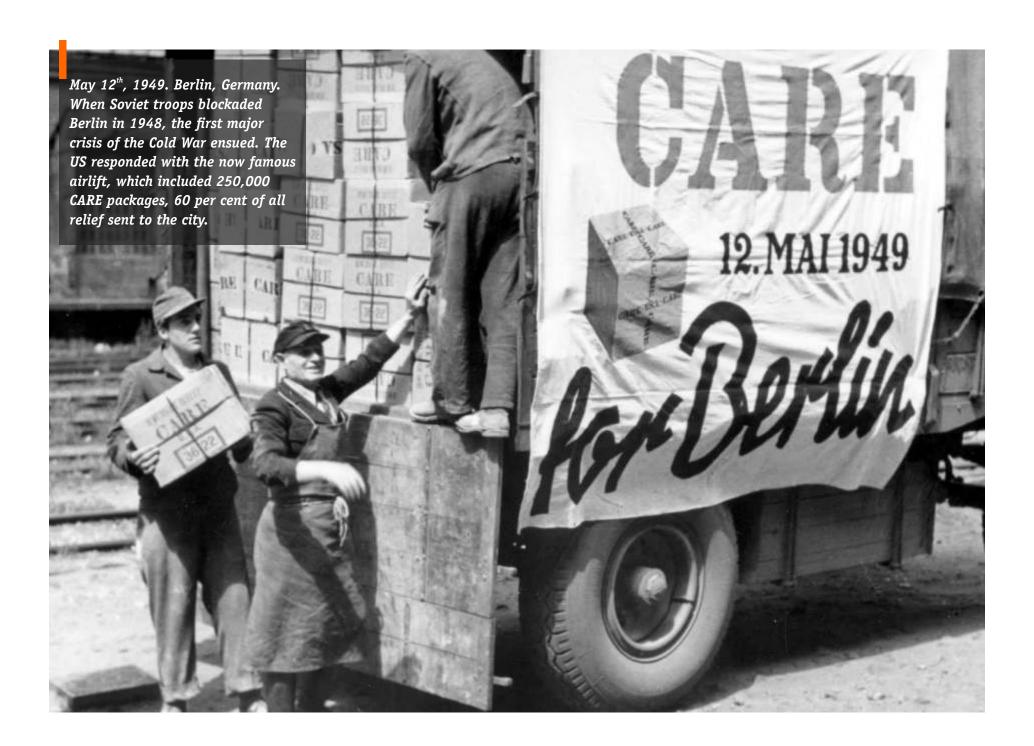






MILESTONES



FOREWORD

More than seven decades ago, CARE was established by 22 charities to send CARE Packages® of food, clothing, medicine and other relief supplies to the survivors of World War II in Europe and Asia after the war. In delivering this aid, the humanitarian organisation faced challenges of limited resources, an unreliable postal system, high shipping costs and poor transportation services.

Around the same time, a newly independent nation, the Republic of India, took its first steps towards self-government. In addition to creating national unity from diverse groups, the nation was facing challenges like an uncertain economic development and the need to build up social services.

Over the years, the paths of this new relief organisation and the new nation intertwined, forging a deep history in which each has played a role in the evolution of the other. Over the past seven decades, CARE has contributed, in few parts, to India's impressive progress on social and economic fronts. And, in turn, much of CARE's programming around the world has its origin from its achievements in India.

Indeed, CARE's work in India had an intense impact on the organisation's evolution as a provider of humanitarian aid and its development work around the world. Long lasting success, wide-reaching experiences and mutual benefits have been the hallmarks of this association.





Pg 2

Setting Foot in India

CARE arrived in India with the signing of 'Indo-CARE bilateral agreement' following which it aided educational institutions, hospitals, set-up relief camps. It also provided food-based relief to people affected by natural disasters.

1960s Pg 8

Expanding Food Assistance

This was the decade of expanding and consolidating food assistance in 14 states of India. Efforts were made to mitigate the woes of drought affected people of Eastern India. Additionally, CARE played a significant role in the expansion of mid-day meal programme in Madras (now known as Chennai), as part of which 96 central kitchens were constructed.







Pq 16 **Indigenising Nutrition**

The period was focused on nutrition programmes. A sum of INR 8.5 million was provided for the construction of the largest food processing complex in Hyderabad. At the end of this period, CARE also started supporting India's Integrated Nutrition and Health Project.

Decade of Expansion

1990s Pg 24

CARE reoriented its role to align with the nation's transforming economy through long-range, cross-sectoral strategic programmatic interventions. It rolled out new projects for improving health care, girls' education with a special emphasis on women livelihoods.





Pg 32

New Millennium, New Vision

At the beginning of the new millennium, CARE made a considerable shift in its programming approach from direct service provision to enabling poor and vulnerable groups. CARE also started evolving as an organisation addressing underlying causes of poverty and social injustice, bringing about sustainable change at scale to improve the lives and livelihoods of marginalised women and girls.

Way Forward Pg 44

Preparing for Next Decade

Most of CARE's programmes are now focused towards reaching the unreached and underserved communities. The organisation is dedicatedly working towards reaching out to people, especially women and girls in districts across the country with poor Human Development Indicators.





1950s **SETTING FOOT IN INDIA**

Parked between the exhilarating tragic forties and later decades of gleaming aspirations, the fifties was a time when solutions to crises-social, political and economic - had to be invented in testing conditions.

This was also the time when CARE first came to India.

Read ahead to learn how a great democracy and an organisation committed to bringing humanitarian relief evolved hand in hand, to serve the people of India.



CARE's relationship with India began over seven decades ago, like many of CARE's introductions to developing nations, with the CARE Package® - plain brown boxes holding food and other essential items that were harbingers of hope for the survivors of World War II.

In 1950, as part of the Indo-CARE agreement signed between CARE and the Government of India, students from Vassar College in Poughkeepsie, New York sent a shipment of CARE packages to students at Indian Universities. And, this was just the beginning.

As India celebrated the birth of the Indian Republic in 1950, natural disasters coming one after the other shook the country. There was almost a perennial crop shortage caused by the failure of the monsoons or excessive rains leading to flooding.

Functioning from the barracks on Delhi's Janpath, in this first decade, CARE provided relief for victims of floods in Kashmir, earthquake in Assam and famine in Uttar Pradesh. Milk powder,

butter oil and cheese embodied CARE relief packages and the beneficiaries included leprosy asylums, orphanages and tuberculosis hospitals. In fact, in the early years, CARE was dominantly known for providing sustenance to the hungry and the impoverished.

In that historic decade, CARE distributed close to 20,000 tons of food in India and this laid the foundations for CARE's nutrition programme.

Gradually, agriculture, health and education programmes were added to CARE's range of interventions. The agriculture support extended to the supply of hand tools, specially designed steel ploughs, construction of roads and irrigation canals.

In the health sector, the emphasis was on training the medical staff and supply of mobile medical units and other equipment, books, midwifery kits and, surgical instruments. To promote education, CARE provided adult literacy materials, book shelves, school kits, and equipment for vocational training.

In this historic decade, CARE distributed close to 20,000 tonnes of food in India, and, this laid the foundation for CARE's nutrition programme.



The CARE Plough

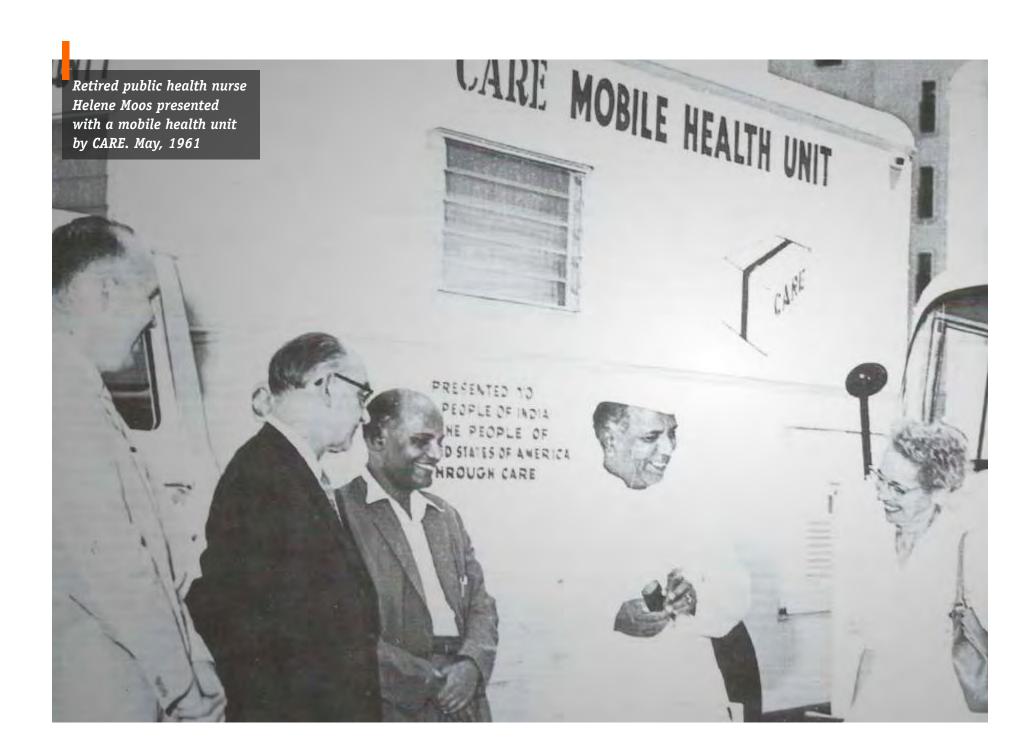
The CARE plough, a six-inch mould-board tool, was specially developed, manufactured and distributed to hundreds of farmers. It was a small but significant intervention. The first of these ploughs was presented to India's first Prime Minister, Jawaharlal Nehru.

Welcoming Dalai Lama

When His Holiness Dalai Lama marched from Lhasa to India with thousands of refugees in 1959, CARE provided food at the reception camp in north-east India. It also provided medical care and blankets to hundreds of sick Tibetan refugees in Kalimpong.

In addition, CARE arranged elementary schooling facilities for those restarting their lives in Darjeeling. It also supplied looms, spindles and woollen yarns for making carpets as well as picks, shovels and crowbars for Tibetans engaged in road building. Scribes were provided with the necessary equipment to write books on Buddhism, and cloth and colours were given to painters for producing the Tibetan Tangkas.

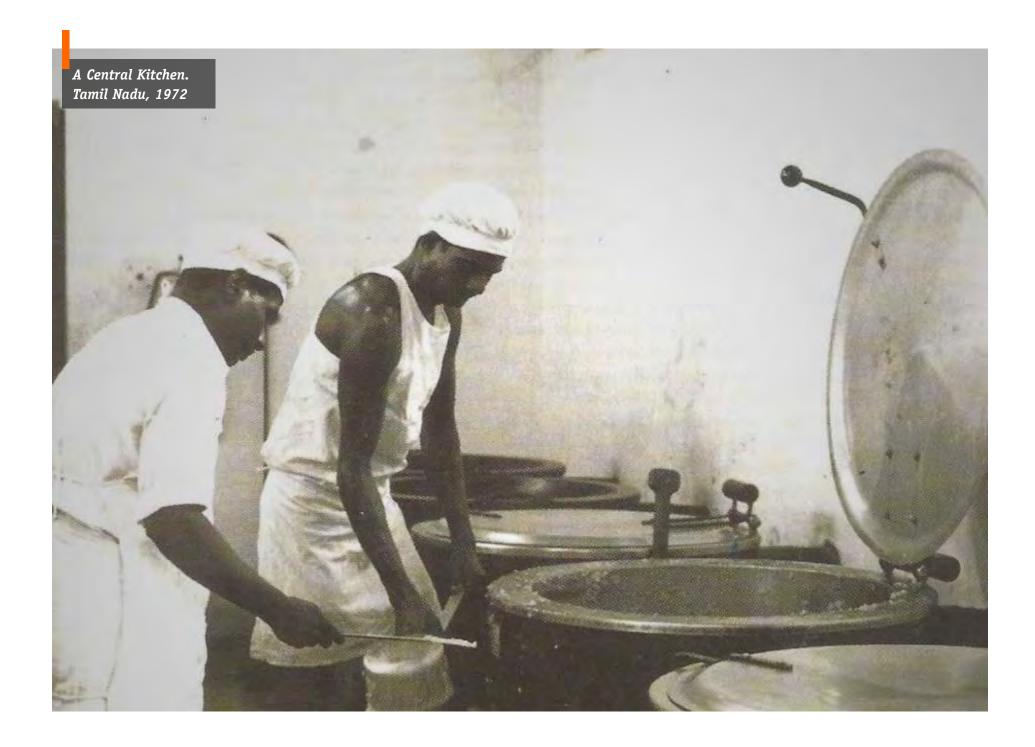




1960s **EXPANDING FOOD ASSISTANCE**

In the sixties, India was facing a major challenge of feeding her people. And the situation got worse with the Bihar famine. One of the then CARE employee noted, "To someone who had never been to Bihar, it was, I admit, a pretty gruesome sight."

How did CARE help the country battle its food crisis? Were Central Kitchens the solution? Read on...



In Madras, now known as Chennai, the mid-day meal scheme had been operational since 1925. It was intended to help poor children who attended school but remained hungry all throughout the day. However, its reach was limited.

The programme received an impetus with Dr C. Subramaniam, the then Finance Minister of India, signing an agreement in Washington in 1961 under which CARE was to provide the nourish-ment while the state government had to bear the administrative costs of the expanded mid-day meal programme. This firmly established the developing world's largest logistical network for free food distribution.

CARE's mid-day meal beneficiaries rose from 7,50,000 in 1960 to 12 million children daily in 1,30,000 schools in 14 states by 1985.

Initially, the programme began with the provision of a glass of milk every day. Later, it included corn-soya milk, corn-soya blend, bulgur wheat, salad oil and rice.

It was a mammoth programme. Every year, till mid-eighties, CARE imported 1,45,000 tons of

food worth USD 44 million. The Food Corporation of India cleared the shipments with the assistance of CARE port officers who supervised their dispatch to district warehouses in the surrounding states.

CARE constructed storage *godowns* and central kitchens for preparing the vast quantities of food.

CARE CHRONICLE

Central Kitchens

The Central Kitchen project was conceived to reduce the involvement of teachers, headmasters and headmistresses in preparing meals, neglecting their prime responsibility of teaching. In the sixties, 30 central kitchens were constructed in Chingleput district. CARE bore this cost as well as that of 66 food delivery vans. In the next decade, CARE constructed another 66 kitchens in two more districts. Commenting on the CARE support, a retired government official in Tamil Nadu said, "The poor children of Tamil Nadu prospered and CARE was loved by all." Even uneducated mothers knew CARE.

CARE's mid-day meal beneficiaries rose from 7,50,000 in 1960 to 12 million children daily in 1,30,000 schools in 14 states by 1985.

Bihar Famine

CARE's many achievements in the 60s also include the response to the extreme scarcity of food during Bihar famine of 1965 and 1966, when rains had failed Bihar for two consecutive years, and, 90 million people in eastern India were caught in the worst drought since independence. Hundreds perished and the deadly consequences of early malnutrition threatened the future of young children. The biggest challenge before the Government, and all development activists, was to prevent Bihar from turning into a massive graveyard. Several voluntary agencies and the Government rushed to combat this natural disaster.

Five million people were given free lunch every day by CARE and over 1,55,000 tons of food was distributed. The one-square-meal-a-day project was run through 27,000 primary schools of the state. CARE's famine relief programme lasted till 1968 to counter the longer impact of drought. The interventions at that time also included supporting the Bihar government with irrigation facilities as well as drinking water.

Clearly, even in those early years when food distribution and emergency relief were CARE's major concern, it was quietly laying the foundations for addressing the long term developing needs of the country.

For instance, when India was in the throes of the Green Revolution, CARE initiated a project for cross-breeding of cows to increase milk yields in the states of Punjab and Haryana. A rural fisheries project was supported in Haryana.

To increase economic viability of small and marginal farmers, agriculture development received special attention. A major irrigation project, Kodpak lift irrigation, was started in Andhra Pradesh, and a tubewell electrification project in Uttar Pradesh.

In Tamil Nadu, Maharashtra, and Madhya Pradesh, tractor rental projects were initiated. By providing the material needs for these projects, CARE was able to improve the credit worthiness of the small farmers.

Five million people were given free lunch every day by CARE and over 1,55,000 tons of food was distributed. The one-square-meal-a-day project was run through 27,000 primary schools of the state.







Source: Fotonovelas and Comic Books - The Use of Popular Graphic Media in Development; By Ronald Parlato | Margaret Burns Parlato | Bonnie J. Cain



Nutrition Comics

CARE produced comic books on nutrition (Lakshman Kills the Tiger, The Adventures of Raju, and Shabash Balwan) for elementary schools in both rural and urban areas and found that they were highly successful in delivering the message and were well-received by teachers and school administrators.

Lakshman Kills the Tiger was produced by CARE for the Government of India, and was, in a way a pioneering attempt in nutrition comic books.

The Adventures of Raju was CARE's second attempt at a children's nutrition comic book, and it was developed as part of a multi-media project for entire rural communities. Raju...was done in two-colours, whereas Lakshman... was done in four, for it was felt that children from a media-scarce environment, literate, but exposed to no comic books, would find a two-colour production as attractive as a four-color. The reduction in cost, of course, was significant. Raju... is a series of three stories about a young boy and his adventures, all relating to his good health and good nutrition.

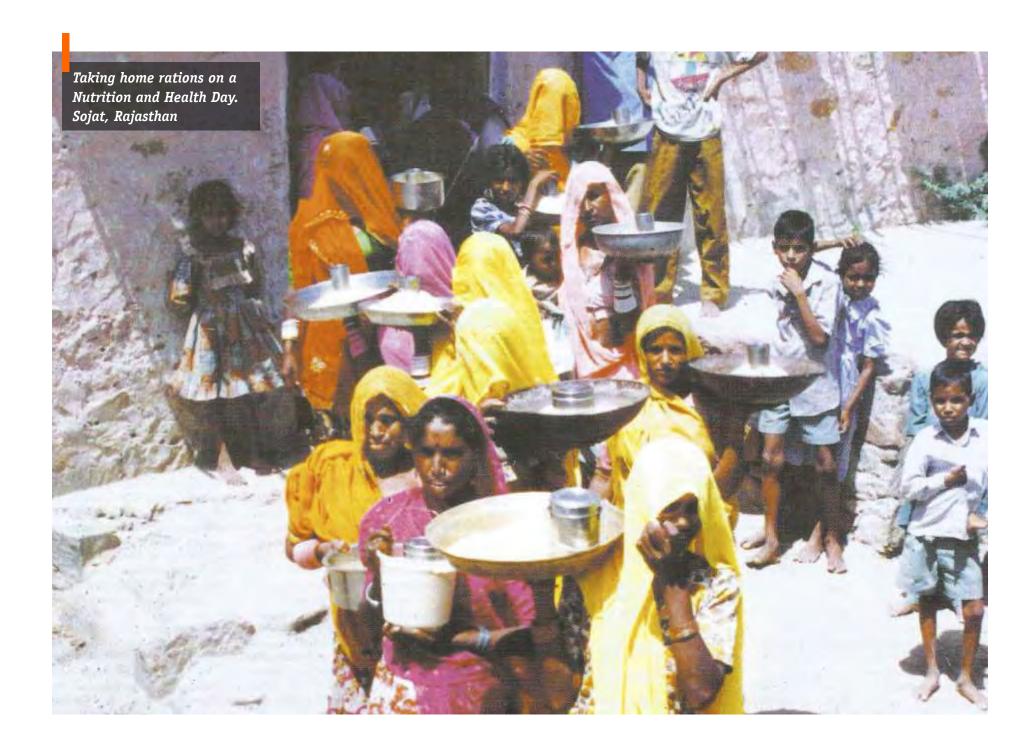
Shabash Balwan was the third in the CARE series on nutrition comic books distributed to children through primary schools. Here the hero is a bit older, but with the same adventures. This comic is the shortest of the three, only four pages long illustration and was designed to permit the publication of several issues about Balwan within a limited budget; thereby increasing the number of media contacts with the audience.



1970s & 80s **INDIGENISING NUTRITION**

This was a turbulent and testing period for India. After the comparative calm of the previous decade, the seventies and eighties were full of ups and downs. India suffered the trauma of another war, which adversely affected the country politically and economically. Nutrition, however, continued to be a priority.

This is when CARE initiated programmes like take-home ration and linked food with other services. Read ahead to know more about these initiatives.



By 1970, half of India's population was malnourished and the challenge for development scientists was to put in place land practices that would take care of people's special nutrition needs. To do its part, CARE launched a rural mass media programme in 1971.

Working closely with the advertising industry, nutritionists, sociologists and language experts, CARE developed meaningful messages about food and community well-being for the rural masses. Radio talks, folk art forms, jingles, films, posters and banners carried messages on nutrition, health, and sanitation. Two of CARE's films on 'breast-feeding' and 'hygiene and sanitation' won the best documentary awards from the Government of Tamil Nadu.

In the mid-seventies, CARE assisted the Central Government in preparing balahar, and indigenous food, and other local foods like panjeeri and sev. Before this, an experimental kitchen was constructed in Kerala to indigenise the mid-day meal in the state. Groundnuts, pulses, wheat, tapioca and the imported CSM (Cornmeal, Soya-

flour, and Milk powder) went into exciting new recipes to suit Indian palates.

Taking Home Nutrition

In 1971, Project Poshak was started in 13 districts of Madhya Pradesh to test the feasibility of a takehome delivery system through the existing rural facilities of the health department.

Health centres, which did not receive many visitors ordinarily, suddenly began attracting women and children as centres of food distribution. Slowly, contraceptives were also made available at the centres.

Linking Food with Other Services

With several thousand tonnes of food arriving every year in the five major port cities – Bombay (now Mumbai), Madras (now Chennai), Calcutta (now Kolkata), Cochin (now Kochi) and Visakhapatnam – for distribution, adequate storage facilities had to be created. From 1970 to 1983, almost 400 warehouses were constructed with CARE assistance at a cost of

In 1971, Project Poshak was started in 13 districts of Madhya Pradesh to test the feasibility of a take-home delivery system through the existing rural facilities of the health department.

INR 20 million. The warehouses constructed by CARE are still in use.

During this period, CARE had been providing nutritious food to several children below the age of six. Very often, pre-school facilities were minimal, and these children met in temples, school verandahs and under trees.

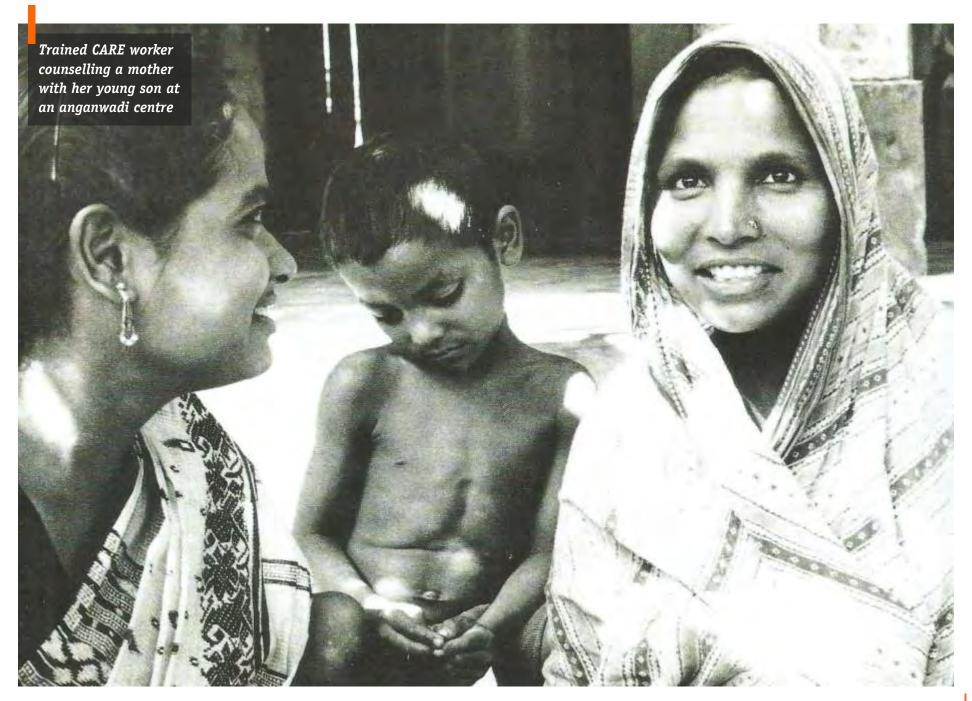
CARE had started expanding its services slowly to support the construction of pre-school facilities so that it became easier to reach the vulnerable children at these sites.

From 1971 to 1983, CARE provided INR 35 million for the construction of 5,500 *Balwadis* (pre-schools) in the 14 Indian states it was operating in. The children going to these *Balwadis* were now able to study and get fed. Besides access to education and supplementary feeding for their children, mothers had the opportunity to meet, talk and share information with trained CARE workers at these centres on an almost daily basis.

Supporting the Integrated Child Development Services Scheme

In 1975, the Government of India introduced the Integrated Child Development Services (ICDS) scheme to provide supplementary nutrition, immunisation, primary health check-up, and referral services to children below six years, as well as pregnant and nursing mothers. In 1984, with food aid from USAID, CARE began to support a portion of the ICDS scheme through its supplementary nutrition programme. Every year food worth US\$ 63 million (approx. INR 651 million) was provided to 1,41,101 Anganwadis on a daily basis. In Gujarat and Orissa (now Odisha), for example, CARE upgraded the special nutrition programme by helping train Anganwadi workers, health workers and supervisors in the delivery of basic health services. It provided nutrition education materials, and equipment for the Anganwadis. All this laid the foundation for the birth of CARE's own Integrated Nutrition and Health Project in the mid-nineties.

From 1971 to 1983, CARE provided INR 35 million for the construction of 5,500 Balwadis (preschools) in the 14 Indian states it was operating in.





Reaching Out

There were several ways in which CARE reached out to the people of India in the 70s and 80s. The hostilities between East and West Pakistan in 1971 led to 10 million people taking refuge in India – namely, in the states of West Bengal, Assam, Meghalaya, Tripura, Manipur and Arunachal Pradesh.

The Indian Red Cross Society (IRCS) sought CARE's support to meet the needs of these refugees. 16 CARE staff members, in two batches, helped round the clock for smooth distribution of the relief materials. When hostilities ceased and Bangladesh was born, the IRCS put on record its appreciation for CARE's help.

Ready to Eat Food

CARE provided INR 8.5 million for the construction of the country's largest food processing complex for nutritious food, on the outskirts of Hyderabad in Andhra Pradesh in 1971.

4,00,000 units of high-protein, high-calorie ready-to-eat food were produced every day and the facility was used by neighbouring states as well.

CARE also assisted the governments of Punjab, Haryana and Uttar Pradesh to establish six food processing plants for ready-to-eat *panjeeri*, a local sweet porridge.

Food for Work

Using the large quantities of food coming into the country under US's Food for Peace programme, CARE helped millions of people to sustain themselves through natural disasters. For example, many roads were constructed facilitating the movement of CARE commodities to schools and nutrition centres. In Udaipur district of Rajasthan, hit by severe drought in 1974-75, CARE in collaboration with the state government provided food grain support for digging 10,000 irrigation wells. For its support, CARE was honoured by the district administration during the 1975 Independence Day celebrations.



1990s **THE DECADE OF EXPANSION**

This decade is perhaps the most memorable. The country went through hitherto unseen changes that took the country from both good as well as bad phases. On one hand, the country witnessed an economic revolution, and on the other, it also witnessed humanitarian crises in the form of natural disasters.

CARE aligned with the changing times and re-oriented its mission to incorporate other developmental aspects as its focus areas. Read ahead to know more.



In the nineties, CARE decided to re-orient its goals and vision to deal with several challenges-increasing population, retaining children in schools, health problems in women and children, food security, degradation of natural resources, gainful employment and credit facilities for women.

Recognising these challenges being critical, CARE decided to reinvent itself by, building a strong foundation of staff, systems and structures, thereby progressing from a pure welfare and service-oriented delivery to a sharper focus on vulnerable women and children from poorer sections of the society.

CARE steadily emerged as the manager of a strategic mix of development interventions, by establishing new parameters for its programmes.

This was reflected in the continuation of working with women and children through the ICDS scheme, while looking at issues related to Girls' Primary Education and Small Economy Activity Development. This would increase women's control of their productive and reproductive lives.

Integrating Nutrition and Health

With 36% of the Indian population still living below the poverty line, CARE decided to provide catalytic leadership in increasing the effectiveness and efficiency of the ICDS, which provides a basket of services at the grassroots and is, therefore, easier to measure. CARE recognised that through the ICDS mechanism, it had the potential to address the major health and survival needs of 40% of the world's neediest children by addressing the major reasons for under-nutrition, illness and death amongst children. When CARE's Integrated Nutrition and Health Programme (INHP) was born, it reached women and children in 10 of the poorest states in India, through the ICDS programme.

The INHP impacted approximately 80,00,000 mothers and children in 1,23,000 villages every day. Several other significant interventions included the Better Health and Nutrition Project, Maternal and Infant Survival Project, the Child Survival Project, the Linkages of Improved Maternal and Infant Health Project and the Anaemia Control Project.

CARE's Integrated Nutrition and Health Programme (INHP) impacted approximately 80,00,000 mothers and children in 1,23,000 villages every day.

Women's Reproductive Health

CARE's project in this area aimed to improve women's access to quality health services and empowering them to make informed decisions about their reproductive health, including the number and spacing between children.

For this purpose, women's groups involved in credit and loan facilities became an integral part of the programme since they had considerable influence on members to achieve control of their own lives through family planning.

Small Economic Activity Development

Early in the nineties, six hundred women – mothers of children covered by the ICDS programme in selected blocks of Andhra Pradesh, were selected for the Savings and Loan Associations (SLA) projects that began in 1991 and continued till 1996.

Most of these women were from backward castes or tribals and were illiterate. Under the project, women's groups were formed at the village level and as a first step, these women were given training in literacy and numeracy.

With the help of a trainer, and with technical guidance from CARE field officers, these women started managing their monthly savings.

Eventually, learning from the field experiences of the Savings and Loan Associations (SLA) project, the CREDIT (Credit Rotation for Empowerment and Development through Institution Building and Training), CASHE (Credit and Savings for Household Enterprise) and KID (Konkan Integrated Development) initiatives were started.

CARE began to look at small economic activity development against the larger canvas of women's economic and social empowerment.

At the end of the nineties, microfinance projects were launched in the state of Bihar, Madhya Pradesh, Andhra Pradesh, Maharashtra, Odisha and West Bengal.

This was done through grassroots mobilisation and organisation of self-help groups.

Girls' Primary Education

The Girls' Primary Education (GPE) Project was CARE's first educational initiative to support Government of India's goal of Education for All.

In line with its revised goals, CARE started working towards increasing girls' access to education by promoting and supporting alternative educational programmes, equivalent to formal schooling, in collaboration with NGOs and community groups.

Started in 1995, the project covered 200 villages of Uttar Pradesh. Later the programme was rolled out in Rajasthan in 1999.

These two states were selected for intervention as they had the lowest female rural literacy rates in the country – 19 and 12 per cent respectively.



Accelerated learning Programme: Udaan

CARE had been managing Udaan project in the state of Uttar Pradesh (Hardoi district) the nineties.

These camps provide learning opportunities to out-of-school girls in the age group 11-14 years who have either dropped out of schools or never been enrolled in a school. Udaan gives these girls an opportunity to break through the vicious cycle of illiteracy and complete class 5-level primary education in a period of 11 months.

The project has been honoured and appreciated through various awards, such as the Commonwealth Learning Award, 2005.

Emergency Assistance

Even as CARE was mainstreaming women and children into the development process, response to emergencies continued to get priority.

On September 30, 1993, an earthquake followed by several tremors destroyed 54 villages in Latur, and in the neighbouring Osmanabad district, in Maharashtra. Thousands of people perished in their sleep when their houses collapsed on them. CARE teams reached the affected areas within two days. They provided 30 water storage tanks for rehabilitation camps in different villages. Saris, dhotis, blankets, garments for children, utensils for cooking, and ploughs were distributed in thousands.

In fact, there were several emergencies in the nineties and CARE was there – assisting earthquake victims in Jabalpur, Madhya Pradesh, cyclone victims in Orissa, Gujarat and Andhra Pradesh and flood victims in Bihar, Uttar Pradesh and West Bengal.

CARE CHRONICLE

Relief and rehabilitation to Odisha Cyclone survivors

The 1999 Orissa (now known as Odisha) cyclone was the strongest recorded tropical cyclone in the North Indian Ocean, and among the most destructive in the region. Even as alarm bells about the gruesome tragedy of Odisha began ringing all over the country and abroad, CARE moved into top gear for their disaster relief operations.

It was the first NGO to provide relief supplies to the affected people. By the end of January 2000, CARE had distributed more than 10,303 metric tonnes of food, to over 4,25,000 families.

The second urgent need was shelter. During the early days, CARE provided plastic sheets to

1,49,000 families, so that they could pitch a temporary shelter. More importantly, CARE conceived the ASHRAYA project to reconstruct houses for the affected families, with future safety and security being central to the project.

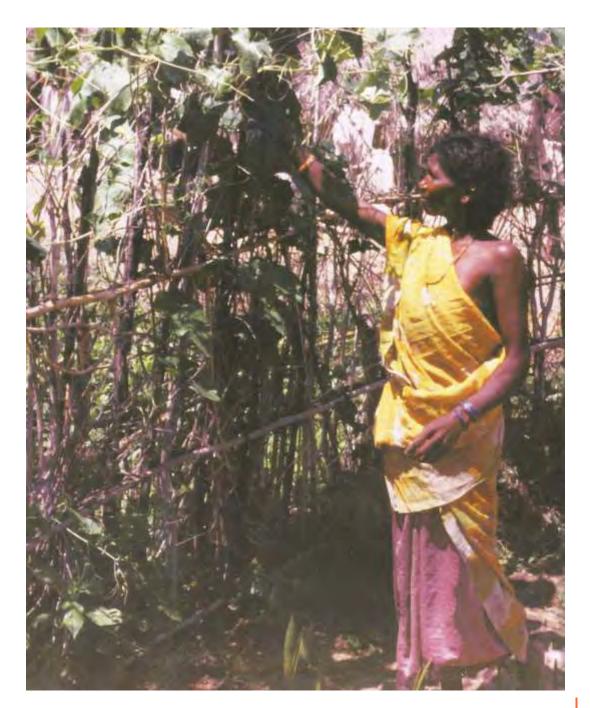
ASHRAYA's good practices were included in the United Nations Habitat 2002 Best Practices Global 100 list, and it was given the coveted UN Habitat award for this innovative housing project.

Later, CARE was congratulated by the Government of India's Ministry of Urban Development and Poverty Alleviation for the award.

Sustainable Tribal Empowerment Project (STEP), Andhra Pradesh

The tribal communities of Andhra Pradesh were amongst the poorest and most deprived in the country. CARE's integrated process-oriented project sought to improve the quality of life of about 2,00,000 tribal households in four tribal districts of Srikakulam, Vizianagaram, Vishakhapatnam and East Godavari in northern Andhra Pradesh. Through the seven-year STEP project, their health, education, income and food security were improved significantly.

This was achieved through the establishment and strengthening of community-based organisations with the capacity to plan and manage their own development agenda. The project's participatory focus was on the communities themselves. Local NGOs and the government too were involved in the project identification, planning, implementation, monitoring and evaluation.





2000s **NEW MILLENNIUM, NEW VISION**

Like for any other nation, the United Nations' development Goals have been the guiding principle for India's development map. CARE has been playing a meaningful role in helping the country achieve these targets.

Read more about CARE's role in this period.



In the beginning of the new millennium, CARE made a considerable shift in its programming approach. From direct service delivery to enabling poor and vulnerable groups, CARE started evolving as an organisation to address underlying causes of poverty. Since then, the focus has been explicitly on the well-being, social position and rights of women and girls from marginalised communities.

In alignment with the United Nations Millennium Development Goals, CARE set three ambitious goals for the next few years to come - quality healthcare, inclusive education and sustainable livelihoods. As a spin off from the new vision and goal, CARE began to look for strategic direction that would feed into the goals of each of its sectors of work.

It saw genuine community participation in all stages of its projects as central to the capacity building of vulnerable people. It also acknowledged partnerships as the mechanism through which its vision and goals could be achieved. CARE's partners included the Government of India, NGOs, the

corporate sector, grassroots level organisations and donors.

Locally Governed and Globally Connected

In 2008, CARE in India initiated the transition process by registering itself as a national entity CARE India Solutions for Sustainable Development (CISSD). The transition process culminated in 2013, with CARE India starting operations as a fully independent entity, and becoming a full member of CARE International Confederation.

During this period, the accountability of CARE India shifted to an Indian Board. In 2008, CARE India's board took shape and it also became an affiliate member of the CARE International Confederation, sitting alongside CARE USA, UK, France, The Netherlands, Germany, Austria, Canada, Australia, Japan, Denmark, Norway and Thailand. The first Board meeting of the national entity was held in March 2009.

In 2008, CARE India's board took shape and it also became an affiliate member of the CARE International Confederation.

Supporting people with HIV/AIDS

In 2008, CARE India began functioning as a Technical Support Unit to assist the State AIDS Control Societies (SACS) to achieve the goals of National AIDS Control Programme (NACP III).

Eventually, CARE India expanded its HIV programmes with an aim to equip communities vulnerable to HIV/AIDS such as sex workers and migrants with relevant knowledge, attitude and behaviours to protect them from HIV/AIDS.

The focus was on building livelihoods and microenterprises for people suffering with HIV/AIDS to provide food security and prevent their further descent into poverty due to the burden of disease. CARE India also worked towards building capacities within communities and advocating policies with governments to reduce the vulnerability of people with HIV/AIDS.

The EMPHASIS Programme

Enhancing Mobile Populations' Access to HIV & AIDS Services Information and Support (EMPHASIS) was a regional project implemented by CARE India to reduce the vulnerabilities to HIV & AIDS among mobile populations crossing Bangladesh and Nepal to and from India. This five-year (August 2009 – July 2014) project piloted a cross-border approach to increase access to prevention and treatment services; to strengthen capacity of civil society, government institutions and policy makers to address the needs of mobile populations; and to create an enabling environment for safer mobility.

Eventually, CARE India became a key partner in the Enhancing Mobile Population Access to HIV/AIDS Services Information and Support (EMPHASIS) along with CARE Nepal and CARE Bangladesh.

Promoting Microenterprise Safety Nets

In early 2000s CARE India started promoting micro-enterprise as a means of providing broad-based viable livelihood options for disaster-hit communities, as well as poor and vulnerable families, such as those affected by HIV and who do not have other employment opportunities.

Additionally, post Tsunami, when many people lost their means of livelihoods, CARE India worked alongside Bajaj Allianz to take micro insurance to communities who were previously excluded from such protection.

Moreover, in Andhra Pradesh, CARE India facilitated a weather index-based insurance policy that protects small-scale salt pan workers against salt production losses, for the first time ever.

Disaster Relief in Gujarat

On January 26, 2001, the state of Gujarat in western India was hit by an earthquake measuring 7.9 on the Richter scale which resulted in an unprecedented level of destruction.

CARE India was one of the first organisations to offer relief. CARE India and the Federation of Indian Chambers of Commerce and Industry (FICCI) entered a strategic alliance with the purpose and goal to assist the people of Gujarat to recover from the devastating effects of the earthquake.

Activities included building of 5,554 houses, 15 schools, 11 community centres, 21 crèches, 12 Panchayat (village council) buildings, five sub-health centres and water and sanitation infrastructure.



India

The Indian Ocean Tsunami of 2004 affected 12 countries around the globe. In India, the Tsunami waves wreaked havoc along the eastern coast of South India, and on the Andaman and Nicobar Islands, killing nearly 10,000 people. About three million people were affected, thousands of whom were forced to leave the wreckage of their homes and seek refuge in nearby community centres and places of worship.

It was a dire situation and called for a concerted and big humanitarian effort. That is where CARE India stepped in. First, CARE India addressed the immediate problems by distributing relief and aid material in the disaster affected areas. It then designed and implemented a holistic response to address the mid-term and long-term problems of people in the coastal areas.

CARE India constructed over 2,000 temporary houses; 2,000 permanent houses; distributed non-food survival items to 600 families;

CARE India's Response to Tsunami in conducted water and sanitation activities like building hand pumps and toilets; provided psychosocial care and begun community development with marginalised communities to ensure their inclusion within long-term development efforts.

> CARE India also pressed the Government of Tamil Nadu to ensure that all titles for new housing were issued jointly in the name of the husband and wife in the family with a view to ensuring protection from eviction for women. A survey later, revealed that this move helped in reducing cases of domestic violence and made women feel empowered.

> CARE India's overall rehabilitation and development plan for Tsunami affected regions was a holistic one. The approach was to ensure that socially and economically vulnerable groups such as fishing communities, tribal families and women who have long been excluded from mainstream society - could participate fully in the process through micro-planning and social audit processes.

"The title of the house will be given in the joint names of the wife and husband if one of them is not alive, in the name of the survivor and the eldest child."

-Annex I for Government Order No. 172



Change Agents to Change Leaders

During the months of January and February 2005, every village in the remote districts of Chhattisgarh celebrated to enjoy the charm of the power of self-rule; to rule their native village government. After the state was born in 2000, the state witnessed its first ever election of local government bodies.

As an organisation that was managing largest nutrition, health and HIV-AIDS programme at the time, CARE India was determined to make Mitanin, grassroot volunteers, peer educators, nutrition and HIV counsellor, care and support workers, and all the marginalised women and girls, to change leaders. For CARE India, it was a mission to demonstrate and empower future generations. These illiterate women, girls and sex workers (who were also known as Change Agents) used to visit homes to spread health and nutrition messages, bring left outs and drop outs to village Anganwari Centres and ensured rightful share of free dalia (broken wheat) from Anganwadis.

CARE India's mission during this opportune moment of first local government election in the state was to inculcate and inspire these women to fight election. Clearly, it was not easy to break the barriers, myths and misconceptions and be mobile and go out of four walls. Their unheard voices and unspoken words never scribbled down but their courage and conviction made them to move on to create an island of excellence.

"Just filing my nomination format the collectorate was a victory for me," said Sunita, a sex worker in Raipur who had often been brought to that building as an accused.

Then the final results were out – a complete victory; a moment of celebration. Out of 70,000 women and children that we supported to contest election in more than 9000 Panchayats and 15 urban local bodies; almost 10,000 women and children got elected. Additionally, in a state wide survey conducted by CARE India in 2006, the malnutrition over five year period reduced by 20% which in itself was a record in the country.

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CARE CHRONICLE

The Gujarat Harmony Project

In 2002, Gujarat was witness to the worst religious violence since India's partition in 1947, which was sparked after the Godhra train incident. To resolve the prevailing conflict and work towards enduring peace between different communities in the state, CARE India initiated the Gujarat Harmony Project (GHP), under which it collaborated with various NGOs, officials in the state administration, and other like-minded individuals and organisations that were interested in restoring normalcy in the state.

The project was conceived as a holistic response of the civil society to the disaster, with three main focus areas - Immediate Relief, Livelihood Restoration and Rehabilitation, Social Reconciliation.



Bihar Technical Support Programme

The Bihar Technical Support Program is a partnership between CARE India, the Bill & Melinda Gates Foundation, and the Government of Bihar, focused on reducing rates of maternal, newborn, and child mortality and malnutrition, and of improving immunization rates and reproductive health services statewide.

Since 2011, the Bihar Technical Support Program has helped the Departments of Health and Social Welfare to improve maternal, newborn, and child health in the state.

Innovations under the programme -

Facility Level

a. Facility quality improvement - In 2013, CARE India, in partnership with the Government of Bihar, developed a solution to improve the quality of services at public health facilities. This approach tackles several tangible and intangible elements of high quality care by upgrading

infrastructure and equipment, improving staff morale, sharpening clinical skills, and updating a range of standard operating procedures, systems, and processes.

b. Mobile Nursing Mentoring - To improve the skills of these nurses and ANMs, CARE India is implementing a nurse mentoring programme called AMANAT. The programme aims to build the capacity of facility nurses and ANMs to manage childbirth complications and provide basic emergency obstetric and newborn care and other reproductive health services including family planning.

Community Level

a. The incremental approach - CARE India partnered with the Government of Bihar to plan and facilitate training sessions for FLWs at health sub-centres. CARE India is leveraging these subcentres as platforms for new purposes: 1) to provide ongoing training and supportive supervision to FLWs, 2) to increase cooperation and coordination between ASHAs and AWWs, and

3) to review and plan the actions of FLWs based on the needs in the community, identified through data collected during home visits.

b. Team based goals and incentives - Recognizing that FLWs in Bihar lacked motivational determinants, CARE India designed and implemented the Team-Based Goals and Incentives (TBGI) innovation to leverage the power of incentives, teamwork, and goal-setting to improve their motivation and job performance.

Systems Level

Weak Newborn Tracking - CARE India is innovating to identify, track and care for very low birth weight newborns. A key part of this innovation is the use of a simple and affordable tool—a digital scale—that is increasing the ANM's accuracy in measuring the weight of newborns immediately after birth. These accurate weights help ANMs, ASHAs, and AWWs to give low birth weight babies the special care they need during the first critical weeks of their lives.



PREPARING FOR THE NEW DECADE

India's growth has not been without challenges - unequal power relations driven by caste and class boundaries, patriarchy, and disparate economic opportunities, have led to further aggravation of poverty and social injustice. The changing socio-economic landscape and unequal pattern of growth across the country has worsened the issue of access and equity for marginalised communities who are striving to break the cycle of poverty and social injustice.

Among the marginalised, women and girls from Dalit and Adivasi communities are particularly excluded from the benefits of development despite several new national policies which envision opportunities for advancement. Most of CARE India's programmes are now focused towards reaching the unreached and underserved communities. The organisation is dedicatedly working towards reaching out to people, especially women and girls in districts across the country with poor Human Development Indicators.

With a view of balancing power sharing in communities as well as in households, each of CARE India's programmes on the ground have been layered with gender transformative change initiatives, along with social analysis and action, leadership and life skills strengthening, building capacities and leadership roles at multiple levels, advocacy on national and international platforms and facilitating links and dialogues between public, private and civil society.

CARE India's key initiatives technically support state and national governments and market systems to be sensitive and capacitated towards the development needs of marginalised communities. To address the underlying cause of poverty, the organisation is working towards addressing unequal power relations and enhancing inclusive governance to monitor reach and the quality of impact on communities. CARE India has a monitoring, evaluation and learning strategy in place. For understanding the impact and effectiveness of its projects on individuals and households, baseline, midterm and end line studies are undertaken regularly.

Annual surveys and special studies are also conducted to track progress on outcomes achieved amongst the communities. For multiplying impact, knowledge sharing and dissemination is a key strategy embedded in all our projects. CARE India facilitates dissemination of knowledge generated by it through national and sub-national level conferences, policy dialogues, consultations, media and other communication channels. These initiatives work towards ensuring national systems are sensitive and capacitated

towards the development needs of vulnerable communities. Based on results from its programmes, CARE India further engages in advocacy and partnerships for influencing policies.

Additionally, to be able to bring about the desired results in the communities we serve, CARE India has developed an open and transparent organisational culture, based on core values of respect, integrity, commitment and excellence. Significant investments have been made in tapping and managing talent, which ensure efficiency and accountability in the work we do.

CARE India has also been working closely with the national and state governments to implement its programmes, and provided inputs in their policy making process. With their support and guidance, CARE India has reached more than 25 million people across 12 states through 40 projects to make positive changes in their lives and livelihoods.

All this would not be possible without the support of CARE India's individual, corporate and institutional partners, along with its stakeholders who have supported its work, which has brought the organisation closer to achieving its goal of impacting 50 million people by 2020.

CARE India's partnership with BMGF and Government of Bihar to improve health systems in the state has further strengthened our resolve to provide access to quality health and nutrition services for some of the poorest communities.



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