TI Evaluation

Naisargik ( The Organization for Natural Care )

Truckers

State : Gujarat

Ahmedabad

Dates : 08 – 10 February, 2014

Evaluation Team :

Dr. Rajat Kumar Das - TL

Dr. Anand Solanki – Programme

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**Annexure: B**

**Reporting Format-B**

**Structure of the Detailed Reporting format**

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

**Introduction**

oBackground of Project and Organisation : ( **Naisargik – Truckers** )

The organization was initiated in 1997 with a focus on natural resources conservation, control of pollution, awareness generation on non conventional energy sources etc. It has received support from Governmneatl agencies such as NABARD and CAPART. This was followed by carrying out HIV AIDS programme for truckers in the current operational area.

oName and address of the Organization : **Naisargik ( The Organization for Natural Care )**

Main office : “ Snehkunj “, Mithiwav, opp. Hanuman Temple, Palanpur, Dist : Banaskantha, Pin :

385 001, Gujarat

Project Office : Opp. Sagar Hotel, Near Ujala Circle, Sarkhej, Ahmedabad

oChief Functionary: Ms. Hinaben Chauhan +91 8128683501

oYear of establishment : March, 1997

oYear and month of project initiation: March 2012

oEvaluation team : Dr. Rajat Kumar Das ( Team Leader ), Dr. Anand Solanki ( Program Evaluator ), ( Finance Evaluator ). Facilitator – Ms. Monali Shah : Ahmedabad SACS

oTime frame 30 June – 02 July, 2015

**Profile of TI**

(Information to be captured)

oTarget Population Profile: FSW / MSM / IDU / TG/TRUCKERS / MIGRANTS :

Truckers

oType of Project: Core/ Core Composite / Bridge population : Bridge Population

Bridge Population

oSize of Target Group(s) : 10,000 – Ten thousand

oSub-Groups and their Size : It was reported that about 30 % are from Rajasthan, 20 % is from Uttar Pradesh and the other major groups are from North India – Punjab, Haryana and Dehi and small groups from other states. However, based on estimates gleaned from field visits to all the sites it would be prudent to mention that the population size would not exceed 3, 000 or somewhat more.

oTarget Area : Sanathal Circle, Shantipura Circle, Sanand Cross Road, S. G. Highway, Ujala Circle and APMC market are the main sites of this project coverage.

**Key Findings and recommendations on Various Project Components**

**I. Organizational support to the programme**

Interaction with key office bearers, 2-3, of the implementing NGO/CBO to see their vision about the project, support to the community, initiation of advocacy activities, monitoring the project etc…

There is a Project Director – Prakashbhai Chauhan and is responsible for this project only and thus is providing project oversight. He seemed to be realistic and has understanding of project issues.

**II. Organizational Capacity**

1. Human resources: Staffing pattern, laid down reporting and supervision structure and adherence, role and commitment to the project, perspective of the office bearers towards the community at a large staff turnover

Most of the office bearers are local and the team is led by a male who was earlier the Counselor since the inception of the project and since a few months is the Project Manager. The lady M&E cum Accountant has over 15 years experience although she has joined this project since 9 months or so. The team has access to the target community and stakeholders. The organization does have laid down policies on Human Resource management and Financial rudimentary norms. There are three project ORWs of which one has left recently.

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

The capacity building aspects have been done to some extent during this project with the M&E cum Accountant and 2 ORWs trained. However, the Project Manager has received training earlier – 3 years ago under another project. PEs have also received some training. The Counselor and 1 ORW has not received any training.

3. Infrastructure of the organization

The organization does not have any land or building and both of it’s offices are rented. The project office is located in a good roadside position on the state highway and has adequate space and furniture. The organization has a computer and printer too and both are functional.

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

The project has a master register with updated information. Other documentation are maintained as per norms such as reporting formats, planning documents, registers as well as soft data which is stored in the project computer. When cross checked a sample target group linkages were found correct in the Counseling register, case sheets, master register and the other registers. There were use of whitener and ink smudging in quite a few of the registers and the method of documentation with regard to assets and medicine use needed improvement.

**III. Program Deliverables**

**Outreach**

1. Line listing of the HRG by category.

Line listing is maintained in the project office in software form with support from the ORWs. There were many short distance truckers who were frequenting the project halt sites routinely.

2. Registration of migrants from 3 service sources i.e. STI clinics, DIC and Counseling. :

3. Registration of truckers from 2 service sources i.e. STI clinics and counseling.

STI clinics in the form of health camps are done on an average of 20 per month and registrations are done there. However, categorization of the truckers with regard to source – destination, time of halt and frequency of visits were not mapped.

4. Micro planning in place and the same is reflected in Quality and documentation. :

Micro planning is in place and there is required documentation maintained as per norm. Some micro plan with maps are displayed on the project office walls too. However, planning on the basis of trucker group type with regard to halt and visit frequency is not well planned.

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

The staff team have developed rapport with the target groups that are frequent visitors and are able to reach out to a substantial portion. However, high risk assessment and mapping is weak.

6. Outreach planning – quality, documentation and reflection in implementation

The ORW team and PEs have developed rapport with the target groups and outreach planning is being done focused on the halt sites but location specific outreach planning is weak.

7. PE: HRG ratio, PE: migrants/truckers

There was maintenance of PE : Truckers ratio earlier but currently there is high turnover and lowered ratio with only 4 PEs available out of the 10 PEs sanctioned.

8. Regular contacts ( as contacting the community members by the outreach workers / Peers at least twice a month and providing services such as condoms and other referral services for FSW and MSM, TG and 20 days in a month and providing Needle and Syringes) - understanding among the project staff, reflection in impact among the community members

The project staff are able to maintain regular contacts with some of the shorter distance truck drivers as they frequently visit the halt sites.

9. Documentation of the peer education

The PEs do maintain their diaries and document essential information.

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

The PEs are aware of the basic messages and condom demonstration skills. However recent departure of a sizeable portion of the PEs have reduced field inputs. Along with this the fund folw problem has caused reduced mobility of the ORWs which is hampering the support to the PEs.

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

There is oversight by the organization’s senior management and mid level management by the project seniors is done through project meetings and regular supervision and monitoring. However, there is a lack of need based supervision plan. Also, the reduced mobility of ORWs caused by erratic fund flow to the organization has caused reduced field support.

**IV. Services**

1. Availability of STI services – mode of delivery, adequacy to the needs of the community.

The STI services are carried out through health camps organized at a frequency of 20 camps per month. The health camps are held for about 2 hours or so and counseling is also carried out during these camps. There is occasional static clinic which is operated in the project office. The clinic sites are the halt points including hotel compounds. However these camps could be more strategically planned with regard to halt timings as per the needs of the target community.

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

In the static clinic which is occasional there is adequate space with at least visual privacy between Counsellor and the physician. The outreach health camps are done with use of canopies / tents where privacy is difficult. In some sites the doctor is positioned in one transporter’s room while the Counselor is positioned in the tent nearby. There has been no stock outs and there is availability of medicines.

3. In case of migrants and truckers the STI drugs are to be purchased by the target population, whether there is a system of procurement and availability of quality drugs with use of revolving funds.

There is procurement of drugs but owing to low budgets the organization is now constrained to undertake procurements. The clients pay for the STI medicines and a revolving fund is operational and there is client willingness to pay.

4. Quality of treatment in the service provisioning- adherence to syndromic treatment protocol, follow up mechanism and adherence, referrals to VCTC,ART, DOTS centre and Community care centres.

There is a qualified local physician who is also experienced and regularly available in the health camps and also Syndromic management is followed as per norm.

5. Documentation- Availability of treatment registers, referral slips, follow up cards (as applicable- mentioned in the proposal), stock register for medicines, documents reflecting presence of system for procurement of medicines as endorsed by NACO/SACS and the supporting official documents in this regard.

Records are available as per norms. The registers are up to date. However, the stock register of medicines along with daily utilization could be changed to enable the user to be more efficient and less time consuming.

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

7. No. of condoms distributed- No. of condoms distributed through different channels/regular contacts.

There is availability of condoms in most of the various outlets visited and the project has set up 37 outlets of which 7 only are traditional. However, in one of the outlets ( Seema Hotel ) there was stock out of condoms during the visit. The project target was to do social marketing of 8 lakhs and 64 thousand condoms during 2014-15 along with support from PSI and the project team was able to do 33,191 during the same period taking into consideration that PSI data is not available. The revolving fund is Rs. 10,000 /-. It is apparent that the target is unrealistic or the PSI support is faltering and not adequate.

8. No. of Needles / Syringes distributed through outreach / DIC.

Not applicable.

9. Information on linkages for ICTC, DOT, ART, STI clinics.

The local ICTC is located at Sarkhej Community Health Centre which is about 1 and ½ kilometers away. There is good linkage with the local ICTC centre too but no DOTS linkage exists..

10. Referrals and follows up

Referrals were 6,600 in the 2014-15 with an average of 472 per month and out of that and follow up appears moderate with 1,092 tested during the same period and 1 was found to be positive. The case was linked to the ART centre. DOTS referrals have not been done.

**V. Community participation**

1. Collectivization activities: No. of SHGs/Community groups/CBOs formed since inception, perspectives of these groups towards the project activities.

Collectivization efforts have not yet been attempted.

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

Community participation is restricted to support in hosting health camps and there is acceptance of the staff.

**VI. Linkages**

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

Linkages have been established with the ICTC and STI testing facilities. Linkage with DOTS is non existent.

2. Percentages of HRGs tested in ICTC and gap between referred and tested.

High risk mapping and identification is not well taken up. The gap between referrals is that 6,600 were referred out of which 1,092 were tested.

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

There is good rapport developed with the different stakeholders including the Transport companies and the Hotels where the halt spots are located.

**VII. Financial systems and procedures**

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

No Deviations Recorded.

2. Systems of payments- Existence and adherence of payments endorsed by SACS/NACO, availability and practice of using printed and serialized vouchers, approval systems and norms, verification of documents with minutes, quotations, bills, vouchers, stock and issue registers, practice of settling of advances before making further payments.

The vouchers are manually made and numbered. Also cash balance was more than Rs 5000 many times during the year due to incomes gained by them.

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

No Deviations Recorded.

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

Audit Report For the year 2014-15 not yet finalized but their Queries are solved.

**VIII. Competency of the project staff**

VIII a. Project Manager

Educational qualification & Experience as per norm, knowledge about the proposal, Quarterly and monthly plan in place, financial management, computerization and management of data, knowledge about program performance indicators, conduct review meetings and action taken based on the minutes, mentoring and field visit & advocacy initiatives etc.

The Project Manager is experienced and has MSW qualification acquired in 2012. He has been associated with the project since inception, first as a Counselor and then recently promoted as Project Manager. He has good knowledge of project issues with team spirit but would need to develop strategic planning skills.

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

The Counselor is a male who has just joined and has little knowledge and skills on Counseling and would thus require training which could begin with on the job by peers especially Project Manager.

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..

There are 3 ORWs with one who has recently joined and is not formally received training. The ORWs are well versed with project issues, STI symptoms and ICTC testing. However, location specific planning is one of the weak areas.

VIII e. Peer educators

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

The existing PEs after a deluge of majority of PEs having left their positions are able to demonstrate the required skills.

VIII f. Peer educators in IDU TI

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

Not Applicable.

VIII g. Peer Educators in Migrant Projects

Whether the Peers represent the source States from where maximum migrants of the area belong to, whether they are able to prioritise the networks/locations where migrants work/reside/access high risk activities, whether the peers are able demonstrate condoms, able to plan their outreach, able to manage the DICs/ health camps, working knowledge about symptoms of STI, issues related to treatment of TB, services in ICTC & ART.

Not applicable.

VIII h. Peer Educators in Truckers Project

Whether the peers represent ex-truckers, active truckers, representing other important stake holders, the knowledge about STI, HIV, and ART.Condom demonstration skills, able to plan their outreach along with mid-media activity, STI clinics.

Majority of the Peer Educators are well experienced and have been around for more than two years. They have good skills as evidenced from their communication drills. The lady PE is mainly utilized for communication with the external centres apart from motivating the stakeholders. However, owing to lack of documentation their services are not adequately recorded.

VIII i. M&E officer

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

There is a lady M & E lady who has B.Com qualification and has considerable experience and is good with data storage and updation. She also has received training.

**IX. a. Outreach activity in Core TI project**

Interact with all PEs (FSW, MSM and IDU), interact with all ORWs. Outreach activities should reflect in the service uptake. Evidence based outreach plan, outreach monitoring, hotspot wise micro plan and its clarity to staff and PEs etc.

Not Applicable.

**IX. b. Outreach activity in Truckers and Migrant Project**

Interact with all PEs and ORWs to understand whether the number of outreach sessions conducted by the team is reflecting in service uptake that is whether enough clinic footfalls, 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.

Outreach services are to some extent hampered owing to short halt timings and inadequate location specific planning of activities.

**X. Services**

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

There is development of rapport by the staff amongst the target groups. HRG assessment and Counseling appears to be weak areas.

**XI. Community involvement**

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

Communities appreciate the staff work as well as project contribution. However, involvement could be enhanced if one of the staff at least could communicate in the southern languages.

**XII. Commodities**

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

The number of condom outlets is about 60 % of the planned target. Supply planning is found to be inadequate with stock out noted on one of the outlets visited. There is availability of STI drugs but the organization is now facing budgetary constraints.

**XIII. Enabling environment**

Systematic plan for advocacy, involvement of community in the advocacy, clarity on advocacy , networks and linkages, community response of project level advocacy and linkages with other services etc. **In case of migrants (project management committee) and truckers (local advisory committee) are formed and they are aware of their role, whether they are engaging in the programme.**

The organization has not set up a local advisory committee.

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

None

**XV. Best Practices if any**

NIL