Annexure: B

Reporting Format-B

Introduction: *Goa is a small state of 3,701 sq. mt and a population of 16 lakhs comprising a main land district and an off shore island, and a popular tourist destination among Indians as well as foreigners. There are two districts North Goa and South Goa and 3 talukas having Six principle cities like Vasco-Da-Gama (Mormugao), Margoa (Salcet) ,Sanvordem (Qupem). Popular tourist place which is considered as a safe tourist destination, Experience, heavy traffic of visitors. Tourist also provides employment to local youths and are engaged in hotels, resorts, tourist transportation and masseurs and Anecdotal evidences from Goa suggest that some of Goan men engaged in MSM activity and hence pressing needs of intervention was observed in the year 2001 who desired to reach out to grass root level MSM in Goa by the team of Humsafar Trust-Mumbai during their visit to Goa and had an approached with some of the Goan gay community members and also after much deliberation with Goa SACS by Mr.Vivek Raj Anand , Sir.Ashok Row Kavi and some of the community members. In May 2002 a group to initiate the work of TI's with MSM in Goa was awarded to The Humsafar Trust to intervene with the groups of 1000 MSM in Goa. The process of the grant application included discussion on HRG behaviour and vulnerability of MSM with various SACS official, which paved the way for a baseline needs assessment of MSM; findings of the same were presented along with the proposal to intervene with MSM in Goa to Goa SACS.*

In the beginning lots of efforts are done by The Humsafar Trust and started the organization with the umbrella supports of Rishtaorganisation, TI in Calangute, with few staff strength of 4 peoples, where more than 1000 MSM's were covered in the entire state of Goa along with the provision of services, likes Education, condoms, Referrals for health check up, testing, counseling and etc.

Later on after a year of intervention we are ordered by GSACS to shift the office from Calangute to Vasco and be independent by 30th June 2003, bravely with confidence we then shifted to Vasco and started our work, with lots of mainstreaming programmes, with general population along with MSM's community programme got lots of publicity in the entire state of Goa and recognized by most of the Goans that the Humsafar Trust Goa is organization of Gay Peoples and working for the cause, more than 7000 Existing MSM Population in Goa and some of them are associated with the Humsafar –Goa accessing for services, .

Initialy lots of induction, refresher trainings were being provided by Humsafar Mumbai. With the lots of Technical, moral supports of Humsafar trust-Mumbai we had done successful work till year Sept 2009. But due to some personal disputes among staff of Goa Humsafar the Humsafar Goa is separated from Humsafar Trust-Mumbai and change the organization to The Humsaath Trust-Goa. Registered under Goa Registration act 1860, HST-Mumbai then Withdrawn its direct support but still provides technical moral support in all the matters.

Since from the beginning to till date we come across more than 7000 peoples in contact. including all types of community members in the entire state of Goa but presently working only in three talukas of south district Goa i.e. Mormugao, Salcete and Quepem with 1344 self identified MSM community being CBO's and recently we are the first organization in Goa to get the CBO budget in NACP PHASE III.

We also have been conducted Advocacy programme since August 2006 on the basis of 8 months contract with the Naz Foundation International Delhi.

We also have been participating in HSS round every year and through study it is learnt that in Goa prevalence rate of MSM is 5%.

It is learnt that in the beginning we had gone through lots of hard work, many crises among community, staff and also with the Board members and tough time when MSM's were not at all interested in the organization or behavior was denial. Due to lack of visibility, Stigma and since Goa is such a small state and easily noticeable in all parts of Goa. But we did not gave up but tried to work hard and over come with all the issues.

***Background of Project and Organization**:*

The HumsaathTrust , Goa is an community based organization working on the issues of Male / Female sexual Health with specific focus on MSM issues. The trust has grown from modest beginnings in to a recognisd organization working on sexual and Human rights.

The Humsaath Trust, Goa (HST-G) has been doing pioneering work in the Male / Female sexual health sector with a special focus on sexual minorities from last 10 years. Since September 2017 the trust began its work with the female sex workers in South Goa targeting 500 HRGs covering old railway station, New Railway Station, Kahreband, Gandhi Market, Colva, KTC, Garden, Sanvordem and Pallollem.

***Name and Address of the Organization:** Humsaath FSW TI South Goa*

***Chief Functionary:** Mr. SandipChodankar, PD / Chairman, Mob: 7498008732*
Mr.LalBaig Project Manager, Mob:9923144588

***Year of Establishment**: May 2002.*
***Year and Month of Project Initiation:** Program was initiated in the year 2018*
***Evaluation Team**: ImthiazAhammed S, Vijaya Prasad K S, Arati Malik.*
***Time Frame**: 27/02/2020 to 28/02/ 2020*

***Profile of TI** (Information to be captured) The organization is registered under Maharashtra State Societies Registration Act, 1860 and Bombay Public Project Act vide Regn. No. 7196/93/Pune dt.05.07.1993 and F-8279/Pune dt. 11.08.1993 respectively. The organization has its own office in Pune, a separate bank account for the project with three signatories to the bank, who are President, Treasurer and Program Manager of which two signatories are must on all documents. They have their PAN card, TAN, registration under 12A of Income Tax, FCRA as well as 80G. They have also registered under Niti AYOG.*

Target Population Profile*: The organization is currently working with FSWs such as street, Home and Lodge based. .*

Type of Project*: FSW TI*
Size of Target Group(s): *500 / 516*
Sub-Groups and their Size:

Typology			***Total***
Street based	***Home based***	***Lodge based***	
323	*68*	*125*	*516*

Target Area: *The TI is implementing project activities in South Goa covering 516 active populations sites like Garden, Old Railway and New Railway Station, Colvo Beach etc.,*

The staffs like ORW's- Sugrabhi Shaik and RanjithaVimal. PEs namely, Vinoda, Tania, Bhanu, Savitha and Renuka are working in the TI.

Key Findings and recommendations on Various Project Components

I. Organizational support to the programme*The organization has formed three committees such as PMC, Clinic, Crisis, Advocacy, Condom and DIC Committee in which the President of the organization, PD, PM, MECA, ANM/Counselor, ORW, PE and HRG of the TI are present in each of the committee. The meetings are conducted once in a quarter. Review of instances of issues is discussed during such meetings and decisions are taken as per need. There is record of planning activities to prevent instances of crisis through advocacy with healthcare providers and other stakeholders during such meetings but the same were not implemented. There is hardly any record of police advocacy except for instances when crisis is reported. The organization needs to provide support to TI on community mobilization aspectsi.e, Domestic Workers Union.*

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 large staff turnover:*** *All staff is on board and 2 ORW was recruited in the beginning of the project in 2018. Activities are implemented and documentation is in place accordingly reports are submitted. There is supervisory oversight provided by President, PD, PM, counselor and ORWs. The president of the organization and the staff along with PEs has commitment towards community and are working in coordination. It is noticed Staff turnover is less.*

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

S. No	***Date***	***Training By***	***Induction/ Refresher***	***No. of Participants***	***Designation***
1	*15/4/2019*	*NGO*	*Refresher on RMC/ICTC*	*14*	*M&E, Counselor*

			Documents, Clinic &ProgMngmnt		
2	*30/04/2019*	*NGO*	*Refresher on Program Management*		*All PEs in TI.*
3	*4/07/2019*	*GSACS*	*Induction on Program Mgmnt*	*1*	*Counselor*
4	*28/6/2019*	*GSACS/NGO*	*Induction on Progrmme*	*3*	*Counselor and all ORW's*
5	*15 & 16.7.2019*	*GSACS*	*Orientation*	*2*	*All 2 ORW's*
6	*13.8.2019*	*GSACS*	*Refresher*	*7*	*2 ORW and 5 PE*
7	*16/10/2019*	*GSACS*	*Refresher*	*2*	*PM and Counselor*
8	*30&31/10/ 19*	*TSU*	*Refresher*	*2*	*PM & Counselor*
7	*27/12/2019*	*GSACS*	*New skills for counselors*	*1*	*Counselor*

3. ***Infrastructure of the organization:*** *The organization has a small office cum DIC is located at Add.F-5, Kadamba Arcade, Maddel, Margao in South Goaadmeasuring about 15*15 sqft. The DIC is furnished computers, laptops, printers and internet connectivity. There is storage area for condoms and records in the same building. Furniture and othe required are in place.*
4.
5. ***Documentation and Reporting:*** *Documentation is maintained at all levels much of which is in duplication consuming lot of time and energy of the staff. Reports are being submitted mostly on time as prescribed by GSACS / NACO. Documentation needs improvement.*

III. Program Deliverables Outreach

1. ***Line listing of the HRG by category.*** *Line listing of all the HRG and site wise is in place. Each ORW and PE has a copy of the latest line list pertaining to her site/s.*

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

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

4. ***Micro planning in place and the same is reflected in Quality and documentation.***
   Micro plan is in place and ORWs are preparing outreach plan along with prioritization. However documentation needs improvement.

5. ***Coverage of target population (sub-group wise):***

	Total
Target	*500 /516*
Registered	*957*

Individual contact	*514*
Regular contact	*593*

6. ***Outreach planning:*** *Outreach planning is done by ORWs in consultation with their peer educators and counselor. Visits and other activities are planned on a routine basis and the ORWs are visiting the field 8 to10 times in a month providing support to the peers which resulting in making the peers depend more on ORWs.*

7. ***PE: HRG ratio, PE: Migrants / Truckers***

8. ***Regular contacts:*** *As per records available in TI the regular contacts are 90 percent during the year 2019-20 respectively. The reconciliation between regular contacts considering new registrations and drop outs is done to ensure cleansing of data. HRGs need to be encouraged to access services on their own such that accompanied referrals come down and so regular contacts with them may not be required.*

9. ***Documentation of the peer education:*** *Basic data of provision of referral services and meetings with community are maintained by peers but much of their narratives are with ORWs who record the same in their diaries.*

10. ***Quality of peer education-*** *While quality can always be improved. There are 05 PE on board as sanctioned by GSACS and all of them are having sound knowledge on risk, vulnerability and project services. There are 5 PEs whose qualification isupper primary and one is illiterate. The NGO should be given them proper training to community.*

11. ***Supervision- mechanism, process, follow-up in action taken etc.,*** *President of the organization cum PD, PM, Counselor and ORWs are providing supervisory oversight. ORWs conduct weekly meetings with PEs to collect data as well as plan for the next week. PM interacts with ORWs to monitor work being done and to assess additional support required. Counselor is updating records with avail of services and providing feedback of not reached for prioritization. Follow up needs strengthening and review meetings do assess action taken.*

III. Services

1. ***Availability of STI services –*** *STI services are being provided by one PPP doctor during the camps and some of the individuals are being referred to HRG.*

2. ***Quality of the services- infrastructure (clinic, equipment etc.), location of the clinic, availability of STI drugs and maintenance of privacy etc.*** *STI services are qualitative and are accessible to the HRGs. The facilities are well equipped with all the paraphernalia ensuring quality service delivery and privacy. RMC achievement is 90% during the both year 2018-19 and 2019-20 respectively. The doctor is trained on SCM having working experience of about 10 years and has been working with this TI for the last 10 years. Further treatment kits are in stock with TI for dispensing.*

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: NA***

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 centers.*** *STI services are qualitative and are accessible to the HRGs. SCM protocol is followed for all the symptomatic cases by the service providers as all of them were trained and have been providing services for more than a decade. About 1% each of HRGs (29and 41 cases) were diagnosed of having STI in the each of the year during the evaluation period and all were provided with treatment. Follow up is done and episodes of partner notification and treatment are not visible to address issues of recurrence of STI cases. Regular follow up need focus in case of STI diagnosed and treated HRGs. Referrals to ICTC and linkage of positive with ART centers and symptomatic referrals to DOTS is visible. Mostly HIV tests are done by the PPP FICTC during the Health Camps conducted in the field. The TI has asked to initiated referrals to DSRC.*

5. ***Documentation:*** *Documentation is maintained at all levels more than the requirement and this results in duplication and results in missing to capture relevant data. This needs strengthening through focused capacity building.*

6. ***Availability of Condoms- Type of distribution channel, accessibility, adequacy etc.*** *There are no instances of stock outs during the evaluation period and the TI has sufficient stocks. The condoms are being distributed through PEs and ORWs. Further there is adequate availability and accessibility of the same is noticed.*

7. ***No. of condoms distributed- No. of condoms distributed through different channels/regular contacts.*** *Condoms are being distributed by the PEs and ORWs during their visits. CGA is in place and there is no gap between demand and distribution.*

Year	***Demand***	***SM demand is 20% actual demand***	***Distribution***		***Total***	***%***	
			Free	***SM***		***Total***	***SM***
2018-19	*117229*	*23445*	*115461*	*3202*	*118663*	*98.49*	*13.6*
2019-20	*97511*	*19502*	*98173*	*2013*	*100186*	*100*	*10.32*

The condoms used for demonstration and re-demonstration are not recorded but it is inclusive of total distribution owing to which distribution is more than demand. There is closing stock of free and SM as on February is 18126 and 00.

8. ***No. of Needles / Syringes distributed through outreach / DIC – NA***

9. ***Information on linkages for ICTC, DOT, ART, STI clinics –*** *The TI has good linkage with ICTC, DOT, ART and DSRC.*

10. ***Referrals and follows up:*** *There is no referral mechanism in place as all the RMC, ICTC and*

STI services are being provided at the hotspots through Health camps by the PPP doctor and FICTC. However it is noticed that some of the HRGs are accessing services in the government health facilities. All the PLHIV are linked with ARTC and are in regular follow up. There are 31 ever registered PLHIV in the TI of which 05 are active. It is noted that that 05 PLHIV are registered during the year 2018-19 and it is informed that majority of them are newly registered. Follow up of STI cases is visible but partner notification is not visible.

IV. Community participation

1. ***Collectivization activities: No. of SHGs/Community groups/CBOs formed since inception, perspectives of these groups towards the project activities.*** *There is no CBO right now and it is informed by the TI that there were attempts to form CBO by mobilizing the community which was not materialized further they are planning to initiate the process again. It is suggested as all HRG belong to Private Based, who are mostly domestic workers and are not willing to project themselves as sex workers, hence mobilize them to form CBO of Domestic Workers.*

2. ***Community participation in project activities- level and extent of participation, reflection of the same in the activities and documents*** *Community participation in project activities is visible as beneficiaries who are also seen in records but the TI has not mentioned whether the HRG is new or old. Further much effort needs to be put in to mobilize them so that they become owners of the response.*

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V. Linkages

1. ***Assess the linkages established with the various services providers like STI, ICTC, TB clinics etc…****The TI has good linkage with STI, ICTC, TB and ART.*

2. ***Percentages of HRGs tested in ICTC and gap between referred and tested.*** *About 67.63% and 96% of the HRGs are tested twice and 31 were identified of having HIV during the year 2018-19 and 2019-20 respectively. There is a need of documentation to verify the gap between referrals.*

3. ***Support system developed with various stakeholders and involvement of various stakeholders in the project.*** *There are good linkages with several stakeholders from the line departments and service providers who are aware and provide support. The approach seems to be more intensive.*

VI. Financial systems and procedures

1. ***System Planning: A****s per NACO guidelines and as directed by the GSACS form time to time that all communication received through e-mail, or through various meetings or as regulated or as directed by technical support unit, the planning systems have been complied.*

2. ***System of Documentation****: Documentation for the purpose of the utilization for the program are in accordance to NACO Guidelines and Bank books and General ledger are maintained in system and regularly updated. Certified hard copies of Cash Book and General ledger are being maintained by the TI.*

3. ***System of Procurements:*** *Procurement system is in place as per NACO guidelines.*

4. ***System of Payments:*** *Availability and practice of using tally accounting software, printed and serially numbered vouchers with supporting documents are in place with proper approval. No cash transaction above Rs.5,000/-.*

VIII. Competency of the project staff

VIII a. Project Manager: *Project ManagerMrs.Carol Matias is a post graduate and having 05 years of experience in TI project activities. Her knowledge and capacities are reflected in addressing project issues but need of focus on monitoring and documentation. Apart from she needs to have induction training or orientation to implement to the project.*

VIII b. ANM/Counselor: *CounselorMrs.ShobhaNishadhas studied up to Graduation and doing her MSW in external. Sheknows about the risk and vulnerability of HRGs and assessment. The drug and kit managements are keep the manual data about the counseling, STI registers etc. Also she knows the TI implementation area and keep good linkages with all line departments.*

VIII c. ANM/Counselor in IDU TI – NA

VIII d. ORW: *There are 2 ORWs Mrs. Sugrabhi Shaik and RanjithaVimal are placed in 6 sitesin the TI. Both of them are good in field and knows of HIV/AIDS, STI and TI activities. Further all of them are having required knowledge and skills to fulfill their job roles.*

VIII e. Peer educators: *There are 05 peer educators like Vinoda , Tania, Bhanu, Savitha and Renuka2 among them are recruited recently.. All the PEs is well equipped with the knowledge on HIV/AIDS, STI, and TB along with good communication skills. They need refresher training to improve their performance.*

VIII f. Peer educators in IDU TI – NA

VIII g. Peer Educators in Migrant Projects – NA

VIII h. Peer Educators in Truckers Project - NA

VIII i. M&E officer: *M&E officer Mrs.Paitty Luis is a commerce graduate who is only 5 months old. She has been experience of working with TI. Further she is oriented by NGO and GSACS. She is good in maintaining the ITS as well as analyzing the data for the TI staffs and submitting the reports to the GSACS in time. Though she needs training on soft skills to analyze the data ensuring quality review and documentation.*

IX. a. Outreach activity in Core TI project: *Outreach planning is in place along with prioritization in micro planning. Periodic reviews should be able to make it more meaningful.*

IX. b. Outreach activity in Truckers and Migrant Project - NA

X. Services: *Community of sex workers are having the services at their step and encouraging them to access services on their own at Govt services. RMC is being done regularly wherein speculum examination is ensured.The concentration on social entitlementsfor the community is very much needed.*

XI. Community involvement: *Community involvement and engagement is limited to accessing*

healthcare services as beneficiaries. Further they also have received other social entitlements but more so as beneficiaries. The organization has provided support in all these case. There is need of addressing the issues of community women on rights and it reduces crisis in the field level.

XII. Commodities: *Commodities such as condoms, STI kits, HIV and Syphilis test kits are observed to be available during the evaluation period and are made available to the community.*

XIII. Enabling environment: *There is very little done to create an enabling environment as more of the services are being provided at their doorstep. It is observed during the 3 FGDs conducted at different sites that they never experience any crisis whereas the TI has reported 10 each incidents which took place during the evaluation period. The team has suggested maintaining the dignity of HRG along with building their capacities for availing services at government health centers. The TI has been informed to do more activities to motivate HRGs availing services at government health facilities and to provide such an environment through sustained engagement with key stakeholders.*

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

The TI has facilitated to provide the Aadhar card, Ration cards and Voter IDs but it is very minimal due to migrants it is very difficult to fulfill the criteria of Goa Govermnet. As such the community women are migrated from different part of the country. However it is suggested to try to helpout the children's of FSWs at CWC, Govt Hostels, WCD Office etc.

XV. Best Practices if any: No