

CARE INDIA

Annual Report 2010



CARE India

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Message from **the Chief Executive Officer**



March 6, 2010 marked 60 years of CARE's engagement in India. Six decades of working with millions of the most disadvantaged women and girls to overcome poverty, exclusion and injustice places CARE India in an unique position to contribute to the agenda of ending endemic poverty at local, national and global levels. To do this more effectively, we are rapidly transforming CARE India into an organisation with local governance, while strengthening our global engagement even further by joining the CARE International Confederation. This is an exciting transformation that will allow CARE India to fight poverty and exclusion with greater impact and scale.

In this past year, as the first South Asian Chief Executive Officer of CARE India, I have been inspired, encouraged and challenged in equal measures. In FY 10 alone, in partnership with public, private and civil society actors, CARE India reached 16 million women and girls from poor and marginalized communities and enabled them to expand their choices, exercise greater control over their lives, increase participation in their communities and local governance, own assets and live healthier lives. Above all, they have broken out of moulds that have held them back and are taking on leadership roles in transforming their own futures and of their communities.

In this annual report, you will read about Kavita, a feisty 22 year old young woman, who after spending a year at our accelerated learning camp, *Udaan*, could negotiate with her parents to pursue further studies and subsequently delay her marriage. Kavita's story is a great example of the kind of change that is possible when you assist in empowering the life of a girl. She is an inspiration to her friends and the benefits she will pass on to her family, and to her community are permanent. We know that educating women and girls is our greatest hope for eliminating extreme poverty. But at least 75 million children who should be in primary school are not, and at least 55 percent of those are girls. Studies have shown that with each additional year of primary education a girl receives, she can boost her earnings by 10-20 percent later in life. And children of mothers who have attended at least five years of school are 40 percent more likely to survive past their fifth birthday. At CARE India, we call it the multiplier effect.

While we revel in Kavita's triumph, we are challenged by the deep rooted underlying causes of poverty and social exclusion which continue to push communities, especially women and girls into deeper levels of poverty. That is why we have concentrated our efforts on long-term solutions in areas of India with the deepest pockets of poverty by targeting the most disadvantaged communities.

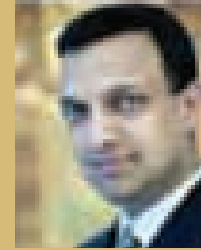
I am extremely encouraged by our talented staff whose commitment, dedication and advocacy for change have helped keep CARE India remain relevant despite the continual changes in India and throughout the region. It is our colleagues, partners and counterparts in the field whose tremendous efforts are the engine behind the lasting social change we create for communities, districts, states across the country.

On behalf of the CARE India team, in this year of transformation I must thank Dr. Nachiket Mor, the Chairman of our Board as well as other members of our Board of Directors who have selflessly given their time and constantly guided and inspired us to set higher standards of performance and impact from our work. I would also like to acknowledge the support of our donors and supporters in India and other countries who have made the past year of success possible.

Now, I proudly present to you our annual report for the FY 2010. I hope that you will be inspired by the strength and courage of the people whose lives have been sustainably changed by CARE. They demonstrate that poverty is not inevitable. It can be overcome! We only need the will to make poverty history.

Dr. Muhammad Musa
CEO, CARE India

Message from **the Chairman**



In India and around the world, CARE is committed to improving the lives of women and girls and their families. CARE globally has set three ambitious goals for the next five years to align with the targets of the United Nations Millennium Development Goals. To achieve maximum impact, we are focussing on three of the most pivotal periods in a woman's life: birth, childhood and adulthood. Through interventions such as maternal health, education, vocational training, access to credit, and civil society building programs, we know that when you transform the life of a girl, the whole community benefits for years to come.

CARE's programmes are vast. Our maternal health programmes last year reached 30 million women in 10 countries. Our girls' education programmes opened new doors for 10 million girls in 20 countries. I am proud to say that a large percentage of these numbers were reached because of CARE's presence in India.

In FY 10, we worked very closely with the Government of India through the Ministry of Women and Child Development, Ministry of Human Resources Development, Integrated Child Development Services, National AIDS Control Organisation, National Rural Health Mission among others to bring better health, quality education and sustainable livelihoods to 16 million women and girls.

In the arena of healthcare we worked with the government as a supplemental service provider to help strengthen health delivery and management systems, and as a result of our strong advocacy efforts, health has remained on the agenda of local governance and within the policy environment. Our Girls Education Programme, reached out to out-of-school older girls to provide alternate schooling options using private resources but mainstreaming them into government schools. Our livelihoods portfolio has focussed on activating market linkages and developing necessary support services using fee based revenue models. While we have been devoting our energies to these three sectors we have also been building our capacities to respond rapidly to disasters.

We could not have reached these milestones without the valuable partnerships we've developed with stakeholders which have been our mainstay in our fight against poverty. We have worked with civil society actors, corporations and individual donors to reach into the deepest pockets of poverty across India to improve the quality of life for the most disadvantaged populations and I am proud of our achievements.

As we stride ahead, engagement with the private sector will be an area of increasing focus for us in reaching our programmatic objectives. Our corporate partners will see benefits along the value chain reaching the last mile such that community empowerment not only improves the lives of the poor, but creates win-win solutions to strengthen markets. We look forward to dramatically scaling up our programs through corporate partnerships in the years ahead.

As we leverage the legacy of CARE across India and transform ourselves into a newer, responsive CARE India with a strong Board of Directors and a capable operating team, we hope you will consider new ways to join us in these endeavours.

With this I present to you the Annual Report of 2010.

Dr. Nachiket Mor
Chair,
Board of Directors

Overview

CARE India is a relief and development organisation working in India for sixty years with 16 million women and girls. We manage a dynamic, multi sector social development and emergency humanitarian response programme across eleven states in India.

We work with the very poor, women and girls in disadvantaged communities to provide access to better health, quality education and secure livelihood opportunities. In particular, we work with communities who face multiple exclusion and marginalisation. For example *dalits*, tribal groups, religious and cultural minorities, and sex workers.

We partner with public and private sector agencies, local partners and communities, designing and implementing models that help poor people to access their rights and entitlements. We collaborate with and provide technical expertise and managerial support to the national and state governments to take our innovations to scale. We also work to promote pro-poor policies and laws that create an overall enabling environment.

In 2008, CARE became nationally registered in India. As a fully independent, locally managed and governed agency, we are discovering exciting possibilities for us to ensure that the poor can benefit from India's new wealth. We are positioned to engage differently with communities in India. We can speak out more readily on sensitive issues and challenge the status quo with greater legitimacy.

Women and girls are at the core of our interventions



Our experience in over 70 countries around the world has shown that women and girls consistently experience violations of their rights and face discrimination in their public and personal lives. Due to social norms that favour men, women and girls are often prevented from becoming involved in community activities and systems outside their traditional roles. They are not able to negotiate choices due to social, cultural and economic constraints and are ignorant of their legal rights.

We believe that when women are equipped with the proper resources, they can articulate their needs, protect their personal assets, participate in decision-making processes, and exert greater control over their future and those of their children – thus helping those families and communities escape poverty.

By developing the potential of women, CARE catalyses lasting positive change in the lives of women, girls, men and boys, across India.



CARE/Anne Heslop

Where we work



INDIA

Geographic Context



CARE reaches areas with maximum concentrations of poverty

CARE has made a deliberate choice to work in those areas where there is widespread poverty and the socio economic indicators are below the national average. Our analyses of government and other data shows that the majority of these backward areas are concentrated in the states of Bihar, Jharkhand, Uttar Pradesh, Orissa, Chhattisgarh and Madhya Pradesh. We prioritise these six states, and also work in the poorest districts in five others, developing ‘learning labs’ - innovative models which can be scaled up for greater impact.



Engaging deeply to fight poverty

Understanding the root causes of poverty

CARE is committed to helping people free themselves from poverty. To achieve this, it is very important to understand what keeps people trapped in poverty generation after generation. To ensure a lasting impact, we undertook an analysis of our programmes to understand what perpetuates poverty, social injustice and rights violation. We found that systematic and structural inequities, alongside an inability to access and demand rights and entitlements, are the main barriers to inclusive development.

We identified three underlying causes of poverty in India:

- **Unequal power relations** – patriarchy, caste, class, race and religion limit the possibility for disadvantaged communities to free themselves from poverty. Women and girls are the worst affected, as they lack control over their lives in personal and private spheres.
- **Poor governance** – progressive policies, legislations and programmes for social inclusion and poverty reduction have not been effective in eliminating poverty in India.
- **Economic exclusion** – India's economic growth has not equally benefitted all members of society. In particular, women, girls and minorities remain unable to participate in and take advantage of the global market economy.

Making long-term commitment

CARE believes that engaging deeply with our constituencies over the long term is crucial to eradicating poverty in India. The roadmap for this engagement is a robust programme strategy and departure from a short-term, project-based approach, towards a deeper engagement with the communities through long-term, holistic programmes.

Simultaneously, we have developed state-specific programme strategies to sharpen our understanding of local power dynamics and barriers to change, which is enabling us to proactively help lift communities out of poverty. As a result, we can better engage in critical activities that lead to real change for poor people, especially women and girls.



CARE/Amelia Andrews

Pathways to empowerment

CARE prioritises four sectors; health and nutrition, education, livelihoods and emergency response. Specifically:

- Quality education - formal education and functional literacy
- Healthcare and nutrition - reproductive and child health, HIV/AIDS and TB
- Economic opportunity – linking community collectives to banks, credit, business loans and micro insurance
- Critical support during disasters and damage mitigation

Cross-cutting programme strategies

CARE aims to reach five million women, girls, and the most disadvantaged by 2012, and help them to make critical choices in personal and public lives for greater participation in society. We do this by:

- Providing platforms for women and girls to speak out, demand their rights, realise their entitlements and by strengthening government systems to ensure effective and equitable services for the poor and vulnerable;
- Building linkages between civil society groups and state institutions, markets and other stakeholders to ensure institutional transparency, accountability and responsiveness for pro-poor local governance;
- Developing strategic alliances and networks to advocate for an enabling policy environment, effective institutional practices, and equitable and inclusive governance.



Empowered with the ability to exercise greater choices in their lives, **women can change the contexts** in which they live and drive the **future of inclusive development in India.**

Expanding Women's Choices

- 70% of the world's 1.4 billion poor are women and girls
- More than 875 million women and girls are illiterate, representing two-thirds of all illiterate people in the world.
- Women work two-thirds of the world's working hours, earn 10% of the world's income and own 1% of the world's property.

This evidence points to the fact that women and girls endure poverty disproportionately. Therefore, they must be central to efforts to ensure sustainable development. This understanding is captured in the United Nation's Millennium Development Goal 3 (MDG3) which promotes gender equality and women's empowerment. With this goal, the U.N. are aiming to ensure access to education and health services, full and decent employment, equal political participation and decision-making in all sectors.

CARE knows that empowered women – women who have the ability and freedom to identify and choose their actions and life courses – will act in ways that lift themselves, their families and communities out of poverty. While women and girls are marginalised around the world, we also know that they can translate even modest gains in knowledge and resources into positive results:

- Each extra year of primary education that a girl receives boosts her wages later in life by 10% to 30%.
- The effect of a mother's education on her child's health and nutrition is so significant that each extra year of maternal education reduces the rate of mortality for children under five by 5-10%, according to a review of extensive evidence from the developing world.

This is why CARE strives to empower women to expand their personal choices, and challenge and change the contexts they live in.

CARE's programmes in FY'10 influenced women to take greater control of their lives. We used diverse approaches to bring change at personal, social and political levels. These included the expansion of education, health, livelihoods opportunities, facilitating women's collectives, providing access to credit and bank linkages, encouraging entrepreneurial activities and building safety nets through insurance.

Through our programmes, women and girls are learning to critically think, analyse and articulate their opinions. They are learning to effectively negotiate, speak in public, manage groups, organise information and facilitate decision making. Young girls who dropped-out or were left out of formal education systems are now receiving schooling, becoming aware of themselves and their environment, developing critical skills, gaining the confidence to lead and have greater aspirations for the future.

Our education programme provides opportunities for young girls to experience personal change through competency and positive self-perception development.

CARE's residential camp, *Udaan* prepares girls to enter formal school systems without any prior schooling. Aged 11-14 years, this is often their last chance to get educated, as their parents are otherwise likely



to get them married off. The girls at *Udaan* have either never been to school or have dropped out due to socio-economic reasons. Through an age-appropriate curriculum, these girls are fast tracked through the first five years of education in a span of eleven months.

Social learning is a major component of the *Udaan* curriculum, encouraging the girls to think critically and develop analytical skills. During the eleven-month programme, they undergo a complete transformation - from being socially shy, with low aspirations, to being confident and articulate. Living and studying together, they also learn that caste, economic status and gender need not perennially relegate or divide them.

Udaan students report that their greater self-confidence changes their behaviour at home, including their ability to negotiate with their family and even influence community norms. Their parents often reluctant to educate their daughters become supportive when they realise that they are not only learning to read and write, but also imbibe life skills. During the reunion of *Udaan*'s alumni, one father admitted that having a daughter who has graduated from *Udaan* is quite prestigious, and other families in his village now look up to him.

Every year, *Udaan* enables 100 girls to enter the formal system of education. Since 1999, 1100 girls have graduated from *Udaan*. CARE India was awarded the Commonwealth Best Practices Award in 2005 for this programme. The experience from *Udaan* informs our work with the formal school system especially government run *Kasturba Gandhi Balika Vidyalaya* (KGBV) boarding schools for girls in the middle school.

In the aftermath of the 2004 tsunami, many women suddenly found themselves head of households and main breadwinners, without any viable source of income. When we initiated our relief and rehabilitation programme, we observed that the women were struggling to build new lives. One of the biggest obstacles they faced was that of illiteracy. As a result, they did not know what they were entitled to or where and how they could access government welfare schemes.

CARE introduced an education for livelihoods (EFL) programme to equip women with skills that would be useful to them in their day-to-day lives.

The women who joined our EFL classes were either completely illiterate, or only able to read the alphabet at the outset. Aged between 16 and 50 years, they worked as unskilled labourers, fisherwomen, salt pan workers and in small-scale agriculture. Together with the learners, we designed a nine-month curriculum based on relevant topics - for example, preparing household budgets. Through simple, participatory exercises, the women have picked up numeracy competencies and learnt how to prioritise domestic needs.

Our students report greater confidence when handling negotiations. Now able to calculate their finances, they are no longer cheated when shopping. On receiving their daily wages, they now know how much is due. The women also report greater mobility as they can read bus numbers and destinations. Their children are also proud of their mothers' newfound skills and feel more motivated in their own studies.

Educated women can get better jobs and earn better wages. They can enter professions that afford greater job security. They can understand and manage their domestic finances, teach their children healthy practices and support them in their own education, so that they too can look forward to a brighter future.

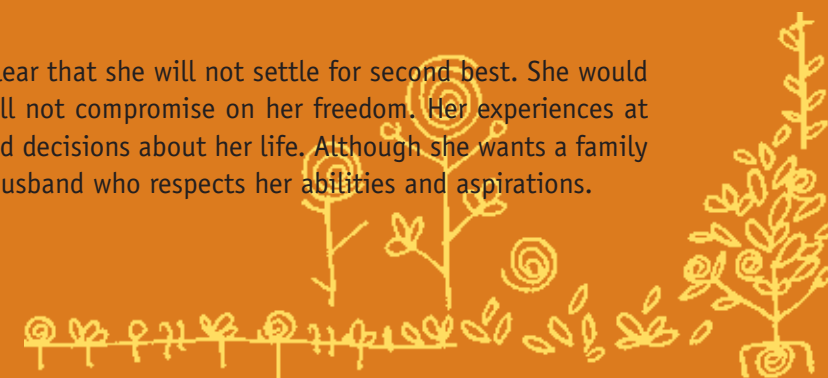
An *Udaan* graduate delays her marriage

When Kavita's parents told their 11-year old daughter she was going to leave home for a school where she would study, eat, sleep and live, for almost a year, she did not want to go. Her knowledge of school was of teachers who beat the children, of copying meaningless symbols from the blackboard and chanting lessons. She couldn't endure that for a year, and certainly not without returning to her home and loving family at the end of the day.

However, when Kavita moved to *Udaan*, she was amazed. The teachers were originally from her neighbourhood. Now they did not taught and also stayed in the school overnight. If Kavita felt lonely, they comforted her like family. Moreover, their classes were fun. They didn't rely on the blackboard. Instead, they taught subjects like math using sticks and stones - encouraging the girls to move them, count them, combine them and participate in learning. The girls studied social issues, including gender, health, ecology and politics. For the first time in their lives, they were encouraged to explore and share ideas, discuss, negotiate and work in groups, with other girls from different castes and backgrounds. They also went on "field trips" to the bank and the post office, and learnt how to ride a bicycle.

After eleven months' intensive academic, practical and social learning, Kavita graduated from *Udaan*, transformed. She returned home to find that her parents had begun making plans for her to marry, but Kavita, imbued with a new sense of purpose, persuaded them to let her continue her studies in a formal school. They agreed. She trained as a teacher and began working in a school that employs *Udaan*-style participatory learning methodology, and is supported by CARE's partner NGO, Sarvodya Ashram. Again, Kavita's parents began pressuring her to marry. She was reluctant because the prospective groom was 30 years her senior, but her parents did not see this as grounds for refusal. However, when he demanded a huge dowry, Kavita put her foot down. She discussed her situation with her colleagues, also *Udaan* graduates, and with their support, confronted the man and told him the marriage was off.

Kavita is still only 22 years old, but she is clear that she will not settle for second best. She would like to marry, but is determined that she will not compromise on her freedom. Her experiences at *Udaan* have empowered her to make informed decisions about her life. Although she wants a family someday, Kavita also wants a career, and a husband who respects her abilities and aspirations.



Negotiating greater control over themselves and their futures

In many places, women defer to their husbands, their in-laws or others when making decisions about their home and family. They need their husband's permission to join a group, to work or sometimes simply leave the house. They can not take decisions on key matters, such as health, especially family planning and birth spacing. They have to shoulder the lion's share of household work yet they are often the last one to eat and get the least share of food. If a woman tries to challenge her subordination, she is likely to face resistance from her family and community.

CARE's experience shows that it is important to influence the relationships in women's lives to enable them to negotiate greater control over themselves and their future. Simultaneously, it is equally imperative to change existing, discriminatory mindsets, stereotypes, traditions and behaviour patterns. This will have a cumulative effect on policies, laws and governance systems, and create an environment which allows women to make choices and influence important decisions.

In CARE's action research project, Inner Spaces Outer Faces Initiatives II, we integrated gender and sexuality rights in a health programme to reduce maternal and child mortality. We were able to demonstrate considerable change in knowledge, attitudes and behaviours of both men and women. Husbands and fathers began to play more supportive roles in pregnancy and newborn care, and understand women's nutritional needs, including the quality, quantity and timing of food needed by pregnant women and new mothers. Our project participants reported greater levels of autonomy, enhanced spousal communication and more equitable relationships.

This project addressed many hidden gender biases that adversely affect maternal health outcomes. We explored gender and rights issues in light of food and work distribution vis-à-vis pregnant women and their households. Health workers counselling pregnant women routinely advise them to eat three meals a day and take adequate rest. However, we found that pregnant women were still often the last to eat and receive the least amount of food. They were still expected to shoulder the majority of domestic chores because of the traditional belief that the more a woman works the easier the delivery of the child.



CARE/Sanjay Kumar

Based on an analysis of emerging issues, we designed interventions:

- To change the attitudes of health workers, thereby changing the attitudes of the community. The project worked closely with Government of India's district health staff to build the capacities of community-based health providers i.e., accredited social health activists, auxiliary nurse wives and *anganwadi* (mother and child health centre) workers. We trained community-based outreach workers to think critically about gender and sexuality issues of discrimination and build their skills to address those issues in their day-to-day work
- To address individuals, couples and women in the larger community.

We encouraged wives and husbands to have more open communications about decision making authority at home, gendered division of household labour, sex and contraception, son preference, limited mobility of women and attitudes about domestic violence.

An exercise which illustrated how the sex of a child is determined was very popular. It was called the "Bead Game", which, with the help of two coloured beads representing the X and Y chromosomes, showed how the sex of a child is determined. The idea that the father's chromosomes determine the sex of the child was overwhelmingly popular with the women, who are often blamed if a girl is born.

We also focused on increasing men's participation in routine care and support during pregnancy, delivery and post-partum, as well as directing efforts towards counselling men about women's rights to negotiate sexual intercourse, provide referrals for cases of domestic violence, and challenge notions about equity in the household.

Community-based couples' meets and new parents' meets afforded women new-found public mobility as well as giving them a non-threatening space in which to bond with their partners. In these forums, we reinforced the importance of husbands helping with the household chores and the need for women to eat with their men. This especially helped women to adopt positive attitudes and behaviours as, when men start changing their behaviour privately, they often worry about negative peer opinion. So when they discussed their views about gender in open forum, they were more likely to put them to practice. Societal sanctions ensured that the changes were sustainable.

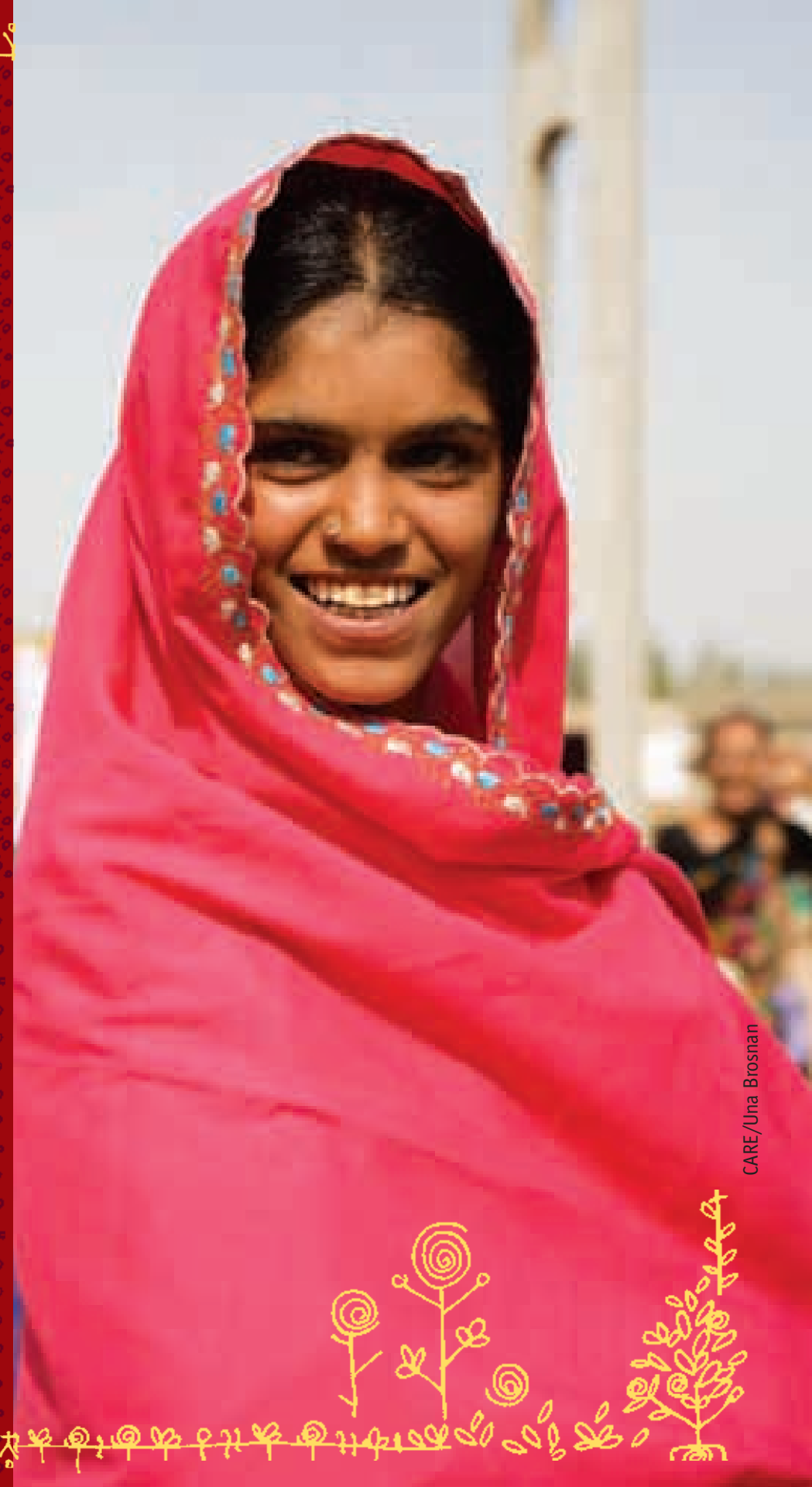
CARE also implemented community media strategies, (for example, accessible street shows and theatre) targeted at changing societal norms. These events brought serious messages about gender and sexuality to all generations.

An Equitable Beginning

Twenty-five-year-old Geeta lived in the village of Pavaiya Veeran in Barabanki with her two children and husband. In March 2009, Geeta was in the last trimester of her pregnancy. Geeta was a mothers' committee member, and regularly came for the meetings held at the anganwadi centre. She and her husband participated in the couples' meet organised in the village, and Geeta made sure that her husband met the health worker during her home visits. She and her husband also attended the local street shows that addressed the social norms related to men's participation in household chores.

In a mothers' group meeting held in her village, Geeta reported that she and her husband had cooked a special dish together, for the first time, and it had been fun.

Geeta shared; "It was the first time that all of us had sat together and eaten, and it was the tastiest food I'd ever had. Being happy adds to the taste of the food and it is such fun to eat with your husband and children. My husband said we should have done this earlier. Now we eat together. And the days when he does not go out for work, he helps in the kitchen."



CARE/Una Brosnan

Enhanced community participation and greater control over productive assets such as capital and microenterprise

Societal norms prevalent in rural India prevent women and girls from interacting with non-family members. In some cases, restrictions over interactions with male family members even require them to cover their face with a veil. They have little access to or control over public resources.

A woman who cannot participate in the public sphere cannot represent her interests when it comes to water, schools, road, security and safety, sanitation and healthcare, government representation, dispute resolution and thousands of other matters. However, women who are able to take an active role in the public sphere:

- *Increase their participation in community life and earn the respect of others,*
- *Influence or join political structures which can bring about tangible change and*
- *Learn the value of their contributions and claim their legitimate place in public life.*

C.1 Access to credit

In Indian society, particularly in rural India, gender roles are very strictly enforced. The men are the main breadwinners and control family finances and assets. Women are mostly never consulted about how to use or administer family funds. If they become widows they are not able to assert control over their husbands' farmland, tools or animals. This often leaves widows destitute while the assets are controlled by the other men in the family. If a woman is allowed to take control, relationships often change for the better and structures become more inclusive.

CARE's experience shows that microfinance raises the income and improves the living standards of the poor by providing access to loans, credit and other financial products and services. It also helps to absorb socio-economic shocks and enhance the coping abilities of the poor, especially women. After the 2004 tsunami, when livelihoods had to be rebuilt, we supported the short- and long-term needs of microfinance institutions by providing them technical assistance to establish adequate policies, procedures, and systems to increase the possibility of loan repayment. We also provided concessional loans to disaster-affected communities through our projects, the South Asia Tsunami Microfinance Investment Fund and South Asia Resource Team.

CARE promotes community collectives as platforms for women and men to build their social capital, participate in and take ownership of processes and decisions about their livelihoods. We mainstream credit linkages between self help groups and financial service providers, and set in place mechanisms that enable institutions to manage large-scale microfinance programmes.



CARE/Joslyn Baun



CARE is collaborating with the State Bank of India and Greater Hyderabad Municipal Corporation on a unique, urban microfinance initiative. In five slum circles around Greater Hyderabad, Andhra Pradesh, we are focusing on the poorest of the urban poor – women, the self-employed, petty traders, vegetable vendors, hawkers, rag pickers, domestic workers, sex workers, construction workers, daily wage workers and the unemployed.

Our overall objective is to enable women in poor households to increase their incomes and achieve economic security. We aim to ensure this by promoting and strengthening women's collectives that recognise the socio-economic needs of their members, and linking them to financial institutions.

In FY'10, CARE facilitated the establishment of 3,194 self help groups – with approximately 40,000 members and linked these to State Bank of India financial services. We also enabled 370 self help groups to access business loans, for the first time ever. We have established a community learning centre, and are conducting microfinance training workshops with bank staff, specific to the urban poor and slum scenario. We are also designing and helping to implement tools and mechanisms that will ensure financial transparency at all levels.

C.2 Promoting microenterprise and safety nets

- *Only 12% enterprises in India are owned by women*
- *30% women operated enterprises have a value of fixed assets less than Rs.1000 (USD 25)*
- *Lack of access to and control over property reinforces the exclusion of women*

CARE promotes microenterprise as a means of providing broad-based viable livelihood options for disaster-hit communities, as well as poor and vulnerable families, such as those infected or affected by HIV and who do not have other employment opportunities.

We provide customised micro insurance solutions to protect the livelihoods and assets of vulnerable communities. We help insurers to develop affordable, client-centric insurance products because we understand the needs of the people we work with. We also facilitate low cost distribution channels, simple claim settlement processes and life and health risk covers for the most vulnerable individuals, spouses and families.

Post tsunami, many people lost their means of livelihoods as their boats, nets and manpower were washed away. Women were the worst sufferers as their

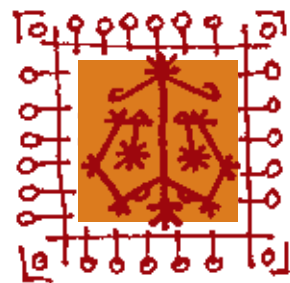
income was dependent on ancillary fishing. Lack of assets and illiteracy exacerbated their vulnerability to exploitation.

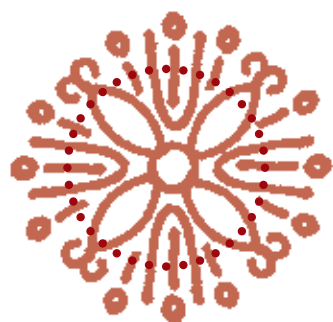
We have formed women's collectives in areas affected by tsunami to overcome their vulnerabilities due to isolation. Some members of women's collectives are working in two cashew nut processing factories that are being developed by CARE and funded by Walmart. To further reduce their vulnerabilities, these women are also attending our functional literacy centres. The members report change in their self-esteem along with the perception heightened respect in their community.

Elsewhere in tsunami affected villages, we have imparted training to the women's collectives built on their existing skills from fishing, coir and agricultural industries.

In Tamil Nadu, the devastation following the tsunami pushed already impoverished communities into further poverty. To protect them in the event of future disaster, we worked alongside Bajaj Allianz to take micro insurance to communities who were previously excluded from such protection. We piloted insurance cover for HIV positive people and affordable insurance policies, with critical illness cover, for the extremely poor. 55,000 households in our target areas are now protected by insurance.

In our operational areas, CARE strove to inculcate a culture of insurance. We provided instruction in financial literacy and made financial security





relevant to wide audiences, through street theatre, puppetry and folk songs. In Andhra Pradesh, with technical support from Weather Risks Management Services Ltd, together with ICICI Lombard, IFFCO Tokio General Insurance and partner NGOs, **CARE facilitated a weather index-based insurance policy that protects small-scale salt pan workers against salt production losses, for the first time ever. 17,000 of the most vulnerable households in Andhra Pradesh are now protected by insurance.**

In Andhra Pradesh, through our Balasahyoga project for children and families infected and affected by HIV/AIDS, we are enabling women to access livelihood enhancing services and entitlements. We have linked HIV positive women to existing self-help groups and micro-finance schemes for income generation. We have encouraged the development of kitchen gardens so that these families have enough to eat and can sell the surplus. This is helping them to meet the additional economic expenses incurred through HIV infection, including loss of income, medical and transportation costs.

C.3 Corporate partnership to strengthen existing livelihoods options

CARE is working to strengthen existing livelihoods options for communities living beside industrial plants. One such initiative is supported by Dalmia Cement (Bharat) Limited in Andhra Pradesh.

Our Dalmia Cement Corporate Social Responsibility Project aims to improve the living conditions of scheduled tribes, castes, backward classes, marginalised farmers and the landless poor, with a focus on women, by:

- Encouraging innovations that strengthen dry land agriculture and animal husbandry;
- Promoting a deeper understanding of productivity enhancement;
- Diversifying livelihoods and enable consistent, stable incomes;
- Developing infrastructures and support systems that will benefit the community at large;
- Promoting insurance as a risk reduction mechanism;
- Raising awareness of water, sanitation, health and environmental issues and
- Increasing vegetation cover in and around the villages to minimise industrial impact.

Since its inception in FY'10, our Dalmia Cement CSR Project has provided 87 families with livestock, farm ponds, agricultural plots, vermi composts and individual latrines. Our community-based activities, including free medical and veterinary health camps, libraries with a variety of materials for adults

and children, youth training programmes and micro insurance awareness drives, have reached 1,832 individuals. We have also enrolled 603 community members in village development and milk producers' committees. Through the committees, previously marginalised farmers have new access to bank loans for the purchase of animals, and repayment plans. Through our other corporate partnership programme with Cargill, we are addressing the intergeneration cycle of extreme poverty. A multi-pronged strategy was needed to bring economic sustainability to the older generation and education to younger generation. Consequently, **Kutch Livelihood Education Advancement Project** was launched in 2008 with the overarching objective of improving the quality of life of extremely disadvantaged communities through improved livelihood options along with enhanced access to quality and equitable education.

Through its livelihood component, we improve the ability of communities to access and benefit from markets. This will result in improved livelihoods, food security and empowerment. The education component influences the formal system of education, develop environment conducive to learning within the classroom and provide opportunities for alternative education to girls who have never been to school or have dropped out.



CARE/Andre Fanthome

Striving for universal access to healthcare services

Universal access to healthcare services means that women and children can enjoy their fundamental right to the highest attainable standard of health. However, *providing universal access to essential healthcare is still a challenge in India because of gender, geographical and transportation challenges coupled with ineffective service delivery systems. Women in particular are discriminated against when trying to access essential health services.*

Every year, between 75,000 and 150,000 women die in India from child birth and pregnancy-related complications. Our experience shows that most of these deaths can be attributed to the lack of continuous care from home to hospital. This includes ante-natal care, assistance of trained birth attendant during delivery, post-natal care and proper immunisation of mother and child. A review of 191 studies analysed the effects of various services delivered in intervention packages along the “home to hospital” continuum of care. It found particularly strong links between maternal and newborn health outcomes¹.

Emerging research shows that the integration of sexual and reproductive health services and HIV interventions reduces the incidence of HIV and sexually transmitted infections. It also encourages the use of condoms and other contraceptives, improves HIV testing and service quality.² By integrating services and promoting equitable access, we can reduce vulnerabilities to HIV infection.

Through our health programmes, in FY 10 CARE worked to improve the nutritional and health status of women and children, and reduce their vulnerability to HIV/AIDS and TB. We strove to improve the quality and coverage of existing health services - making them more effective and accessible to vulnerable communities.

In Bihar and Orissa, we are working with the state governments to instigate reforms and catalyse an integrated approach to health, sanitation and welfare. Together, we are working to improve the health and nutritional status, of women, the poor and most disadvantaged, by ensuring quality, essential healthcare, nutrition, water and sanitation services can be accessed by all. We are strengthening and developing systems and processes to ensure efficient, effective, inclusive service delivery.

**Entitlements =
Human rights +
proper resources**

1. “Continuum of care for maternal, newborn and child health: from slogan to delivery” Kerber KJ et al. Lancet 2007

2. “Linking sexual and reproductive health and HIV interventions: A systematic review”, Kennedy CE et al. J Int AIDS Society 2010



CARE/Ami Vitale

We are working closely with the Government of India's large-scale national health programmes: Integrated Child Development Services (ICDS) and Reproductive and Child Health (RCH) Program, under the National Rural Health Mission (NRHM), to strengthen service delivery and train the public health workforce. We are working closely with the Revised National TB Control Programme to improve TB treatment completion rates by multi-drug resistant patients in West Bengal. We are also assisting the National AIDS Control Society through its State AIDS Control Societies to conceptualise and implement HIV prevention strategies.

By implementing innovative interventions to reach migrant populations vulnerable to HIV in India, Nepal and Bangladesh, we are testing a model of cross-border HIV/AIDS related healthcare services. The knowledge generated through this model will be used to influence and changes laws and policies, attitudes, knowledge and behaviours.

D.1 Revitalising health delivery systems

CARE has adopted a two-pronged approach to achieve sustainable improvement in the nutrition and health status of women and children in India. We are focusing on building the capacities of frontline health workers - namely *anganwadi* workers, auxiliary nurses

and midwives and accredited social health activists. We are also providing tools to monitor health indicators, improve supportive supervision, and promote convergence between health departments and Integrated Child Development Services, at all levels. Simple innovations at the community level are enabling even the poorest and most isolated to receive their entitlements to essential healthcare.

Following our interventions, the government has adopted specific measures to strengthen their service delivery mechanisms:

- *Nutrition and Health Day: Fixed day fixed site delivery of ante-natal care and immunisation services* - dedicated, coordinated efforts of *anganwadi* workers, and auxiliary nurses and midwives at *anganwadi* centres to ensure maximum outreach to pregnant women and children under five .
- *Prioritizing home visits* – ensuring home visits by health workers during critical periods of pregnancy and neonatal development (late pregnancy, day of delivery, first week, first month, 1-5 months, 6-8 months, 9-11 months) to reduce the likelihood of neo-natal or maternal mortality.
- *Sector strengthening* - focusing on strengthening Integrated Child Development Services by reviving and building the capacity of sector supervisors and mid-management functionaries so they can better plan and coordinate community outreach activities.
- *Supply chain management* – to guarantee timely, universal availability of food items, such as oats and other locally-produced food at the *anganwadi* centre. This intervention helps to ensure that food items are planned, distributed and optimally-managed to last longer and reach those most in need.

D.2 Strengthening local governance

CARE is helping *panchayats* (local governance institutions) to prioritise health and nutrition issues, become more responsive and accountable for the well being of their constituency and ensure equitable service delivery.

In five of the most underprivileged districts of West Bengal, we are striving to help *panchayat* institutions become capable of ensuring the participation of rural families in demanding and monitoring public health services and outcomes. In FY'10, we helped build the capacities of *panchayats* and local women's collectives to plan, implement and monitor health programmes for their communities. We also promoted convergence between government health and welfare service providers to overcome gaps in existing systems and improve service delivery.



At the grassroots level, we worked to rejuvenate Village Health and Sanitation Committees. Since these committees are comprised of *anganwadi* workers, auxiliary nurses and midwives, accredited social health activists and village teachers, they are powerful bodies that can bring much-needed, widespread change. In Uttar Pradesh, we worked to ensure the formation and rejuvenation of village health and sanitation committees in 800 villages, orienting them on their roles and responsibility to improve maternal and child health, develop village health and transportation plans for emergency obstetrics care in their locales.

By promoting active and responsible local governance, we aim to:

- Reduce infant and maternal mortality,
- Improve the nutritional status of infants, young children and women,
- Enable communities to understand and control vector borne disease,
- Promote early access to and ensure compliance with treatment for TB and
- Activate total sanitation and safe drinking water campaigns

D.3 Reforming health systems in Bihar and Orissa

CARE, our partners, and the Governments of Bihar and Orissa, are currently working on an integrated approach to bring about health sector reforms in these states.

Within the next five years, we aim to ensure quality, essential healthcare, nutrition, water and sanitation that can be accessed by all - with particular focus on improving the health and nutritional status, of women, the poor and marginalised. In collaboration with the state Government and our partners, CARE is striving to reduce maternal and infant mortality, unwanted pregnancy, improve nutrition and promote convergence between service providers.

We are providing technical assistance and managerial support to help usher reforms within the Departments of Health, Social Welfare and Public Health Engineering to:

- Ensure equitable access to reformed health care systems with stronger systems,
- Strengthen human resources management,
- Transparent financial systems,
- Promote informed health seeking behaviour,
- Promote public-private partnerships and
- Encourage convergence between health, welfare and sanitation departments.

D.3.1 Equitable access to reformed healthcare systems

In FY'10, we helped to systematically address issues of inequity in health services by facilitating consultations in Orissa between marginalised groups, service providers, government departments and civil society organisations. We reviewed government policies, programmes and action plans, taking into account the impact of new challenges, such as climate change, upon health and nutritional security. We also studied the perceptions, needs and constraints upon marginalised groups in Orissa.

Through our work in Bihar, CARE recognised that tackling the widespread yet hidden violence against women needs to be challenged to bring about better health outcomes. Consequently, CARE, our partners and the Social Welfare Department, developed plans to integrate effective existing strategies and past experiences to tackle the widespread problem of violence against women in Bihar.

We made plans to work alongside the Department of Health to strengthen their adolescent sexual reproductive health services. We proposed improved communication and empowerment activities in schools, colleges and through women's collectives. We supported better identification, referral and monitoring of victims



CARE/Amelia Andrews

by healthcare workers, and training for courts and the police on intervention tactics and legal support services. We also proposed methods to strengthen village councils and community-based organisations' ability to identify and deal with cases of violence against women.

Our findings informed the development of a five-year action plan and equity strategy that promotes cross-sectoral convergence, aims to enhance the quality, efficiency and outreach of health services, and improve state-wide health and nutrition indicators.

D.3.2 Human resource management and training the health workforce

In FY'10, in Bihar and Orissa, we put systems and processes in place to address issues related to human resource management. These included steps to identify gaps in filling vacancies, counter absenteeism, train and build the capacity of health functionaries and develop more transparent, accountable infrastructures.

In Orissa, the CARE team helped establish a state human resource management unit to address human resource issues, formulate new policies, improve planning, management, and ensure that there are sufficient adequately skilled health personnel. We also helped set-up a centre of excellence on communication to develop infrastructures, harness

professional manpower, and build the capacity of personnel and healthcare systems.

We facilitated the compilation of a database of doctors and a pool of senior personnel to improve management and promotion practices. This is helping to reduce absenteeism and improve service delivery. We also helped to find a nursing management support unit. Over the next three years, this unit will implement operational plans and new policies to build the capacity of nurses, and impact maternal and infant mortality rates.

We initiated plans to extend telemedicine facilities, and supported the establishment of a state equipment maintenance unit to provide efficient, effective repair services to all healthcare institutions. We also helped link around two thousand health workers to the mobile support unit, mission connect.

In Bihar, we helped establish a human resource cell to deal with all aspects of recruitment - from situational analyses and identifying gaps in manpower, to wages, appraisals and grievances. We prepared guidelines for the recruitment of doctors, nurses and other medical staff. We also reviewed current organisational structures to identify staffing gaps, barriers to service implementation, and helped prepare an induction programme and materials for the new staff.

We helped the public health engineering department prepare and deliver training for community health workers about the importance of clean water and sanitation, and prepare them to inform their communities about the same.

D.3.3 Health management systems

In FY'10, we strengthened government health management systems in Bihar and Orissa by establishing new systems and improving existing systems, including more transparent supply chain management, referral systems and critical care services, by promoting standardised village health and nutrition days, and setting-up computerised data centres for better monitoring.

- ***Procurement Cells***

To address weaknesses in the current drug, medical equipment, services and supply systems in Bihar, we helped establish an autonomous procurement agency. This body is responsible for ensuring the delivery of quality health and welfare services, strengthening supply chains, and ensuring the equitable delivery of affordable, quality medicines.



We supported the setting up of transparent drugs procurement mechanisms and helped establish procurement, tracking and monitoring systems to ensure that essential medicines reach those most in need. In Orissa, we drafted a framework to monitor the movement of medicines. This has resulted in reducing corrupt transactions, so that essential medicines really reach those in need. We have facilitated improved coordination between communities, drug manufacturers, suppliers and the State Health Society.

- *Referral networks*

We facilitated the establishment of 53 first referral medical units in 27 of the 30 districts in Orissa, and helped strengthen the capacity of Burla Medical College to provide specialist sickle cell care. By assessing and working alongside four major hospitals, we helped improve casualty units and critical care services. We also worked alongside community health workers to promote standardised village health and nutrition days at community mother and child care centres.

- *Computerised data centres for better monitoring and evaluation*

CARE supported computerised patient, finance and human resource databases. Until our intervention, all medical information in Bihar was recorded manually. In FY'10, we helped set up a data centre with ten computers and ten telephone lines for use by the Integrated Child Development Services. Nine systems were also established in the regional office of the Deputy Director, 38 were set up in District Development Protection Offices and 544 in Child Development Protection Offices.

We facilitated computerised monitoring systems for all children registered at community mother and child care centres. A mobile software package including height and weight scales, fingerprint readers and a web-based reporting system is now helping ensure transparency and keep track of beneficiaries, especially malnourished children.

D.3.4 Financial management systems

In FY'10, we developed internal auditing and expenditure manuals, which are motivating a substantial increase in financial transparency and appropriate use of development funds, at all levels. We also supported government plans to phase-in the National Health Insurance Scheme for below poverty line households

D.3.5 Promoting health-seeking behaviour

CARE and our partners are working to promote health-seeking behaviour through media and behaviour change campaigns. In Bihar, we have proposed incentives to reward enhanced health-seeking behaviours.

In Orissa, in FY'10, the technical management support team began work on a five-year health communication document to integrate health services, enhance community participation, and achieve and sustain Millennium Development Goal health targets.

We developed tools for assessing the healthcare needs of tribal groups, and facilitated the roll-out of a state nutrition operating plan with annual performance targets to ensure sustained progress. We also designed and coordinated the implementation of state-wide media campaigns on maternal, child health, sanitation and adolescent anaemia.

We have proposed conditional cash transfers to be implemented in the poorest pockets of Bihar. Cash transfers are a support system based on the premise that poverty causes malnutrition and stunted growth amongst children. Conditional cash transfers stipulate conditions that have to be met before the cash is handed over – including regular height and weight measurements, attendance of food and nutrition education sessions, measles immunisation and family planning clinics. We identified key conditions to ensure effective cash transfers as follows:

- The money must be given to the mother, using as few intermediaries as possible, and without putting the mother at risk,
- The transfer should equal 30% the total household income and
- Transfers should be paid from the date of birth until the child is 36 months, and preferably also during pregnancy.

We also proposed a randomised controlled community trial and feasibility study to assess the effectiveness of cash transfers, monitor fraud and gauge their efficacy and impact.

Through these efforts, we aim to motivate people to avail of health care services thereby decreasing the prevalence of curable diseases and deaths by preventable causes.

D.3.6 Public-private sector partnerships

In FY'10, CARE helped draft a policy paper to encourage private sector partners to provide quality, affordable health services for the underprivileged. This framework included indicators to monitor service and health improvements brought about by increased private-public partnerships.

D.4 Strengthening government HIV/AIDS and TB control programmes

D 4.1 Implementing HIV prevention strategies

Across the states of Jharkhand, West Bengal, and Orissa, we are assisting the government's state AIDS control societies to conceptualise and implement large-scale HIV prevention strategies.

Under the third phase of the National AIDS Control Programme, targeted interventions aim at linking core high-risk groups to various support services e.g., including STI clinics, treatment



and counselling, and access to condoms. CARE's technical support units have been instrumental in rolling out strategies and micro plans for targeted interventions.

Through our mainstreaming resource unit in Chhattisgarh, we have also taken messages about HIV infection, prevention and treatment to frontline health service providers, people employed under the national employment scheme and women's collectives. We continue to assist industrial units in Durg, Korba and Raipur to help them analyse the impact of HIV/AIDS on their work and formulate adequate workplace policies.

Strategic trainings for medical college faculties, counsellors, laboratory staff, district medical officers and frontline health service providers are also helping to foster greater sensitivity to people living with HIV/AIDS. Inclusion of HIV prevention messages in other departments such as police, prison and Integrated Child Development Services are allowing us to take HIV prevention messages to a diverse audience.

D4.2 Building greater coverage of the TB control programme

CARE is working to reduce mortality rates due to multi-drug resistant TB in West Bengal by ensuring treatment initiation, adherence and completion by multi-drug resistant TB patients. In collaboration with the Revised National TB Control Programme, our IMPACT programme supports Directly Observed Treatment (DOTS Plus) services to provide the psychosocial counselling and support necessary to encourage multi-drug resistant TB patients to begin, continue and complete medical treatment.

In FY'10, CARE provided training and resources to improve the capacity of DOTS Plus centres to administer blood tests and treatment for multi-drug resistant TB. We trained service providers to counsel patients and overcome misconceptions that TB is incurable. We coordinated with the Revised National TB Control Programme and DOTS Plus sites to improve home visits, on-site counselling and help make DOTS Plus sites patient-friendly environments, with recreational materials and information leaflets in local languages.

During FY'10, we reached 121 multi-drug resistant TB patients and counselled them into initiating and continuing DOTS Plus TB treatment. We also trained fifteen DOTS Plus providers and twenty senior treatment supervisors in counselling methods and treatment administration.



A Listener Speaks Out

Our project participants often tell us how CARE projects have changed their lives. Our partners speak out less often. Here is the story of one woman's experience of being a DOTS Plus TB counsellor.

Shikha's role as a DOTS Plus counsellor is to provide psycho-social counselling and periodically follow-up with her dedicated patient base on the DOTS Plus site and through home visits. Shikha's warm, friendly manner pervades the clinic, enhancing the patient-friendly environment CARE promotes to encourage multi-drug resistant patients to attend and complete their medication.

Known for her tact and diplomacy, Shikha is excellent at counselling difficult patients and encouraging them to persevere until the end of their treatment. Like all counsellors on our DOTS Plus sites, Shikha has been trained to understand the different government welfare schemes, and is able to offer advice and information to impoverished patients so that they can receive support during times of sickness or unemployment.

Shikha and her colleagues are active in developing training materials for new counsellors. They are also encouraged to participate in regular staff meetings, where they share and discuss problems, and brainstorm ways to enhance the capacity of DOTS Plus services.

One of the challenges Shikha regularly faces is that multi-drug resistant TB patients admitted to the DOTS Plus site have major misconceptions about the disease. She says, *"I often meet patients who say they have heard that it is a disease that cannot be cured. When they believe this, they become hopeless and give up on life. I try and counsel them to understand that if they persevere with their treatment, they can get better. My patients often tell me that they simply did not know it could be any other way."*

Thanks to the hard work and dedication of counsellors like Shikha, multi-drug resistant DOTS Plus patients at our West Bengal site are now aware that they can be treated, and that they can receive government support to help them through difficult times. Enhanced links between DOTS Plus patients and government departments is ensuring multi-drug resistant patients are better monitored and assessed, while training programmes developed for and by our counsellors is seeing our services go from strength to strength.



E. Emergency preparedness and disaster response

To ensure a gender sensitive, rights based response when responding to emergencies, CARE adheres to international (SPHERE and CARE International) standards for situation and beneficiary assessment, targeting, monitoring and reporting.

As a member of the Inter-Agency Group, CARE collates, shares and analyses information from the field with government bodies and other NGOs involved in emergency interventions. This allows us to plan and coordinate relief, effectively mobilise resources, identify and reach those most in need.

In October 2009, flash floods in Andhra Pradesh and Karnataka affected over two million people across 21 districts. More than 1.8 million of those affected were from Andhra Pradesh. Around 300 people were reported dead and over 700,000 houses were damaged or destroyed. Rail and road transport ground to a halt as bridges connecting villages to the main highway were washed away. The Prime Minister of India declared the floods a National Calamity.

CARE was on the frontline of emergency relief efforts. We conducted rapid needs assessments in the worst hit districts of Andhra Pradesh (Kurnool, Mahabubnagar, Guntur and Krishna) and Karnataka (Bijapur, Gulbarga and Raichur). Based on these assessments, we intervened in the most severely affected districts of Andhra Pradesh: Kurnool, Krishna and Mahabubnagar, and in Karnataka: Gulbarga and Raichur.

We carried out baseline surveys to identify the most severely affected and their immediate needs, and collaborated with local NGOs and civil society groups to take assistance into

communities. With the support of elected community representatives and village elders, we ensured emergency supplies reached the most vulnerable – specifically scheduled castes, scheduled tribes and women headed households.

From October 20th - 30th, 2009, we took emergency supplies to 10,000 households (approximately 50,000 individuals) in Andhra Pradesh and Karnataka.

Each emergency relief kit we distributed costs approximately INR 700 (USD 14). They included hygiene items and toiletries (soap, toothpaste, a toothbrush, comb, hair oil, nail clippers, sanitary towels and antiseptic), water purification tablets, a water container and household items (a floor mat, bed sheet, cooking and eating utensils, and a mosquito net).

In the rehabilitation phase, CARE identified the 48 *Chenchu* tribal families in Amaragiri village, Mahabubnagar, Andhra Pradesh as the most in need of support following the floods.

To determine the most pressing needs of the *Chenchus*, CARE interviewed the 48 families who had been relocated to Amaragiri village. Our representatives discovered that despite being relocated to safety, they did not have any safe space for the belongings they had recovered. The beneficiaries' first request was for storage trunks and we provided one for each family.

CARE also discovered that there was no electricity in the village, so mobility after dark was limited and individual safety impaired. Thus, we supplied each family with a solar lamp. When an electricity connection was installed in Amaragiri, CARE also provided emergency solar lights for the *Chenchu* families.



CARE/Ani Vitale

- The *Chenchus* are one of the most primitive tribes to be found in the Kurnool, Prakasham, Guntur, Mahabubnagar and Nalgonda districts of Andhra Pradesh
- The *Chenchus'* average literacy rate is just 17.68% - the male literacy rate stands at 25% and female just 10% (Census, 1991)
- The *Chenchu* families currently inhabiting Amaragiri were relocated here by the Government of Andhra Pradesh, following the floods in October 2009





A Life Washed Away, Opportunity Washed In

For a very long time Lingamma had nightmares about snakes and scorpions crawling all over her house, or that she was in the midst of flood waters with her husband and two young children, with no way to reach safety. Lingamma had faced these situations when waters flooded her house in Gundlapenta, a small village largely inhabited by members of backward castes and *Chenchu* tribals, like Lingamma and her family, in Mahbubnagar district, Andhra Pradesh in January 2009. In Lingamma's village alone, the houses of approximately thirty-five *Chenchu* families were completely flooded, forcing everyone to flee to a nearby hill, where they stayed for seven days without food, drinking water or shelter.

When those who had taken shelter in the hills returned to the village, everything was lost - livestock, homes, earnings, household utensils - everything. Lingamma led the other families through the jungles in search of shelter. They walked for hours until they reached Mulachindalapalli village. There they met local officials, who arranged for temporary shelter and food for them. Later, all villagers, including Lingamma, were shifted to Amaragiri village.

Life was still difficult for Lingamma once she and her family reached Amaragiri. With government bodies slow to react and all sources of livelihood and assets lost, Lingamma and her neighbours knew that they would have to work really hard in the days to come in order to make ends meet. Initially, they relied on CARE's tents and relief kits, but how they would rebuild their livelihoods and generate sustainable incomes remained uncertain.

CARE met the villagers, listened to their troubles and decided to provide Lingamma and her fellow *Chenchus* with new houses and animals. Lingamma received goats, which gave birth to the first pair of new goats in the community. She is not sure whether she will sell the babies or the milk produced by them. For the time being she is happy because she has more options to generate an independent income for her family.

Lingamma and her fellow *Chenchus* are grateful for CARE's assistance, which is giving them the independence and confidence to take charge of their own future, and no longer sit forgotten on the margins of society.

Engaging with CARE in India

Women's Day Festival

On March 8th 2010, we celebrated International Women's Day in Delhi. With support from the Indian Council for Cultural Relations, Sewara Hospitality, Prospect Events Management, Evolve Brands, Marketing Solutions Ltd., and media partners The Mail Today, Better Homes and Gardens and Red FM, CARE hosted an outdoor festival headlined by Leni Stern and her band, Africa, in the beautiful setting of Lodi, the Garden Restaurant. We also enjoyed poetry readings from women members of Delhi Poetree, and stalls of handmade silk stoles by Eco Tasar. Between March 6th and 8th, the celebrated painter M. Sivanesan also exhibited his work on our behalf within the grounds of the Garden Restaurant.

The festival allowed CARE India, as a national entity, to reach wide corporate and general public audiences, raising awareness, gathering support for and leveraging funds towards our work. This was the first time CARE India had organised an event of this kind. Following its success, we are planning an even bigger and better event for 2011!

Pfizer's Global Health Fellows Programme

Pfizer's Global Health Fellows programme is a talent development opportunity wherein Pfizer arranges for colleagues from a wide variety of backgrounds to work at NGOs all over the world, for six months. The goal is to provide a mutually beneficial experience where the NGO and Pfizer can exchange cultural learning experiences, technical skills, project knowledge and integrate their working relationships.

In FY'10, Pfizer sent three fellows from the USA and Canada to work out at the Delhi Head Office. The fellowships provided a tremendous opportunity for Pfizer to gain direct experience of poverty alleviation, livelihood enhancement and health development projects in India, as well as utilising their skills and experience to inform CARE's interventions. Over the course of their fellowships, Pfizer fellows had the opportunity to see projects first-hand, in field visits to sites throughout India. In their final evaluations, all three Pfizer fellows praised CARE's work and the value of the Global Health Fellow Programme as a life-changing experience.

Reaching Out to Our Supporters

Keeping our supporters informed of our work is a priority for CARE India, and we were very excited about the launch of our new website in February 2010. The new site includes real life stories and pictures from the field, regular programme updates, and blogs written by colleagues from all over India.

In FY'10, we also joined the global social network, through Facebook and Twitter, and keep our ever-increasing 'fan' base updated with CARE news, on a daily basis.



Financial Report of year



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AUDITOR'S REPORT


To

The Members,
Care India Solutions for Sustainable Development,
New Delhi

- 1 We have audited the attached Balance Sheet of **CARE INDIA SOLUTIONS FOR SUSTAINABLE DEVELOPMENT**, New Delhi as at **31st March, 2010** and also the Income and Expenditure Account for the year ended on that date annexed thereto. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audit.
- 2 We have conducted our audit in accordance with Auditing Standards generally accepted in India. These Standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by the management, as well as, evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.
- 3 The Companies (Auditor's Report) Order, 2003, is not applicable to the Company as it is a Company licensed under Section 25 of the Companies Act, 1956.
- 4 We report that:
- (i) We have obtained all the information and explanations which to the best of our knowledge and belief were necessary for the purpose of our audit.
 - (ii) In our opinion, the Company has kept proper books of accounts as required by law so far as appears from our examination of the books.
 - (iii) The Balance Sheet and Income and Expenditure Account referred to in this report are in agreement with the books of accounts.

- (iv) In our opinion, the Balance Sheet and Income and Expenditure Account have been complied with the Accounting Standards referred to in sub-section (3C) of section 211 of the Companies Act, 1956 except as otherwise stated in Accounting Policies and Notes to Accounts given in Schedule-X.
- (v) On the basis of the written representations received from the Directors and taken on record by the Board of Directors, we report that none of the directors are disqualified as on 31st March 2010, from being appointed as Directors in terms of clause (g) of sub-section (1) of Section 274 of the Companies Act, 1956.
- (vi) In our opinion and to the best of our information and according to the explanation given to us subject to *Accounting Policy No. 1 regarding accounting of incomes on cash basis, Note No. 4 regarding applicability of the amended provisions of Section 2(15) of the Income Tax Act, 1961, Note No.5 regarding exemption from the provisions of Foreign Contribution (Regulation) Act, 1976, Note No. 10 regarding the receipt & payment of Service Tax*, the said financial statements together with Accounting Policies and Notes to Accounts given in Schedule X give the information required by the Companies Act, 1956 in the manner so required and give a true & fair view in conformity with the accounting principles generally accepted in India:
 - (a) in case of the Balance Sheet, of the state of affairs of the Company as at 31st March, 2010.
 - (b) in case of the Income and Expenditure Account of the surplus for the year ended 31st March, 2010.

For and on behalf of
KUMAR MITTAL & CO.
Chartered Accountants


(AMRISH KUMAR)
Partner
M. No. 90553
FRN 10500N

Place : New Delhi
Date : 29 July 2010



CARE INDIA SOLUTIONS FOR SUSTAINABLE DEVELOPMENT NEW DELHI			
BALANCE SHEET AS AT 31ST MARCH 2010			
	Schedule	As at 31.03.2010 Amount (Rs.)	As at 31.03.2009 Amount (Rs.)
SOURCES OF FUNDS			
Share Capital	I	200	200
General Fund	II	10,239,735	1,998,225
Disaster Management Fund		2,500,000	-
Sustainability Fund		1,000,000	1,000,000
Assets Fund Account	III	1,803,239	-
Unutilised Grants	IV	36,958,844	3,084,704
TOTAL		52,502,018	6,083,129
APPLICATION OF FUNDS			
Fixed Assets	V		
Gross Block		1,839,383	-
Less : Depreciation		36,144	-
Net Block		1,803,239	-
Investments	VI	26,195,657	-
Current Assets, Loans & Advances			
Cash and Bank Balances	VII	25,074,512	5,540,164
Loans and Advances	VIII	6,442,811	1,835,394
		31,517,323	7,375,558
Less: Current Liabilities & Provisions	IX	7,014,201	1,292,429
Net Current Assets		24,503,122	6,083,129
TOTAL		52,502,018	6,083,129
Significant Accounting Policies and Notes forming an integral part of accounts			
X			
This is the Balance Sheet referred to in our report of even date.		The Schedules referred to above form an integral part of the Balance Sheet.	
For and on behalf of KUMAR MITTAL & CO. Chartered Accountants		By order of the Board For and on behalf of CARE INDIA SOLUTIONS FOR SUSTAINABLE DEVELOPMENT	
(AMRISH KUMAR) Partner M. No. 90553 FRN 10500N Place : New Delhi Date : 29.July. 2010		(DIRECTORS)	

CARE INDIA SOLUTIONS FOR SUSTAINABLE DEVELOPMENT NEW DELHI			
CONSOLIDATED INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31ST MARCH 2010			
	Schedule	Current Year Amount (Rs.)	Previous Amount (Rs.)
INCOME			
Grants Received		131,974,163	12,835,299
		131,974,163	12,835,299
EXPENDITURE			
Programme Costs			
- Developing Community based monitoring system and Base Line Survey/ coordination between CBO's, Local NGO's & Govt.		4,985,630	787,169
- Technical and Management Support to Department of Health and Family Welfare, Orissa in Developing Capacity Health Sector		1,044,784	756,000
- Support to commitment building and advocacy for Nutrition		381,000	778,672
- Promoting Self Help Group (SHG) for urban poor in slums of Hyderabad		1,406,474	1,048,881
- Help build supportive policy environment for Family Welfare & Health Programs		82,000	794,893
- Documentary film on Panchayati Raj Institution		264,720	195,000
- Monitoring of Training Program for Panchayati Raj Institution		80,000	165,000
- Capacity building of Govt Functionaries, Panchayat & SHG's		263,960	-
- Emergency Response & Resource Mobilization Initiative		177,580	-
- Support small & marginal Farmers, Women Households, Landless & other vulnerable households		81,000	-
- Developing community based institution & ensure sustainability		186,010	-
- Increase Enrolment & Treatment Adeherence		105,884	-
- Information & Support Services for Migrants on HIV-AIDS		1,659,328	-
- Strategy for Improvement of Health Indicators in Bihar		60,005,560	-
- Formation & Linkages of SHG's		1,000,000	-
- World Women Day Activity		150,000	-
- Audio/ Video Production of Health & Nutrition messages		288,236	-
- Research & Development		275,750	-
Training and Materials			
- Training to key stakeholders for Kolhan and Chalbasa region		312,642	166,252
- Developing Training Module, AOL kits for tribal's & training of trainers		892,312	12,775
- Purchase of Solar Lights, Aluminium Trunks and other relief materials		112,600	-
- Training of Govt Functionaries, Panchayat & SHG's		590,920	-
- Training of National Field Level Staff & Partners		51,033	-
- Training of ASHA/ANM on Water & Sanitation on health care		108,898	-
- Other Training Expenses		29,055	75,355
Grants Paid			
- Gramin Vikas Trust		2,196,662	116,437
- Sharoff Foundation Trust		2,635,317	-
- Raghukul Parivar Trust		265,962	-
- Gram Shakti Foundation		244,233	-
- Rathwa Samaj Seva Trust		247,516	-
- AWAM		250,875	-
- Prakriti Foundation		246,719	-
- Gujarat Adivasi Pragati Parishad		238,514	-
			Contd.

	Schedule	Current Year Amount (Rs.)	Previous Amount (Rs.)
- Centre for Legislative Research & Advocacy		256,603	-
- Social Activities for Rural Development Society		1,384,665	-
- Anchal Charitable Trust		131,555	-
- Human Development & Research Institute		109,885	-
- Modicare Foundation		103,716	-
- Satyagrah Seva Samiti		93,426	-
- Boruka Public Welfare Trust		69,471	-
- Others			729,526
Traveling Expenses		2,665,967	535,579
Distribution of relief material in Bihar Floods			266,000
Foreign Exchange Loss		1,202,519	-
Administrative Costs		870,054	388,580
Rent & Brokerage		706,613	-
Quality Assurance and Oversight Costs		432,315	-
Office Supplies		335,192	41,906
Communication		258,772	38,965
Fixed Assets			
- Server Load Balancer		744,656	-
- ISP Link Load Balancer		766,344	-
- Laptops		303,783	-
- Camera		19,600	-
- External Hard Disk		5,000	-
Audit & Certification Fees		124,640	-
Computer Stationery & Maintenance		37,823	39,103
Printing and Stationary		204,384	106,594
Volunteers and Internship			29,500
Other Expenses		180,231	228,216
Amount transferred to Disaster Management Fund		2,500,000	-
		94,368,388	7,300,403
Unspent /(Overspent) during the year transferred to Grant Account	I	37,605,775	5,534,896
Significant Accounting Policies and Notes forming an integral part of accounts	IX		
This is the Income & Expenditure Account referred to in our report of even date.		The Schedules referred to above form an integral part of the Income & Expenditure Account	
For and on behalf of KUMAR MITTAL & CO. Chartered Accountants		By order of the Board For and on behalf of CARE INDIA SOLUTIONS FOR SUSTAINABLE DEVELOPMENT (DIRECTORS)	
(AMRISH KUMAR) Partner M. No. 90553 FRN 10500N Place : New Delhi Date : 29.July. 2010			

Annexure 1

Projects of CARE India Solutions for Sustainable Development for 2009-2010

Enhancing Tribal Development Outcomes - SAMRATH

Funded by
Government of
Gujarat

Duration: 2008-2011 Value:\$1.26 million Location: Gujarat

SAMRATH aims to improve the quality of life of the poorest and most disadvantaged members of tribal society in Gujarat, through community empowerment initiatives. It strives to significantly and sustainably improve health, education, household income, drinking water, irrigation and food security by strengthening community capacities to plan and manage their own development activities. It also strives to strengthen the capacity of local organisations, and encourage cross-sectoral convergence to improve the quality and outreach of services.

Enhancing Mobile Populations' Access to HIV-AIDS Services Information & Support (EMPHASIS)

Funded by Big
Lottery Fund

Dates: 2008-2013 Value: \$2.25million Location India, Nepal and Bangladesh

EMPHASIS aims to reduce the vulnerabilities to HIV/AIDS amongst populations migrating from Bangladesh and Nepal to India for work. Multifaceted and multilayered Interventions are being targetted at source, transit and destination to all women and single men aged between fifteen and forty-nine, who are migrating to India for more than three months and less than five years from Nepal and Bangladesh.

Web based Emergency Response

Funded by ICICI
Foundation

Dates: 2009-10 Value: \$ 0.1 million

With funding support from ICICI Foundation, CARE India has developed a model for mobilising resources to support emergency response, rehabilitation and disaster risk reduction.. This web based system will ensure a user-friendly and trusted platform through which CARE can maintain its visibility in the emergency scene with a much wider audience. The project presents a unique initiative which draws on the critical expertise of global emergency response, information technology and resource mobilisation.

Sector Wide Approach to Strengthen Health (SWASTH)

Funded by DFID

Duration:2009-2014 Value:\$26.18million Location: Bihar

Through SWASTH we aim to ensure that quality, essential healthcare, nutrition, water and sanitation can be accessed by all, with particular focus on improving the health and nutritional status, of women, the poor and marginalised. In collaboration with the State Government and our consortium partners, CARE is striving to reduce maternal and infant mortality, unwanted pregnancy, improve nutrition and promote convergence between service providers.

Community Health Care Management Initiative (CHCMI)

Funded by
Government of West
Bengal

Duration:2010-2012 Value:\$1.25 million Location: West Bengal

Through CHCMI, we are working with the Government of West Bengal to push forward the public health agenda by engaging with local self governance, civil society organisations and government departments. The project aims to strengthen health and nutrition interventions and ensure representation of women from the poorest and most marginalised groups. The project aims to improve health care delivery system and bring about the convergence of health and Integrated Child Development Services.

Orissa Health Sector Plan

Funded by DFID

Duration:2008-2011 Value:\$0.07 million Location: Orissa

The overall goals of the Orissa Health Sector Plan (OHSP)are to reduce mortality & morbidity, particularly maternal, infant and child mortality besides providing equitable and accessible health care to protect the poor and disadvantaged from the financial costs of illness.

Dalmia Cement Corporate Social Responsibility Project

Funded by Dalmia
Cement

Duration: 2009-2012 Value: 0.24 million Location: Tamil Nadu

The project goal is to improve the quality of life of the residents of the six villages surrounding the Dalmia Cement Factory at Dalmiapuram. The project will create and strengthen self-help groups and community based organizations, to enable access to

financial and other services for improved social and economic opportunities. Another objective is to improve water supply and sanitation in the project area. The project will also create opportunities for residents to practice diversified livelihoods and provide options for risk reduction around life and non life shocks including health risks.

Andhra Pradesh Flood Response			Funded by ICICI Prudential
Duration: 2009-2011	Value: \$0.4 million	Location:Andhra Pradesh	

The overall goal of the project is rehabilitation of the families affected by flood in the two worst affected districts of Mehbubnagar and Kurnool. The project includes a package of interventions focused on reconstruction of disaster resilient houses/homes, income generating and sustaining livelihoods. Resuming farming activities that will help in increasing subsistence consumption, provision of farm equipments, livestock, micro enterprise initiatives and restoration of some vital productive assets are some of the crucial rehabilitation interventions proposed.

SEHAT			Funded by Government of Madhya Pradesh
Duration:2009- 2013	Value:\$0.15 Million	Location: Madhya Pradesh	

The goal is to improve nutrition and health status of women and children and enable access to quality education for children from Scheduled Tribe (ST) and Scheduled Caste (SC) communities in 500 villages across Sidhi and Shahdol districts of Madhya Pradesh. The main objectives are to strengthen the system that addresses malnutrition, improves quality of formal education up to primary level; increases enrollment & attendance and improves access to livelihood options.

Project: Urban Reproductive Health Initiative (URHI)			Gates Foundation
Duration:2009- 2014	Value: \$7.5 million	Location: UP	

URHI is designed to contribute to India’s efforts to achieve the Millennium Development Target of universal access to Reproductive Health by 2015. The overarching goal of the Initiative is to increase Contraceptive Prevalence Rate (CPR) by 20% in four cities of U.P—Allahabad, Aligarh, Agra and Gorakhpur. The project is being implemented by six core partners— Family Health International, the Hindustan Latex Limited Family Planning Promotion Trust, Futures, the Family Planning Association of India, Johns Hopkins University’s Center for Communication Programs and CARE India; and five technical assistance partners: Ipas India, the Urban Health Resource Center, Abt Associates, White Ribbon Alliance and Marie Stopes International.

Promoting Institutions for Reducing Urban Vulnerability			Funded by State Bank of India
Duration: 2008-2009	Value: \$ 0.7 million	Location: Andhra Pradesh	

Through this project we aim to ensure financial inclusion for poor urban women from the informal sector such as petty traders, rag-pickers and domestic workers by developing access to credit. This has been done through promoting and strengthening women collectives.

Tamil Nadu State Non-Governmental Organisations and Volunteer Resource Centre			Funded by Government of Tamil Nadu
Duration: 2008-2009	Value: \$ 0.7 million	Location: Tamil Nadu	

Tamil Nadu State Non-Governmental Organisation and Volunteer Resource Centre has been initiated by the Tamil Nadu Corporation for the Development of Women. It aims to strengthen the capabilities and improving the accountability of government officials, NGOs and community-based organisations in the area. The resource centre focused on training of trainers on book-keeping courses, financial management and audit programmes.

TB Grant			Funded by Eli Lilly
Duration: 2009-2011	Location: West Bengal		

IMPACT project has been designed to improve TB treatment completion rates by multi-drug resistant patients in West Bengal. In collaboration with the Revised National TB Control Programme, IMPACT supports Directly Observed Treatment (DOTS Plus) services to provide the psychosocial counselling and support necessary to encourage multi-drug resistant TB patients to begin, continue and complete medical treatment.

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