**TI Evaluation**

**All India Institute of Local Self Government**

IDU

State : Gujarat

Ahmedabad

Dates : 06 July – 08 July, 2015

Evaluation Team :

Dr. Rajat Kumar Das - TL

Dr. Anand Solanki – Programme

Ms. Vruti Patel. - Finance

**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 : ( **All India Institute of Local self Government – IDU** )

The organization which is a self financed and supported by the Government was initiated in 1926 with a focus on research and training of different functionaries such as Sanitary inspectors, clerks and accountants of the Ahmedabad Municipal Corporation.

oName and address of the Organization : **All India Institute of Local self Government**

Main office : Barfiwala, Khanpur, near Kama Hotel, Ahmedabad, Gujarat

Project Office :including DIC : Uthwali Chali, Gautam Nagar char Rasta, Beherampura, , Ahmedabad - 380022

oChief Functionary: Executive Dirctor- Nachiket Dhruva +91 792560 1296

oYear of establishment : March, 1926

oYear and month of project initiation: June 2013

oEvaluation team : Dr. Rajat Kumar Das ( Team Leader ), Dr. Anand Solanki ( Program Evaluator ), ( Finance Evaluator ). Facilitator – Ms. Jignasha Panchal, Dy. Director: Ahmedabad SACS

oTime frame 06 July – 08 July, 2015

**Profile of TI**

(Information to be captured)

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

IDU

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

Core Population

oSize of Target Group(s) : 400 – Four Hundred

oSub-Groups and their Size : It was reported that about 90 % are Muslims, around 5-10 % are Migrants and about 40 % are in the age group of 25 – 40 years range. About 80 % use brown sugar antihistaminic ( avil ) mix. All are males and currently one is an MSM and is also an HIV positive. Another similar nature person has died.

oTarget Area : There are 26 hotspots which is spread over and scattered in 09 areas in the city : Shahalam, Lal Darwaza, Gomtipur, Khamasha, Shahpur, Bapunagar, Meghaninagar, Saraspur and Vatwa are the main areas 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 – Mr. Vasudev Trivedi who is also the Executive Director of the organization too and is responsible for this project and attends monthly and other meetings 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 female who was earlier the Counselor since the inception of the project and since one year is the Project Manager. There is a lady M&E cum Accountant who is also there since inception. The team has access to the target community and stakeholders. The organization does have laid down policies on Human Resource management and Financial norms. There are two ORWs out of which one is a lady working since inception. The ANM cum Counselor has recently left ( since mid June 2015 ) the project.

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 for many of the project staff including Project Manager, Doctor, ANM and ORWs.

3. Infrastructure of the organization

The organization operates from the land and building of the Ahmedabad Municipal Corporation which was earlier the Zonal Office of the Corporation but has been given to the organization for multiple activities including hosting the project office and DIC is located. The project office is located in a good roadside position and outreach access is available for most of the hotspots except for one site named Lal Darwaza. The organization’s project office has adequate space and furniture apart from 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.

There is Good form A documentation with ORW keeping area wise summaries. 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. There is use of whitener and ink smudging in the ANM/Counseling register and others.

**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 and hard copy printouts are also available. Although recently death and drop outs were validated, data analysis such as collation of daily and weekly users appears to be weak.

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

Not Applicable

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

Not applicable.

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. Operational area maps are also displayed on the project office walls. Micro plans are developed by the ORWs on an area wise activity basis. However, there is no mention of timings although this is a crucial issue in most sites.

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

The staff team have developed rapport with the target groups and some of the PEs have been there since inception who supports the activities. However, high risk assessment has been done and is followed up. Despite this coverage is low possibly owing to scattered area and distance for ORWs along with PEs not always performing optimally.

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 activity wise targets to be reached. Tracking of some of the target persons especially who are relatively mobile and go off to other places is difficult.

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

There is maintenance of PE : HRG ratio and PE : IDU ratio. However, sometimes the PEs go off ( often as they are jailed ) but gaps cannot be filled as they return after some time. Two of the PEs are currently in jail which hampers project activities. One of the 10 PEs is currently positive.

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 about 50 to 60 % of the target group as reported by the team. This is mainly owing to change in ORW, mobile IDUs and scattered area amongst others.

9. Documentation of the peer education

The PEs do not maintain their diaries and documents relating to essential information is mostly done by the PRWs and staff team.

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

The PEs are aware of the basic messages and needle syringe exchange skills. However some of the absent PEs have reduced field inputs. Along with this the fund flow problem has caused reduced mobility which is affecting PE support.

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

There is some oversight by the organization project manager who provides field support. However major field supervision is done by the lady ORW. There is a lack of need based supervision plan.

**IV. Services**

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

The STI services are mainly carried out from the static clinic at the project office where the clinic timings are in the afternoon from 2 to 5 Pm during Monday to Thursdays and in the morning from 9.30 am to 12 noon on Fridays and Saturdays. Also there have been a few health camps usually once or twice a month with occasional months being left out too. The health camps arte attended by some of the IDUs with total health camp attendance at 14 – 20 or so. In the static clinic it was reported good variation with sometimes there are seven or eight clients or none at all.

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 there is adequate space with privacy for Counselor and the physician. The outreach health camps are under some shades and trees with lack of visual and audio privacy. However, the number of health camps are now very few. 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 and low budgets have not deterred the organization from making timely procurements.

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 static clinic and occasional health camps and also Syndromic management is followed as per norm. Currently the doctor has a fracture neck femur and thus a replacement for this month is available who is also a retired qualified physician.

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.

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

There has not been any shortage of condoms. The distribution channel depe3nds heavily on the PEs. Once there was a stock out of condoms but replenished immediately from another organization through AMC support.

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

During the year 2014 – 15 the total number of condoms distributed were 8,675 where the planned target was 7,690. However all the condoms were given free without any social marketing although the planned target for CSM was 768.

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

The number of 1,27,046 needles were distributed against a planned target of 2,15,040 which is achievement of 59.1 %. The number 60,383 syringes were distributed against a planned target of 1,07,520 which is achievement of 56.2 % during the same period. In sites with weak PEs the ORW distributes or these are given from the DIC.

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

The local ICTC is located very close by at Beherampura Referral Hospital which is only about a few yards away. Other centres all over Ahmedabad such as Gomtipur, Dalinimra urban Health centre, Civil Hospital etc. There is good linkage with the local ICTC centre too. The ICTC centre nearby receives about 10 cases per day while the number of TI referred IDUs are about 5 – 6 per month. The reports are collected either by the IDUs themselves or by the project team as the Counselor there is experienced and has worked in TIs earlier. ART linkage has been done with the centre at V. S. hospital with about 10 – 12 linked during a year or so. The project has referred about 34 positive cases during the whole duration of which 30 registered and 4 unregistered. The ART centre was initiated in 2010 and about 50 cases of IDUs have been registered. During 2014 – 15, 18 cases of ART of which 8 are on ART treatment with 4 regulars. The ART centre gets IDUs referred from other centres including private centres too.

10. Referrals and follows up

Referrals during 2014 – 15 to ART centre was 9 out the planned 14 which is about 64.3 %. During 2013 – 14 there were 205 ICTC tested as most referrals are escorted to the ICTC centre.

**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 implementation of the field activities and there is acceptance of the staff. New cases are reported and brought to the DIC by the community.

**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 ART treatment facilities. There has been linkage established with the OST centre at L.G. Hospital With efforts of the Ahmedabad SACS and prodding of the TI long pending vacancies were filled in the OST with a young Doctor and Counselor newly joined. Currently there are 16 cases there of which 12 are regular and within them 9 are reportedly very regular. Out of the 16 cases 11 have been referred by the TI project and all the 4 irregular cases are amongst them.

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

High risk mapping and identification is being done and followed up to some extent. The gap between referrals and testing is reduced or apparently non existent owing to the staff team and PEs escorting the cases. However, the overall coverage is inadequate.

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 Police personnel especially in the hot spots.

**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.

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.

**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 a lady with MSW just completed but has not received her certificate yet. She has also done part MA ( Pshycology ) part I and has experience as ORW in migrants project. He has knowledge of project issues and provides field support too. She does field visits to check presence of PEs and does linkage with the ICTC, ART and OST centres.

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

Not Applicable.

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.

The lady ANM cum Counselor has just left the project and hence interaction was not possible. From the interactions with the existing staff and scrutiny of records reflected that the lady was more skilled as an ANM and was poor in documentation as well as Counseling. Thus Counseling appears to be handled mostly by the lady ORW aand supported by the Project Manager.

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 two ORWs. The lady ORW is well experienced as acts as a pivot for this project. The other ORW position has seen changes and currently a new male has joined and will take considerable time to gain the required skills and rapport building with the target community. However, the lady ORW is assisting in his on the job support.

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.

Not Applicable.

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.

The existing PEs number is 10 of which 2 are in jail. One PE is HIV positive and reportedly 5t are active PEs. One active PE has also been able to close down one drug outlet a medical store near TV 9 Although prioritization of hotspots are done the coverage of such a scattered outreach is inadequate.

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.

Not Applicable.

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 in the accounting area and is in this project since the last two years i.e. since inception. She also has received training during the previous year.

**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.

Although outreach activities are relatively quite good in some of the hotspots visited mostly through the experienced lady ORW apparently there is inadequate coverage of such a scattered outreach area which is compounded with the new induction of the inexperienced male ORW

**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.

**X. Services**

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

There is good quality field work in a sizeable number of hotspots but the scattered nature of the areas result in low achievement of targets – owing to new ORW, reduced number of active PEs, reduced mobility and overall fund flow problems.

**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 with particular reference to the field ORWs. Some of the PEs are also ensuring community involvement.

**XII. Commodities**

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

Tracking the mobile IDUs who leave their areas for period of time owing to sudden spurt of money and stocks make it difficult to keep the targets of commodity distribution difficult.

**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