**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:**

Niramaya Arogya Dham nonprofit organization established in 1991 having vast experience in implementation of HIV prevention programs. Till date, organization has implemented many health programmes, acknowledged by funding agencies and awarded HIV interventions. The vision of the organization is “To improve the health and quality of life of people.” NAD formed 2 CBOs and strengthened them to manage the Interventions independently. Kranti Mahila Sangh FSW CBO and DOSTANA MSM CBOs are implementing the targeted interventions in Sholapur district.

**Name and Address of the Organization**

|  |  |
| --- | --- |
| Name and address of the Organization: | Niramaya Arogya Dham TI 1  15/C, Navi Peth, Gold Finch Peth, Behind Saraswati Book Depo, Solapur - 413 007 |
| Chief Functionary: | Dr. Seema Kinikar |
| Year of establishment: | 1991 |
| 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: | 23rd to 25th 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): FSW 1500

Target Area: Solapur and Akalkot of Solapur district

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Sub Typology** | | | | **Risk Volume** | | | |
| BB | HB | SB | **Total** | High | Medium | Low | **Total** |
| 37 | 1245 | 158 | **1440** | 17 | 89 | 1334 | **1440** |

**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…**

Organization was started with the aim of improve the health and quality of life of people and implemented many health awareness programmes. It has vast experience in implementing the FSW and MSM community programmes and has empowered and capacitated them to independently manage the interventions. Doctors and philanthropists are the body members of the organization and extend their support by understanding and addressing the needs/issues of communities. Organization president is the Project director for the intervention.

The organization have succeeded in advocating the non-sexual health needs of HRGs; provides ration cards, employment cards, sewing machines etc. Vocational trainings are provided in sewing, knitting and etc.

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 positions were filled as per the contract. 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 are available at project level but not distributed to staff, for which they do not have 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 poor. Field visits of the project staff are not effective and support to the field staff is 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.

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

The staff is qualified and experienced. They have experience in project implementation but it was observed that they do not follow NACO guidelines. Formal trainings were not 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 Solapur and Akalkot sites and has good infrastructure in Solapur office with good furniture, separate clinic, DIC and sufficient space of office. 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 available in soft copy. Review meetings are happening with specific agenda and reviewed the project performance and plan for next month but support/feedback mechanism is poor. 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 documented. 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 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 reaching the community as outreach plan was not prepared. ORW has 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 poor as micro plan is not updated 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 1500 and project was able to reach out to 1440 HRG during the project period. As per the available records, the project was able to reach out 95% 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. 38 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 having monthly due list for service and mobilizing the HRGs as per the due list but weekly outreach plan is not preparing. Further Outreach plans may be prepared with logical approach prioritizing HRGs for service delivery.

1. **PE: HRG ratio:**

PE: HRG ratio is maintained as per the NACO guidelines

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **No.** | **PEER Name** | **Line List** | **%** |  | **No.** | **Name of the ORW** | **HRGs** | **%** |
| 1 | Mahadevi More-2 | 53 | 88% |  | 1 | Mukund Kadam | 263 | 105% |
| 2 | Janabai Babare-1 | 52 | 87% |  | 2 | Anil Bagale | 221 | 88% |
| 3 | Sojar Phulsundar-3 | 54 | 90% |  | 3 | Yuvraj Chabukswar | 278 | 111% |
| 4 | Sharada Kamble-4 | 52 | 87% |  | 4 | Meena Mane | 243 | 97% |
| 5 | Chatura Randive-5 | 52 | 87% |  | 5 | Shashikala Sakhare | 226 | 90% |
| 6 | Sunanda Badure-6 | 65 | 108% |  | 6 | Sapna Chilvery | 209 | 84% |
| 7 | Surekha Kamble-7 | 68 | 113% |  |  | Total | 1440 |  |
| 8 | Mahadevi Bansode-8 | 49 | 82% |  |  |  |  |  |
| 9 | Surekha Ucche/Chavan-9 | 39 | 65% |  |  |  |  |  |
| 10 | Anuradha Konda-10 | 70 | 117% |  |  |  |  |  |
| 11 | Shakuntala Safar-11 | 62 | 103% |  |  |  |  |  |
| 12 | Shakuntala Yedur-12 | 59 | 98% |  |  |  |  |  |
| 13 | Ambika Bichal-13 | 34 | 57% |  |  |  |  |  |
| 14 | Nagmani Jakkan-14 | 53 | 88% |  |  |  |  |  |
| 15 | Padma Chityal-15 | 63 | 105% |  |  |  |  |  |
| 16 | Renuka Mettu-16 | 59 | 98% |  |  |  |  |  |
| 17 | Minakshi Mamdyal-17 | 60 | 100% |  |  |  |  |  |
| 18 | Radha Sherla-18 | 61 | 102% |  |  |  |  |  |
| 19 | Vijaylaxmi Chilmeti-19 | 46 | 77% |  |  |  |  |  |
| 20 | Ambika Mandal-20 | 43 | 72% |  |  |  |  |  |
| 21 | Nilabai Sutari-21 | 67 | 112% |  |  |  |  |  |
| 22 | Shridevi Sutar | 70 | 117% |  |  |  |  |  |
| 23 | Rekha Birajdar-23 | 65 | 108% |  |  |  |  |  |
| 24 | Anuradha Pola-24 | 67 | 112% |  |  |  |  |  |
| 25 | Chatura Matpati-25 | 77 | 128% |  |  |  |  |  |
|  | Total | 1440 |  |  |  |  |  |  |

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 is shown as more than 95%. The effectiveness of OR is poor as the project witnessed 5% of STI cases and 6 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 as internal examination is not happening. 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 literates and are not trained, their documentation is maintained by ORWs but core elements of planning and achievements are missing from 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 have good knowledge on HIV/STIs and project services but key messages are not imparted to the community and also condom negotiation skills were found to be poor. It is observed that majority of peer educators are 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 is 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 25 peer educators on board. 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 not qualitative and 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 7 PPP/camp and Government health facilities. Dr. Mahesh, Dr. Aruna, Pallavi, Dr. Rajesh, Dr. Sudharani, Dr. More and Dr. Ayyar are PPP doctors and their qualification is BAMS and required training on SCM approach. HRGs are referring to PPP clinics for RMC services directly by ORWs but without counseling. During interaction with the Doctors, it was noticed that internal examination is not happening to all HRGs.

1. **Quality of the services-infrastructure (clinic, equipment etc), location of the clinic,** **availability of STI drugs and maintenance of privacy etc.** PPP clinics are established near to the project sites and very much accessible to the HRGs. ORW/PEs are accompanying the HRGs and taking them to clinics for clinical services. Infrastructure in the PPP clinics are not as per the guidelines and even doctors are not aware on NACO guidelines. Privacy is maintaining in some of the clinics and STI drugs are available with PPP doctors. Drugs are matched with the stock register and physical stock.
2. **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. Follow up of the STI cases is poor as 37 STI cases followed up among 84 STI cases. PLHIV are linked with ART. The project shall take necessary steps to identify all cases and strictly referred them for services and necessary follow up through PEs or ORWs shall be initiated. Government health facilities are there in the project area but linkages are very poor.

36 new HRGs identified and only 11 HRGs provided 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.

Counseling is not doing to the HRGs as HRGs are directly visiting the PPP clinics but mentioned that all HRGs were counseled in the counseling register.

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. Single referral slips are maintaining where as triplicate copies should be maintained.

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 17000 per month. 93% of the HRGs are in Low level risk behavior which has to reviewed and CGA has to be done qualitatively.

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **Demand** | **Distribution** | **SMP** |
| 2014-15 | 310732 | 310014 | 6414 |
| 2015-16 | 222224 | 147715 | 3516 |

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. DSRC services are available in Solapur civil hospital but project staff is not aware to utilize the RPR services in the DSRC and referring the HRGs’ to SMC ICTC for RPR testing.

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 not found in the services centers. Follow up of STI 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.** NGOs formed 2 CBOs and strengthened them to manage the interventions independently but the experience was not evidenced in the present intervention. Collectivization activities not conducted and noticed only two committees are formed but not in active.
3. **Community participation in project activities-level and extent of participation, reflection of the same in the activities and documents.** Project conducted 3 awareness generation events and more than 100 HRGs participated. Community participation was not witnessed in community mobilization activities which will help to reach more population with qualitative services.
4. **Linkages**
5. **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.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Year** | **Once tested** | **Twice tested** | **Never tested** |
| 2014-15 | 98% | 71% | 3% |
| 2015-16 | 92% | 70% | 2% |

1. **Support system developed with various stakeholders and involvement of various stakeholders in the project.** The project linkages health service providers are average. During the interaction with HRGs, it was noticed that crisis is happening at hotspots but project was noticed and not initiated any advocacy activities. Project is not involving other stakeholders like Police, Lawyers and etc. in this direction to support the HRG. Advocacy with government department is good and able to provide social entitlements to the HRGs. Some of the HRGs are got employment cards, Insurance cards and financial schemes.
2. **Financial system and procedures**
3. **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 97%, 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 Mr. Satish Rathode is well qualified and experience professional in TI programme but not reflected quality in the programme. He is not aware on NACO guidelines and required capacity building on Progamme management, and guidelines. 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 Ms. Geeta well qualified and experienced. Her knowledge is poor and 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.** All ORWs are on board and have experience in implementation of the TI programme which is replicated in the field implementation. ORWs’ knowledge, skills, clarity on their roles and responsibilities on project services are good. Field level support witnessed to Peer educators through ORWs field visits. Outreach plan of PEs are not in place no prioritization in outreach was observed.

**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.**

25 Peer Educators were on board and there is huge turnover noticed. Their knowledge, skills and project services are good. Knowledge on risk volumes is good. Condom demonstration skills are very good but negotiation skills need to strengthen. Outreach plan is not happening with the prioritization.

**VIII f. Peer educators in IDU TI** -

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.**

MECA Mr. Hemanth Goske is experienced and expertise which replicated in implementation. He is involvement was visible in the programme as he updating all information and providing the due list to the ORW/PEs time to time.

**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 pioneer in community empowerment and CBO strengthening, need to focus on community involvement in project activities. Project should focus on the advocacy issues, to provide conducive environment and also should make efforts to strengthen the monitoring component in order to provide the quality services to HRGs.

1. **Commodities-Hotspot/project level planning for condoms, needles and syringes. Method of demand calculation Female condom programme if any.** Condom Gap analysis is done but quality was missing. During the field visit, it was observed that either PEs or HRGs are not having condoms and project is not having buffer stock as present stock is only around 16000, condoms where as demand is 10000 per month. 93% of HRGs are in Low Level risk which need to review and qualitative CGA should be conduct again.
2. **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.** Project has good advocacy linkages with the Government departments and succeeded in providing the social entitlements which will help in reducing the risk behaviors. Crisis is taking place in the hotspots which needs focus on advocacy meetings. Linkages with other department of governments needs to be strengthen.

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

|  |  |  |
| --- | --- | --- |
| **S. N.** | **Name of the SCHEME** | **No. of HRG beneficiaries** |
| 1 | Sanjay Gandhi Yojna | 27(41 in process) |
| 2 | Kesari Ration Card | 44 |
| 3 | BPL Ration Card –NAD | 95 |
| 4 | BPL Ration Card –WCD | 158 |
| 5 | Income Generation | 100 |
| 6 | Aadhar Card | 126 |
| 7 | Bank Account | 186 |
| 8 | JAN-DHAN | 38 |
| 9 | Sewing Machine DPC fund | 55 |
| 10 | Vocational Training of Mehendi ,Purse Making and fashion designing | 66 |
| 11 | Other (PLHV Certificate & Caste Cert., Domicile Cert. etc) | 275 |
| 12 | Voter ID | 90 |
| 13 | Bandkam Kamgar Yojana | 67 |
| 14 | Gharelu Kamgar Yojana | 189 |

**XV. Best Practices if any.**

* Social Entitlement for HRG and PLHIV – Project succeeded in providing the social entitlements and the number is increasing year by year.
* Innovations
  + Skills Building Activities
  + Vocational Training
  + PLHA line list

**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:** | Niramaya Arogya Dhan |
| **Typology of the target population:** | Core Composite: MSM and TG |
| **Total population being covered against target:** | 932 out of 800 |
| **Dates of Visit:** | 23rd to 25th April 2016 |
| **Place of Visit:** | Garkhul, 70 Feet road, Market yard, |

**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 continuation |
| >80% | A | Very Good | Recommended for continuation with specific focus for developing learning sites. |

**Specific Recommendations:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** | | --- | --- | | * Weekly Outreach plan is not in place – Monthly due list is preparing but no prioritization of risk and vulnerability * As per the CGA, 93% of HRGs are in Low level risk which can be reviewed | * Weekly outreach plan should be prepared on risk and vulnerability * CGA and risk assessment should be done with qualitatively and can be used for outreach plan | | * Clinical services are providing in 7 PPP clinics without counseling * All PPP Medical officer qualification is BAMS and untrained * Internal examination is very poor | * Training should be provided to PPP clinic doctors and guidelines should be provided * Counseling component should be strengthened * Medical officer qualification can be reviewed and training should be provided on SCM * Internal examination should done | | * 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 buffer stock is not maintained | * Stock management should done regularly * Condom stock should monitored and planned for buffer stock | | * Monitoring and support supervision is poor | * 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 | | * Crisis incidences are taking place in the hotspots but project was not noticed * Coordination gap in between Field staff and Project Manager | * Coordination should be strengthened and crisis incidences should be addressed | | * Advocacy components is very poor | * Project director and organization should focus on advocacy issues and planned meetings | | * Government health facilities linkages and utilization of services are poor | * Strengthen the linkages and improve the utilization of services | |

|  |  |
| --- | --- |
| **Name of the Evaluators** | **Signature** |
| M. Ramesh |  |
| Dr. Manisha Gore |  |
| Surwase Vikrant (DAPCU Accountant) – Finance Evaluator |  |