

Reporting Format - B**Structure of the Detailed Reporting format****(To be submitted by Evaluators to SACS for DIA evaluated with a copy to NACO)****Introduction**

Operating in a vacuum often leaves a project's achievements as mere anecdotes; however, independent evaluation serves as the essential bridge that transforms perceived success into verifiable evidence of impact. By reinforcing institutional accountability and facilitating data-driven decision-making, external assessments provide the empirical foundation necessary for long-term growth. Commissioned by the **Jharkhand State AIDS Control Society (JSACS)**, this report offers a comprehensive, independent evaluation of the Targeted Interventions for Female Sex Workers (TI-FSW) implemented by **Gramin Samaj Kalyan Vikas Manch (GSKVM)** in Deoghar, Jharkhand. This assessment rigorously analyzes a two-year performance period spanning the financial years 2024–25 and 2025–26 to ensure the program's outcomes align with its critical public health mandates.

o Background of Scheme and Organization**1. Background of the Scheme (Targeted Intervention for FSW)**

Context: The Targeted Intervention (TI) for Female Sex Workers in Deoghar is a core preventive strategy under the **Jharkhand State AIDS Control Society (JSACS)** and **NACP Phase V**. It aims to minimize HIV/STI transmission within one of the state's most culturally complex districts.

- **District Vulnerability:** Deoghar is a high-footfall "temple town" and a major hub for the Santhal Pargana region. The constant influx of over **5 million pilgrims annually** (peaking during Shravani Mela) creates a massive "floating population." This creates a fragmented and often clandestine market for sex work, where FSWs are at higher risk due to the anonymity of their clients (bridge populations like pilgrims, tourists, and transit workers).
- **The Problem:** Many FSWs in Deoghar are "home-based" or operate near transit points like the **Jasidih Railway Station** and local bus stands. Because of the religious nature of the town, social stigma is exceptionally high, driving the community underground and making them harder to reach with essential health services.
- **Core Objectives:**
 - o **Risk Mitigation:** Ensuring 100% condom availability and usage through peer-led outreach.
 - o **Health Linkages:** Facilitating regular health check-ups and quarterly HIV testing to ensure early detection and treatment (ART) linkage.
 - o **Stigma Reduction:** Creating an "enabling environment" through community mobilization and crisis management.

2. Background of the Organization (GSKVM)

Identity: **Gramin Samaj Kalyan Vikas Manch (GSKVM)** is a leading non-profit organization founded in 1990, dedicated to the socio-economic upliftment of marginalized communities across Jharkhand.



- **Proven Track Record:** With over 30 years of experience, GSKVM has built a robust reputation for managing complex health and social projects. Our work ranges from running **Specialized Adoption Agencies (SAA)** to implementing large-scale **TB and HIV/AIDS interventions**.
- **Expertise in Deoghar:** GSKVM has a long-standing operational presence in Deoghar (headquartered near VIP Chowk). We have successfully implemented the FSW TI project here by navigating the sensitive cultural landscape of the holy city. Our deep local rapport allows us to identify "hidden" hotspots that outside agencies might overlook.
- **Operational Strengths:**
 - **Target Achievement:** TI currently manage a registered pool of FSWs, consistently meeting targets for STI screenings and ICTC referrals as mandated by JSACS.
 - **Quality Care:** It's **Drop-In-Center (DIC)** in Deoghar provides a safe, stigma-free space where community members receive counseling, medical referrals, and peer support.
 - **Technical Proficiency:** TI team is fully trained in the **SOCH portal**, ensuring high-quality, real-time data reporting and transparency.
- **Community-Centric Leadership:** Led by a team of dedicated professionals and community peers, GSKVM ensures that the project is not just a service delivery model but a movement for the health and dignity of the FSW community.

Vision: - *Dreaming together for a better world for all; (A caring, sharing and self-reliant society founded on the value of justice, peace and love)*

Name and address of the Organization

Gramin Samaj Kalyan Vikas Manch (GSKVM)
Saheb Pokhar Road, Near V2 Mall, VIP Chowk
Jharkhand-814112

Chief Functionary-

Md. Hashmat Rabbani, Secretary, GSKVM
Project Director-TI

Year of establishment:

1990

Year and month of scheme initiation:

2010

Evaluation team:

Mr. Swarup Kumar Nag (1st evaluator - Team Leader)
Mr. Phillip Mohan Nag (2nd Evaluator)
Mr. Pallab Bhattacharya (Finance Evaluator)

○ **Time frame (dates of evaluation) :**

Project Period- Two Years (2024-25 and 2025-26)

Evaluation Period- 18th Feb to 20th Feb' 2026

Feedback session for TI- 3rd day of evaluation (20.02.2026)

Profile of TI



General Information

Organization's Name	Gramin Samaj Kalyan Vikas Manch (GSKVM)
Registered Address	Hamidganj, Daltonganj, Palamu, Jharkhand-822101
Phone & Fax	06562-222867
Contact Persons	Md. Hashmat Rabbani (9572462647)
Project Offices	Saheb Pokhar Road, Near V2 Mall, VIP Chowk, Deoghar, Jharkhand-814112
Society Registration Details	Regd. No-322/2006-07, Dated: 05.10.2006
DARPAN Registration Details	2009/0002734
FCRA Registration Details	337790015
Income Tax Registration Details	12A- AAAAV1296N25PT01, Dated: 30.09.2025 80G- AAAAV1296N25PT02, Dated: 30.09.2025
PAN No	AAAAV1296N
Organization Email	gskvm@yahoo.com Website: www.gskvm.Ingo.in

(Information to be captured)

o Target Population break-up: (HRG, Bridge, Vulnerable population)

Heads	Details	Remarks
Target Population Profile	Core: FSWs	Core TI
Type of Project	Core composite	FSWs,
Size of Target Groups	FSWs: Target: 1400 Active: 1691 Dynamic: 27 Positive: 05 Dropout: 11	Active FSWs: Home based: 421 Street based: 911 Dhaba based: 70 Brothel based: 13 Lodge based: 271 Slum based: 01 Specify: 01 Any Other: 03
Target Area	Deoghar	10 Blocks
Total No. of Sites	10	
Total No. of hot-spots	30	

The Targeted Intervention (TI) profile for Deoghar reveals a highly active and expansive program that has successfully exceeded its initial reach. While the project set a target of 1,400 Female Sex Workers (FSWs), it currently manages an active population of 1,691, indicating strong community mobilization and outreach across its 30 hotspots and 10 sites. The demographic breakdown shows a diverse operational landscape, with Street-based (911) and Home-based (421) individuals forming the majority of the cohort, followed by significant numbers in lodges. Notably, the project maintains a low attrition rate with only 11 dropouts,

though the identification of 5 HIV-positive individuals emphasizes the ongoing necessity of these clinical interventions.

Key Findings and Recommendations on Various Scheme 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 scheme, support to the community, initiation of advocacy activities, monitoring the scheme etc.)

During the interaction with **Mr. Md. Hashmat Rabbani** (Project Director and Secretary of GSKVM), the evaluation team noted several key findings regarding the Targeted Intervention (TI) project's leadership and operational oversight:

- **Proactive Oversight:** The Project Director (PD) is deeply involved in program implementation. He maintains continuous engagement with the project team to monitor progress, resolve field-level challenges, and refine service delivery based on staff feedback.
- **Technical Proficiency:** Mr. Rabbani demonstrated a comprehensive understanding of the program's various components and strategic goals.
- **Operational Resilience:** Although the organization's Head Office is located **500 km** from the TI project site, the PD provides consistent and timely support across technical, financial, and operational domains, effectively overcoming geographical barriers.
- **Strategic Support:** The parent organization has been instrumental in helping the project team build rapport with target communities and key stakeholders, providing a solid foundation for field activities.
- **Review Participation:** Formal records, such as meeting registers, confirm that the PD consistently attends monthly review meetings alongside relevant team members.
- **Stakeholder Advocacy:** While the PD is present for internal reviews, there is a noted need for more active leadership in high-level stakeholder mobilization. Specifically, increased advocacy with government health officials would further strengthen the project's influence.
- **Governance Field Presence:** The evaluation team found no documented evidence of direct field engagement by the Secretary or other Governing Body members. Enhancing the visibility of senior leadership in the field could provide better firsthand insights and boost team morale.

II. Organizational Capacity

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

Sl No	Name of Staff	Designation	Qualification	Date of Resign	Date of Joining	Role Clarity
1	Md. Hashmat Rabbani	PD	B.ED		04-01-2029	Fully aligned
2	Full Kumari	PM (Graduated from Counselor)	ANM, Sociology (H)		31-12-2021	Fully aligned
3	Vinay Kr. Chaudhary	M&E	B.Com		31-12-2021	Full aligned



4	Pratima Kumari	Counselor (Graduated from ORW)	BA		01-01-2025	Partially aligned
5	Anil Mahatha	ORW1	BA		01-01-2025	Not yet aligned
6	Mantu Kr. Manjhi	ORW3	BA		31-01-2022	Fully aligned
7	Aloka Kumari	ORW2	BA		27-04-2023	Fully aligned
8	Punam Kumari	ORW4	Inter		05-11-2023	Fully aligned
9	Sheela Hembrom	ORW5	BA		01-05-2021	Not yet aligned
10	Pratima Kumari	ORW	BA	31.03.2025	01-05-2021	Fully aligned

This data reveals a workforce with strong foundational tenure, yet highlights a critical need for targeted on boarding and role alignment. While **70% of the team** (7 out of 10 members) is fully aligned with their responsibilities, there are notable gaps among both new and long-term staff. Specifically, while newer members like **Anil Mahatha** (joined Jan 2025) are not yet aligned, veteran staff such as **Sheela Hembrom** (joined 2021) also remains unaligned, suggesting a potential breakdown in ongoing supervision or role evolution. Furthermore, the internal promotion of **Full Kumari** and **Pratima Kumari** demonstrates a positive trend in staff development, but the "Partially aligned" status of the newly promoted Counselor indicates that transition support is still required to ensure full operational commitment to the scheme. Retention rate is high as most staff have been with the project since 2021/2022. Only one recorded resignation (Pratima Kumari from her previous ORW role), indicating a stable staff turnover environment.

2. Capacity building: modular (I, II and III&IV- Where ever applicable)&refresher training conducted, contents and quality of training materials used, documentation of training, impact assessment if any.

Date	Type of Training	Content/Theme	Training By	Participants
01-04-2024 to 05-04-2024	Induction	HIV Prevention	JSACS, KSHAMTA KENDRA	COUNSELLOR
28-05-2024	Induction	Gender Community	REACH	PM
09-01-2025	Induction	SPA/Massage	KSHAMTA KENDRA	PM
10-01-2025	Induction	SPA/Massage	KSHAMTA KENDRA	3 ORW
06-02-2025	Induction	SPA/Massage	KSHAMTA KENDRA	1 ORW
24-04-2025	Induction	p-MPSE	JSACS	PM, M&E-CUM- ACCOUNTANT, 2 ORW, PEE
12-09-2025	Induction	SOCH	JSACS	PM, M&E-CUM- ACCOUNTANT, COUNSELLOR
18-12-2025 to 19-12-2025	Refresher	HSS Plus-2026	JSACS	PM, COUNSELLOR
09-02-2026	Refresher	NACP-V	JSACS	COUNSELLOR

While the training schedule demonstrates a broad range of technical topics and consistent engagement with JSACS and Kshymata Kendra, the program faces a significant **compliance gap in accountability**. The current lack of formal documentation and the absence of any structured **impact assessment** make it impossible to verify the quality of knowledge transfer or the effectiveness of the training materials used. Without pre- and post-training evaluations or documented attendance records, the transition from Induction to Refresher training remains a purely administrative exercise rather than a measurable improvement in staff competency. This lack of evidence-based reporting prevents the evaluation team from determining if these sessions are actually translating into better service delivery for the High-Risk Groups.

Critical Areas for Improvement

- **Documentation:** Establish a standard repository for attendance sheets, training modules, and session photos.
- **Impact Assessment:** Implement pre-test and post-test evaluations to measure knowledge gain among participants (PMs, ORWs, and Counsellors).
- **Quality Control:** Document the specific versions of modular materials (I-IV) used to ensure alignment with current NACP-V guidelines.

3. Infrastructure of the organization

The TI project operates from a rented building that is well-equipped with the necessary amenities for smooth administrative functioning. The GSKVM project office has adequate infrastructure, including a reliable supply of electricity, fans, furniture, internet connectivity, computers, and essential equipment to support professional activities.

Visual aids such as social mapping and IEC materials prominently displayed in the project office and It is less in the Drop-In Centre (DIC), and different committees names are not displayed in the project office reflecting an unorganized and uninformative setup.

The asset register is properly maintained, with not all fixed assets appropriately coded. Few assets are codified properly. However, it is recommended that the register also include the date of purchase but lack note the condition of assets—particularly if they are not in use—in the remarks column, for improved tracking and accountability.

S. No.	Specification of Fixed Assets	Quantity
1	Computer	2
2	Printer	2
3	Almirah	1
4	Moving Chair	1
5	Computer Chair	1
6	Table (Double Drawer)	1
7	Table (Single Drawer)	2
8	Computer Table	1
9	T.V. (Samsung)	1
10	DVD	1
11	Chair (Nilkamal)	20
12	Land Line Telephone	1

13	Tata Photon Modem	1
14	Refrigerators Freeze (Haier)	1
15	UPS	1
16	Fan	6
17	HP Webcam W200	1
18	iSONiX Computer Speaker	1
19	Exide Battery	1
20	Inverter	1
21	Free Disc (chhatri)	

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.

Form	Details	Status	Remarks
A	HRG Registration Format	Good	Sign of PM and ORW missing on some forms.
B	Peer Educator Weekly Planning & Activity Sheet	Appropriate	ORWs play role in maintaining the form B for majority of peer educator
C	PE wise Individual HRG Compiled Monthly Sheet	Good	
C 1	Monthly Summary	Good	
D	Outreach Weekly Report	Good	
E	HRG Master Register	Appropriate	
F	Network Clinic Register (STI-RTI)	Good	Properly maintained
FF	Clinic Daily Summary Sheet	Appropriate	Updated
G	Medicine Stock Register	Appropriate	Updated
H	Referral Slips and Register	Appropriate	For HIV testing most of the cases are tested under CBS
I	Counseling Register	Good	Updated need to be documented properly.
J	Advocacy Activity Report	Appropriate	Advocacy plan and follow up activities were not properly documented. It is not in the NACO's prescribed format.
K	Crisis Management Report	Appropriate	Few crisis reported during contract period but documentation is not in prescribed format
L	Training Register	Good	Updated but details are missing.
M	Drop-in-Center Register	Good	Updated but couldn't reflect much attendance of HRGs. Visiting time and purpose is missing.
N	Commodity stock Register	Good	Updated
O	Movement Register	Good	Maintained but visit plans are not approved by PD/PM either.
P	Community Mobilization Activity Register	Good	Updated

III. Program Deliverables

I. Line listing of the HRG by category.

Indicator	2024-25	2025-26
Target	1200	1400
New HRGs Registration	180	122
HRG Drop Out	10	11
Active HRG	1569	1691
Entry in SOCH	1569 (100%)	1404 (83%) Upto Dec' 2025

The program shows a strong **growth in the active HRG base**, which increased from 1,569 to 1,691, consistently exceeding the set targets for both years. However, there is a noticeable **slowdown in new registrations** for 2025-26 (122 compared to 180 in the previous year), which may suggest a maturing field or a need for intensified outreach. The most critical area for attention is **SOCH entry compliance**. While the program achieved a perfect 100% data entry rate in 2024-25, the current year stands at **83% (up to December 2025)**. To maintain data integrity and meet the previous year's gold standard, the remaining 287 active cases must be documented in the system by the end of the final quarter.

2. Dynamic list of HRGs by category.

3.Registration of Bridge Populations (Migrants, Transport Workers and Other Vulnerable Population) following risk assessments NA

4. Micro planning in place and the same is translated in field and documented.

Age (Risk Profile)	Number of HRGs (FSWs)	% of Active HRGs (1691)
18-20	35	2%
21-30	1434	85%
31-40	222	13%
41-50	0	

Year	Active Line list	High Risk	Medium risk	Low risk
2024-25	1569			1569
2025-26	1691			1691

SI	Name of Site	SI. No	Name of Hotspots	Home	Street	Lodge	Dhababa	Slum	Brothel	Specify	Any Oth
1	Satsang Chowk	1	Satsang Chowk	32	47	31	4		1		1
		2	Belatukur	30	17	6	2				
2	Jhundi	3	Jhundi	10	53						
		4	Thariyari		18						
3	Barmasiya	5	Barmasiya Chowk	33	69	29	1				
		6	Azad Chowk	1	13	6	3				
4	Azad Chowk	7	Baidnath Tokies	6	13	13					
		8	Narsing Tokies	5	21	4	1				1
		9	Ptv. BusStand	13	47	2					
		10									
5	Bajla Chowk	11	Bajla Chowk	23	25	15					
		12	Govt. Bus Stand		8	1					
6	Chopa More	13	Chopa More	14	37	9	11				
7	Bagdaha	14	Bagdaha	38	53	17	8		2		1
8	Palojori	15	Polojori	49	51	25		3	1	1	
		16	Chitra	24	58	5	11				
10	Madhupur	17	Madhupur Rly. Station	58	64	19	15				
		18	Jheel Talab	9	41	2					
11	Sarth	19	Sarath Bus Stand	15	13	2					
		20	Sapaha	2	1						
		21	Bherwa	2	8	3					
		22	Ashana More	3	16	9					
12	Kunda	23	Kunda	3	13	23	1		6		
		24	Nandan Pahar	1	28	5					
		25	Rikhiya	13	3						
13	Mohanpur	26	Mohanpur	8	92	29	3		3		
14	Jasidih Rly. St.	27	Jasidih Rly. St.	7	41	6	2				
		28	Deoghar Rly. St.	5	15	8	5				
15	Deoghar Rly. St.	29	Ranga More	12	22	1					
		30	Gidhni	5	24	1					

The current profile reveals a highly concentrated demographic, with **85% of Active HRGs (High-Risk Groups)** falling within the **21-30 age bracket**. This suggests that the project's outreach and services are correctly prioritized toward the most active reproductive and professional age group. However, the risk classification for the 2024-2026 period appears

generic; while the active line list has grown from 1569 to 1691, 100% of the population is categorized as "Low Risk." This lacks the nuance required for effective micro-planning, as field reality usually dictates a mix of high and medium-risk individuals based on client volume and unprotected acts.

Spatial Distribution & Hotspot Dynamics

The hotspot data shows a diverse operational landscape:

- **Primary Typology:** The intervention is heavily "Street-based" and "Home-based," with sites like **Mohanpur (92 street-based)** and **Madhupur Railway Station (58 home-based/64 street-based)** acting as major hubs.
- **Infrastructure Gaps:** While the Drop-In Centre (DIC) has suitable displays, the **absence of specific area maps** is a critical flaw. Without these maps, the "translation to the field" is incomplete, making it difficult for Outreach Workers (ORWs) and Peer Educators (PEs) to track migrant movement or pinpoint specific "cruising" spots within high-volume areas like **Satsang Chowk** or **Bagdaha**.

5. Differentiated Service Delivery planning in place and the same is reflected in documentation.

The evaluation team observed that **Differentiated Service Delivery (DSD)** planning is not yet effectively operationalised, particularly concerning the tailored management of **PLHIV** and **STI** cases. While basic records exist, the current approach lacks the patient-centric stratification required to adapt service frequency, location, and intensity to individual needs. Without a robust DSD framework in place, the project risks providing a "one-size-fits-all" service model that may overlook high-risk STI clusters or fail to provide the specialized adherence support necessary for stable PLHIV. Strengthening this planning is essential to ensure that resources are directed toward those with the highest clinical and social vulnerabilities.

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

Target	Active (1691)							Dynamic	Dropouts
	HB	SB	DB	BB	LB	SB	Others		
1400	421	911	70	13	271	01	04	27	11

Coverage of target population (sub-group wise)

7. Outreach planning – Secondary distribution of Needles and Syringes NA

8. Outreach planning – Peer Navigation

While records for previously identified People Living with HIV (PLHIV) are maintained, there is a clear need to refine the **risk-scoring and tracking mechanisms** for the Targeted Intervention (TI) team to ensure Peer-led activities are truly effective. During the evaluation period, no new PLHIV cases were identified, which—while potentially positive—underscores the necessity for a more nuanced assessment of the existing "Old" cases. To improve field outcomes, the TI team requires greater clarity on **scoring metrics** that prioritize follow-up care and treatment adherence; without a data-driven approach to categorize these individuals, Peer Educators may

struggle to provide the specific, high-intensity support required for long-term health management and viral suppression.

9. Outreach planning – Reaching out to HRGs who are uncovered/hard to reach/hidden with services including CBS and health camp.

The outreach staff demonstrate a clear and sound understanding of the strategic importance of health camps and Community-Based Screening (CBS) in reaching underserved and hard-to-reach populations. However, a significant disparity exists between this understanding and the actual frequency of implementation; only one health camp was conducted over the two-year evaluation period. In contrast, CBS activities showed more consistency, with 17 camps conducted in 2024–25 and a slight increase to 19 camps in 2025–26, suggesting a functional framework for screening that could be leveraged to revitalize the broader health camp initiative.

10. Outreach planning – Increasing new and young HRGs registration through strengthened outreach approach model

The project currently lacks a comprehensive understanding of the "Strengthened Outreach Approach" model, resulting in a gap between theoretical outreach and modern engagement strategies. At the time of evaluation, there was no documented evidence of High-Risk Group (HRG) members being formally registered or engaged through social media platforms, digital sites, or other virtual networks. This absence of a digital footprint suggests a need to modernize outreach protocols to better align with contemporary communication trends and improve the identification and tracking of target populations.

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

The project maintains a structured outreach framework that adheres to NACO guidelines, with standardized documentation and detailed micro-plans available for every hotspot. These plans effectively track critical indicators such as pending ICTC, RMC, and Syphilis testing, while also capturing essential data on risk updates, vulnerability, and condom demand. While these processes are operationally sound and well-maintained, there remains an opportunity to further enhance the qualitative depth of the outreach planning to drive more impactful field engagement.

12. PE: HRG ratio, PE: Bridge Population ratio.

SL Num	Name of the PE/Address	Hotspot	Age (PE)	Area Assigned	Number of HRG
1	Chanda Devi Bus Stand Govt.	Bajla Chowk		Bajla Chowk	63
				Bus Stand Govt.	09
				Rangamore	35
				Total	107
2	Rikku Kumari Deoghar Rly Station	Jasidih Rly Station		Jasidih Rly Station	56
				Deoghar Rly Station	33
				Total	89
3	Renu Devi Madhupur	Madhupur		Madhupur	156
				Total	156

4	Tinku Kumari Kunda	Kunda	Kunda	46
			Nandan Pahar	34
			Rikhiya	16
			Total	96
5	Gudiya Kri. Singh Sarath	Sarath	Sarath	30
			Sapaha	3
			Asanamore	28
			Bhairwa	13
			Total	74
6	Rita Devi Satsang	Satsang Chowk	Belatukur	55
			Satsang Chowk	116
			Bagdaha	119
			Total	290
7	Priyanka Kumari Chitra	Chitra	Chitra	98
			Palojori	130
			Total	228
8	Pammy Kumari	Azad Chowk	Azad Chowk	23
			Narsingh Tokies	32
			Pvt. Bus Stand	62
			Baidynath Tokies	33
			Total	150
9	Aloka Kumari	Barmasiya	Mohanpur	135
			Barmasiya	132
			Total	267



10	Munki Devi	Chopamore	Chopamore	71
			Jhundi	63
			Total	134
11	Asha Devi	Gidhani	Gidhani	30
			Tharyari	18
			Jheelalab	52
			Total	100
All Total				1691

The distribution of caseloads among the 11 Peer Educators (PEs) reveals a high degree of variation in field responsibility, with individual portfolios ranging from 74 to 290 High-Risk Groups (HRGs). While the average caseload is approximately **154 HRGs per PE**, certain personnel like **Rita Devi (290)** and **Aloka Kumari (267)** are managing significantly higher volumes, particularly in high-traffic areas like Satsang Chowk and Barmasiya. Conversely, areas like Sarath and Gidhani show lighter caseloads, suggesting either lower population density or an opportunity for geographic redistribution. The total coverage of **1,691 HRGs** across diverse hotspots—including railway stations, bus stands, and rural junctions—underscores the program's extensive reach, but also highlights a critical need to balance PE workloads to prevent burnout and ensure the quality of interpersonal behavior change communication (BCC) remains consistent across all sites.

13. Regular contacts The no. of HRGs contacted as per the Differentiated Prevention Service Delivery model – The frequency of visit and the commodities/medicine distribution such as OST, STI care, PT, RMC, condom, lubes, syringe and needles, abscess treatment, etc., should be referred with SACS.

Regular Contact for 2024-25

Indicator	Apr '24	May '24	Jun '24	July '24	Aug '24	Sep '24	Oct '24	Nov '24	Dec '24	Jan '25	Feb '25	Mar '25	Total
1-1 Contact	1319	1388	1359	1378	1383	1382	1401	1420	1439	1498	1475	1490	16932

Regular Contact for 2025-26

Indicator	Apr '25	May '25	Jun '25	July '25	Aug '25	Sept '25	Oct '25	Nov '25	Dec '25	Jan '26	Feb '25	Mar '25	Total
1-1 Contact	1495	1504	1509	1519	1526	1536	1550	1565	1584	1606			15394

The above table shows the regular contact by TI for evaluation period. Also it is verified during visits.

14. Documentation of the PEs & ORWs

The maintenance of field documentation reveals a mix of adherence to NACO protocols and gaps in individual reporting. While Peer Educators (PEs) consistently maintain Form B, personal diary maintenance is inconsistent; many PEs rely on Outreach Workers (ORWs) to complete these records, occasionally leading to the omission of critical STI and ICTC service data. Conversely, ORWs systematically manage Form A registrations and monthly updates for Form C and C1. However, rather than maintaining dedicated diaries for nuanced field observations, most ORWs utilize the Form D field visit report as their primary record of activity.

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

The evaluation team engaged with 8 of the 11 Peer Educators (PEs), observing that while most come from non-community backgrounds, they are effective communicators with a strong grasp of core program elements, including HIV prevention, ICTC, STI management, and condom promotion. During focus group discussions, the PEs demonstrated practical skills in outreach and condom demonstration, while also providing valuable insights into the local drug-use landscape; however, a knowledge gap was identified regarding the specific provisions of the HIV/AIDS Act, 2017. Despite the PEs' diverse backgrounds, interviewed HRG members successfully identified their assigned PEs and Outreach Workers (ORWs), expressing a high level of trust and acceptance of services, particularly when delivered by staff with community roots.

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

The Secretary of the NGO serves as the dedicated Project Director, providing oversight through both desk reviews and field visits. He is supported by a Project Manager who conducts structured field monitoring and monthly progress reviews according to a set plan. External oversight is provided by the District Tuberculosis Officer (DTO) or District Nodal Officer, who offers periodic guidance on improving service delivery. At the operational level, Outreach Workers (ORWs) supervise Peer Educators (PEs) through field-based monitoring and bi-monthly review meetings. However, while these layers of supervision exist, the review meeting registers currently fail to document the specific processes or follow-up actions taken based on these evaluations.

IV. Services

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

Name of the Doctor	Qualification	Clinic Address	Contact Number	Distance from DIC	Letter of Understanding LoU signed Y/N

Dr. A.P Singh	MBBS	Static Clinic-TI Office	6205060377	0	LoU signed with AMAN and seal missing as well
Raj Kishor Das	BMLT	AASHISH PATHOLAB, Krishna Hospital, Sarwan Road, Jamunajor Pull, Deoghar ,Jharkhand	8271517806		LoU signed with AMAN and seal missing as well

The clinical infrastructure for the Deoghar project indicates a functional but administratively incomplete health delivery system. While the program successfully operates a **Static Clinic** at the TI Office headed by an MBBS-qualified physician and maintains a partnership with **Aashish Patholab** for diagnostics, there are significant compliance gaps in the formal documentation. Both the Doctor and the Pathologist have signed Letters of Understanding (LoU) with "AMAN" rather than the implementing agency, GSKVM, and both documents lack official institutional seals. These discrepancies pose a risk to administrative accountability and should be rectified immediately to ensure that legal and operational agreements correctly reflect the current project management and institutional identity.

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

The project maintains a static clinic within its office premises, staffed by a qualified Senior Surgeon who has completed online training and adheres to the Syndromic Case Management (SCM) protocol. The clinic provides essential services, including the distribution of STI Kits 1 and 2 based on symptomatic diagnosis; however, there is a recognized need to increase patient footfall. Feedback from focus group discussions (FGDs) indicates high community satisfaction regarding the maintenance of privacy and confidentiality, a sentiment echoed by the medical staff who confirm full adherence to established clinical standards.

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 ICTC, ART,

Clinical treatment services are delivered with high standards of communication and professional counseling by the Counsellor, ensuring that all interventions are grounded in informed consent, confidentiality, and strict privacy policies. Patient consent is systematically obtained and




documented whenever required, reflecting a strong ethical framework. Furthermore, follow-up care for ICTC and ART services is seamlessly integrated through effective coordination with the outreach team, ensuring a continuous and supportive continuum of care for the community. However, a significant challenge remains in case identification; feedback from the ART counselor indicates a concerning lack of new PLHIV cases identified during both the current evaluation period and the preceding five years, suggesting a potential gap in high-risk screening or outreach effectiveness.

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.

The clinic demonstrates rigorous administrative compliance by maintaining a comprehensive suite of NACO-standard documentation, including registers for clinic access (Form F), abscess management (Form F1), medicine stock (Form G), referrals (Form H), counseling (Form I), and DIC/PLHIV tracking (Form M). The counselor effectively utilizes a line-list to track critical service timelines, such as ICTC due dates and syphilis screening.

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

Condom distribution is effectively managed through both outreach initiatives and the Drop-In Centre (DIC), relying exclusively on the free supply channel to ensure barrier-free access. Field observations and interactions with High-Risk Groups (HRGs) confirm that condoms are consistently well-stocked and easily accessible, with the community expressing a high level of satisfaction regarding both availability and the distribution process.

7. Availability and Accessibility of OST – Provision of OST through NGO/CBO / Public Health facilities / Satellite OST centers NA

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

Typology FSW	Free Condom Demand	Free Condom Distributed	Social Marketing
2024-25	204600	200400	No
2025-26	185287	180720	No

An analysis of condom distribution data for the TI reveals a consistent reliance on free supply channels, with no social marketing initiatives implemented during the evaluation period. While demand for free condoms remained high, there was a noticeable decrease in both demand and distribution from 2024–25 (204,600 and 200,400 respectively) to 2025–26 (185,287 and 180,720). Despite this slight downward trend, the project maintained a high fulfillment rate, successfully meeting approximately 98% of the stated demand in both years, which underscores a reliable and responsive logistical supply chain.

9. No. of Needles / Syringes distributed through outreach /DIC / Secondary distribution of Needles / Syringes outlets. NA

10. Information on linkages for ICTC,ART, STI clinics.



Typology (FSW)	Contacts	Regular Contacts	Counselling	Found Positive	Linked to ART
2024-25	16932	15071	3395	0	0
2025-26	15394	13768	3302	0	0

The project maintains consistent engagement with the FSW typology, recording **16,932** contacts in 2024–25 and **15,394** in 2025–26, with a high proportion of these being regular contacts. While counseling services remained steady—reaching over **3,300** individuals annually—the official data reflects zero new HIV-positive cases identified during the reporting period. Although the team actively manages and links five previously known cases to ART services, the lack of new identification remains a critical observation; the Project Manager noted only one potential new case in the current year, which remains unregistered due to pending documentation. This stagnation in new case detection, despite high contact volumes, suggests a need to evaluate the effectiveness of current screening strategies in reaching higher-risk sub-segments of the population.

11. Referrals and follow up.

The project utilizes a robust referral system characterized by standardized documentation, counselor-led tracking, and the high-impact practice of "accompanied referrals" to ensure successful service uptake. Over the last two years, this framework enabled the seamless transition of 31 Community-Based Screening (CBS) reactive cases to ICTC for confirmatory testing. While all 31 cases ultimately returned negative results, the meticulous archiving of referral slips and documented follow-up by Peer Educators demonstrate a high level of operational discipline and a commitment to ensuring no reactive case is lost to the system.

V. Community participation

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

Established in 2024, **SAHELI** is a Community Based Organization (CBO) designed to champion the social security and protection of High-Risk Groups (HRGs) through a collaborative membership of HRGs and Targeted Intervention (TI) team members. While the organization underwent a committee reformation in 2025 and is still building the momentum necessary for high-impact milestones, its foundational role is already evident. Current documentation reflects a steady integration into the field, with SAHELI actively co-hosting various community events alongside the TI team to establish its presence and mission.

2. Community participation in project activities- level and extent of participation, reflection of the same in the activities like Mapping and Population Size Estimation, finding new HRGs, reaching out to spouse and partners of HRGs etc. and documents, Strengthening community participation relies on the active integration of Community Based Organizations (CBOs), project committees, key stakeholders, and hotspot-level support groups. During the assessment, the evaluation team noted that community engagement is currently most robust within the project’s core clinical and outreach services, particularly in areas such as HIV testing, Referral and Medical Care (RMC), and condom distribution. While these essential services provide a strong foundation for involvement, there remains a strategic opportunity to further leverage these established networks to deepen participation across all project activities.

3. Community Systems Strengthening: Engagements of Community Champions and community led monitoring in TI




Currently, there is no documented evidence of the engagement of **Community Champions** or the implementation of a **Community-Led Monitoring (CLM)** system within the TI project.

VI. Linkages

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

ICTC-VDRL-ART			
Sl. No	Facility	Name of Service Centers	Distance from TI
1	ICTC	Sadar Hospital Deoghar	1 KM
2	ART	Sadar Hospital Deoghar	1KM

The TI Project demonstrates exceptional institutional integration, with primary service facilities like the **ICTC and ART centers at Sadar Hospital Deoghar** located within a strategic **1 KM radius** of the project office. This geographical proximity, combined with the "seamless" follow-up mechanisms noted by the evaluation team, has created a highly efficient service loop for the existing community.

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

All testing done through CBS and reactive cases referred for confirmatory test at ICTC. No gap among referral and testing existed.

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

Functional support system observed in place from FGDs with different stakeholders.

VII. Financial systems and procedures

1. Systems of planning: Existence and adherence to NGO-CBO guidelines or any approved accounting principles endorsed by SACS/NACO, supporting official communication form NACO/SACS for any deviance needs to be presented.

Generally, NGO followed all guidelines from SACS/NACO. Official communication done by email.

2. Systems of payments- Existence and adherence of system of payment endorsed by SACS/NACO, adherence to PFMS, availability and practice of using printed and numbered vouchers, approval systems and norms, verification of all documents related to payments, quotations, bills, vouchers, stock and issue registers, practice of settling of advances before making further payments and adherence to other general accounting principles.

NGO has maintained system of payment through PFMS portal. All vouchers are printed and machine numbered.

3. System of procurement- Existence and adherence of systems and mechanism of procurement as endorsed by SACS/NACO.

No Procurement done by NGO/TI in the financial year 2024-25 & 2025-26.




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

Name of Bank Account – State Bank of India, Daltongaunge Branch. It is CNA zero (0) balance account Bank Account no - 41607310124

Few Observations:

- I. It is observed that One number Set of computer (CPU,Monitor,UPS), Printer and Camera supplied by Jharkhand SACS.
- II. It is explained that fixed assets like furniture, Electrical fittings etc are purchased before 2023.
- III. It is suggested that Income tax - TDS system is to be introduced while paying to Rent to Landlord and payment to Doctor honorarium.
- IV. It is observed that books of accounts maintained in accounting software but that software system is not with NGO. It is suggested NGO should have accounting software system with their own computer and also suggest that Accountant employed should have proper training in accounting software.
- V. It is observed that Rent agreement with Ms Poonan Shukla, made in Rs.50.00 (Rupees fifty only) non Judicial stamp paper. However, it is suggested that this should be on Rs.100.00 (Rupees One hundred) non judicial stamp paper.

VIII. Competency of the project staff

a) Project Manager)

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

Ms. Full Kumari, Project Manager: An ANM and Sociology graduate, Her professional trajectory—rising from Counselor to Project Manager—has provided her with a robust technical foundation. She demonstrates a comprehensive understanding of program proposals, performance indicators, and core TI objectives. Ms. Kumari is highly proficient in data management and digital reporting, with structured monthly and quarterly plans already in place. She is good in supervising field team and organising advocacy activities. To further enhance program impact, it is recommended that she refine her review strategy to foster more seamless coordination between outreach teams and clinical services.

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, clarity on risk assessment and risk reduction, symptoms of STIs, maintenance and updating of data and registers etc.



Ms. Pratima Kumari, Counselor: She holds a BA degree. She was earlier posted as ORW in the TI and has become graduated to Counselor in the same TI. She joined the project As Counselor in the year 2025. She received induction training and other training relating with clinic. She has good knowledge on basic counseling. She is well verse of HIV, symptoms of STIs, maintenance and updating of data and registers. She too made field visit for CBS and health camps. She needs to coordinate with ICTC and ART Counselor rigourously.

c) ANM/Counselor in PWID TI

ANM/counselor of PWID TI needs working knowledge about local drug abuse scenario, drug-related counseling techniques (MET, RP, etc.), drug-related laws and drug abuse treatments including Opioid Substitution Therapy (OST) For ANM, adequate abscess prevention and management skills will also be evaluated.

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, knowledge about TI programme etc.

Outreach Team Performance: The outreach team comprise of 5 ORWs, all are graduate. Three out of five demonstrates a high level of competency, possessing significant experience in the HIV sector and a strong command of service delivery targets, including outreach planning, STI referral protocols, and ICTC linkages. Two ORWs have poor understanding of outreach planning, microplanning tool. Both have adequate understanding of STI and ICTC testing. They were found not clear on risk prioritization. While their collective theoretical knowledge is consistent, there is a noted variance in their individual capacities to execute field activities effectively. They need to undergo training on risk prioritization.

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 project has sanctioned 11 PEs. Evaluation team met eight out of eleven and found none of them from community but they belong to the area where project has hotspots. While the Peer Educator (PE) cohort is currently at full strength and demonstrates promising foundational skills, there is a clear need for standardized professional development. During the evaluation, five out of eight PEs present exhibited strong technical competencies—particularly in condom demonstration and STI service knowledge—with approximately one-third showing advanced proficiency in calculating condom demand. However, a comprehensive re-orientation on core roles and responsibilities is required across the team to ensure operational consistency.

f) Navigator

Identification of PLHIV, escorting PLHIV to ART centre, ensuring linkages, follow-up, etc.

g) Peer Educators in PWID TI

Prioritization of hotspots, condom demonstration, importance of RMC and ICTC testing, knowledge about condom depot, symptoms of STI, well informed knowledge about safer injecting practices, hierarchy of harm reduction, good knowledge about abscess prevention and management, overdose prevention and management, local drug abuse scenario, Opioid Substitution therapy and de-addiction facilities, etc.

h) Peer Leaders in Bridge Population TIs

Whether the Peers represent the source States from where maximum migrants of the area belong to, whether they are able to prioritize 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.

i) 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.

j) M&E cum Accounts Assistant

Whether the M&E cum Accounts Assistant 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 SIMS reports.

Mr. Vinay Kumar Chaudhary, M&E cum Accountant: A Commerce graduate has been a dedicated member of the TI team for four years. He brings significant practical experience in accounts management and strong data handling skills. The evaluation identifies a clear need for Vinay to strengthen his technical understanding of **NACP protocols, TI frameworks, and key performance indicators.**

IX. Outreach activity in Core TI project

Interact with all PEs (FSW, MSM, HTG and PWID), 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.

Data Consistency & Coordination: A significant mismatch exists between outreach and clinic records (Forms A/B vs. C/D). The Program Manager must lead better coordination between these teams to align service delivery planning with actual field data.

Visual Mapping & Monitoring: While hotspot maps exist, a comprehensive **Area Map** is missing and must be displayed at the Drop-in-Center (DIC). Additionally, monthly activity monitoring needs to be strictly reviewed against the original plan.



Critical Shortfall in New HRG Registrations The project is mandated to register **20% new High-Risk Groups (HRGs)** annually to ensure program expansion and reach. However, there is a significant performance gap over the last two years:

- **2024-25:** Only **180** new HRGs were registered against a target of **120** (a **15%** achievement rate).
- **2025-26:** Performance remained stagnant with only **122** registrations against a target of **1400** (a **9%** achievement rate).

This consistent underperformance indicates that the project is failing to identify and enroll new members of the community, resulting in a stagnant reach that falls far below the required transition and coverage benchmarks.

Outreach & Community Planning: Despite utilizing 10 Site (SOAs) over two years, During the evaluation period, no new PLHIV cases were identified, which—while potentially positive—underscores the necessity for a more nuanced assessment of the existing "Old" cases. This suggests a need for more effective, **community-led planning** rather than a top-down approach.

DIC Utilization: Attendance is critically low, with only **23% of HRGs** visiting the DIC. The NGO must implement a strategy to ensure newly registered HRGs visit the DIC at least 2–3 times to build rapport and ensure service linkage.

X. 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 Counseling and clinic footfalls are 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. **NA**

XI. Services

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

The TI Project has successfully cultivated robust and effective linkages with **ICTC, DOT, and ART services**, demonstrating a high level of coordination and seamless referral mechanisms. Evaluation visits confirmed that the outreach team is deeply integrated into the follow-up process, ensuring a stable continuum of care for the community. Data from the 2024–2026 period shows a high volume of Referral and Medical Care (RMC) activity, with **5,357** visits in 2024-25 and **5,028** in 2025-26. While ICTC testing referrals nearly tripled from **54 to 150** year-over-year, a critical strategic gap has emerged regarding case identification. Despite these strong institutional ties, the project has not identified any new **PLHIV** cases in the current evaluation period—a trend the ART counselor notes has persisted for five years. This stagnation in new case detection, despite the increase in testing volume, suggests an urgent need to re-evaluate high-risk screening protocols and outreach effectiveness to ensure that the project is successfully reaching the most vulnerable, undiagnosed individuals within the community. Below table gives clear picture of linkages.



INDICATOR	2024-25	2025-26
RMC	5357	5028
PT	180	85
STI	17	27
ICTC TESTING	54	150
REFERAL	54	150
POSITIVE	5 (Old case)	5 (Old case)
LINK TO ART	5 (Old case)	5 (Old case)

XII. Community involvement

How the TI has positioned the community participation in the TI, role of community in planning, implementation, advocacy, monitoring and providing periodic feedback about the prevention service delivery, etc.

Purposeful community involvement in the TI existed, as emerged through field FGDs.

XIII. Commodities

Hotspot/project level planning for condoms, needles and syringes. Method of demand calculation.

Regarding commodities, evaluation team did an analysis of condom distribution data for the TI reveals a consistent reliance on free supply channels, with no social marketing initiatives implemented during the evaluation period. While demand for free condoms remained high, there was a noticeable decrease in both demand and distribution from 2024-25 (204,600 and 200,400 respectively) to 2025-26 (185,287 and 180,720). Despite this slight downward trend, the project maintained a high fulfillment rate, successfully meeting approximately 98% of the stated demand in both years, which underscores a reliable and responsive logistical supply chain.

XIV. Enabling environment

Systematic plan for advocacy, involvement of stakeholders and 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 whether they are aware of their role, whether they are engaging in the program.

As many as 10 advocacy meetings and 22 Crisis meetings were conducted on record, but suitable planning for implementation and follow up found wanting.

XV. Innovation at project level

The TI NGO linked their HRGs under various social security schemes facilitated in obtaining Ration card, Aadhar card, voter ID,

XVI. Details of Best Practices if any

SAHELI is being established to create awareness among HRGs and work for the betterment of HRGs on social security and protection.

