cases at field level and clinic level is poor. PLHIV follow up is very poor and most of linked PLHAs are in LFU. Since inception project had 84 PLHAs and but only 34 PLHAs are there with the project and among them majority are LFU for ART services. The project shall take necessary steps to identify all cases and strictly referred them for ART and necessary follow up through PEs or ORWs shall be initiated. No linkages with the DOTs and no activity on TB verbal screening and referrals to DOTs.

Out of 168 new HRGs identified but only 104 HRGs were prescribed with PT. On the other side more than 95% of the HRG are regularly reached by the project for providing services, but these contacts are not able to motivate and bring the HRG for quality service uptake. This denoted the quality of communication, effectiveness of the peer education process, monitoring and tracking system in the project.

Counselor is not trained and he is unable to provide counseling services to the HRG who are coming for the clinics and field visits are also very limited that to without any specific plan.

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 officials documents in this regard.**

Documentation is very poor and found gaps in the registers. Referrals mechanism is also poor and not filing all columns in the referral form and some of the referral forms evidenced with empty.

Stock management is not maintaining properly as variances noticed in RPR kits and free condoms stock. 26 RPR kits stock deficit and 9500 excess condoms variance noticed. Meetings registers are maintaining with same minutes and missing qualitative information.

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

Free and Social marketing condoms are promoting through the Peer education and outreach. Condom distribution in the field is very poor. The project is not maintaining the buffer stock as present stock is only nil stock where as the project monthly requirement is 69000 per month. Project is not accountable in condom distribution and stock management as 9500 are excess stock which was not noticed since 3 months.

1. **No. of condoms distributed through outreach/DIC.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | FSW | | | MSM | | |
|  | Free | | SMP | Free | | SMP |
|  | Demand | Distribution |  | Demand | Distribution |  |
| 2014-15 | 906636 | 929702 | 103418 | 11176 | 11484 | 172 |
| 2015-16 | 818860 | 649642 | 74675 | 11056 | 10134 | 486 |

1. **No. of Needles/Syringes Distributed through outreach/DIC.**

Not Applicable

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

Project team relations and linkages are not visible except ICTC. No linkages were established with the DOTS.

1. **Referrals and follows up.**

Referral system is in place but very poor. Referral slips are not filling completely and results are not updating in the referral slips and registers. Some of the referral forms evidenced empty and not found in the services centers. Follow up of STI and PLHIV is very poor.

1. **Community participation:**
2. **Collectivization activities: No. of SHGs/Community groups/CBO’s formed since inception, perspectives of these groups towards the project activities.**

Being a CBO, collectivization activities not conducted and noticed only two committees are formed but not in active.

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

Project was conducted 4 awareness generation events and more than 100 HRGs participated. Community participation not witnessed in community mobilization activities which will help to reach more population with qualitative services.

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

The service facilities are accessible but the linkages are not established up to the mark. Project team relations and linkages are not visible except ICTC. No linkages were established with the DOTS. The involvement of NGO needs to improve in enabling the project to establish the linkages.

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **1st Half Year** | | **TOTAL** | **Second Half Year** | |
|  | **FSW** | **MSM** |  | **FSW** | **MSM** |
| 2014-15 | 914 | 47 | **961** | 911 | 17 |
| 2015-16 | 981 | 60 | **1041** | 710 | 48 |

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

The project linkages health service providers are good. It was observed that project is not involving other stakeholders in this direction to support the HRG

1. **Financial system and procedures**
2. **System of planning: Existence and adherence to NGO-CBO guidelines/any approved systems endorse by SACS/NACO-supporting officials communication.**

Utilization of budget against grant is 98%, indicating and excellent spend rate. System planning and adherence to NGO guidelines exists, no budget head has been exceeded

1. **Systems of payments** - **Existence and adherence of payments endorsed by SACS/NACO, availability and practice of using printed and serialized vouchers, stock and issues registers, practice of setting of advances before making further payments.**

* It is observed all the payments are under the SACS guidelines and approved by the Project Director TI.
* The Vouchers are printed and is serialized Nos.
* The cash in hand Maintained as per the guidelines below Rs. 5000/-
* Asset register is maintained and duly coded

1. **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.**

* During the review period, there was new purchase of assets. Procurement committee in place

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

* Separate bank account for the TI is maintained
* Salary aquitance register is maintained but signatures putting without revenue stamps.
* BRS maintained by month wise, and Audit Reports are available with the TI

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

**VII a. Project Manager**

Project Manager Ms. Renuka Jadhav is joined 2 years old in the project and very much experienced in the TI programme but not reflected in the programme. She is not aware on NACO guidelines and required capacity building on Progamme management, and guidelines. It was observed that her learning attitude is very poor. Monitoring the programme and support supervision is very poor which need to strengthen immediately.

**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 Mr. Girish joined in February 2016 and new to project but he has 2 years experience in same position in Migrant intervention. His experience was not witnessed in the field and his involvement is very poor. He required to capacity building on TI program and basic counseling skills. Documentation is also very poor.

**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.**

5 ORWs are in place and majority of them are experienced in TI programme. ORWs are not having clarity on their roles and responsibilities and also on project services. Outreach plan of PEs are not in place not prioritization in outreach. It was noticed that field visits are very low and support to the PEs is not visible.

**VIII e. Peer educators- Prioritization of hotspot, importance of RMC and ICTC testing, condom demonstration skill, knowledge about condom depot, symptoms of STI, knowledge about services facilities etc.**

16 Peer Educators were on board and huge turnover noticed. Their knowledge levels very poor and even they did not aware about project services and also about the risks of HRGs and themselves. Further more than 50% PEs have not availed the project services for the last six months. All of them required training of Induction and respective modules on priority basis

**VIII f. Peer educators in IDU TI** -Prioritization of Prioritization of hotspot, importance of RMC and ICTC testing, condom demonstration skill, knowledge about condom depot, symptoms of STI, working knowledge about abscess management, local drug abuse scenario, de-addiction facilities etc.

Not Applicable

**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 priorities the networks/locations where migrants work/reside/access high risk activities, whether the peers are able demonstrate condom, able to plan their outreach, able to manage the DIC’s/health camps, working knowledge about symptoms of STI, issues related to treatment of TB, service in ICTC & ART.**

Not Applicable

**VIII h. peer educator in Truckers Project-Whether the peers represent ex-truckers, active truckers, representing other important 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

**VIII j. M&E Officer-Whether the M&E officer (FSW & MSM/TG TIs with more than 800 population and all migrant TIs are eligible for separate M&E officer) is able to provide analytical information about the gaps in outreach, service uptake to the project staff. Whether able to provide key information about various indicators reported in TI and STI CMIS reports.**

M&E officer Ms. Jyothi was joined in May 2015 and she has knowledge on programme. She was not aware about her roles and responsibilities which was reflected in the tracking of HRGs through outreach by the PEs/OREWs.

**Ix a. Outreach activity in core TI project-Interact with all PEs (FSW, MSM and IDU) interact with all ORW’s 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 services uptake that is whether enough clinic footfall, 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

1. **Services**

Overall, the project is providing services without any logic/prioritization and quality part is very poor. Outreach plan need to prepare and replicate in the field and also counseling component need to strengthen immediately.

1. **Community involvement-How the TI has positioned the community participation in the TI, role of community in planning implementation, Advocacy, monitoring etc.**

Community involvement in the program is not visible. The committees which were formed are not active. Being a CBO, the project need to focus on community involvement in project activities.

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

Condom Gap analysis done but quality was missed. During the field visit, it is observed either PEs or HRGs not having condoms and project is not having buffer stock as present stock is only Nil condoms where as demand is 69000 per month.

1. **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.**

Organization is not putting efforts to provide the conducive environment for HRGs which is reflecting on the HRGs behavior change. The project has to focus on establishing good rapport with primary and secondary stakeholders for creating conducive atmosphere for the HRGs.

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

Project succeeded in providing the social entitlements to 30% of HRGs.

**XV. Best Practices if any.**

Nil

**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.** |
| M. Ramesh | **9963470855 ramtaneek@gmail.com** |
| Dr. Manisha Gore | **9763345091 manishagr755@gmail.com** |
| Surwase Vikrant (DAPCU Accountant) – Finance Evaluator |  |
| Officials from SACS/TSU (as facilitator) | Mr. Bhagawan Bhusari-DPO |

|  |  |
| --- | --- |
| **Name of the NGO:** | Kranti Mahila Sangh |
| **Typology of the target population:** | Core Composite-FSM,MSM |
| **Total population being covered against target:** | 1132 out of 1100 |
| **Dates of Visit:** | 14th to 16th April 2016 |
| **Place of Visit:** | Tembhurni, Barshi and Sholapur |

Overall Rating based programme delivery score:

|  |  |  |  |
| --- | --- | --- | --- |
| **Total Score Obtained (in %)** | **Category** | **Rating** | **Recommendations** |
| Below 40% | D | Poor | Recommended for discontinuation |
| **41%-60%** | **C** | **Average** | **Recommended for continuation for 3 months and further extended based performance/evaluation** |
| 61%-80% | B | Good | Recommended for |
| >80% | A | Very Good | Recommended for continuation with specific focus for developing learning sites. |

**Specific Recommendations:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Overall the project has been functioning within the guidelines, 2 day visit has given the evaluators a limited scope to understand the program for recommending following points:**   | **Observation** | **Recommendation** | | --- | --- | | * Line list and Micro Plan is in place but not updated * HRGs form A are not available | * Regular updation of line list and Micro plan * Form A should be maintained and filed securely for future references | | * Weekly Outreach plan is not in place – Monthly due list is preparing but no prioritization of risk and vulnerability * CGA and Risk assessment was not updated | * Weekly outreach plan should be prepared on risk and vulnerability * CGA and risk assessment should be updated and can be used for outreach plan | | * Outreach by the Peer education and ORWs very poor and it was noticed that field visits are very less as 5 to 7 days in the month – affecting the quality of services | * ORWs should visit the field regularly and support the peer educators for quality services | | * Project implementation is in Barshi, Tembhurni, Kurdwadi and Mohol but project is operating from Sholapur which is more than 75km. * ORWs are staying in Sholapur and traveling to sites which affecting outreach and quality of services | * Outreach workers should stay in respective sites which helps in regular field visits * Shifting of project office from Sholapur to Barshi or Timbhurni immediately | | * Clinical services are providing through camp based in sites * Medical officer, Counselor and ORW are travelling from Sholapur to clinical sites which are more than 75 km * Medical officer qualification is BAMS and untrained * Internal examination is very poor * Clinical services places does not have any basic infrastructures ie. Table, lamp, gloves, water and etc. | * PPP clinics can be established locally and can be utilized the services in their clinics * Medical officer qualification can be reviewed and training should be provided on SCM * Internal examination should done * Tembhurni DIC can be shifted and search for new DIC with good infrastructure for even clinic setup | | * Counselor is experienced but counseling services and follow up is very poor | * Counseling should be strengthened * Follow up mechanism should be developed and strengthened * Counselor should be trained on counseling component and also on guidelines immediately | | * Documentation is good but need to strengthen * DIC register is not maintaining regularly | * Documentation need to strengthen as information of performance, learning’s, challenges, strategies and important elements also should be captures * DIC and Hot spot meetings minutes should maintained well and updated regularly | | * Referral system in place but very poor as majority of referrals completely not filled and some of the referrals evidenced empty * Referrals are not matching with the service centers and some of referrals not found * Referrals register is not updated | * Referrals should be filled completely and triplicate copies should be maintained * Referral register should be updated regularly | | * It was noticed that more than 90% of HRGs availed clinical, ICTC, RPR services but referrals/reports are not available in the project | * Clinical reports should be collected and filed in the individual HRG clinical files | | * Community mobilization not evidenced in the project | * Community committees should formed and strengthened | | * Condom distribution is distributing in group but not as per demand | * Condom distribution should be streamlined and ensure to reach all HRGs as per the demand | | * Condom and RPR kits Stock management is poor as 26 RPR kits shortage and 9500 condoms excess noticed * Condom buffer stock not maintaining | * Stock management should done regularly * Condom stock should monitored and planned for buffer stock | | * Monitoring and support supervision is poor   + Project manager field visits are less and project level registers/reports monitoring also not evidenced   + ORWs monitoring and support also not evidenced | * Monitoring and support supervision should be strengthened in all levels | | * Awareness on NACO guidelines is poor - CBO/Project staff not aware | * CBO/Project staff should keep all guidelines and get awareness | | * Project is also working with tamasha artists but outreach and clinical services are poor * Working since 2 years but new girls Tamasha artists were not registered * Tamasha artists sites are very long | * Review the work with Tamasha artists | | * New HRGs are available in field but identified and registered | * Outreach should be strengthened and focus on new HRG identification and registration | | * ORW/PE:HRG ratio is not as per guidelines | * ORW/PE:HRG ratio can be reviewed and revised based on accessibility of Peer education | | * 60% of Peer educators are more than 30 years age | * Peer educator placement can be reviewed and guidelines followed | | * Peer educators knowledge and skills are very poor | * Regular training should be provided | |

**Name of the Evaluators Signature**

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| M. Ramesh |  |
| Dr. Manisha Gore |  |
| Surwase Vikrant (DAPCU Accountant) – Finance Evaluator |  |