# Evaluation report of the

**Care Foundation**

**Targeted intervention forDrug Users/OST**

**Imphal East, Manipur**

**Introduction**

**Background of Project and Organisation:**

Care Foundation is community base organisation founded in 2000 by a group who are infected and affected by the epidemic of HIV/AIDS. During that time health facilities for treatment of PLHIV was very limited. ART was very costly as there was no free ART roll out. Either you buy ART or die of OI Besides stigma and discrimination by society was very high. They negotiated with pharmaceutical companies for bulk purchase in order to live. Slowly their work started recognition, so in 2002 they began the TI programme under MACS. After two years they shifted to AVAHAN project ORCHID.

**Profile of the TI**

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| **Name of Organization** | Care Foundation |
| **Chief Functionary** | Open Kumar |
| **Yearofestablishment** | 2000 |
| **Type of Project** | IDU/OST |
| **Year and month of project initiation** | Dec 2013 |
| **Size of target Groups** | IDU-150, OST-120 |
| **Target Areas** | Nongmeibung, Chassad Avenue, New Checkon , Dimdailong, Porampat Thawanthaba, Mission land, Pormpat Pangan Leirak, Maring lane, Tribal colony, Purana Rajbari, Pureiromba, Konung Mamnag, Top Khonangmakhong |
| **Sub groups and their size** |  |
| **Evaluation Period** | April 2014- sep 2015 |
| **Visit Dates** | 17th to 18th Oct 2015 |
| **Persons Met** | Executive Board Member- PD, PM, Nurse, ME/ Accountant, ORWs and PE, HRGs. Stakeholders |

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

1. **Organizational support to the programme**

The organisation is playing supportive role in implementation of project activities mainly in service delivery. Records found for consultation with the community for shared responsibility. Records for two meetings held with HRGs found. A CBO is formed but not functioning properly. GB members played active role in addressing issues of crisis/stigma/discrimination faced by community by networking with the stakeholders. Team met 6 stakeholders out of which 4 have clearly narrated on the role of GB members in addressing the issues. Project has conducted staff meeting on monthly basis. During the period 18 meetings were conducted and PD attended in all the meetings. Record is mainly focused on the target achievement but did not mentioned on the gap and challenges of the issues.

1. **Organizational Capacity**
2. **Human resources**:

All staff positions filled as per project proposal. The organization has maintained the contract agreement of all the staff. Contract to staff is updated yearly and available in the TI. Date of joining and attendance register do not match for most of the staffs There is need to match the date of joining with letter and attendance register. Staff turnover is witnessed in the project. 62% of the staff found to be turnover during the period. In the attendance register one of the OWR have not sign for two months (May and June 2014). The staff has joined on May 2014 as per joining letter. Written job description given to all staff along with appointment letters and available in DIC. The staffs have some understanding of their roles and responsibilities as per one to one interaction. PE turnover noticed as per attendance register but replace done within two months. 6 PE has been replaced. Only one PE remains unchanged. The PE needs more clarity on their role and responsibilities. Attendance and leave registers of staffs is in place. All the leave letters of staff match with the leave written in attendance register. The leave letter should have sign of concerned responsible person in the project (PM or PD) for approval of leave.

1. **Capacity building:**

The staffs and PEs have attended Induction or orientation organised by STRC as per records. The staffs and PE are not provided induction training by the TI internally just after recruitment as there was no records. The project staffs have understanding of the project activities and documentation whereas PE still lack clarity in some areas especially data collection tools, risk assessment and community mobilisation process.

1. **Infrastructure of the organization:**

The TI is equipped with the necessary infrastructure. Adequate infrastructures according to the costing are there. There are five rooms- 1 for Project Manager, 1 Accountant, 1 common staff room, 1 recreation room (DIC) and 1 clinic. All assets are codified. Separate clinic room but it is too much congested. Maintenance of privacy in the clinic room needs improvement. The administrative rooms are big and spacious. Recreational room for is in basement. The rooms suffocating and need to be hygienic.

1. **Documentation and Reporting:**

Documentation and reporting system is in place. However, documentation system needs to improve. There is no feedback mechanism. Review meeting is conducted; the impact of action taken is correlated but need to improve regarding action taken report based on previous meeting and also to include other issues apart from ICTC, STI, Needle and syringes and condom distribution.

Monthly reports (SIMS) are send to MSACS timely. Required documents for recruitment are available like appointment letters, job responsibilities etc. Attendance and leave register available. Training registers available but no in house trainings records found. All the formats for STI clinics are maintained by the nurse like counselling, STI testing, ART referral, ICTC etc. The ORWs and PEs are maintaining the formats as per NACO guidelines. All the meeting registers (demand generation, DIC, Advocacy, etc ) are maintained. But there is need to include the details of discussion, resolution taken, decision made, planning, etc.

**111. Program Deliverables**

**Outreach**

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

Active HRGs list (Jul-Sep 2015) is updated in computerised form is available both for TI and OST. Age not updated in the computer while cross checking with form A.

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

Micro plan for each hotspot is available. The micro plan is being use to track to follow up pending ICTC, RMC, Syphilis testing cases while crosschecking. Updating of risk, vulnerability, condom demand needle syringes data are done quarterly. However, the PEs lacks clarity in micro planning for TI. Beside, Form B/B 1 maintained. Out of 4 PEs, interacted with 3 only. Two of them have no knowledge about the whole micro planning process. and not able to explain risk and vulnerability. According to PE spot analysis is done quarterly and contact mapping is done every month. However, ORW have understanding about outreach and micro planning and able to explain the process of risk assessment, Contact mapping, spot analysis. Only one PE was able to explain the process to same extent like social mapping, hotspot analysis etc. Project area map of PE needs to include peddlers, hotspots etc.

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

In TI 190 HRGs are registered during the evaluation period. 6 have expired. Age not updated in the computer while cross checking with form A. OST has 143 as active OST clients. 44 HRGS from TI are enrolled in OST. 49 spouses of IDUs are registered in the project,

1. **Outreach planning:**

Outreach plan in place at project level which is updated quarterly basis. Micro plan is for each hotspot available. The micro plan is being use to track to follow up pending ICTC, RMC, Syphilis testing cases while crosschecking. Updating of risk, vulnerability, condom demand needle syringes data are done quarterly. However, the PEs lacks clarity in micro planning for TI. Beside, Form B/B 1 maintained. Out of 4 PEs, interacted with 3 only. Two of them have no knowledge about the whole micro planning process. and not able to explain risk and vulnerability. According to PE spot analysis is done quarterly and contact mapping is done every month. However, ORW have understanding about outreach and micro planning and able to explain the process of risk assessment, Contact mapping, spot analysis. Only one PE was able to explain the process to same extent like social mapping, hotspot analysis etc. Project area map of PE needs to include peddlers, hotspots etc.

1. **Regular contacts:**

All the HRGs reached by the project as per records and the HRGS interacted express that they have received the services. Only very few knew about STI and crisis committee but none knew about social marketing of condoms. As per records more than 60% of the HRGs are regularly met. But according to PE average regular HRGs which they are able to meet is about 20 only. During the interaction with HRGs community, it was verified.

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

Documentation of peer education is in place. All the required formats as per NACO guidelines are maintained like Form B 1/1, Form C. Form D, etc. But the PE do not understand the formats they are using by relating to the work they are doing. They are unable to explain the use of formats. Besides, dairies only have entry of no of condom and N/S distributed and do not reflect any other activities.

1. **Quality of peer education:**

The quality of peer education needs to be improved. The Peer Educators are not well informed about the project activities. Two Peer educator have no knowledge about STI, ICTC referral. They just knew about distribution of condoms and syringes. They do not know about social marketing of condoms. The HRGs interacted have no information about crisis management team, social marketing of condoms. Though they have done HIV testing, they only talk to PEs and sometimes with ORW. No counselling provided. However, documentation of peer education in outreach plans and micro planning need to be improve. Among IDUs community peer education requires more attention in terms of safer injecting practices like reuse of N/S. The topics of the meetings conducted with HRGs are all related to service like HIV, STI, OST etc which is very important. The meetings can also focus on discussion formation of groups, crisis management, review of previous meetings, planning of project activities etc. Most of the HRGs in FGS have knowledge about Condom, N/S and ICTC. Some of them have heard about STI but very few know the symptoms of STI and its treatment. Therefore HRGs need to be educated with other project activities like community mobilisation-- formation of crisis committee, STI treatment, condom social marketing etc. as many are not aware during FGDs.

1. **Supervision:**

The overall supervision and monitoring of the TI project is looked after by the PD. The PM is responsible for management of staffs. The ORW monitors the PEs and responsible for their outreach activities.

**IV. Services**

1. **Availability of STI services:**

STI clinic is set up as NACO guidelines. All the required registers and formats are well maintained and documented. It is observed that the clinic is congested and lack privacy especially for internal examination. The clinic is well equipped and attached to DIC. HRGs accessed the clinic very conveniently

1. **Quality of the services:**

The TI is having a STI clinic, with all the requisite kits for STI management. Syphilis testing Kits are also available in the TI. All the 191 HRGs have attended STI clinic and counselled. The data found matches with the CMIS report. However few of the HRGs interacted have knowledge about STI. As per report by the counselor/nurse, P.E identified and motivated the HRGs to turn up to the DIC and referred to Nurse to provide counseling and ICTC referral and syphilis test and regular health check up. The Doctor of the project clinic done health check up and STI treatment those HRGs who were turned up at the DIC. However while interaction with the HRGs P.E. directly referred to ICTCs.

The project has provides the drugs supplied by NACO and kept the STI drugs in buffer stock. Counselor have well maintained of confidentiality and sensitive in the issue. However while interaction with the HRGs at the hotspots, very few have interacted with the nurse

1. **Quality of treatment in the service provisioning**:

STI treatment and testing is provided at STI clinic by the nurse. ICTC and STI referral mechanism has been utilized by the project. 555 syphilis test of HRGs found. Out of 25 HRGs interacted only 8 of the know about STI. The data found matches with the CMIS report. Few of them mentioned about undergoing the test. No Abscess case detected. 6 Tb cases is referred without consultation from doctor. Project is referring HRGs for both Syphilis test and ICTC at one time and follow the given project guidelines. However data found mismatch of CMIS report and referral register. Need to document the reports systematically. Follow up mechanism is done through individual tracking sheet. All the identified cases of HIV need to link to the ART centre. And also need to available all the required documents those who have already linked with the ART centres. 5 HRGs referred to DOT, available referral slips with result but referrals done without doctor advice.

1. **Documentation:**

TI is maintaining all registers related to services including STI and ICTC referral, counselling registers, condom stock and distribution registers, Medicine stock register, Asset register etc. Referral slips are being maintained for HIV testing. Documents related to ART referral kept. Records of TB maintained. the Ti maintained all copies of official letters to SACS and indent.

1. **Availability of Condoms:**

Condoms are distributed through DIC and Outreach. Social marketing implemented but no proper records maintained for selling. None of the HRGs in FGDs know about social marketing of condoms.

1. **No. of condoms distributed:**

3036 condoms is distributed against 3300 requirement (Jul to Sep 15). The PE has no clear understanding about condom gap analysis. Out of 25 HRGs interacted only 11 of them have taken condoms.

1. **No. of Needles / Syringes distributed through outreach / DIC**:

10718 N/S is distributed against the requirement of 13464 N/S (Jul to Sep 15). The PE have no clear understanding about N/S gap analysis. All 25 HRGs interacted inject minimum 2 to 3 times daily. But in the records it is shown that only 2 HRG inject 2 times daily (line list). As per interaction with IDUs and PEs about 50% are able to return N/S. Some of them reuse the N/S. Waste disposal mechanism is in place like disinfection done at DIC but final disposal is not as per guidelines. No proper records for waste disposal maintained. The PE is taking returned N/S warp in paper or polythene. Therefore, proper final disposal of waste should be done like linking with hospitals.

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

Linkages are established with ICTC, ART, STI clinic and OST. 22 HRGs are found to be HIV positive. 15 are on ART. 4 are registered at for pre ART. 3 are not linked with ART. Out of which 1 is sp. 15 are on ART. 44 HRGs from TI are referred to OST. There is overlapping services of OST and TI. It is observed while cross checking that some of the active OST clients are still taking N/S. In FGDs some of the OST clients are current user. This need to be check and avoided.

1. **Referrals and follows up:**

Referral mechanism is being maintained by the TI for ICTC and ART. Only ICTC referral slips are maintained. Follow up for OST clients in project area of TI is done. Those OST clients out of project area no referral is done to the concerned areas TI for other services. There is no records of referral from other TI except from Nirvana and

**V. Community participation**

1. **Collectivizationactivities:**

Only one CBO is form. No other committees formed by HRGs. HRG need to be informed related with the project activities like community mobilisation-- formation of crisis committee /DIC /clinic committee and condom social marketing as many are not aware during FGDs.

**2. Community participation in project activities:**

The project is lacking in community participation though community events are held. Community events are held but there are no proper records of participants. Proper records need to be maintained.

**VI. Linkages**

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

ICTC referral is established with government and private hospitals. STI counselling and syphilis test conducted nut the HRGs interacted have limited knowledge about STI. 5 HRGs referred are done to DOT centre. Referral is send without doctor advice.

1. **Percentages of HRGs tested in ICTC:**

590 ICTC referral services found. Out of which 8 are spouses and 97 OST clients. Most of HRGs were taken by the PE from the field for HIV test without proper counselling with the counselor.

1. **Support system:**

GB members played active role in addressing issues of crisis/stigma/discrimination faced by community by networking with the stakeholders. Team met 6 stakeholders out of which 4 have clearly narrated on the role of GB members in addressing the issues. Involvement of the Community at the advocacy level and planning level as well as TI activities is a must and needs to intensified and increased.

**VII. Financial systems and procedures**

1. System of planning: - Existing and adherence to NGO guidelines/any approved system endorsed by SAC/NACO-supporting official communication.

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| Sl. No | Particulars | Remark/suggestion for improvement |
| 1 | Budget preparation/Project report | Annual work plan indicating month-wise has been prepared and monthly/quarterly progress report and Financial Statement of Expenditure [SOE] are submitted regularly to the Manipur State Aids Control Society. |

1. System of payments: Existing and adherence of payment endorsed by SACS/NACO, available and practice of using printed and serialized VOUCHERS, proved system and norms, verification of documents with minutes, bills, stock and issued register, practice of settling of advances before making further payments.

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| Sl. No | Particulars | Remark |
| 1 | Adherence of Payment endorsed by SACS/NACO | Some large amount of Paymentswas made in cash as such payments endorsed by NACO not strictly followed. It is suggested that payments endorsed by SACS/NACO should follow as far as practicable. |
| 2 | Debit Vouchers serialized Manual/Printed and Supporting Cash Memo, APRs Bills, Money receipts etc | Debit voucher are Printed, the supporting vouchers are maintained properly and verified by Program Manager |
| 3 | Books of accounts | Regular books of accounts have been maintained. |

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.

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| Sl. No | Particulars | Remark |
| 1 | Formation of Procurement Committee | Procurement Committee is formed comprising ofProgram Manager, secretary andM&E Accountant. |
| 2 | Adherence of WHO-GMP/Jan AusadhiYojanaGuideline | Most of the medicine items are under the GMP/ Jan AusadhiYojanaproducts. |
| 2 | System of Procurement / Purchase& mode of payment | Purchases are made through purchase committee, after obtaining threequotations from different firms and payments are made by cheque. |
| 4 | Stock register of Inventories, Consumables & Periodical Physical Verification | Stock register are maintained and entering in stock register is quite satisfactory.No periodical physical verification is not carried out by any competent authority. |

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

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| Sl. No | Particulars | Remark |
| 1 | Separate bank account for Project and Authorised signatory | Separate bank account is maintained with  Indaian Overseas Bank A/c No: 073202000000736  Imphal Branch, Jointly |
| 2 | Preparation of Bank reconciliation statement | Bank reconciliation is prepared for every month |
| 3 | Audit of Books of Account& comments & observations from Auditors | The books of account are audited by SL Gangwal Charter Accountants, Imphal upto 31.3.2015. The Internal Auditors, Asbiswas& Company, Charter Accountantsreport from MACS isalso Presented. Ngo has complied with the audit observations and has given adequate attention to audit recommendations and action were taken.  There is no information regarding revolving fund (social marketing of condom) in audit observation. |

**Achievements, Areas of improvement and Recommendations: (on financial system and procedures)**

1. The overall financial system & procedure is satisfactory except those pointed out in the Evaluation Tool for Finance.
2. **Accounting policy:**

The system of accounts followed is on both cash and bank basis.

1. **Vouchers**

The quality of vouchers is quite satisfactory.

1. **Format.-**

It is suggested that the formats given in the NGO/CBO Guideline should be used.

1. Withdrawal from bank account is made on ad-hoc basis. Drawls from bank should be made on the basis of a fair estimate of expenses to be incurred in a particular expenditure period so that cash should not be held in hand for an unfairly long period. The estimates so prepared should be placed before the designated committee of the Organisation for sanction and be drawn from the bank.
2. The Operational Guidelines for NGOs/CBOs published by the National Aids Control Organisation should follow strictly.

**VIII. Competency of the project staff**

**VIII a. Project Manager**

The PM has 9 years experience in TI programme. His qualification is B,sc Agree. He has joined the organisation on 21st July 2014. He is well capacitated through trainings by NACO, SACS and STRC under various modules. He has work in other TI before joining Care Foundation.

**VIII b. ANM/Counsellor in IDU TI**

ANM/Counselor for IDU TI is an GNM. She has joined on 1st April 2015. She has attended OST Induction and Basic counselling training. She knows her roled n=and responsibilities, Nurse for OST is an ANM. She joined the project on 1st May 2013. She has been trained on Induction on OST.

**VIIId.ORW**

Both the ORWs for TI and OST understand their role and responsibilities. The ORW for OST is a graduate and has joined on 2nd Dec 2013. He has been trained on harm reduction, NACP VI, OST and have attended refresher training at TI. The ORW for TI is 12 the pass and has joined on 15th Nov 2014. He has attended trainings on harm reduction and OST. He has cleared concept of the process of Outreach and Micro plan..

**VIIIf. Peer educators in IDU TI**

There are 4 PEs under the TI. 50% of the PEs is from the age group below 30 years. Two of them are 12 pass and 2 are matric pass. All are trained on PE module. Inspite of the training 2 are clear about their role and responsinbilyies. They lack knowledge about basic concept like STI, micro plan etc.

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

Outreach activities in the TI level are an area that needs to be increased. Although there are indication that activities are being implemented by the outreach team, proper documentation and reflection of these is not being highlighted in the outreach plans, hot spot wise micro plan and the importance and clarity to the PEs needs to be reorient and made understood from time to time at the TI level. BCC/IEC activities need to ne intensified as most of the HRGs interacted lack information about STI, crisis management, formation of group, social marketing of condoms etc.

Proper monitoring and follow up of outreach activities needs to be effectively implemented and intensified.

**X. Services**

Overall service uptake in the project and quality of service and service delivery (Condom promotion, STI and ICTC referrals and linkages to other services) is in place but need to strenghened. Services provided by the organization are well received but are not satisfactory to the HRGs. All the HRGs express that they getting condoms and N/S as their demand and do not have much idea about other services like STI treatment, community mobilisation etc. All the HRGs express that they getting condoms and N/S as their demand which is not reflected in the reports as their requirement for N/S is quite high.

**XI. Community involvement**

Community involvement engaging the HRGs in programme planning needs to be improved. Consultation with HRGs community is taking place but should be on regular basis with proper faormation of SHGs , committees etc. Apart from forming a CBO of HRGs, no other groups or committees have been formed. Some of them are part of the project as OWRs and PE.

**XII. Commodities**

Commodities like N/S, condom distribution are done as per condom demand and N/S requirement analysis. It is reflected in outreach and micro planning. However the PE are cleared of the whole process. All the HRGs in FGDs express that they getting condoms and N/S as their demand and do not have much idea about other services like STI treatment, community mobilisation etc All the HRGs express that they getting condoms and N/S as their demand which is not reflected in the reports as their requirement for N/S is quite. Condoms are sold as per records but none of the HRGs in FGDs are aware about it.

**XIII. Enabling environment**

The project is doing advocacy activities without any specific plans. Records for formation of crisis management team available. 11 overdose cases recorded, Whereas most of the HRGs interacted have no information about crisis management team. Few of them know about formation of crisis management team but have no idea who are the members and responsibilities. Therefore there is need to do stakeholders analysis and developed a plan accordingly.