



CARE INDIA
2014 - 16



**IMPACT
REPORT**

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IMPACT REPORT

2014-16



CARE India
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FOREWORD

I am very happy to present CARE India's first impact report which is a consolidation of significant changes in the lives of the marginalised population that CARE India worked with. This report synthesises the major impacts and outcomes from evaluations and assessments carried out during 2014–16. It is an attempt to account for set of impact and outcomes that our projects have been able to make either directly or through strong partnerships in the last three years in various sectors, which help us achieve our vision and mission in India. We greatly value and acknowledge contributions made by several partners, including the government and civil society organisations, to achieve these results for the programme participants.

This report covers CARE India's various interventions through 51 projects implemented across 15 states, reaching 41.9 million participants during 2014–16.

CARE India is part of the CARE International Confederation, which has been involved in a worldwide movement dedicated to fighting poverty. CARE has been operational in India since 1950 and for more than six decades contributed to the Government of India's fight against ending poverty and social injustice. In line with the vision and mission of CARE India, the programme strategy aims at transformational change in the lives of women and girls from poor and marginalised communities by alleviating poverty and social injustice. We choose to focus on women and girls because they are disproportionately affected by poverty and discrimination. When women and girls are equipped with the proper resources, they have the power to help families and communities escape poverty.

Through our programmes in the areas of health, education, livelihoods and disaster management, we strive to address the underlying causes of poverty in ways that deepen the impact for the most marginalised people, especially women and girls. To achieve lasting and sustainable change for the community, CARE India's programme is built on three pillars viz. working with the communities to catalyse demand and their leadership, promoting local capacities and supportive environment, and strengthening systems to deliver quality and equitable services. CARE India works with a multi-sectoral approach to address the key challenges in development through direct implementation, technical assistance in

systems strengthening, and community-based demand generation and advocacy.

Our health interventions aim to secure access to quality health services particularly women and children in underserved areas. We work towards identifying the root causes of healthcare challenges, work in partnerships to develop innovative solutions, and help implement quality healthcare services.

The Girls' Education Programme addresses the social and systemic barriers in providing opportunities to girls through increased participation in the formal education system, as well as improving their life skills. We have developed several innovative and scalable programmes which include interventions for in-and-out-of-school girls, early childhood development, life skills and leadership, capacities of teachers, and strengthening the government system through technical support.

Our Livelihood programmes promote sustainable livelihoods and skill building of women smallholder farmers, develop markets and value chains that are equitable, and government extension services. Our interventions improve access, control and knowledge of women over natural and technological resources, as well as support entrepreneurship and employability of women.

CARE India's work around immediate relief and rehabilitation of communities affected by natural and manmade disasters are directed towards helping disaster affected people build their capacity to cope with and recover from disasters. The response particularly covers aspects like shelter, food and nutrition, livelihoods, WASH (water, sanitation and hygiene), and gender in emergencies.

This being our first report of this nature, it is a beginning of an onward journey to hold ourselves accountable in ensuring a dignified life for our project participants that fulfil their human potential and fundamental right to life with dignity. We will continue to produce similar reports for deeper engagement, dialogue and collaboration to build a better future for our communities.

Madhu Deshmukh
Chief Executive Officer
CARE India

ABBREVIATIONS

AGLC	Adolescent Girl's Learning Centre
AHS	Annual Health Survey
AIDS	Acquired Immuno-Deficiency Syndrome
AMTSL	Active Management of Third Stage of Labour
ANC	Ante Natal Care
BEmONC	Basic Emergency Obstetric and Neonatal Care
CAS	Common Application Software
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CFA	Comprehensive Facility Assessments
CRC	Cluster Resource Centre
DISE	District Information System for Education
DLHS	District Level Household Survey
DLSS	District Level SWASTH Survey
DoD	Direct Observation of Deliveries
DRR	Disaster Risk Reduction
ECCE	Early Childhood Care and Education
FRC	Forest Rights Committee
GoB	Government of Bihar
GTC	Gender Transformative Change
HIV	Human Immuno-deficiency Virus
ICDS	Integrated Child Development Services
ICT	Information and Communication Technology
IEC	Information, Education and Communication
ILA	Incremental Learning Approach
IMR	Infant Mortality Rate
IYCF	Infant and Young Child Feeding
KGBV	Kasturba Gandhi Balika Vidyalaya
KMC	Kangaroo Mother Care
LQAS	Lot Quality Assessment Sampling
MAM	Moderate Acute Malnutrition
MDR-TB	Multi-Drug Resistant Tuberculosis
MIS	Management Information System
MMR	Maternal Mortality Rate
NFHS	National Family Health Survey
NFI	Non-Food Item
NGO	Non-Government Organisation
NIN	National Institute of Nutrition
PNC	Post-Natal Care
PRI	<i>Panchayati Raj Institution</i>
PWDV	Protection of Women from Domestic Violence
RtE	Right to Education
SAM	Severe Acute Malnutrition
SCERT	State Council of Education Research and Training
SDG	Sustainable Development Goals
SHG	Self-Help Group
SMC	Social Monitoring Committee
SRH	Sexual and Reproductive Health
SRS	Sample Registration Survey
SSA	<i>Sarva Shiksha Abhiyan</i>

STC	Special Training Centre
STEM	Science, Technology, Engineering and Mathematics
TB	Tuberculosis
U5MR	Under-five Mortality Rate
VAWG	Violence Against Women and Girls
VHSND	Village Health Sanitation and Nutrition Day
WASH	Water Sanitation and Hygiene

Project Name Acronyms

EMPHASIS	Enhancing Mobile Populations' Access to HIV & AIDS Services, Information and Support
BoC	Banking on Change
BTAST	Bihar Technical Assistance and Support Programme
CCA-RSSTP	Climate Change Adaptation for Resilient Small-scale Tea Production
DVC	From Microfinance to Dairy Value Chain Financing
ECCD	Early Childhood Care and Development
EnSIGN	Enhancing the Sustainable Farming Initiative by Integrating Gender and Nutrition
IFHI	Integrated Family Health Initiative
JMV	Join My Village
KLEAP	Kutch Livelihood and Education Advancement Project
MDR TB	Treatment Adherence and Follow up of Multi Drug Resistant TB Patients
MPNP	Madhya Pradesh Nutrition Project
NBS	New Born Survival Project
Pragati	Special Training Centres for Out-of-School Children
SERT	Start Early: Read in Time
SIP-PCTFI	School Improvement Programme-Pasty Collins Trust Fund Initiative
TCH	Improved Quality of Community and Low-level Facility Management of Childhood Pneumonia and Diarrhoea in Bihar
TRL	Teachers' Resource Laboratory
TSU	Technical Support Unit
Udaan	Accelerated Residential Learning Programme for Girls
UHI	Urban Health Initiative
VHSND	Leveraging the Village Health, Sanitation and Nutrition Days to improve the reach of Community Health Workers in Bihar
VL	Scale up of Visceral Leishmaniasis (<i>Kala-azar</i>) Control Activities
WLSME	Women Leadership in Small and Medium Enterprises
WtRF	Where the Rain Falls

EXECUTIVE SUMMARY

For more than 65 years, CARE India, a non-profit organisation, has been working to eradicate poverty and social injustice among the poor and marginalised communities in India. CARE India's programming approach aims at long-term positive changes for individuals, especially women and children from marginalised through its work in the areas of health, education, livelihoods, and disaster preparedness and response.

The goal of bringing positive change in the lives of women and girls from poor and marginalised communities is planned through ably designed and implemented programmes which have the potential to transform lives. The change we hope to realise is implemented by improving capacities and capabilities of individuals and collectives, increasing influential leadership, strengthening positive attitude and support of key stakeholders, enhancing effective access and control of productive resources/opportunities along with advocating for an enabling policy environment support. CARE India's programmes recognise the underlying causes of poverty that arise from poor governance, unequal power relations and failure of markets, which adversely affect the well-being of the programme participants. Hence, they form the cross-cutting approaches of CARE India's programming. By harnessing the support of the community, local institutions, governments, markets and technology, CARE India strives to make fundamental and lasting changes.

This report presents CARE India's programme impact based on the assessment of projects undertaken between

2013–14 and 2015–2016. The impact and outcome presented in this report draws upon a broad range of evaluations and assessments undertaken during the life of various projects. The report does not synthesise all the changes captured in the projects but aims to provide a succinct account of relevant impact and outcomes to showcase the organisation's contribution to improving the life of the poor and marginalised. It fulfils CARE India's intent to hold itself accountable to all those with whom it works, and to those who entrust with resources to promote development and respond to emergencies.

CARE India's project impacts are narrated on four technical areas, spanning health, education, livelihoods, and disaster preparedness and response. By implementing projects at multiple levels, i.e., national, state and district, the projects contribute broadly towards achieving eight sustainable development goals (SDGs). These include: SDG 1 – ending poverty; SDG 2 – zero hunger; SDG 3 – good health and well-being; SDG 4 – inclusive and equitable quality education; SDG 5 – gender equality and women's and girls' empowerment; SDG 6 – equitable access to water and sanitation; SDG 8 – inclusive productive employment and decent work; and SDG 13 – combating climate change and its impacts.

This report covers CARE India's landscape of 51 projects, implemented across 15 states, reaching 41.9 million participants directly through project activities or through a partner.





HEALTH

9
STATES

41,351,238
INDIVIDUALS REACHED

Health interventions by CARE India in nine states reached 41,351,238 individuals, with the aim to impact the lives of communities in the areas of maternal and reproductive health, child health and nutrition, and communicable diseases. Significant improvements have been made in the quality of healthcare delivery services and health and nutrition outcomes of people. An Incremental Learning Approach (ILA) piloted in Bihar that contributed in improving the quality of health service delivery by frontline workers has been scaled up in 162 districts across India. The Mobile Nurse-Mentoring programme called AMANAT mentored a total of 3,224 staff nurses across 400 facilities on Basic Emergency Obstetric and Neonatal Care (BEmONC) services. **Handwashing and gloving practices of service providers improved by 43 percentage points**, as part of quality of care in facilities for infection control during obstetric care. **Active Management of the Third Stage of Labour (AMTSL) improved 12 folds**, and the malpractice of pre-delivery administration of oxytocin reduced to 0.5%.

Maternal Mortality Ratio in Bihar reduced by more than one-fifth in 2015–16, as compared to that in 2007–09. **Institutional deliveries in Bihar improved remarkably by 21.2 percentage points** (from 2010–11 to 2015–16). Nearly 50% of women in Bihar received at least three antenatal check-ups during the last pregnancy (in 2016) as against one-fifth of women (in 2014). **In Ajaygarh, one of the most backward blocks of Panna district in Madhya Pradesh, the full ANC coverage during the last pregnancy increased by nearly two times.** In the Join My Village (JMV) project in Barabanki district of Uttar Pradesh, positive attitudes

of service providers for facilitating men's support during antenatal and post-natal visits enhanced remarkably, resulting in higher accompaniment of men. Working through public-private partnerships in reproductive healthcare, the **use of modern contraceptives in six cities of Uttar Pradesh has increased by approximately 5–10 percentage points** in all the cities. **In Bihar, the use of modern contraceptives among mothers of children aged 6–8 months has moved up by 1% in a year.**

In districts of Panna, Tikamgarh and Chhatarpur in Madhya Pradesh, malnutrition among children under 5 years declined by 19 percentage points between 2010 and 2016. The project, facilitated the referral of 4,688 malnourished children to Nutrition Rehabilitation Centres, thereby reducing malnutrition among 2,792 Severe Acute Malnourished (SAM) and Moderate Acute Malnourished (MAM) children. **In Bihar, malnutrition (weight-for-age) among children under 5 years reduced by 10.2 percentage points** between 2005–06 and 2015–16 during the Bihar Technical Assistance and Support intervention.

Newborn care practices changed significantly at the facility level between 2014 and 2016 in Bihar, showing an **increase of 27 percentage points in the practice of skin-to-skin care at birth and increase of 6 percentage points in dry cord care at birth.** Kangaroo mother care provided to the low birth-weight babies increased by 39 percentage points in the Ajaygarh block of Panna district, Madhya Pradesh. **Timely initiation of breastfeeding in public facility deliveries increased by 7 percentage points** and the

appropriate frequency of complementary feeding at 6-8 months increased by 19 percentage points, in Bihar. In the Ajaygarh block of Madhya Pradesh, early initiation of breastfeeding progressed by 23 percentage points, while exclusive breastfeeding among 0-5 month children improved by 17 percentage points.

In Bihar, 80% of children aged 12-23 months were fully immunised in 2016, with an average annual increment of 2% over three years. During the past decade (2005-06 to 2015-16), the **Infant Mortality Rate (IMR) has come down to 47.9 from 62 per 1,000 live births**, while the **Under-five Mortality Rates (U5MR) decreased drastically to 58 from 95 per 1,000 live births in Bihar**. Significant improvements in institutional delivery, newborn

care, infant and child feeding practices and child immunisation have contributed to reducing infant and child deaths.

Through Active Case Finding strategy, CARE India identified 194,391 presumptive TB cases for referral in Madhya Pradesh, Jharkhand and Chhattisgarh. Multi-Drug Resistant (MDR) TB intervention in West Bengal counselled 1,262 MDR TB patients and 135 MDR TB patients were linked with government welfare schemes. In the *Kala-azar* elimination drive in Bihar and Jharkhand, CARE India's intervention contributed to making **62 endemic blocks free from *Kala-azar***. There has been a steady decline in the number of cases reported, from 8,028 cases in 2014 to 4,774 cases at the end of 2016.



CARE India's Girls' Education Programme is spread across six states, reaching over 224,879 children in more than 1,500 schools, contributed to improving the learning outcomes of children, strengthening the formal education system by providing technical support, building the capacity of teachers and developing innovations for scaling up the programme. Significant impact was achieved through the projects focussing on early childhood development, early grade reading, Science, Technology, Engineering and Mathematics (STEM) education, mainstreaming out-of-school children, girls' leadership, teachers' development and system level changes.

The implementation of a Five-by-Five Model for early childhood development in Chhattisgarh resulted in

32 percentage points improvement in the school readiness levels of children in the age group of 3-6 years, and 28 percentage points improvement in the adaptive skills of children aged 5-5.5. Scalable solutions such as **Child Development Milestone Card** to track the progress of children, **bi-lingual workbooks and storybooks**, **development of early childhood education curriculum and quality standards**, using CARE India's innovative approaches were adopted by state and national governments.

Enhancing reading skills among grade 2 children showing a change of 17 percentage points through an intervention in various districts of Uttar Pradesh and Odisha has been a significant achievement. Reading continuum among grade 2 children has progressed

across 9 competencies, for example, picture description, listening comprehension, alphabet recognition, etc., between the baseline and endline. A noteworthy contribution of the project has been the identification of solutions to address reading issues among children, the adoption of teacher's training manual on language to train primary teachers by the government, and incorporation of learning indicators specific to language under the Right to Education (RtE) model rules in Uttar Pradesh.

The ***Udaan* model, recognised as a best practice by the Commonwealth Ministries of Education in 2006, mainstreamed 92% of 1,087 enrolled out-of-school girls** in the age group of 9–14 years to age-appropriate grades in the formal education system. The leadership curriculum of *Udaan* has the potential to impact 70,000 girls, across 746 *Kasturba Gandhi Balika Vidyalyayas* (KGBVs), owing to the adoption of the curriculum by state-run KGBVs. Almost **100% of out-of-school children enrolled in 15 special training centres, across four selected districts in Bihar, has been mainstreamed into age-appropriate grades.** In the KGBVs supported by CARE India in Uttar Pradesh, **90% of girls achieved the required competence of grade**

5 level in language, while 72% of girls achieved competence of grade 5 level in mathematics.

Teacher development has a positive relationship with the learning outcomes of children, as is evident from the steady improvement in grade 2 and 3 Mathematics among boys and girls, through a longitudinal study in the Shrawasti district of Uttar Pradesh. A teacher's behaviour during a classroom transaction in the form of participatory pedagogy and mixed seating approach contributed to better learning outcomes. To improve teacher's instructional methods and building conceptual clarity and scientific temperament, the model resource centres for subjects like Science, Mathematics and Language for primary, upper primary and KGBV school teachers, has been found to be very effective.

Working in close alignment with the existing government policies and partnering with government bodies such as the State Council of Education Research and Training (SCERT) and *Sarva Shiksha Abhiyan* (SSA), helped achieve sustainable and scalable results. CARE India used its learning to contribute to impact at the system level by supporting the annual state workplan process, development of curriculum, teaching learning materials, child tracking tool and policy formulation.



CARE India, through its livelihood interventions in five states, reached 217,584 individuals, including 139,002 women, by focussing on enhancing income, access and control over productive resources, value chain promotion, increasing productivity, adoption of climate resilient practices, and food and nutrition security. Aimed at the economic development of small and marginal farmers, the project intervention in the Kutch district of Gujarat contributed to **increase the dairy income of farmers by three times, and 46%**

of farmers increased their mean household income from agriculture. The Pathways intervention in Odisha helped raise the mean monthly per capita household farm income by 2.6 times and 14% women-headed households graduated from their pre-project below poverty line status. **The mean asset index of the household increased by almost 13%, while the overall asset values for households increased by 15%.**

While working to improve women's access and control over resources, in the Enhancing the Sustainable Farming

Initiative by Integrating Gender and Nutrition (EnSIGN) project of Bankura district in West Bengal, **women's control over household income and expenditure in the household decision-making domain increased by 20 percentage points**; and **women's sole or joint ownership of household assets increased by 12.9 percentage points**. With regards to the access and control of women's empowerment, there have been transformative changes in the areas of **women selling and purchasing assets (increased by 24 percentage points)**, and their **access to agricultural extension services (increased by 65 percentage points)**. **Agricultural inputs increased by 53 percentage points** in the Pathways project.

Significant change has been seen in the Banking on Change (BoC) project in Tamil Nadu, where the proportion of women who freely use their own **income generated from various income generation activities increased by 18.9 percentage points**. In the EnSIGN project, **women expressing attitudes that support gender equitable roles in family life (scoring 4 out of 4) increased from 20.8% to 53.4%**. Women's representation in leadership positions in the Pathways project increased by 40 percentage points. In terms of overall women's empowerment, the **percentage of women achieving empowerment score of 0.80 or more increased from 4.7% to 10.7%** in the Pathways project.

In building climate-resilient livelihoods of women farmers, CARE India's intervention in Chhattisgarh through the Where the Rain Falls (WtRF) project brought

changes in agricultural practices. Adoption of the 5% model technique by 53.8% farmers helped in increasing the productivity of paddy and enabled the cultivation of a second crop. In the Pathways project, **improved agricultural practices resulted in 27% increase in rice production**.

The livelihood interventions aimed at ensuring nutrition security and enhancing coping capabilities helped to diversify livelihood opportunities. In the EnSIGN project, an increased uptake of growing and maintaining kitchen gardens by women smallholders impacted their dietary diversity, increasing it by one food group. The project tripled the practice of growing nutrition sensitive crops by households. In the Pathways project, the **mean household dietary diversity score increased significantly from 4.1 to 5.4**, while the **mean intra-household food access by women-headed households increased by 42%**. The **household coping index changed from 3.2% to 9.7% when faced with food shortage**.

Working through collectives also contributed to bringing significant changes to the households and communities. **CARE India supported more than 4,000 collectives** including more than 54,000 women members in its livelihood projects. One of the changes facilitated by the power of collectives is the enhanced access to financial services for participant communities under the BoC project, which resulted in a three-fold increase in credit access by mobilising funds from financial institutions (₹216.41 million to ₹1.03 billion).



DISASTER MANAGEMENT

10 STATES | **1,80,000** PERSONS REACHED

Responding to humanitarian emergencies is an essential part of CARE's work to fight poverty and injustice, and we recognise that emergencies are the cause and effect of both. CARE India helps people cope with

crises through disaster risk reduction, emergency relief, preparedness and post-crisis recovery. CARE India is a signatory of and holds itself accountable to accepted International Humanitarian Principles, Standards and

Codes of Conduct including the Red Cross/Crescent and NGO code of conduct, the SPHERE Standard, Humanitarian Accountability Partnership, and the Core Humanitarian Standard.

Recognising that people have the fundamental right to life with dignity, CARE India strives to address people's vulnerabilities and shocks wherever affected people are in need. From 2014 to 2016, India witnessed numerous disasters, ranging from floods in Assam, Jammu & Kashmir, Uttarakhand, West Bengal, Tamil Nadu, Uttar Pradesh and Odisha; cyclones in Andhra Pradesh and Odisha; droughts in Maharashtra and Madhya Pradesh; conflict situations in Uttar Pradesh and Assam; and an earthquake across borders in Nepal along with some Indian states. CARE India responded to 14 disasters across 10 states, supporting immediate relief and recovery of the worst affected communities. Through relief and recovery interventions, a **total of 1,80,000 persons, including 91,228 men and 89,150 women across 32,541 households, benefitted.**

CARE India's emergency relief contributed to meet the immediate needs of affected people in the key areas of shelter, Water, Sanitation and Hygiene (WASH), livelihood and food security, and Sexual and Reproductive Health (SRH) support. **More than 8,500 households with damaged or destroyed houses during floods or cyclones, were supported with shelter and relief kits.** Efforts towards making disaster-affected dwellings liveable after partial or complete damage were addressed by providing transitional shelters, and through repairs and reconstruction while ensuring integration of disaster risk reduction features. In the recovery phase of the Tamil Nadu floods, Uttarakhand floods and Cyclone Phailin, a total of **596 transitional shelters were provided to disaster-affected households, while 604 shelters were repaired.** Repair and reconstruction work followed strategies that reduce gender inequalities by integrating women in the process of rebuilding activities, which has led to the **creation of 102 local women masons while responding to cyclone Hudhud and Phailin.** CARE India also promotes joint ownership of land and property during the recovery and reconstruction phases. This strengthens access and control of women over property.

In the areas of drinking water, CARE India ensured access to safe drinking water by distributing water purification tablets, providing jerry cans for storing water, and installing high capacity water tanks. To address hygiene as an important priority after emergencies, in the aftermath of floods, cyclones and

earthquakes, **23,189 households were provided with hygiene and dignity kits.**

Besides providing immediate relief items, to recover from economic shocks and meet the immediate cash requirements of affected people, CARE India employed interventions such as unconditional cash transfer and cash for work. Through unconditional cash transfers, **1,225 households were supported for 25 days in Odisha and Tamil Nadu, and for 15 days in West Bengal.** As part of wage employment, **75,670 person days of work opportunities were created** and paid at the average wage rate of approximately ₹164 per person per day. **Provisioning of dry ration food packages in West Bengal and Jammu & Kashmir helped reduced food insecurity in 2,554 households.**

Targeting the specific needs of women and girls with respect to sexual and reproductive health, emergency interventions ensured access to menstrual hygiene items through hygiene-cum-dignity kits and built awareness on proper disposal of menstrual waste.

Emergency preparedness planning practices is driven by CARE's overall Core Humanitarian Principles and Accountability Framework. To strengthen CARE India's emergency response and preparedness in the continuum of relief to recovery, it ensures adherence to principles and standards for humanitarian accountability, generating knowledge and evidence on good practices through After-Action Reviews, post-distribution monitoring and complaint and feedback mechanism. Social monitoring committees are also promoted to ensure participatory monitoring by the community. CARE India's capacity to respond in an effective and timely manner is ensured by pre-positioning relief items and building the capacities of the staff and local NGO partners.





GENDER-BASED VIOLENCE

One of the overarching strategies of CARE India in bridging inequalities between men and women and reduce gender-based violence is through the promotion of gender transformative changes at individual and community levels. By building women's agency to challenge social norms, CARE India made positive changes among women and their households in different projects across sectors.

While working to improve sexual and reproductive health in the JMV project, facilitating changes in gender attitudes and behaviour change increased the awareness of the community on the Domestic Violence Act. In the livelihood project Pathways, **women disagreeing with the statement that most decisions should be made by men, increased by 20 percentage points, and the proportion of women adopting roles that were traditionally in the domain of men changed by nearly two folds.** Women in the intervention areas of WtRF project were more confident in raising issues for discussion in a public forum, as compared to a comparison group by 23.3 percentage points. Women entering market spaces by directly dealing with buyers and sellers of agricultural commodities has transformed the relationship between value chain actors.

CARE India advocated for strengthening the implementation of the Protection of Women from Domestic Violence (PWDV) Act in Bihar through policy focussed action research. Based on the research findings, the Government of Bihar (GoB) has recognised

the gaps in the implementation of the Act for ensuring better protection of women in the state.

By bringing together the impact and outcome level changes in the life of the poor and marginalised, CARE India has been able to learn about significant contributions it made in different areas of its work. These insights helped CARE India to drive future strategies to achieve the intended impact, which is aligned with its Vision and Mission.





CHAPTER 1

CARE India's Programme Context and Footprints

Introduction

CARE India is a member of the CARE International Confederation that works in 94 countries in the world, fighting and striving to create an environment for people to live with dignity and security. To attain the overall goal of ending poverty and bring about equitable change, CARE has been working for last 65 years in India focussing on planning and co-developing strategies as a structured process to achieve long-term impact.

In the last two decades, India's economic growth rate has significantly increased crediting it as one of fastest growing economies in the world, which clocked a growth rate of 7.6% in 2015. Despite significant improvement in the economy and equality parameters, extreme inequalities persist in India. As per the Global Hunger Index report 2017, India ranks 100 among 119 developing countries on the Global Hunger Index. India ranks 132 on Inequality Index (World Inequality Report 2018) and 125, out of 152 countries, on the Gender Inequality Index (Human Development Report 2015).

According to the Oxford Poverty Human Development Initiative (OPHI) 2016 Report, India has the highest multi-dimensional poverty after Afghanistan in South Asia. Nearly 54% of the Indian population is multi-dimensionally poor, as compared to 66% in Afghanistan. The poorest region in South Asia is Bihar, followed by 'South' Afghanistan. The poorest 15 subnational regions in South Asia are all in India or Afghanistan, plus one region (Baluchistan) in Pakistan. There are more multi-dimensional poor people (421 million) in the eight poorest Indian states (Bihar, Chhattisgarh,

Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh, and West Bengal) than in 26 of the poorest African countries combined (410 million). Within India, the development outcomes are disproportionately spread and concentrated in certain geographies and communities that deserve focussed interventions.

India's dynamically changing economic and social development context, despite many significant achievements and progress requires concerted efforts by several organisations and governments to tackle the issues of the deprived populations. CARE India's programmes are designed to contribute to the SDGs through well planned and comprehensive programmes in health, education, livelihood and disaster preparedness and response. Those SDGs to which CARE India's projects are contributing towards include SDG 1 that speaks of poverty eradication in all forms and SDG 5 which aims to achieve gender equality and empower all women and girls. Numerous interventions in the livelihood sector focus on ending hunger, achieving food security and improved nutrition for vulnerable populations (SDG 2), ensuring equitable access to safe drinking water, and implementation of integrated water resource management (SDG 6); and try to promote sustained, inclusive and

CARE India's Work on SDG Scale



sustainable economic growth, full and productive employment (SDG 8). Ensuring healthy lives and well-being at all ages (SDG 3) has been the focus of its health interventions. Inclusive and equitable quality education for all (SDG 4) has been the root of all its programmes in the education sector, while SDG 13 is addressed through the efficient response to disasters across the country.

Purpose of the Report

The report consolidates the analyses of CARE India's overall achievements and long-term impacts through its interventions in the period 2014–16. In a dynamic and demanding environment, where complexities surround change making process on social change, CARE India's effort, here, is to understand the extent to which changes has been made in the life of communities in different locations and across sectors.

Through synthesising the outcomes and impacts from a diverse range of assessments, this report aims to represent not only CARE India's contribution towards the realisation of its mission, but also learn and hold ourselves accountable for improvements in future programme implementation. This report is an attempt to bring transparency in the work vis-à-vis the impact and outcome it has achieved with the support of stakeholders, partners, donors and agencies.

CARE India's Theory of Change and its Pathways

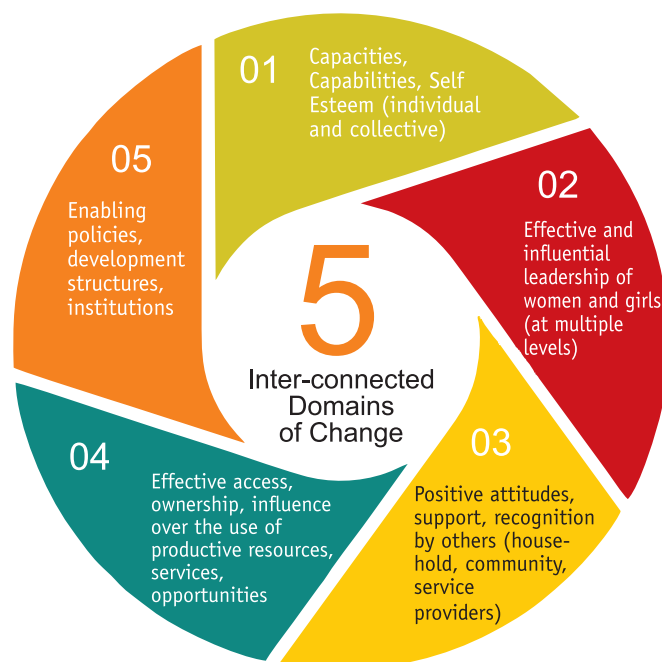
CARE India works with a vision to build a world of hope, tolerance and social justice, where poverty has been overcome, and people live in dignity and security. With the understanding that poverty and inequality need to be tackled by addressing the underlying causes of poverty and marginalisation, CARE India has identified the following causes:

- Failure of governance to uphold accountability to India's poorest citizens
- Exploitative and unequal power relations at multiple levels
- Failure of markets to be inclusive and fair

Recognising the failure of governance at multiple levels, failure of markets to be inclusive and fair, and unequal power relations that work themselves into the nature of India's growth trajectory, CARE India's programmes have

evolved a comprehensive theory of change. At the heart of the theory of change is a set of change outcomes called the domains of change, which CARE India believes are necessary and sufficient for achieving the various elements of the goal.

The five interconnected domains of change have been presented in the figure.



The five domains of change are inter-connected through a set of assumptions. They mutually reinforce each other as they serve as critical preconditions for the impact groups¹ to overcome poverty, empower themselves, live in dignity, and have secure and resilient lives. The critical pathways identified in bringing lasting change include work with communities to catalyse demand and leadership, promote local capacities and supportive environment and strengthen systems to deliver quality and equitable services.

The CARE 2020 Vision explicitly focusses on a Gender Transformative Change (GTC) approach to impact the lives of women and their relationships within households and communities, in a gender equitable manner. CARE India has based its gender-focussed intervention on key programming approaches like social analysis and action, leadership and life skills strengthening, gender transformative value chain approaches, building capacities and leadership roles at multiple levels, advocacy on national platforms, and facilitating links and dialogues between public, private and civil society.

¹ Impact group refers to the poor and most marginalised population, especially women and girls, among whom CARE India intends to make an impact.

CARE India's Programme Strategy puts people at the centre of its programming and positions the organisation to contribute to transformational impact in the lives of specific impact population groups. CARE views people in these impact groups as agents of change rather than beneficiaries, focussing on outcomes that these groups value, rather than only those defined by other development actors.

While CARE India holds itself accountable to change in the lives of these specific impact groups, the strategy acknowledges the necessity of working with others to influence relationships, behaviours and attitudes that perpetuate their poverty and marginalisation. These include spouses and other family and community members, service providers, local authorities and market actors at different levels. CARE India and its partners work directly with all these actors, resulting in wellbeing benefits for many of them. In addition, through its programmes CARE India works with a wide range of stakeholders and development partners, including government, civil society and private sector organisations, and community institutions to influence systems, policies and processes in favour of these impact groups.

The poor and marginalised groups are scattered across India, with pockets of higher concentration in some districts, unsurprisingly clustered in the states with the highest levels of poverty. CARE India's Strategic Programming Framework (SPF) deliberately chose to work in selected geographic areas to help the poor and marginalised secure maximum benefit in pockets of high prevalence of poverty. The SPF drives strategic operations in fewer districts, and a strategy for scaling and positively influencing the lives of the impact groups in large areas. CARE India aims to situate most of its project operations (> 70 percent) in these districts, with clear

strategies to influence change in the lives of the impact groups in other districts, states, as at a national level.

The long-term programmes within SPF guide CARE India's strategies, relationships, positions, advocacy, learning and organisational structure. All projects aligned to the long-term programmes built coherence and accountability across CARE India projects toward shaping impact in the lives of the impact groups. This approach enabled projects to garner lessons from the past and pay greater attention to future programming.

CARE India's programme niche has been designed to drive focus in its programming and investment priorities; to build credibility among other development actors; and to hold itself accountable to deep impact in the lives of impact groups. It uses a multi-sectoral approach to address the key challenges in development. All sector programme designs embed three crosscutting strategies aimed at facilitating more inclusive governance in favour of impact populations; enhancing their resilience; and contributing to more equitable gender relations and norms.

Five strategic roles of CARE India's programming include capacity and organisational strengthening of local organisations, facilitating links and triggering dialogue between development actors, facilitating learning and knowledge building, model development to scale impact and influence change, and social and policy advocacy. These strategic roles drive relationships, including choice of partners, roles that CARE India undertakes in consortia with others, and the constituencies it engages with. By following the above-mentioned roles, CARE India is able to have a greater influence and impact on the poor and marginalised population groups beyond the operational areas for achieving sustainable and long-lasting changes.



CARE India's Programme Areas

CARE India's projects are focussed across four technical areas spanning health, education, livelihoods, and disaster preparedness and response. The projects have comprehensive approaches and niche specialisation around leading innovative solutions focussing on ending poverty and social injustice. It works with multiple stakeholders for effective delivery at scale through direct intervention, technical assistance and government partnership and advocacy. Project implementation embeds integration of cross-cutting themes such as gender and inclusive governance, which aims to address unequal powers and social norms that hinder achievement of developmental outcomes for the households. The strategies for ensuring sustainable and long-term solutions incorporate aspects of building resilience within its planned interventions across the four thematic areas of work.

HEALTH

CARE India's interventions in the health sector work to improve access to quality health services for the poor and excluded communities. By identifying the root causes of healthcare challenges, CARE India works at the individual, community and systemic levels to develop innovative solutions and help implement quality healthcare services. The work with community groups, collaborative work with government and civil society organisations include cross-cutting strategies to improve the health and nutrition status of the poorest and excluded groups, particularly women and children. With a focus on policy advocacy and system strengthening, CARE India builds the capacities of health and Integrated Child Development Services (ICDS) service providers to create impact at scale.

Health interventions across **nine states** have reached more than **41,351,238 individuals**, including **30,290,910 women and girls**. The work in the areas of health include improving the quality of services for maternal and reproductive health, child health and nutrition, and communicable diseases such Tuberculosis (TB), Kala-azar, pneumonia, diarrhoea and HIV. To increase the uptake of services, besides the supply side interventions, many projects worked with communities and groups of mothers to break social barriers by engaging men and other key decision makers in rural households. The aim of the health interventions is to strengthen and promote comprehensive health for women and girls, and create a positive and enabling environment for accessing quality healthcare services.



GIRLS' EDUCATION

CARE India's Girls' Education Programme focusses on addressing social and pedagogical barriers that impedes the participation of children, especially girls from poor and marginalised communities, in education. The education intervention worked on early childhood development, early grade learning outcomes, and inculcating life skills, leadership and self confidence among girls. Reaching out to over **224,879 children** including **112,365 girls** in more than **1,500 schools** across **six states**, CARE India's outreach programmes developed innovative and scalable programmes at multiple levels. Technical support through programme interventions helped build the capacities of teachers, contributing to strengthening the government's education system. The goal of CARE India's Girls' Education Programme is to empower girls from marginalised communities by building capacities, self-esteem and leadership skills, that enable them to influence change at the individual, social and systemic levels.



LIVELIHOOD

Through its livelihood projects, CARE India focusses on improving access and control of women from marginalised communities over productive resources, services and opportunities; enhancing their food and nutrition security; and improving their abilities in climate change resilience. Reaching out to over **217,584 individuals** including **139,002 women** across **five states**, CARE India has built the capacities of individuals and collectives. By supporting more than **4,000 collectives**, the interventions intended to address the barriers such as unequal power relations and enabling the transformation of gender norms at multiple levels, CARE India's livelihood interventions seek to empower women from poor and marginalised communities and their households to climb out of the poverty trap, permanently and with dignity.



DISASTER PREPAREDNESS AND RESPONSE

India has witnessed numerous disasters over the years, ranging from floods, cyclones, conflicts, droughts and earthquakes. Through its response, relief and recovery interventions for **14 disasters** in **ten states**, CARE India has benefitted more than **180,000 persons** by working in collaboration with multiple partners. CARE India's humanitarian responses provided emergency support to the worst-affected communities and helped them to meet their immediate needs, primarily in the areas of shelter, WASH, livelihoods and food security, and SRH. CARE India's work on disaster management and response aims to reach out to disaster-affected families through timely and effective humanitarian assistance and disaster preparedness interventions.



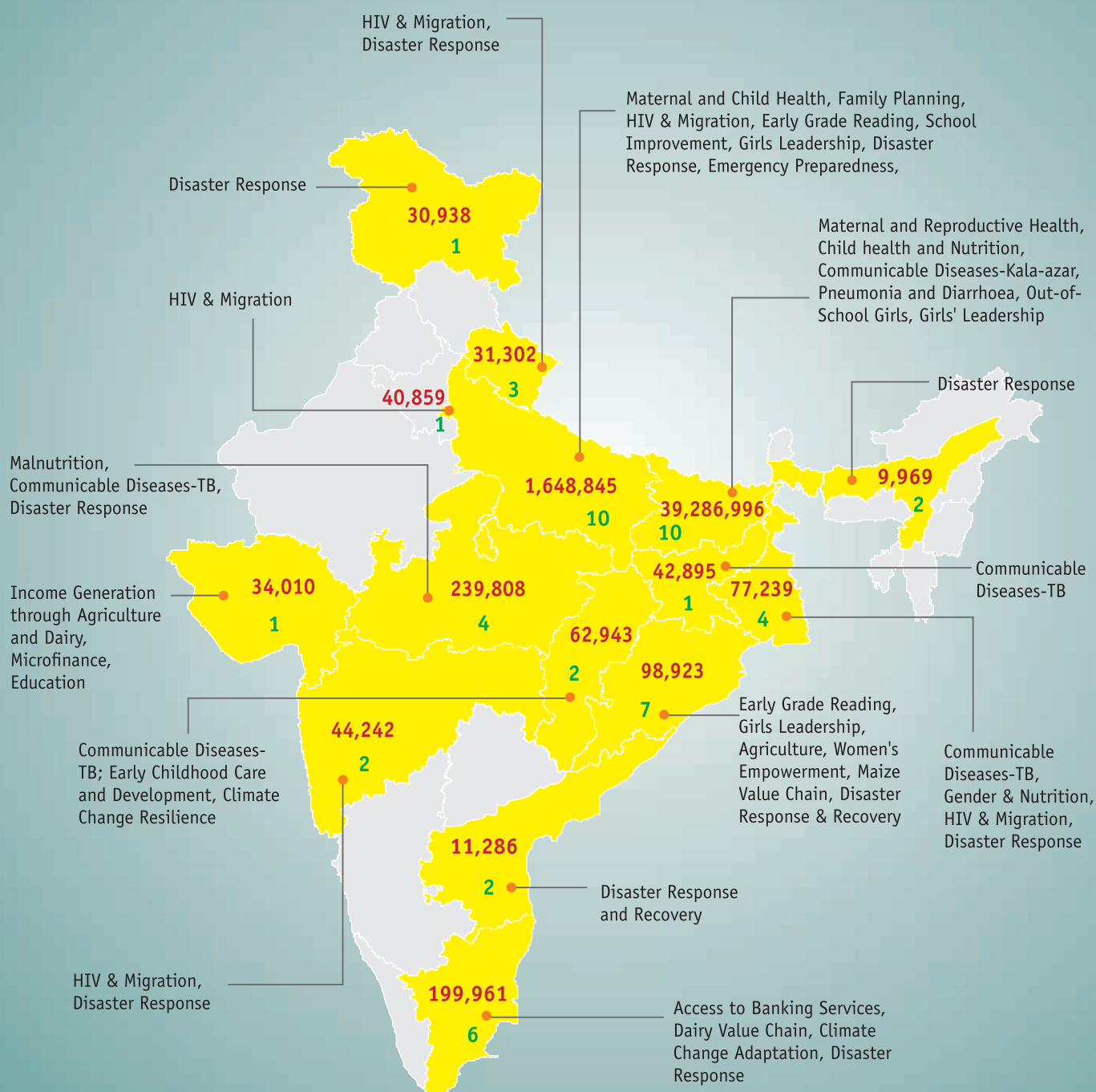
GENDER-BASED VIOLENCE

CARE India aims to bring about change in gender norms and attitudes by engaging with multiple stakeholders at the individual, household and institutional levels. While every sectoral strategy has a gender-transformative approach embedded within it, CARE India also works on programme interventions aimed towards identifying, spreading awareness, and addressing the root causes of gender-based violence. One of CARE India's significant action research programmes focussed on the understanding of the implementation and effects of the Protection of Women from Domestic Violence Act, 2005, particularly in Bihar.



REACH, PROJECTS AND THEMATIC AREAS BY STATES

2014-16



No. of projects



Thematic areas



Number of participants reached directly



• ଦ୍ରବ୍ୟ ଚୋରା ଚୋରା ଶିଶୁ ଶେଷେଇବେଳେ ଦାବେ ପେଟଚେର
ଠାକୁ ହେଁ ଗୋରା ନିଜର ପ୍ରକୃତ ଲୋକର ପ୍ରମୁଖ ଆକର୍ଷଣ ହୋଇଥାଏ ।



କର କରକ

- ଚଳୁ ବୟସ ଚୋର ଦାବେ ପେଟ ଶିଶୁର ଶେଷେଇବେଳେ ଦାବେ ପେଟଚେର କରା ହେଉଛି ।
- ଯଦି ଦେ ପେଟର ଶିଶୁ କାହିଁ ନାହିଁ ତେବେ ତାର ଲୋକ ଲୋକ ସଂସ୍ଥା କରାବୁ ।
- ଆବଶ୍ୟକ ହେଲେ ସାବଧାନତା ସହ ନିଜ ପ୍ରକୃତ ସଂସ୍ଥା କରାବୁ ଚାହୁଁ ଶିଶୁର ଶେଷେଇବେଳେ ଦାବେ ପେଟଚେର ।

• ବିଦ୍ୟାବାର ଶିଶୁର ପିଲା ନିଜକୁ । ଯଦି ଶିଶୁର ପିଲା ନିଜକୁ ନାହିଁ ତେବେ ତାର ଲୋକ ଲୋକ ସଂସ୍ଥା କରାବୁ ।



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- ଯଦି ନାମ ଲୋକର ଶିଶୁ ଶେଷେଇବେଳେ ଦାବେ ପେଟଚେର କରା ହେଉଛି ।
- ଶିଶୁର ପିଲା ଲୋକର ଶେଷେଇବେଳେ ଦାବେ ପେଟଚେର କରା ହେଉଛି ।
- ଯଦି ଦେ ପେଟର ଶିଶୁ କାହିଁ ନାହିଁ ତେବେ ତାର ଲୋକ ଲୋକ ସଂସ୍ଥା କରାବୁ ।
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CHAPTER 2

METHODOLOGY

This report is a systematic analytical review of CARE India's interventions, assessed for the period 2014–16. It is a product of desk-based analyses of 51 projects that undertook end-term evaluations or any assessment during the period. The methodology used follows a consistent and comprehensive approach for synthesising findings across projects, based on (a) identification of impact and outcome level indicators for sectors as per CARE India's programme strategy; and (b) reviewing existing project implementation, evaluation and concurrent monitoring data and reports, using both quantitative and qualitative data.

The documents reviewed include project evaluations, mid-term reviews, end-of-project reports, concurrent monitoring data and case studies. Of the 51 projects reviewed, 13 projects were from the health sector, eight projects were from the education sector, nine projects were from the livelihood sector, and 20 projects were from the disaster management and response sector.

Information/data from secondary sources were also used to situate the change evident from the project interventions, in the larger context. Secondary data from various sources, such as the National Family Health Survey (NFHS), Sample Registration Survey (SRS), National Institute of Nutrition (NIN), Census of India, District Information System for Education (DISE) and the World Bank were used to build the context.

The main limitation of the process included lack of availability of quantitative data-sets for all projects implemented in this timeframe to help assess CARE India's interventions along the theory of change. Another difficulty was in synthesising higher-level outcomes due to a diverse range of indicators across thematic areas. Being a desk-based review, this report has its limitations in terms of comprehending and interpreting every change in a meaningful way, thereby unable to provide a detailed explanation about the change.



CHAPTER 3

HEALTH

Context and Strategy

India has achieved significant strides in improving the health of its population. Since independence, the country has introduced numerous health schemes and campaigns to improve the quality of healthcare. Although India has brought down its maternal and child mortality, it fell short of achieving the associated SDG. As per SRS 2014-16, the Maternal Mortality Rate (MMR) of India stood at 130, the IMR has declined to 37 and U5MR is at 43 per 1000. India still accounts for the highest burden of under-five deaths—close to a million children below five years die in the country every year.

Malnutrition, another major cause of under-five mortality, is very high in Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Uttar Pradesh and West Bengal. As per the Global Nutrition Report, 2017, about 38% of under-five children are affected by stunting and 21% of children under five are 'wasted' or 'severely wasted'. India accounts for more than three out of every 10 stunted children in the world.

India has 2.7 million estimated incidences of Tuberculosis (TB) in 2016, out of the 10.4 million TB incidences globally. This makes India the country with the highest TB burden in the world. About 40% of the Indian population is estimated to be infected with the TB bacteria, most being latent rather than active cases TB infection.

Over the past three years, CARE India has carried out a series of interventions that focus on creating an enabling health environment, specifically for women and children. Engaging closely with stakeholders at multiple levels—women and men, frontline service providers and local agencies—the interventions have focussed on affecting behavioural change in issues such as family planning, gender-based violence and gender-biased social norms and practices. A key focus of CARE India's health sector strategy is enhancing access to quality healthcare services, strengthening quality healthcare by service providers and providing sustainable solutions to reduce the burden of communicable diseases such

as Pneumonia, Diarrhoea, Kala-azar, Tuberculosis and HIV. Among the outcomes from the health sector interventions, the important ones for the poor and marginalised communities include maternal, neonatal and adolescent health; reproductive health and nutrition; and communicable diseases.

The core strategies of CARE India's interventions include:



Capacity building of frontline workers for last mile quality service delivery



Enhance access to and control of health services for women and girls



Strengthen health system in provision of equitable quality health care services to underserved communities on scale



Create an enabling environment through evidence-based policy influence and changing social norms for quality health services



Develop scalable solutions for emerging health issues of marginalised communities with innovations and knowledge management

CARE India's Health Project Portfolio and SDGs:

Areas of Convergence

SDG 3: Ensure healthy lives and promote well-being for all at all ages

- 3.1. Reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- 3.2. End preventable deaths of newborns and children under 5 years of age, and reduce neonatal mortality to at least as low as 12 per 1,000 live births
- 3.3. End the epidemics of AIDS, tuberculosis, and malaria and ...other communicable diseases
- 3.7. Ensure universal access to sexual and reproductive healthcare services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes

SDG 5: Achieve gender equality and empower all women and girls

- 5.6. Ensure universal access to sexual and reproductive health and reproductive rights

CARE India's health strategy primarily works in three domains—maternal and reproductive health, child health and nutrition and communicable diseases. The health interventions by CARE India worked at three levels, i.e., outreach, facility and systems. The interventions, namely Bihar Technical Assistance and Support Programme (BTAST) and Technical Support Unit (TSU) worked at all three levels, while projects such as the Madhya Pradesh Nutrition Project (MPNP), Newborn Survival (NBS) project and Urban Health Initiative (UHI) worked at the outreach and facility levels, while the *Axshaya* project worked only at the outreach level.



HEALTH PORTFOLIO

Snapshot 2014-16

13

Projects

9

States

65+

Districts



41,351,238

Participants reached directly



30,290,910

Women participants

Key Areas of Work



Maternal and child health



Child health and nutrition



Communicable diseases

Maternal and Reproductive Health

Improvement in Quality and Delivery of Services

The Bihar Technical Support Unit (TSU) of CARE India helped the public health services to improve the quality of intra-natal care and immediate postnatal care provided to women delivering in government facilities.

This resulted in a steady improvement through a combination of quality improvement interventions and onsite clinical mentoring of staff nurses and doctors, with relatively high levels of ownership and monitoring by departmental leadership.

Significant improvements in indicators of quality of care in facilities for Basic Emergency Obstetric and Neonatal Care (BEmONC)

Indicator	Source	Baseline/2015	Achieved/2016
1. Knowledge scores			
Overall knowledge of Obstetric and Neonatal care (AMANAT BEmONC Phase II and III) – Percentage of correct answers		38%	71%
2. Infection control			
Availability of functional autoclave machines, hub cutters and at least one coloured waste bin	CFA	21%	80%
Correct segregation of hospital waste	CFA	56%	70%
Delivery conductors washed hands and wore gloves	DoD	35%	78%
3. Equipment availability			
Functional BP Equipment	CFA	52%	62%
Mucous Sucker	CFA	52%	76%
Oxygen Cylinder with key	CFA	47%	79%
Functional Radiant Warmer	CFA	69%	77%
4. Clinical care			
Pulse	DoD	7%	63%
Blood Pressure	DoD	25%	80%
Foetal Heart Rate	DoD	11%	74%
Administration of Oxytocin 10 Intra-uterine intra-muscularly in third stage of labour (irrespective of time)	DoD	59%	85%
Manual fundal pressure applied	DoD	37%	15%
Active Management of the Third Stage of Labour (AMTSL)	DoD	4%	48%
Foetal heart rate measured on admission	DoD	11%	74%
Oxytocin administered before delivery	DoD	11%	0.5%
Proportion of caesarean section out of all deliveries	LQAS	7%	7%

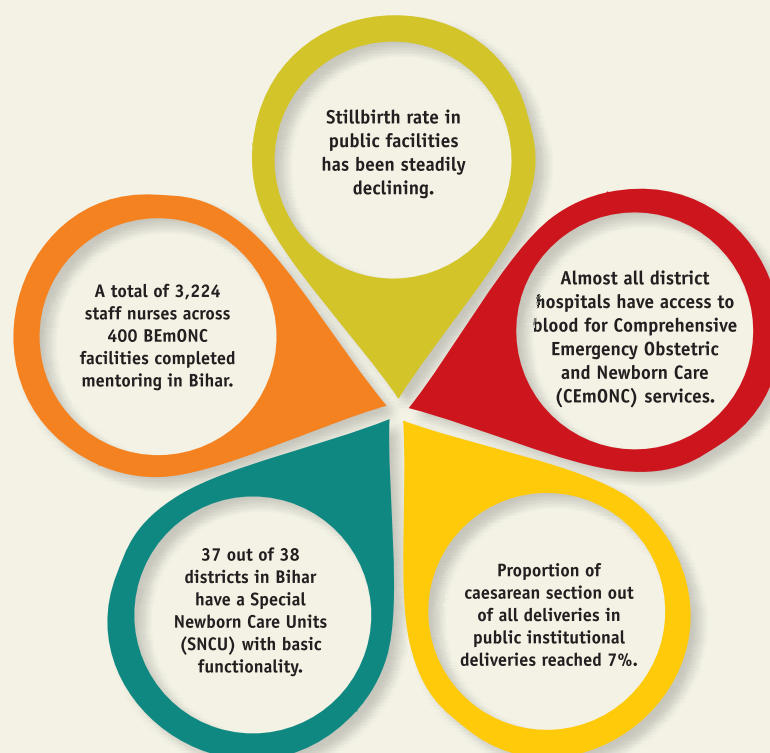
DoD = Direct observation of Deliveries²; CFA = Comprehensive Facility Assessments (infrastructure, supplies, equipment)³; LQAS = Lot Quality Assessment Sampling based household surveys⁴.

²Conducted prior to (baseline) and post-intervention (endline) in each phase of AMANAT nurse mentoring (there have been 4 BEmONC and CEmONC phases so far). As the name suggests, the evaluating nurses passively observed deliveries conducted at mentored facilities and filled up a structured instrument consisting of questions on recommended delivery practices.

³Conducted approximately at annual intervals. Each assessment was carried out at all public facilities of Bihar (above Additional Primary Health Centre (APHC) level, excluding medical colleges) where deliveries were conducted. Data was collected by trained investigators using either observation (e.g. infrastructure or equipment), record review, interview (e.g. for practices) and physical counting (e.g. supplies of drugs).

⁴A multi-stage cluster sample survey which is conducted annually on a sample of 78,435 mothers (and their children) comprising of 5 sub-groups – mothers of 0-2 months, 3-5 months, 6-8 months, 9-11 months and 12-23 months old children. Data is collected from all 534 blocks across 38 districts in Bihar. The sample size is powered to provide district level estimates.

Key Highlights from Improvements in Quality and Delivery of Services in Bihar



Source: Assessments by Concurrent Measurement & Learning Unit in Bihar; HMIS 2016-17

Scaled-up Models Based on Lessons

Strengthening ICDS MIS through Common Application Software

A revised ICDS Management Information System (MIS) called the digital Common Application Software (CAS) was supported by CARE India with the objective of systematically refocussing the programme's attention from handling only supplementary feeding programme to behaviour change interventions covering the full Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) spectrum. With the implementation of this 'Integrated Performance Management System' through an ICT mobile app, it made real time information easily accessible for monitoring and supervision of a range of stakeholders. Based on the initial success of ICDS-CAS, the real time monitoring tool was scaled-up to eight states under the ICDS system strengthening and nutrition programme, supported by the World Bank. This initiative is further being scaled up nation-wide by the Ministry of Women and Child Development.

Incremental Learning Approach

Recognising that most adults retain information more effectively through active hands-on training than by reading or listening, CARE India evolved ILA to impart and build the skills of frontline workers through monthly sub-centre level meetings. After witnessing improvement in the services of the frontline workers, ILA has been replicated in all districts of Bihar and adopted for scaling up in 162 districts across eight states.

Village Health Sanitation and Nutrition Day

The monthly Village Health Sanitation and Nutrition Day (VHSND) platform was redesigned to make the platform attractive for mothers and children to attend, and more reliable in terms of the availability of a range of supplies including nutritional supplements, contraceptives and ORS-Zn. Service providers were provided enhanced job aids to facilitate communication with clients on the VHSND.

Systematic Review and Planning Practices in Clinical Management

The initiative called *Ek Chhoti si Pahal* – 'One small beginning' attempted to inculcate improvement of concepts through periodic participatory planning and reviews by using a set of negotiated 'change ideas' to drive improved utilisation of evidence-based clinical practices. To implement this initiative, the Institute for Healthcare Improvement (IHI) piloted the Quality Improvement initiative in 10 CEmONC centres and all district hospitals in Bihar.

CARE India, through BTAST, contributed in ensuring service provision in the state as part of the Sector-Wide Approach to Strengthening Health (SWASTH) programme of the Government of Bihar. An External Process Evaluation of the 'Quality Improvement of Public Health Facilities' was undertaken in 2016 based on the National Quality Assurance Standards (NQAS) and State Quality Assurance Standards (SQAS) criteria. The results showed quality improvements in the Family Friendly Hospital Initiative (FFHI) parameters, between survey round I (2014) and round II (2016). The key highlights from the study are enlisted below.

Percentage of facilities with:

- More than 18 hours of electricity increased from 31% to 38%.
- Display of *Rogi Kalyan Samiti (RKS)* information increased from 32% to 43%.
- Display of available services increased from 69% to 77%.
- Display of medicines increased from 70% to 81%.
- Curtains/screens in labour room to ensure privacy increased from 77% to 84%.
- At least two labour tables in the labour room increased from 75% to 76%.
- Privacy in maternity ward increased from 34% to 44%.

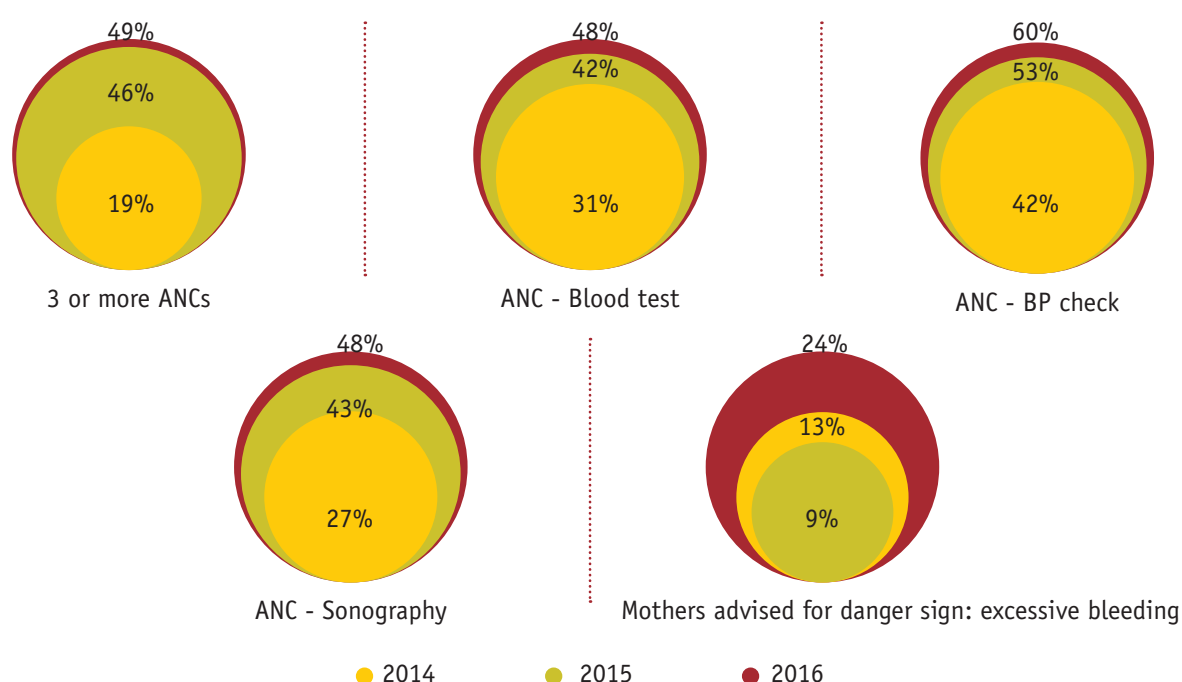
Working through barriers such as workforce issues, delays in resource allocation and lack of accountability from facility staff, the technical support intervention contributed towards improvement in the quality of services at the healthcare facilities.

Antenatal Care

Antenatal Care (ANC) service coverage indicators have been consistently improving in Bihar, as is evident from three rounds of Annual Household Surveys (using a multi-stage cluster sample design). Improvement in ANC coverage has been driven primarily by the Government of Bihar's programme priorities and private sector players. Almost all women in rural Bihar (97%) reported that they have received at least one antenatal check-up, while about 50% of women reported receiving at least three check-ups in 2016.

Intervention focussing on newborn survival, in Ajaygarh, which is one of the backward blocks of Panna district in Madhya Pradesh, showed that 14% of women received full ANC during their last pregnancy (i.e., three or more ANC check-ups, 100 Iron Folic Acid tablets and two doses of Tetanus Toxoid) as compared to 5% during the baseline. The percentage of mothers whose blood pressure was taken, and blood tested for haemoglobin during ANC improved from 64% to 75% and 69% to 84%, respectively, between the baseline and endline.

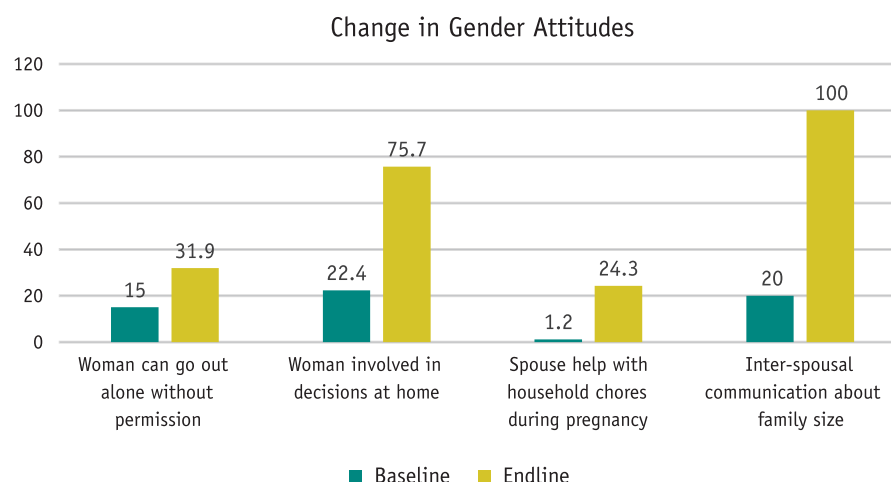
Trend across ANC Services in Bihar from 2014 to 2016



Source: Annual Household Surveys 2014 to 2016

Change in Gender Attitudes

CARE India's health strategy aims to mitigate social and gender determinants of health. The health interventions in JMV project have had a positive impact on gender attitudes, which is evident from the change in indicators such as mobility, decision-making and domestic violence among the project populations.



- A significant impact at the individual level include stories of positive deviance among men. This is evident from the change recorded from the first year when only 648 men accompanied women for pre- and postnatal check-ups. By the third year, 1,194 men reported that they accompanied their wife for ANC and PNC check-ups. This can be attributed to the pathway of change tracked by CARE India for men who participated in the meetings.
- Attitudes and awareness around domestic violence significantly improved. While 45% women in the intervention arm reported experiencing domestic violence in the last six months during the baseline assessment, only 2% reported the same at the end of the programme.

Enhancing Knowledge, Attitude and Practices of Frontline Workers

In Barabanki district of Uttar Pradesh, changing perceptions of frontline workers, viz. Accredited Social Health Activist (ASHAs), Anganwadi workers (AWWs) and Auxiliary Nurse Midwife (ANMs) by engaging them through reflective exercises to unpack their personal biases was an important step in addressing the structural barriers to the quality of healthcare showed improvement in knowledge and attitudinal indicators.

- 97% of service providers in the endline believed that spouse should accompany for ANC and 90% of service providers believed that spouse should be involved in PNC, as compared to 71% and 57% service providers, respectively, in the baseline.
- 54% service providers counselled husbands during home visits on ANC as against 20% in the baseline.
- 89% of services providers were aware about at least five danger signs in pregnancy, as compared to 4% in the baseline.



Institutional Deliveries

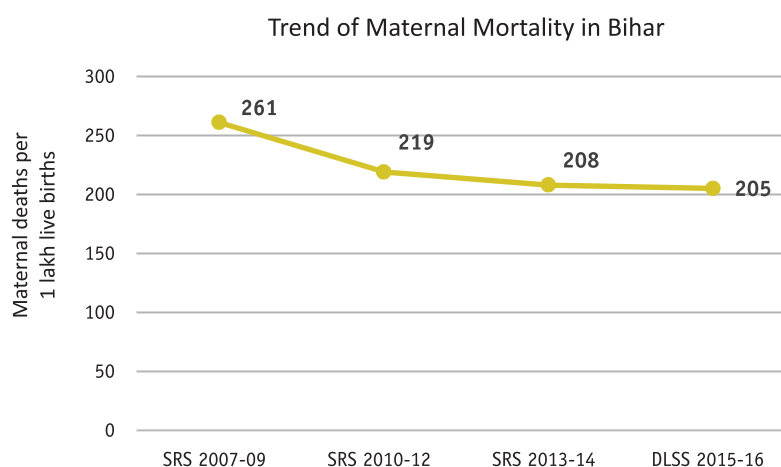
CARE India's health interventions in states such as Bihar, Uttar Pradesh and Madhya Pradesh have contributed towards the improvement of institutional deliveries. In Bihar, a district-level SWASTH Survey was conducted in 2015–16, which showed 21.2 percentage points increase in institutional deliveries (47.7% in AHS 2010–11 to 68.9% in DLSS 2015–16). In Barabanki district, one of CARE India's intervention showed 26.9 percentage

points increment in institutional deliveries (70.9% in the baseline to 97.8% in the endline). Through the New Born Survival intervention in Panna district of Madhya Pradesh, the project showed a 2 percentage points increase in institutional deliveries (96.2% in the baseline to 98.2% in the endline).

In Bihar, under the TSU project, deliveries conducted by skilled birth attendants increased from 70% (LQAS, round 8 in 2017) to 76% (LQAS, round 9 in 2018).

Reduction in Maternal Mortality Ratio from 261 (SRS-2007-09) to 205 (DLSS 2015-16)

The SWASTH programme was implemented by Government of Bihar where CARE India provided technical assistance through Technical Support Assisting Teams (BTAST) focussed on special interventions like awareness creation (*Gram Varta*), community participation (VHSND), strengthening ICDS (*Udeepan*), promoting safe drinking water and Open Defecation Free Panchayat and addressing Violence Against Women (women helplines).



Source: SRS Data

The completion of the programme B-TAST in 2016 records a significant improvement in Maternal Mortality Ratio. CARE India's interventions in Bihar focussed on reducing maternal mortality. The DLSS survey findings reveal a vast improvement post BTAST implementation, supported by CARE India and consortium partners.

Awareness and Uptake of Family Planning

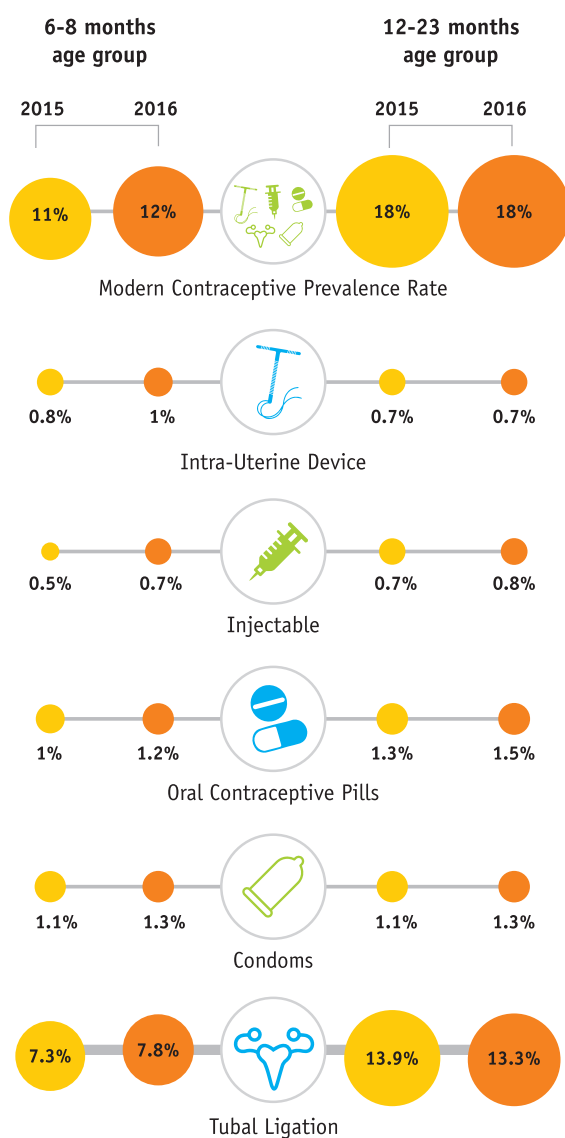
CARE India worked to increase access and use of family planning services by women and men through various interventions in two of the most populous states in India—Uttar Pradesh and Bihar. The JMV project in Barabanki district of Uttar Pradesh that focussed on addressing socio-cultural norms, has resulted in an increase in inter-spousal communication (20% to 82.2%) and home visits by service providers (5.3% to 43.2%). These increments were instrumental in improving the uptake of any family planning method by couples (from 6.5% in baseline to 33.0% in endline).

Working through public-private partnerships in reproductive healthcare, UHI intervention focussed on integration of family planning with ANC, PNC and post-abortion care services. The intervention targeted

the urban poor in six cities of Uttar Pradesh. Using longitudinal panel design, the final evaluation showed significant increase in the use of modern contraceptives by approximately 5 to 10 percentage points in all the cities. By the end of the intervention, use of modern contraceptive methods ranged from 48.1% in Aligarh to 59.6% in Moradabad.

Access to family planning services in Bihar has improved through the work of CARE India and its partners. Modern contraceptive prevalence rates show an improvement of 1% (from LQAS round 6 to round 7) among mothers of children aged 6–8 months, while there is no change among mothers of children aged 12–23 months. The data indicated marginal improvement in the use of spacing methods between two rounds of survey.

Access to Family Planning Services in Bihar



Source: LQAS Round 7 (2015) and Round 8 (2016)

TSU in Bihar contributed in improving family planning service delivery by ensuring availability of services at facility level and building capacity of health staff.

- Around 450 out of 600 public facilities have local Post-Partum Intra Uterine Contraceptive Device (PPIUCD) providers with the population coverage of nearly 1%.
- Interval Intra Uterine Contraceptive Device (IUCD) services available in more than 400 facilities, fixed day female sterilisation services available in 348 facilities round the year.
- Through the nurse mentoring programme, 2,700 nurses trained in the placement of IUDs across 400 of 600 public sector health facilities.

Child Health and Nutrition

Malnutrition

Malnutrition is one of the biggest public health problems in India. Data on the nutritional status of children reflect that 36.1% children under five years are underweight, 41.6% children under five years are stunted, and 17.5% children under five years are wasted⁵. In one of the high prevalent states, i.e., Madhya Pradesh, where 42.8% children under five years are underweight, 42.0% children under five years are stunted, and 25.8% children under five years are wasted, CARE India worked in three districts, namely Panna, Tikamgarh and Chhatarpur, through community-led interventions involving 344 nutrition volunteers.

The intervention contributed towards reducing malnutrition by 19 percentage points (<-2SD - from 49.0% in NIN survey 2010 to 29.7% in the project endline in 2016) among children under five years. A noteworthy achievement of the project was the strengthening of SAM and MAM referral mechanism through capacity building of 1,300 frontline workers from ICDS. The project successfully identified and referred a total of 4,688 malnourished children to the Nutrition Rehabilitation Centres. The project reduced malnutrition among 2,792 SAM and MAM children under the age of five years.

During the BTAST intervention, child health nutrition indicators showed improvement in the state of Bihar. Data from DLSS 2015-16 indicate a decline by 10.2 percentage points in weight-for-age indicator (from 55.9% in NFHS 2005-06 to 45.7% in DLSS 2015-16) among under five years children.

Newborn Care

In Bihar and Madhya Pradesh, CARE India's intervention contributed towards reducing neonatal mortality by promoting critical newborn care practices such as thermal care and cord care. Through technical support in Bihar, skin-to-skin care and dry cord care at birth in public facility deliveries increased by 27 percentage points and 6 percentage points between 2014 and 2016 (21% to 41% and 86% to 92%, respectively). The practice of low birth weight tracking in Bihar contributed to significantly enhancing the proportion of very low birth babies receiving KMC at home from 4% to 29%.

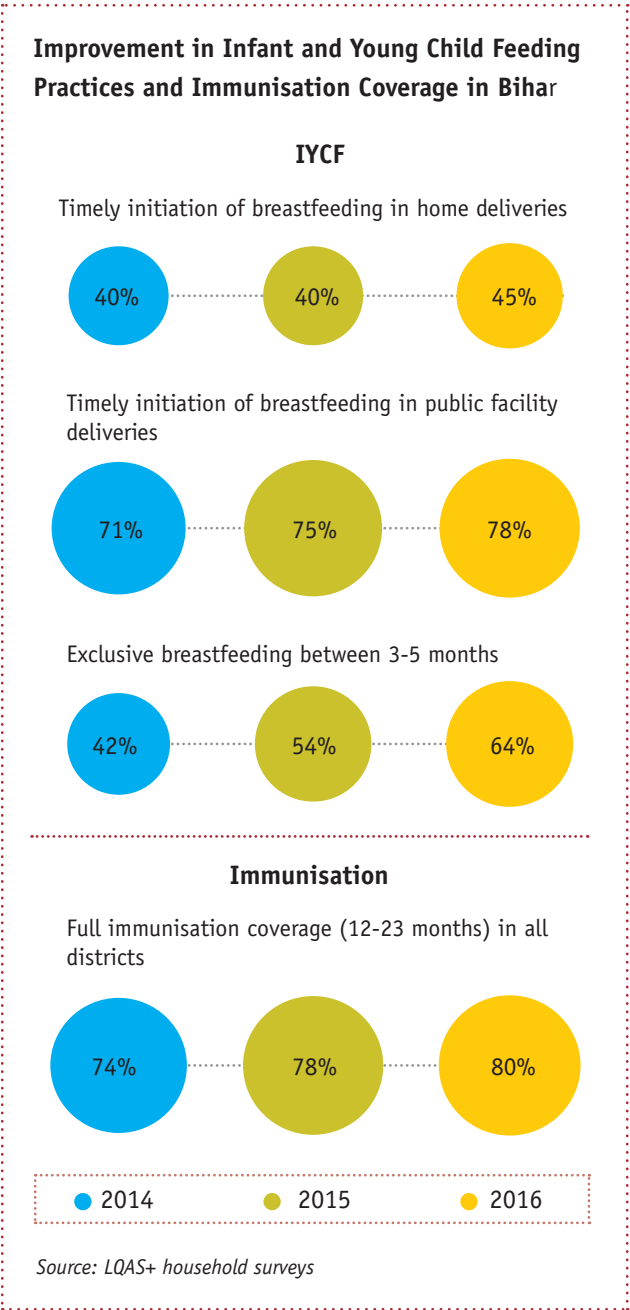
The NBS project in Ajaygarh, Panna district, Madhya Pradesh, showed that KMC provided to the low birth-

⁵ Rapid Survey on Children 2013-2014- Factsheet, Ministry of Women and Child Development, Government of India.

weight babies increased by 39 percentage points (22% to 61% from baseline to endline). Change in delayed bathing practices for newborns increased by 33 percentage points (54% to 92% from baseline to endline).

Infant and Young Child Feeding Practices and Immunisation

In Bihar, the TSU interventions focussed to strengthen the system to provide better infant and young child feeding (IYCF) practices by timely initiation of breastfeeding, exclusive breastfeeding and complementary feeding practices. Timely initiation of breastfeeding (among home deliveries and public facility deliveries) and exclusive breastfeeding among 3-5 months infants have increased significantly in Bihar.



The improvement in indicators were strongly associated with home visits and advice provided by the frontline workers. The frequency of home visits and counselling also improved over the same period. Full immunisation coverage for children of 12–23 months in all districts of Bihar improved to 71% in 2016 from 68% in 2014.

In Madhya Pradesh, MPNP intervention contributed to improvements in practices and behaviours around child health and nutrition – 32% of mothers reported to have first breastfed the child within an hour of the delivery, 38% of mothers practiced exclusive breastfeeding up to 6 months and 67% of mothers reported the initiation of complimentary feeding at 6 months. NBS intervention showed significant improvement in early initiation of breastfeeding within one hour from 41% in the baseline to 64% in the endline. Exclusive breastfeeding among 0-5 months children improved from 37% in the baseline to 54% in the endline.



CASE STUDY: Correct feeding practices helped attain better nutritional status

28-year-old Maya Mishra belongs to Chaikuwa village, Badamalhera block, Madhya Pradesh. Maya's husband is a farmer and the only earning hand in the family. Their source of income is a piece of two-acre land. Due to lack of proper resources Maya has always had a tough time ensuring good health and well-being of her children.

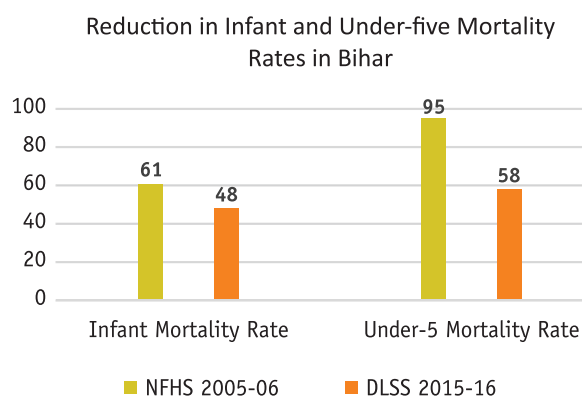
CARE India's Nutrition Volunteer first met Maya as part of regular home visits in the village. At that time Maya's youngest son Arsh was 22 days old and elder daughter Deepali was 14 months old. Maya shared that although she was breastfeeding Arsh two to three times a day, he was still in the yellow area of the growth chart. Hearing the plight of her baby, Maya was advised to increase the feeding to eight to 10 times a day. She was also counselled for eating one additional meal everyday so that her health does not deteriorate. Volunteers shared the importance of a proper balanced diet for any child's growth and their development process from six months to two years of age.

During the conversation, it was learned that Maya's daughter Deepali was also extremely weak. She was severely underweight and fell under the red zone of the growth chart. Maya shared that after her son Arsh was born, she could not focus on her daughter much and stopped breastfeeding Deepali, which further deteriorated her condition. She was advised on how to prepare and give nutritious and hygienic food to her four to five times a day. Within a month's time, both Arsh's and Deepali's situation improved. Arsh gained one kg of weight after a month. Maya was now regularly breastfeeding her son eight to 10 times a day. Maya's children are now completely healthy and figure in the normal grade on the health chart. She is extremely happy that her children have recovered.

This change in behaviour of Maya exemplifies the value of the role of home visit and nutrition counselling. In one of the SAM meetings (a meeting for Severely Acute Malnourished children), CARE India's team requested Maya to share her experience with other participants, explaining how correct feeding practices helped her in improving the overall well-being of her children. Maya's story is an example of the changes possible due to correct feeding practices and has inspired many in the community. Her journey showed the path for significant adoption.

Reduction in Infant Mortality Rate and Under-Five Mortality Rate

CARE India's partnership with the GoB under the SWASTH programme recorded a decreasing trend in IMR and U5MR in Bihar. IMR reduced to 47.9 per 1,000 live births from 62 per 1,000 live births, while U5MR decreased drastically to 58 per 1,000 live births from 95 per 1,000 live births (data source DLSS 2015-16 and NFHS 2005-06, respectively).



Communicable Diseases

India has formulated robust disease control programmes for infectious diseases through routine immunisation, vaccination and provision of essential drugs. Many places in India still face the devastating effects of various communicable diseases such as Pneumonia, Diarrhoea, Tuberculosis, *Kala-azar* and HIV.

Recognising the adverse consequences of neglecting social determinants of health and the need for contributing towards the SDG 3, CARE India has undertaken varied interventions to tackle the lack of knowledge, social stigma and poor accessibility to health services to prevent and reduce the burden of diseases.

Tuberculosis

Accounting for one fifth of the global TB incidence, an estimated number of 4,80,000 Indians lose their life to TB every year (NSP, 2017⁶). About 2.6 million people live with HIV and 1.2 million are TB-HIV co-infected. India has one of the highest MDR-TB cases, globally with 70,000 cases annually.

CARE India's *Axshaya* project and MDR-TB project supported the National Revised TB Control Programme (RNTCP) in implementing its Active Case Finding strategy, in partnership with World Vision. CARE India carried out door-to-door campaigns in Madhya Pradesh, Jharkhand

⁶ National Strategic Plan for Tuberculosis Elimination 2017-2025

and Chhattisgarh to generate TB awareness, identify presumptive TB cases, assess current health seeking practices on TB, especially in difficult-to-reach pockets, and connect the rural community with health services. The *Axshaya* project successfully reached and referred 194,391 individuals as presumptive TB cases.

In West Bengal, CARE India launched a programme for MDR-TB patients to provide them with psychosocial counselling. The counselling focussed on completing the course of treatment and helping the patients and their families to cope with the disease. A total of 1,262 MDR TB patients were counselled at the MDR TB Centre during the course of the intervention and 135 MDR TB patients were linked with government welfare schemes. Training pharmacists and referral services for new patients, CARE India's key impact resulted in stakeholders successfully identifying TB cases and referring them for check-ups. Due to sustained efforts, counselling and monitoring, 58% of total patients successfully completed the treatment. The programme has received state support as well in the form of financial and food support to MDR TB patients. CARE India's efforts resulted in the Government of West Bengal initiating the recruitment of counsellors at each MDR TB centre in the state.

Kala-azar

CARE India has been lending technical and operational support to the *Kala-azar* Link Workers to tackle the menace of *Kala-azar* (or Visceral leishmaniasis or VL) in Bihar and Jharkhand through case identification and treatment, coupled with Indoor Residual Spraying (IRS).

An absolute increase in the amount of spraying was reported in 2016 in 24 out of 33 endemic districts, where 71% more households were sprayed in Round II of 2016 (82.6%), as compared to Round I of 2014 (48.3%). This has shown positive results with a steady decline in the number of reported cases over the years (8,028 reported cases in 2014 reduced to 4,774 cases at the end of 2016, as reported by state programme office).

As a result of CARE India's intervention, the number of *Kala-azar* endemic blocks⁷ (as recognised by National Vector Borne Disease Control Programme⁸) reduced from 130 in 2014 to 68 in 2016. CARE India supported the implementation of *Kala-azar* MIS, which has become an asset to all *Kala-azar* elimination efforts by the government, as it documents all cases reported in public facilities and assists surveillance.

⁷Endemic blocks mean blocks with 1 or more cases per 10000 population

⁸Accelerated Plan for *Kala-azar* elimination 2017. Directorate, National Vector Borne Disease Control Programme (NVBDCP). http://www.who.int/leishmaniasis/resources/Accelerated-Plan-Kala-azar1-Feb2017_light.pdf

⁹NACO Annual Report 2010-11. Department of AIDS Control. Ministry of Health & Family Welfare. <http://naco.gov.in/sites/default/files/NACO%20Annual%20Report%202010-11.pdf>

Pneumonia and Diarrhoea

The project focussing on improving the quality of services in Bihar for childhood pneumonia and diarrhoea (TCH) attempted to operationalise in-patient care in eight facilities across the two districts of Samastipur and Purnea for in-patient care covering district hospitals, sub-district hospitals and primary health centres. The efforts started with district and block level visioning and planning meetings in which a minimum set of 12 services, based on the level of the facility, were agreed upon to operationalise for in-patient care. Data from a population of about 100,000 in nine sub-centre clusters suggested that short-duration bacterial pneumonia and acute dehydrating diarrhoea are responsible for only 10% to 15% of post-neonatal U5MR, as suspected.

Care-seeking for serious illnesses was prompt in over 90% of cases of eventual death, and nearly half of all children were seen by a qualified practitioner before death. Illnesses lasting more than a week account for about two thirds of deaths; most deaths occurred in children younger than six months; and in about 20% of cases, the fatal illness began in the neonatal period. The number of referred children admitted in facilities in these districts were 77 in quarter 1 (Nov 2016 - Jan 2017) and 213 in quarter 4 (Aug - Oct 2017).

HIV

The National AIDS Control Organisation (2011)⁹ estimates that about 2.4 million Indians are living with HIV (1.93–3.04 million) with an adult prevalence of 0.31%. Children (<15 years) account for 3.5% of all infections, while 83% are in the age group of 15–49 years. Of all HIV infections, 39% (930,000) are among women. The likelihood of HIV incidence is markedly increased in mobile and migrating populations, where the women and adolescent girls of vulnerable communities are at higher risk.

The EMPHASIS, a regional initiative, was implemented by CARE in India, Nepal and Bangladesh to reduce HIV vulnerability among cross-border mobile populations from Bangladesh and Nepal coming to India. By the end of the project, the percentage of Nepali migrant population in India who were able to identify at least two major modes of transmission of HIV showed significant increase over the baseline (75.9% to 96.4%), while migrants who can discuss about HIV with their spouse and partners increased from 24.3% in the baseline to 49.5% in the endline. The community managed drop-in-centres and peer education resulted in increased awareness regarding support needed by HIV affected populations such as the confidentiality of HIV tests, treatment and support services.



CHAPTER 4

GIRLS' EDUCATION

Context and Strategy

Historically, India has taken important steps towards improving a person's access to education through the National Policy of Education 1986, Programme of action, and implementation of District Primary Education Programme, National Curriculum Framework and SSA¹⁰. In 2009, India enacted the Right to Education (RtE) Act 2009¹¹ which mandates provision of free and compulsory education to all children in the age group of 6 to 14 years, as a fundamental right. The Act expedited progress and ensured growth on important educational indicators such as school infrastructure, student enrolment and transition of children across primary grades, although the overall RtE compliance rates of schools remain fairly low. India is also committed to fulfil the SDGs.

The estimates from DISE 2015–16 suggests that the primary grade net enrolment ratio has reached 87%, gross enrolment has improved to 99% and transition rate for primary to upper primary has increased to 90%. However, improvements in critical educational parameters such as retention rate, dropout and learning outcomes are lagging. A deeper analysis of trends in the education indicators reflect the poor retention rate of students at the secondary level (57.4%), as per DISE 2015–16; and poor learning levels of students of grade 5 (average achievement 58 and 53 for language and mathematics, respectively) as per the National Achievement Survey 2017.

Disparities in education participation across region, caste, tribes and gender exist in India. Gender disparity in education, especially in terms of drop-out rates across states is well-documented. Girls from marginalised

communities face physical and social barriers to participation in education due to social norms, discrimination and poverty. According to DISE 2015–16, the dropout rate increases for girls as compared to boys at the upper primary level (girls dropout rate 4.6%; boys dropout rate 3.5%) and so does the dropout rates of Scheduled Tribe and Scheduled Caste children (8.6% and 5.5%, respectively). Further, the retention rate of 70.9% among Scheduled Tribe children at primary level is much lower as compared to the overall retention levels (84.2%).



¹⁰Sarva Shiksha Abhiyan (SSA) or 'Education for All' is Government of India's flagship Program for achievement of Universalisation of Elementary Education (UEE) in a time bound manner, as mandated by 86th amendment to the Constitution of India making free and compulsory Education to the Children of 6-14 years age group, a Fundamental Right.

¹¹Right to Education (RtE) Forum is a platform of national education networks, teachers' unions, peoples' movements and prominent educationists with a combined strength of 10,000 NGOs from all over India. RtE Forum has been working towards building a people's movement to achieve the goal of equitable and quality education to all children through the realisation of

CARE India's Girls' Education Programme Portfolio and SDGs: Areas of Convergence

SDG 4: Inclusive and equitable quality education

- 4.1: Completion of free, equitable and quality primary and secondary education with relevant and effective learning outcomes for both sexes
- 4.2: Quality early childhood development, care and pre-primary education
- 4.5: Elimination of gender disparities in education and provision of equal access to all levels of education and vocational training for the vulnerable, including People with Disabilities (PwD), indigenous peoples and children in vulnerable situations
- 4.a: Upgradation of education facilities that are child, and gender sensitive and provide safe, non-violent, inclusive and effective learning environments for all
- 4.c: Increased supply of qualified teachers

CARE India's Girls' Education Programme is working with a focus on empowerment and gender equity through strengthening the education system and engaging with civil society organisations/forums/communities to foster partnerships and alliance. The key interventions focus on mitigating the underlying causes behind low education participation, poor transition, out-of-school children and low learning outcomes, especially among girls from marginalised communities. Working at five levels – children, community, schools, system and policy, CARE India combines grassroots level implementation and evidence-based research along with advocacy at various levels. Through its work, the programme supports the achievement of the global Sustainable Development Goal pertaining to quality education (SDG 4).



GIRLS' EDUCATION PORTFOLIO

Snapshot 2014-16

8

Projects

6

States

18

Districts



1,500+

Schools/Centres



112,365

Girls reached



224,879

Children reached directly

Key Areas of Work



Early childhood
development



School
improvement and
learning outcomes



Out-of-school
education



STEM
education



Girls
leadership

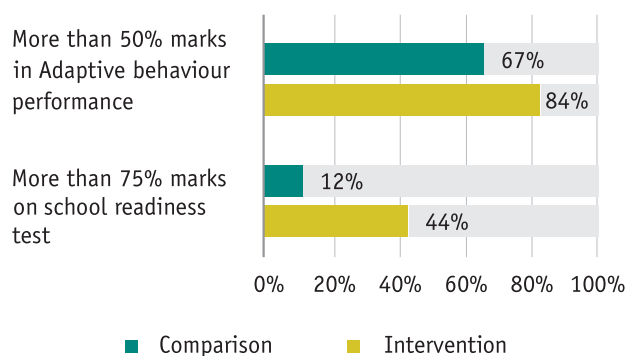
Early Childhood Development: Age Appropriate Development and Growth

The Early Childhood Care and Development (ECCD) Project using a Five-by-Five Model—Health, Nutrition, Care and Development, Rights and Protection, and Economic Strengthening. To address the holistic needs of children below six years of age, the intervention primarily worked at two levels: 1) improving services at Anganwadi Centres and sensitising community members; and 2) working with national level bodies. The intervention aimed to improve the nutrition intake of a child, early stimulation and school readiness, develop the understanding of parents and caregivers on the importance of pre-school education and facilitate them in building a positive and stimulating environment for children.

An evaluation conducted in Chhattisgarh indicated that the ECCD project has had a direct positive impact on all stakeholders – children, parents and the supply-side ICDS functionaries. The project showed improvement in the development milestones of children, such as school readiness and adaptability.

- Intervention group showed improvement in school readiness level of children in the age group of 3-6 years (44%) as compared to comparison group (12%), with children belonging to SC and OBC doing marginally better as compared to other children in the intervention areas.
- Adaptive skills of children in the age group of 5-5.5 years (who scored ≥ 33) increased by 28% from the baseline to endline (24.3% to 52.3%).

School readiness and development status of children aged 5-5.5 years



- Mean home visits made by an Anganwadi worker increased on an average to 16-24 visits every month with each visit lasting for a duration of at least 30 minutes during the endline. In comparison, the baseline indicated mean home visits on an average of 11-13 visits every month, each lasting for a duration of 20-25 minutes.

Advocacy highlights – System level Impact

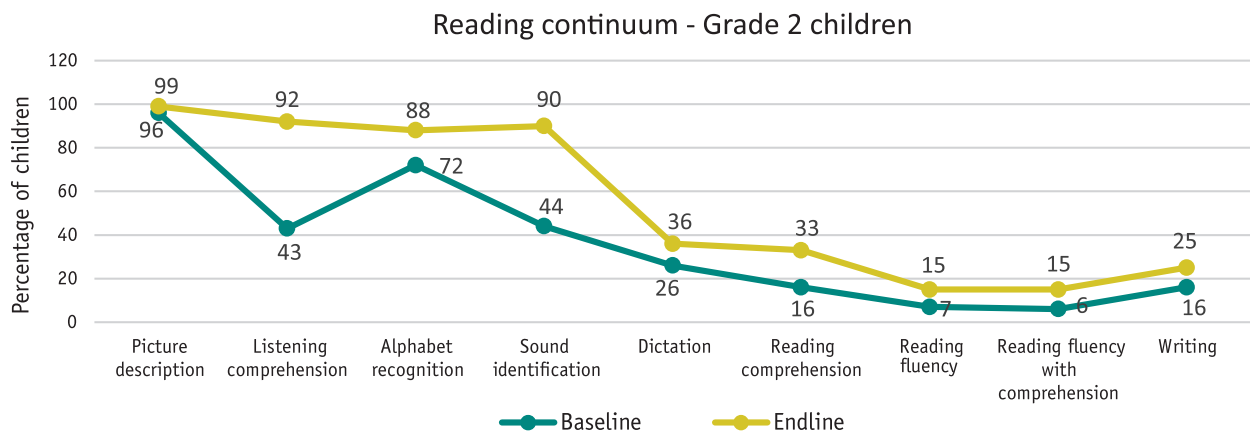
- The Child Development Milestone card to track a child's progress in the early years piloted and tested under the project, adopted as prototype by Ministry of Women & Child Development**
- Development of children's workbooks and story books, which has been adopted by Chhattisgarh Government**
- Development of policy briefs to generate discussions and advocacy on issues**
- CARE India contributed to drafting the National Policy on ECCE, Curriculum and Quality Standards, as a core member of the drafting committee.**

LESSONS LEARNED

- Continuous comprehensive training of Anganwadi workers through residential programmes
- Pre-School Education Package with bi-lingual local stories and lullabies, activity bank, learning kit and IEC material
- Use of toys and vibrant materials at Anganwadi centres to improve the learning environment
- Monthly reflective for a with mothers and caregivers

Enhancing Learning Outcomes of Early Grade Children

CARE India recognises inappropriate curricula, pedagogy and children materials, learning environment in schools, limited capacity and motivation of teachers and system functionaries as the prime barriers to ensuring quality education for marginalised children. Various studies have also indicated poor learning outcomes amongst school children in India. In this context, CARE India has designed projects based on School Improvement Framework for the most deprived districts of Odisha and Uttar Pradesh.



The School Improvement Programme is an overall framework to improve the quality of education in government schools, with a focus on language pedagogy and learner assessment, contextual learning and reading materials for children, improving education environment and pedagogy, cluster-based teacher development approach, and community and system engagement at decentralised levels. SIP also focussed to promote platforms such as school committees for morning assembly to provide girls with an opportunity to learn leadership skills.

Under this framework, the Start Early: Read in Time project, implemented in select districts of Uttar Pradesh and Odisha, aimed at improving the early grade reading skills of children (6–9 years of age) in government schools.

Enhanced Reading Skills in Children:

- The project evaluation indicated a 17 percentage point improvement in reading comprehension among grade 2 children (16% to 33% from baseline to endline).
- In grade 2 children, listening skills increased from 43% to 92%, phonics competency increased from 72% to 88% and phonemic awareness increased from 44% to 90% over the baseline.

K-LEAP worked in 132 formal schools in five blocks of the Kutch district in Gujarat. It contributed towards improving the quality and accessibility of primary education for over 43,000 children. The project evaluation showed improved access to child development activities such as games/ drama/melas/picnic, cultural activities and physical development activities through learning materials and new teaching methods.

Improving Quality of Education in KGBVs

CARE India has worked towards improving Kasturba Gandhi Balika Vidyalayas (KGBVs), a residential system of schooling (Classes 6 to 8), for adolescent girls belonging predominantly to SC, ST, OBC and minority communities. Through various interventions, CARE India has supported 75,000 girls in KGBVs in selected districts of Uttar Pradesh, Gujarat, Odisha and Bihar to improve the school's overall quality and build an empowerment-based education model.

- Annual assessments in Uttar Pradesh showed that 90% of KGBV girls achieved competence of grade five level in language, while 72% of girls achieved competence of grade five level in mathematics.
- Access and exposure to computer has increased overall levels of confidence among girls within and outside of the classroom.
- Girls acquired a new spirit of questioning and logical reasoning as well as the ability to interact freely with visitors and others from outside the school.
- KGBV teachers became the key advocates of the learner-centred instruction approach and to address safety and security issues in KGBVs

The endline evaluation showed that the contribution of the K-LEAP project towards improving the use of science and mathematics kit, stationary and text books and different teaching methods including classroom competitions for teaching the students in KGBVs.

System-Level Impact

- Recognising the reading continuum as an important approach, teacher training manual developed under the project adopted by the Uttar Pradesh Government to train all primary teachers.
- Oriented state level resource group on early language and literacy approach and its implications for teachers' training through monthly sharing meetings in Odisha.
- Developed framework of monthly sharing meeting for teacher development in language which was used by SSA in the entire state.
- Decentralised teacher forum is recognised as an essential platform for teacher development and school progress in the Mayurbhanj district of Odisha.
- Learning indicators specific to reading incorporated as part of language learning outcomes in the Right to Education model rules in Uttar Pradesh.
- Contextual children reading material such as story books in mother tongue recognised as a good practice for classroom processes.
- Community library initiative in Shravasti district replicated in 100 villages in collaboration with the Uttar Pradesh state government.
- A paper on 'Early Language and Literacy' published in three languages used by several universities as an essential reading.
- Contributed towards development of policy formulation during the 12th Five Year Plan on Early Language and Literacy.
- Provided inputs to SSA Uttar Pradesh for development of Annual Work Plans on quality education and teachers training.
- Supported SSA in revision of guidelines/ instructions for Padhe Bharat Badhe Bharat scheme to promote literacy in children.
- Supported Uttar Pradesh government to formulate a vision framework for safety and security of girls including specific provisions in the state annual work plan and budget to implement it.

Key areas supported to improve KGBVs

- Key areas supported to improve KGBVs
- Provided administrative support to KGBVs
- Developed Bridge Course for out-of-school girls
- Ensured smooth transition of girls to mainstream schooling
- Build teacher's capacity
- Created context specific content for teaching scientific concepts
- Addressed safety and security issues
- Build platforms of collectivisation and supportive supervision for teachers
- Developed monitoring framework to capture leadership and quality-based parameters in KGBV schools
- Advocated through technical support to state government cells



CASE STUDY: Creating opportunities and moulding life with a tiny bold action

Rubina was the first in her village to send her daughter to school. "I was always interested in studying and definitely wanted to give my daughter the opportunity to study. People were against my decision and said many things like she will get spoilt and that nobody will guide her, but I took the plunge and later found that they did more than just guide!", shared Rubina with a big, warm smile. Rubina's daughter, Daraksha Noori, was 12 years old when she began her studies at the KGBV Jarwal in Bahraich, Uttar Pradesh four years ago. She is now completing her tenth-grade studies at Mili Islamic School.

CARE India's Join my Village project brought access to KGBV Jarwal, providing opportunity for Daraksha to enrol. Rubina shared that she did not sleep the first four nights after her daughter was enrolled in the school. Daraksha added, "I was elated to find that the school was going to be so close by. But it was very tough for me when I was coming to KGBV for the first time; and now that I have left KGBV to continue my studies further I want to come back here again!" Rubina proudly says that "At KGBV, Daraksha excelled in everything - studies, sports, sewing and more. She was favourite of teachers as she was an all-rounder." Encouragement from her family helped Daraksha achieve what many girls from her community could never even dream of.

Rubina, who lives in a community where girls are not educated, is a strong advocate for girls' education. She made sure that others, including her brother's daughter and two other girls, who had never been enrolled before were admitted to school. On the importance of education, she says, "If you sit in front of four people you will have knowledge, so I always wanted to study. If a person has no knowledge, then he or she is no one." Rubina wants Daraksha to become a teacher and educate other children. She says, "The toughest time for me was when I had three small children. Daraksha was the eldest so she could have helped me in household chores, but I wanted to give her the chance to study. So I managed everything by myself." Rubina's other daughter, 11-year-old Sumaya Noori, is in sixth grade at National Public School and has been given the opportunity to study ever since she started walking.

Rubina's husband Mustakim has studied only till fifth grade. He always wanted to continue his education but considering the financial condition at his home was not stable he had to earn a living instead. Even though Mustakim himself never went to school he ensured his wife went to school after their marriage. With support and encouragement from her husband Rubina completed ninth grade at the age of 22.

Their entire family is an advocate of educating girls. Even though Rubina does not need to but she goes to KGBV regularly. She helps the teachers with their stitching classes. She shared, "I make sure that there is nothing lacking for the students to learn stitching."

Institutionalising Critical Processes

- Set up internal supervision mission with SSA and UNICEF to monitor the quality of provisions in KGBVs, the report used as a tool for planning process.
- Provided technical inputs to SSA in development of teacher development manual on science, language and mathematics subjects at upper primary level for KGBV; conducted training of Master trainers to train science teachers of KGBVs.
- Supported Uttar Pradesh government to expand Adolescent Girls Leadership Curriculum to all KGBV schools across the state.

Improving Access, Participation and Mainstreaming of Out-of-School Children

In the context of high dropout rates and low education participation, CARE India extensively works with out-of-school children, specifically girls, to facilitate their entry in the education system on one hand and impart them with skills to facilitate their empowerment on the other.

The *Udaan* project targeted out-of-school girls, including those who dropped out of school or were never enrolled in formal education. It facilitated adolescent girls aged 9-14 years to complete Grades 1 to 5 over a period of 11 months through an accelerated curriculum. It builds their critical thinking skills and sense of identity, and enable them to set their goals. Between 2013-14 to 2016-17, CARE India reached out to 1,087 girls through residential and non-residential *Udaan* centres in Uttar Pradesh, Odisha, Bihar and Haryana, one in each state. The *Udaan* model was recognised as a Best Practice by the Commonwealth Ministries of Education in 2006.

Key Achievements

- 92% of *Udaan* girls mainstreamed to age-appropriate grades in government schools.
- Adoption of *Udaan* based 'Special Training Curriculum' as a bridge course by state-run Special Training Centres (STCs) for out-of-school children. The leadership curriculum of *Udaan*, adopted by state government as specific skill curriculum, reaches out to 70,000 girls across 746 KGBVs in Uttar Pradesh with support of Uttar Pradesh SCERT.
- Alumni Scoping Study (2016) showed that girls who were part of *Udaan* are more likely to undergo or complete Intermediate education as compared to their siblings; 25.0% of alumni have either completed or are still pursuing graduation as compared to 16.8% of sisters of alumni students.
- Qualitative assessment of psycho-social empowerment and leadership skills (21st century skills) of girls showed that *Udaan* girls express greater aspiration for financial independence and building career as compared to government school going and out-of-school girls.

CASE STUDY: The first to pursue secondary school education - *Udaan* shows the way

Murshida was the first girl, from the village Mahaun in Mewat district of Haryana, to study beyond primary school. An *Udaan* graduate, she studied until third grade in the village school and then dropped out. It was only when a CARE India's team member went to her village, met her hesitant parents and convinced them to enrol her at *Udaan*, that Murshida got the opportunity to re-start education and consequently enter secondary school.

Twelve-year old Murshida now studies and lives in the government residential school Kasturba Gandhi Balika Vidyalaya. She is currently awaiting results of her eighth-grade exams and will begin ninth grade studies soon. Murshida is thankful to her father for supporting her to continue her education. Murshida has a nine-year old sister Naheeda, who is in second grade and is studying at the village school. Murshida wishes that her sister Naheeda also gets enrolled in the residential school.

She shared that her father would not have sent her to study given the social milieu in the village about girls' education. But after his daughter's experience at *Udaan*, he now inspires other girls' fathers in the village to send them to school, too. Murshida says that her father is now very proud of her and tells her, "No other girl has studied from our village before, but I will educate you." Murshida's father's progressive notion towards girl's education is motivating other parents to educate their daughters.

The *Pragati project*, working in four districts of Bihar, aims to mainstream out-of-school children of age group 8-14 years in education by imparting age-appropriate learning and leadership skills. The programme works with teachers to build their skills on the specific needs of out-of-school children and to ensure their smooth transition, in addition to working with community members via School Management Committees and state functionaries. Out of the 750 children enrolled in 15 STCs in 2015-16, 749 children were mainstreamed into age-appropriate grades, majority of which were girls. The programme assessment demonstrates that the competency levels of participating girls improved by the end of the programme.

Advocacy at the State Level

- Quality monitoring indicators, developed by CARE India, for monitoring of special training centres adopted by Bihar state government.
- Supported SSA Bihar in training of STC coordinators of all districts; a training manual developed by CARE India, adopted by SSA to train education volunteers/teachers engaged in imparting special training programme.

K-LEAP, implemented in the Kutch district of Gujarat, worked with 260 adolescent girls through the Adolescent Girl's Learning Centre (AGLC) to help out-of-school girls to learn vocational and life skills and build confidence using a multi-pronged gender transformative approach. The endline evaluation of the project indicated that:

- 90% of the households with an adolescent girl were benefitted by a *Bal Sakhi Kendra* or AGLC.
- Adolescent girls at AGLCs gained three skills (literacy skills 94.4%, livelihood skills 77.8% and life skills 56.6%).
- 71% of adolescent girls reported that they were motivated by AGLC coordinators to enrol in a KGBV, of which 5% of adolescent girls joined a KGBV.

Leadership of Adolescent Girls

Agrani project, implemented in 100 formal elementary schools in the districts of Gaya and Nalanda in Bihar, focussed on adolescent girl's leadership skills to help them gain control over their own lives and create an enabling environment for others. The project developed and strengthened effective fora for girls such as Children Committees (*Bal Sansad*), morning assembly, fora of co-curricular activities, and sports and school-based adolescent collectives (*Meena Manch*) in government schools.

A qualitative assessment of the interventions in schools showed an increased participation of girls in conducting and leading several platforms like school assembly, co-curricular activities and issues pertaining to library management. *Meena Manch* gained vigour and became vibrant and functional. Schools started allocating separate rooms for organising *Meena Manch*. Levels of confidence and expressivity of girls improved. Participatory avenues for girls widened the scope for application of knowledge and mutual learning.

Innovations and Successful Approaches

An essential contribution of CARE India's work in the education domain has been bringing the attention to teacher development. The longitudinal research on teacher development demonstrated a positive relationship between teacher development, learner centred pedagogic methods and learning outcomes of children. Conducted from 2010 to 2014 in Shravasti district of Uttar Pradesh, the study indicated that decentralised teacher development programme can positively influence teaching methods, perspective and sensitivity of teachers.

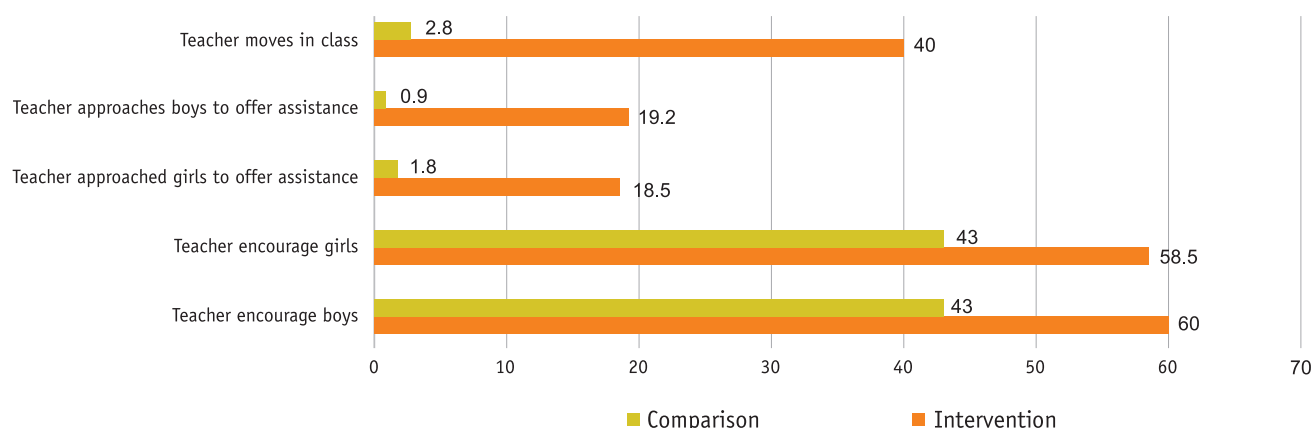
- Performance on some of the behavioural and pedagogic indicators among teachers such as encouraging girls and boys, offering assistance, moving around the class and encouraging shy and hesitant students improved in the intervention clusters when compared to comparison group.
- Achievement outcomes in mathematics and language improved steadily in intervention schools.
- The trend analysis showed steady improvement in both grade 2 and 3 Mathematics among boys and girls.
- Participatory pedagogic methods allowed children to work in groups and mixed seating arrangements for boys and girls, provided more opportunity and assistance to children especially girls resulted in having a positive impact on learning outcomes.

Learning Outcomes in Intervention Site

Time	Mathematics			
	Grade 2		Grade 3	
	Boys	Girls	Boys	Girls
2010	4.4	2.5	6.5	4.9
2011	6.9	4.5	8.5	5.8
2012	7.5	5.0	7.3	5.8
2013	8.3	5.9	8.9	7.3
2014	7.2	5.4	9.5	8.1

CARE India established decentralised teacher development fora to improve teachers' understanding and skills on various aspects such as early grade reading and its techniques, classroom environment, children participation, material development and gender sensitive classroom management. The approach of decentralised

Teachers' behaviour during classroom transaction (% teachers)



teachers' development through Cluster Resource Centres (CRC) promoted self-help commune of teachers. The rationale for cluster intervention is to improve the cluster resource centre to aid the development of a teacher's skill building process through onsite academic support.

Model Cluster Schools were identified as sites to receive focussed efforts for change in terms of teaching and learning, which led to:

1. Enhanced learning achievement of learners
2. Improved school community relationship
3. Strengthened academic support structure.

Besides the improvement in the cluster infrastructure, the CRC platform was used to develop a vast range of books and teachers' learning material created by teachers and students from different schools. This initiative led to a transformation in the traditional pedagogy to a more participatory and child-centred, learner-centred and progressive teaching-learning practices. It created a democratic learning environment in schools and the teacher's autonomy improved to make space for diversity amongst students.

The Teachers' Resource Laboratory (TRL) intervention worked with government school teachers to improve their

instructional methods, conceptual clarity and strengthen the capacities of educational functionaries. Rolled out in Uttar Pradesh through 3 TRLs, the model resource centres for subjects like Science, Mathematics and Language for primary, upper primary and KGBV school teachers, contributed to build capacity of teachers and inculcation of scientific temperament.

The Mentoring Support Programme connected girl students with TRL and developed conceptual understanding using reflective pedagogies. Recognised as an innovative model at both state and national levels, the intervention trained 126 teachers and reached 8,000 students in one-year of its operation.

A learning from the intervention is that, for furthering teaching science and technology using innovative pedagogic techniques to children, Teacher's Resource Lab could be a model.

CARE India rolls out its programmes in close alignment with existing government policies and partners with government bodies, SCERTs and SSA which enables them to achieve sustainable and scalable results. It has worked very closely with the RtE Forum and advocated for effective implementation of the RtE Act.

Teachers' Resource Labs, Uttar Pradesh

57
Schools

126
Teachers

3
Successful TRLs

8,000+
Students



CHAPTER 5

LIVELIHOODS

Context and Strategy

Over the last five years, while the population living below poverty line in India has declined by 15.7%, from 37.7% in 2004-2005 to 22% in 2011-12 as per National Sample Survey Office (NSSO), India still has the second largest number of poor people among all the countries in the world. The average monthly per capita expenditure is ₹1,430

CARE India's Livelihoods Project Portfolio and SDGs: Areas of Convergence

SDG 1: End poverty in all its forms everywhere

1.4: Gender-based equal rights to economic resources, access to basic services, ownership and control over land and financial services including microfinance

1.5: Build the resilience of the poor and those in vulnerable situations

SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture

2.3: Double the agricultural productivity and incomes of small-scale food producers, in particular women...including through secure and equal access to land, other productive resources and inputs, knowledge, financial services, markets and opportunities for value addition and non-farm employment

2.4: Ensure sustainable food production systems and implement resilient agricultural practices

SDG 5: Achieve gender equality and empower all women and girls

5.4: Recognise and value unpaid care and domestic work

5a: Undertake reforms to give women equal rights to economic resources, access to ownership and control over land, other forms of property, financial services, inheritance and natural resources

SDG 6: Ensure availability and sustainable management of water and sanitation for all

6.1: Achieve universal and equitable access to safe and affordable drinking water for all

6.4: Increase water-use efficiency across all sectors and ensure sustainable withdrawals and supply of freshwater to address water scarcity and substantially reduce the number of people suffering from water scarcity

6.5: Implement integrated water resources management at all levels, including through transboundary cooperation as appropriate

SDG 8: Promote sustained inclusive and sustainable economic growth, full and productive employment and decent work for all

8.3: support productive activities, decent job creation, entrepreneurship, creativity and innovation, and encourage micro-, small- and medium-sized enterprises, including through access to financial services

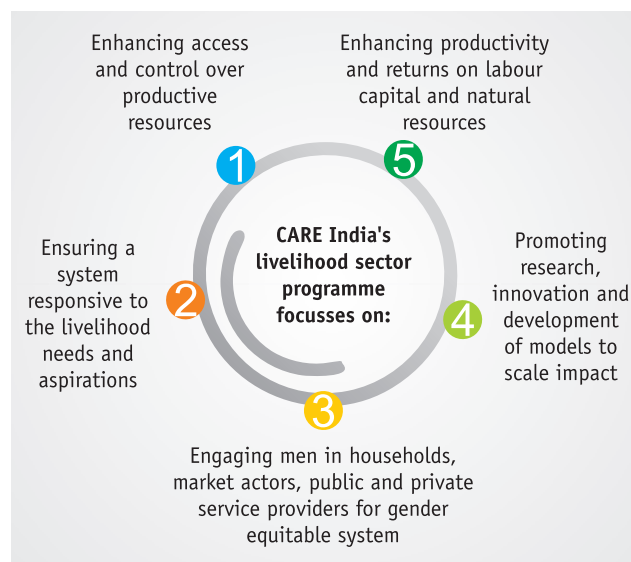
8.5: Achieve full and productive employment and decent work for all women and men...and equal pay for work of equal value

8.10: Strengthen the capacity of domestic financial institutions to encourage and expand access to banking, insurance and financial services for all

SDG 13: Take urgent action to combat climate change and its impact

13.1: Strengthen resilience & adaptive capacity to climate-related hazards & natural disasters

in rural areas and 2,630 in urban areas of India. NFHS 2015-16 shows that 56% of India's rural population falls in the two lowest wealth quintiles. According to Socio-Economic Caste Census (SECC) 2011, 30% of the landless households derive a major part of their income from casual labour. Key issues that affect livelihoods of the poor include: (i) poor capabilities in terms of skills, network, resources, assets; (ii) poor access to services, finance, assets and markets; and (iii) lack of due recognition as labourers/farmers/entrepreneurs (or lack of voice). This vulnerability is further accentuated in case of women by widespread migration, lack of transferrable vocational skills, unequal wages, feminisation of low-paid and unpaid labour, seasonal nature of labour engagement, lack of opportunity, poor asset ownership, landlessness, and their lack of access to finance.



LIVELIHOOD PORTFOLIO

Snapshot 2014-16

9

Number of projects

5

Number of states

9

Districts



217,584

Total participants reached directly



139,002

Total women reached

Key Areas of Work



Women's economic empowerment



Agriculture and nutrition security
climate change resilience

Empowering Rural Women through Income and Asset Generation

CARE India has worked intensively with women from poor and marginalised households, by improving their access to productive resources – human, financial, natural, physical, and social; associated services and opportunities, thereby increasing their productivity and engagement in profitable value chains and creating a system responsive to their needs and aspirations. CARE India's livelihood initiatives also aim to transform gender norms and rectify unequal power relations at multiple levels – within households, in communities, value chains, and markets, for empowerment of women.

The KLEAP initiative implemented in Kutch district of Gujarat aimed at economic development of small and marginal farmers by improving their agricultural practices, supporting dairy interventions and market linkages. Endline evaluation of the project showed several changes in the livelihood capacities and endowments of project participants after a combination of interventions lasting more than four years.

- Mean annual dairy income of farmers increased by >3 times from ₹22,000 to ₹70,865 between baseline and endline.
- Mean annual household income from agriculture at the end of project was ₹7,3604; 46% farmers reported to have increased income post project intervention
- Around 60.8% of livestock rearers reported that their household income increased post project intervention
- Farmers who availed productive loan increased from 10% to 33.1% from baseline to endline
- Around 44.7% of farmers reported availing services from agriculture service centres during the past 12 months, out of 34.6% farmers who were aware of those services
- Around 62.3% of farmers reported availing services of SMS-based agriculture update during the past 12 months, out of 50.7% who were aware of services
- Around 52.2% of farmers reported availing agricultural loan services during the past 12 months, out of 66.9% farmers who were aware of services

- Around 48.1% of farmers reported availing fodder bank during the past 12 months, out of 29.5% farmers who were aware about fodder banks

Similar significant improvements have been reported in income and assets of women smallholders participating in CARE India's Pathways programme in Odisha. These changes between baseline and endline status in Pathways include:

- The mean monthly per capita household income from farm increased from ₹53 to ₹140¹².
- Percentage of households with women earning income from agricultural production and/or related processing activities increased from 32% to 85%.
- Percentage of non-farm income to overall income improved from 5% to 17%.
- Mean asset index significantly increased from 148.9 to 171.7.
- Overall asset values for households rose by 15%, with a further 21% growth in asset values when calculated without agricultural land.
- Households with ownership of small livestock (goats and sheep) increased from 26.0% to 34.2%; ownership of poultry increased from 52.0% to 62.8%
- Women's access to additional land increased significantly from 2.3% to 28.8%.
- Percentage of households with diversified income generating activities increased significantly from 18.2% to 38.3%.
- Female headed households below poverty line criteria dropped from 49.2% in the baseline to 34.5% in the endline.

Pathways evaluation showed that overall adapted Women's Empowerment in Agriculture Index (WEAI) in project households improved from 0.47 to 0.53 between baseline and endline; the percentage of women achieving empowerment score of 0.80 or greater increased from 4.7% to 10.7%.

¹²The final evaluation of Pathways project reported increase in mean monthly per capita household income from farm increased from \$0.80 to \$2.12.

CASE STUDY: Realising her potential as a women smallholder farmer

Sarojini Pradhan lives in Dadapada village of Kandhamal district. She belongs to a tribal family and has experienced years of oppression and neglect throughout her life. Being a woman, that too from a community with an orthodox mindset, it was not easy for her to step out of her house and join a self-help group. The income of her husband was not enough to sustain the family and it was very difficult for her family to make ends meet. Despite her engagement in agricultural practices, they were not able to save. They decided to take a loan so that they could buy a new plot, seeds, and fertilizers, and save some money for the future. They used the loan amount for the household and for agricultural purposes. Due to the low productivity of crops and the poor quality of *sal* and *mauah* seeds, it became difficult to repay the loan.

Inspired by CARE India's Pathways initiative for women's empowerment, Sarojini joined the self-help group. There she learned more about agricultural practices and organic farming techniques. Pathways provided her with training in line sowing and kitchen gardening through demonstrations, optimal use of local resources, and skill building.

Today Sarojini is engaged with the Farmers' Club which has strengthened her knowledge about sustainable practices. For the first time, the market traders have bought 32 quintals of *mauah* seeds from her. After a few rounds of training in specialized processing techniques, the quality of her *sal* and *mauah* seeds has improved. With the money she earned, Sarojini repaid her loan and has been saving money for the education and health of her children. With the help of the Pathways team, collective strengthening of the self-help groups and her engagement with the market traders earned her a good name in the market.

She shared, "Due to Pathways, I am confident about my work and have realised my potential as a woman farmer. I feel confident when I sell my seeds to the buyer and that too at a good price. There is a sense of achievement and I will never look back."

The EnSIGN project was implemented in Bankura district of West Bengal with the objective to enhance the Sustainable Farming Initiative (SFI) through integration of gender and nutrition. Women's sole or joint ownership of household assets in EnSIGN participants increased from 8.3% during the baseline to 21.2% during the

endline. In Banking on Change project, implemented in three districts of Tamil Nadu, 57% of youth reported having purchased assets for business or income generation.

Change in Women's Access and Control over Income and Resources

EnSIGN

- Women's control over household income and expenditures in household decision-making domain has increased from 50% to 70% from baseline to endline in EnSIGN
- Joint or sole ownership of at least 50 percent of the household assets by women increased by 1.5 times (8.3% to 21.1% from baseline to endline)
- Joint or sole control of women over purchase or sale of 80% of household assets increased from 0.8% in the baseline to 2.6% in the endline

Pathways

- In Pathways, sole or joint decision-making and control over household assets by women increased from 40% to 68% over the project period; Sole or joint decision-making and control over agricultural assets by women increased from 53% to 77%
- Significantly more women are empowered in selling or purchasing household assets from 29% to 54% of women
- Access to agricultural extension services by women increased from 24% to 89% over baseline; percentage of women accessing agricultural inputs (seeds, fertilisers, etc.) improved from 36% to 89%

BoC

- 32.2% of women reported that they can use income from income generation activity freely, as compared to 13.3% of women in the baseline of BoC project.
- Women who purchased assets over the last one year grew around six times from 5% to 29% by the project-end.

WtRF

- WtRF project evaluation showed increase in women's access to financial services, mobility and social interaction, independent decision-making capacity pertaining to economic resources, agricultural product selling, and governance. 76.9% of women had a bank account in their name as compared to 56.7% in the baseline.

BoC, focussed on delivering a savings-led microfinance intervention with the aim of improving financial inclusion by mobilising individuals into savings groups so they could save regularly, and borrow small amounts at a fair rate of interest. The project established 21,000 new groups in Phase 1 with over ₹429 million in savings

and ₹330 million in loans¹³. Youth were targeted to increase their financial literacy, employability and entrepreneurship skills. Loan availed has increased among new youth from 50.2% to 75.8% from baseline to endline.

Areas of Transformative Change for Women

The Dairy Value Chain (DVC) project contributed to transforming various traditional roles of women.

- Women gained self-confidence to become entrepreneurs from being a support in the dairy value chain
- Women broke deep rooted inequity barriers by forming collectives, became leaders in the value chain and were able to negotiate and seek better prices
- Women have access to sustainable income with the acquisition of productive assets and access to credit
- The assets owned by women members increased from 16% to 36%; their access to credit for milch animals increased from meagre 3% in baseline to 30% in endline.
- Women members engaged in business activities increased from 6.5% to 39.8% in endline.

The DVC model has subsequently been adopted by the State Planning Commission of Tamil Nadu for its demonstrated impact on engendering inclusive value chain promotion and invested ₹2.1 million for replication in newer geography.

EnSIGN project evaluation showed that:

- Around 17% women were confident in speaking about gender and other community issues at the local level (3 of 4 topics), and 8% of women were active in political participation, as against 0% in the baseline.
- Women expressing attitudes that support gender equitable roles in family life (scoring 4 out of 4) increased from 20.8% to 53.4% from baseline to endline.

In the Pathways project:

- Women confident of speaking about gender and other community issues at the local level improved from 68.8% in baseline to 74.9% in the endline.
- Women who were active in political participation increased from 20.1% to 60.0% between baseline and endline. Women were represented in leadership positions of Self-Help Groups (SHGs) across all Pathways villages and women held important community positions, such as *Sarpanch* and ward members.



Climate Change Resilience and Nutrition Security

CARE India worked with women smallholder farmers in Chhattisgarh, Odisha, Tamil Nadu and West Bengal to support sustainable and climate resilient agricultural practices, improve nutrition security and build climate change resilience against various kinds of shocks and stresses. To bring about holistic change in the areas of resilience and nutrition, it is necessary to sustain resources for future, promote individual and institutional capacities and transform vulnerability to risks in the

areas of agriculture and livelihood. CARE India's work focusses on building asset-base, knowledge, information on institutional entitlements and governance, to improve climate change resilience and nutrition security.

WtRF project focussed on building climate change resilience among rainfed agriculture communities. The intervention implemented in the Jashpur district of Chhattisgarh aimed to increase resilience of women farmers to shocks and stresses related to water, mainly owing to climate change. Findings from endline study of indicated that women in the intervention

¹³This is an estimated figure based on conversion rate in year 2016. The original figure in USD stands at \$6.5 million in savings and \$5 million in loans.

areas had enhanced their capacities to practice several climate resilient agricultural practices like System of Rice Intensification (68.3% from 4.3%), mixed cropping (64.2% from 30.1%), deep tilling (55.4% from 60.9%) and land levelling (81.1% from 44.3%). The 5% model technique of water re-charge has been adopted by 53.8% of farmers and has helped them in increasing productivity of paddy and enabling the cultivation of a second crop. Among the farmers who were trained on agriculture coping mechanisms, 61.9% of farmers believed that they were better able to adapt to harsh climate change conditions.

CASE STUDY: Changing lives with resilient agriculture practices

Anila Deewan is a woman farmer from Chandagarh village, Pathalgaon block, Jashpur district, Chhattisgarh. Her family is totally dependent on agriculture for their living. Earlier a major part of her income used to go towards procurement of inputs for agriculture like purchasing seeds, fertilizers, pesticides, etc. She took a loan of approximately ₹20,000 for this purpose prior to every harvest season. Majority of her income from the harvest went in returning the loan and she was left with a very minimal amount to run her family expense.

After the intervention of Where the Rain Falls (WtRF) project by CARE India she was invited to participate in a training on Climate-Smart Agriculture (like vermicompost production, use of traditional varieties of paddy, etc.) The training gave her exposure to all the sustainable methods of crop production practices. During her interaction in the training and meetings he learnt about vermicomposting, its benefits, the importance of traditional crop and varieties of paddy.

When she first shared her learnings with her husband he was hesitant to adopt these practices since agriculture was their sole source of income but after repeated rounds of interaction, he agreed to test it. They started vermicomposting on their small piece of land. To their surprise, the yield on the land where vermicompost was used increased considerably. The production of crop increased up to 1.5 times. Also, water requirement in that part of the field was comparatively lesser than where chemical fertilizers were being used. The pest infestation in the field also reduced extensively. The taste of organic produce distinguished from those which were grown with the application of the chemical fertilizers. The shelf-life of vegetables increased relatively. Now they are only using vermicompost in their field.

Every year Anila produces 35 quintals of vermicompost out of which she used 15 quintals for her own agriculture land and sells the rest to other farmers at ₹12 per kg. Her agricultural yield has become profitable now. She is motivating other farmers to adopt vermicompost production methodology and other climate-smart agricultural practices.

In the Pathways project, adoption of improved agricultural practices resulted in 27% increase in rice production from 851 kg per hectare to 1081 kg per hectare, over the project period. The contribution of project to strengthening food security of women has been evident by the increase in diversity of livelihood sources. Women's access to labour opportunity under the Mahatma Gandhi National Rural Employment Guarantee Scheme (MNREGS) increased from 36% to 55% from baseline to endline. Women's knowledge on the optimum method of collecting fruits/herbs/shrubs from the forest area without affecting the forest resources increased from 37.4% to 94.6% during this period, which in turn helped in securing higher yields for subsequent years.

The EnSIGN project in Bankura district of West Bengal aimed to improve health and nutritional status of women smallholders by promoting health affirming behaviour, encouraging kitchen gardening, awareness generation and establishing linkages with public health services. The uptake of kitchen gardens in a span of two years of implementation of the programme increased by 2.5 times (from 23.5% to 82.3%). Project's efforts resulted in tripling the practice of growing nutrition sensitive crops by households from 14.3% to 55.8% between baseline and endline. Around 45% of women who were not using any improved agriculture practices during the last 12 months at the baseline had significantly come down to 7% during the endline.

Further, women's dietary diversity increased by one food group, indicating a dietary diversity score of 6.7 to 7.1 between baseline and endline. In particular, consumption of eggs and fish by women has significantly increased from 11.7% to 35.0% and 44.2% to 60.8%, respectively, over the project period. While the incidence of severe anaemia among women was 3% at the time of the baseline, no cases of severe anaemia were found during the endline.

The Pathways project's evaluation similarly showed that mean household dietary diversity score increased significantly from 4.1 to 5.4 between baseline and endline. Access to all food groups increased for households, notably for access to vegetables (57.1% to 75.5%). Households have significantly increased their coping index from 3.2% to 9.7% when faced with food shortage. Households using at least one adaptation strategy to reduce the impact of future shocks increased from 56.5% to 94.8% between baseline and endline. Mean intra-household food access by female-headed households increased by 42% (3.5 to 5.3) over the increase in male headed households (4.0 to 5.3).

Change Supported through Collectives

CARE India has used collectivisation as one of the key strategies to organise and strengthen local capacities in order to address barriers to unequal power relations, and access to resources and opportunities for advancing their agenda through collective voice and influencing. To improve financial access and independence and enable marginalised groups to exercise their rights, choices and voice, people have been organised into collectives such as SHGs, Farmer's Club, Water Management Groups, Village Development Committees (VDCs), Forest Rights Committees (FRCs), etc.

- In Pathways project, for enhancing access to forest land under the Forest Rights Act 2006, the strengthened FRC facilitated claim submissions and submitted a total of 812 applications, out of which 424 applications were approved by *Gram Sabha* and forwarded to the Divisional Level Committee
- In BoC project, access to financial services was enhanced for the participant communities through SHGs which enabled a three-fold increase in credit mobilisation in the form of funds from financial institutions (₹216.41 million to ₹1.03 billion). A total of 15,286 members were facilitated to have access to micro insurance (an increase of about 40%) and micro pension services (an increase of almost 100%)
- In WtRF project, collectives were instrumental in empowering women. The evaluation findings indicated that a higher proportion of Adivasi women were coming out of their houses to attend Village Development Committee meetings; from 21.4% during the baseline to 42.1% at endline.

Collectives supported by CARE India in livelihood projects

Project Name	Number of collectives supported	Number of collective members
BoC	2,599	36,535
DVC	166	1992
K-LEAP	415	5,000
Maize Pathways	90	1,035
Pathways	591	8,010
WtRF	175	1,914
Total	4,036	54,486



Under its livelihoods sector initiatives, CARE India has strengthened and worked with diverse community institutions, viz. farmers' producer companies, SHGs of women, water management groups, and forest protection groups. A rapid review of the self-reliance and sustainability of selected community-based institutions those were supported through implementation partners, was carried out. In the context of SHG federations in Gujarat and Tamil Nadu, and Producer Companies of farmers in Gujarat as well as cashew processors in Tamil Nadu, the following were the insights:

- **Vision:** All institutions had a clear sense of future planning, but their vision was being driven by the NGOs working with them. The implementation partners were not able to continue intensive and supportive engagement with community institutions post-grant phase.
- **Governance:** All studied institutions had been registered and were compliant of the statutory requirements. However, the Board of Directors retain much influence and control, with limited delegation of management decisions.

- **Management:** When financial services were offered, the products were profitable and the portfolio well managed. However, the institutions required professional management support and diversification of business portfolio for optimum utilisation of the assets created under CARE India supported programmes.
- **Profitability:** Federations became financially stable, though SHGs needed to pursue businesses in a sustained manner. Where the institution's income depended on the financial fortunes of farmers, there was shared vulnerabilities to the vagaries of monsoon and crop failures.
- **Infrastructure:** The bare-bone infrastructure created under grant initiatives for most institutions became insufficient for supporting institutional growth; continued credit support and lack of capital affects growth and expansion.

Going ahead, the investment and growth path for various kinds of collectives require a clear vision and strategic engagement.



CHAPTER 6

DISASTER PREPAREDNESS AND RESPONSE

Context and Strategy

India is vulnerable, in varying degrees, to a large number of disasters. As per the National Disaster Management Authority (NDMA), more than 58.6% of the landmass is prone to earthquakes of moderate to very high intensity; over 40 million hectares (12%) of its land is prone to floods and river erosion; close to 5,700 km, out of the 7,516 km long coastline is prone to cyclones and tsunamis; 68% of its cultivable area is vulnerable to droughts; and, its hilly areas are at risk from landslides, hailstorms and avalanches. Moreover, India is also vulnerable to Chemical, Biological, Radiological and Nuclear (CBRN) emergencies and other man-made disasters.

Disaster risks in India are further compounded by increasing vulnerabilities related to changing demographics and socio-economic conditions, unplanned urbanisation, development within high-risk zones, environmental degradation, climate change, geological hazards, epidemics and pandemics. Clearly, all these contribute to a situation where disasters seriously threaten India's economy, its population and sustainable development. Disasters affect the most marginalised communities significantly.

CARE India has been responding to disasters in India for more than 65 years. Considering disaster preparedness and response as a critical aspect of its organisational mandate, CARE India's response ranges from providing emergency relief, recovery and rehabilitation and disaster preparedness. Apart from responding to disasters, emergency preparedness and resilience building activities are integrated into long-term development projects in different states.

CARE India responds to emergencies in any location, where there are gaps in response and unmet immediate survival needs, irrespective of the organisation's presence in that state or Union Territory. In the past,



CARE India has responded to all major disasters that have struck in the country: Odisha Super Cyclone-1999, Gujarat Earthquake-2001, Tsunami-2004, Jammu & Kashmir Earthquake-2005, Uttar Pradesh Floods-2007, Kosi Floods-2008, Cyclone Aila-2009, Uttarakhand Floods-2013, Cyclone Phailin-2013, Jammu & Kashmir Flood-2014, Uttar Pradesh Floods-2014, Cyclone Hudhud-2015, Nepal Earthquake-2015, West Bengal Floods-2015, Assam Floods-2015, Tamil Nadu Floods-2015, Madhya Pradesh and Maharashtra Drought-2016.

Understanding the role of local agencies play at the grassroots, CARE India worked with multiple agencies to tackle the massive challenges and to advance emergency response to disasters. The partnerships ranged from donors to suppliers and technical assistance institutions and focussed on mutual learning, growth and led to a more sustainable, empowered recovery in the affected regions.

Between FY14 and FY16 CARE India responded to

14 disasters

that struck across

10 states

in the country, and one regional disaster response in Nepal. CARE India reached out to

180,000+ persons

who were from the worst affected communities. During this period the disaster interventions benefitted

91,228 men and

89,150 women across **32,541 households.**

The key areas of work include: Shelter; Water, Sanitation and Hygiene; Livelihood and Food Security; and Sexual and Reproductive Health.

CARE India's Disaster Management and Response Reach Snapshot: 2014-16

Disaster	States	Households reached	Individual participants
Cyclone	Andhra Pradesh, Odisha	3,510	16,832
Floods	Assam, Jammu & Kashmir, Uttarakhand, West Bengal, Tamil Nadu, Uttar Pradesh, Odisha	20,541	1,19,185
Drought	Maharashtra, Madhya Pradesh	2,610	14,496
Earthquake	Nepal	2,500	12,500
Conflict	Assam, Uttar Pradesh	1,170	6,138

Disaster Preparedness and Risk Reduction

With a commitment towards sustainability and resilience, CARE India identifies vulnerable locations in India, to enhance preparedness to respond to disasters as well as build resilience of communities. The primary focus with respect to disaster preparedness and risk reduction includes:

- Promotion of structures and systems that are safer, with Disaster Risk Reduction (DRR) features
- Involvement of community in design and monitoring of humanitarian projects
- Integration of gender in all phases of project management
- Ensuring quality and accountability at multiple levels

CARE India works at the following three levels under its emergency preparedness program:

- **Organisational preparedness:** CARE India maintains a robust Emergency Roster of Response Teams at national and state levels to make timely decisions in emergency situations. The team members are trained in emergency assessments, relief distribution, thematic areas of response and functional areas like camp management, conflict management and media management.
- **Prepositioned relief stocks:** To ensure quick and timely response to disasters, a prepositioned relief stock of at least 500 kits is maintained at six strategic locations. This include shelter kits and hygiene-cum-dignity kits.
- **Community level preparedness:** CARE India focusses on strengthening *Panchayati Raj* Institutions (PRIs) and local partner's capacities to assess, plan and implement disaster preparedness and response. Through community training programmes it assists vulnerable societies in building back safer structures and becoming disaster resilient.

Emergency preparedness planning practices continues to be driven by CARE's overall Core Humanitarian Principles and Accountability Framework. Vulnerability and Capacity Assessments (VCA) carried out in three multi-hazard prone districts of Uttar Pradesh, Bihar and West Bengal led to disaster preparedness work with local NGO partners, community-based organisations and PRIs. In turn, District Emergency Operation Centre in three intervention districts became better equipped with well-developed Information, Education and Communication (IEC) material and recognised future pathways for sustainable disaster response and preparedness.

Disaster Response and Recovery

The emergency response and recovery start with the rapid need assessment focussing on shelter, WASH, livelihoods, SRH needs and issues of safety and security of affected communities.

- In the area of shelter, CARE India promote construction of new structures that incorporate DRR features and facilitate capacities of local masons and community members to acquire knowledge and skills on safe and resilient shelters.
- To ensure emergency WASH relief, the response aim to provide access to clean drinking water at household and community level. During early recovery phase, interventions focus to repair and install raised hand pumps with accessibility features

and construction of toilets to meet specific needs of women and girls in affected communities.

- To ensure immediate food security and livelihood needs of affected communities, the interventions focus on conditional and unconditional cash transfers and distribution of dry rations.

Participants Validation System by CARE India: Best Practice

Based on the impact of disaster a criterion is drawn for selection of participants. Out of the affected population, the poorest of the poor; Women headed households; Disabled people; Dalits; and Adivasis are prioritised. By facilitating focus group discussions with key stakeholders and community members, CARE India with the help of local implementing partners consciously identifies the groups/communities who are more affected from disasters and have lesser coping capacities.

Meeting Urgent Needs in Priority Sectors

Shelter

In India, CARE has been responding to shelter needs of disaster affected people both in the immediate aftermath of a disaster as well as during the early recovery phase. Shelter was provided to affected communities through a range of activities such as provision of shelter, non-food items (NFI), emergency shelter and technical support.

Relief Kits:

- More than 8,500 households benefitted through shelter and relief kits across Uttarakhand, Andhra Pradesh, Assam, and Jammu & Kashmir.
- 400 raincoats in addition to NFI kits provided to flood affected households during Uttarakhand floods.
- Following the principle of targeting the most vulnerable, relief efforts during Cyclone Phailin reached 26.8% of total participants who were differentially abled, with NFI kits.
- 870 blankets and winterised items kit provided in conflict-stricken areas of Assam and Muzaffarnagar.
- Reached 12,500 persons with NFIs in Nepal Earthquake.

- CARE India played lead role as a CARE International Member Partner to facilitate procurement and transportation of 4,405 Tarpaulins, 6,000 shelter kits and 600 shelter tool kits to Nepal.

Shelter NFI Kit Items:

One Tarpaulin, One Rope, Two Plastic floor mats, One Jerry Can of 20 litres capacity, One Treated Mosquito Net

Repair:

As one of the key components, CARE India ensured that DRR features are integrated in shelter repairs and constructions.

- In Tamil Nadu flood recovery phase, 130 households were repaired with the assistance of CARE India's support, out of which 67% were women-headed households, while 8% households belonged to differently abled persons.
- 84 transitional shelters were constructed with support of communities for flood affected families as part of Uttarakhand flood recovery.
- 512 transitional shelters provided to flood affected and 474 shelters repaired during Cyclone Phailin recovery phase, benefitting over 800 persons.

Reconstruction:

CARE India ensured 94% participants, out of 2,002 participants, in Cyclone Phailin shelter intervention, accessed inclusive and disaster resilient shelters. The reconstruction features ensured integration of DRR features. In the recovery phases of shelter intervention, CARE India aimed to promote joint land and property titles to women to widen the process of gender equality and empowerment.

After CARE India's relief response to Cyclone Phailin, residents of Hatipada village came together – "We express our gratitude to CARE India and ECHO for the timely support and helping us to come out from such a horrifying situation. We would be sleeping on the road side or in any emergency shelter, if were not given this shelter but now we feel safe and protected from rain, cold and scorching heat. Our dignity is preserved and will remain ever grateful to the noble work done by the organisation for us".

*Tulsi, Programme Participants
Ganjam District, Odisha*

As a part of the disaster rehabilitation and relief programme CARE India built shelter homes. An evaluation undertaken by CARE India to understand medium and long-term effectiveness of post-disaster shelter responses suggests that the construction of durable houses as part of post disaster shelter recovery programme delivers both essential safe and dignified shelter and valuable assets to the participants. Shelter intervention gives participants the security to focus on other urgent priorities and prevents them falling into destitution.

CASE STUDY: Access to shelter secures girl's home and future

Whenever an emergency strikes, the most affected of all groups are women and adolescent girls. The vulnerability of this community is usually exacerbated by the chaos of a crisis. Many times, women and girls lose all their development opportunities after such a crisis in the name of safety and security and family pressure. As a part of the disaster rehabilitation and relief programme CARE India built 100 shelter homes, in Sunkesla village, Kurnool district after the 2009 Andhra Pradesh and Telangana floods. In the year 2015, CARE India team went to study the impact of these shelter homes that were built six years ago.

20 years old Bismillah is one such girl from the minority community who shifted with her family to the shelter home after the floods. On sharing about how the shelter has been useful for her, she said, "due to this house my late-night studies were ensured, and I was able to prepare for all my exams so far. I admit that if I would have discontinued my studies, my father would have got me married." She was extremely thankful to CARE India team for their support in providing shelter after devastating flood. Bismillah was soon going to complete her Bachelor of Science in nursing and get married. Bismillah is afraid that she might not be able to complete her Master's degree due to lack of money.

She recalled and shared that before she started living in this shelter studying during nights was a nightmare as snakes and scorpions used to appear in her house time to time. During emergencies, the number of such incidents increases due to waterlogging and other difficulties.

Although shelter has enabled her to pursue her higher education for Bismillah, there are many girls who still consider higher education a farfetched dream. Emergency poses challenges in accessing necessities like school, hospital and market for the whole community, but for

women, it adds another layer of vulnerability in the name of safety and security.

Masons Training:

In the shelter repair and reconstructions work, CARE India's attempt has been to strengthen gender equality and women's leadership by integrating women in the process of rebuilding activities. One such important initiative has been to include women as masons training to build technical knowledge and skills and ensure livelihoods of women. By complementing local knowledge and skills of masons to construct safe shelters, the training incorporates DRR features in shelter repairs and maintenance. After the Jammu & Kashmir floods, CARE India identified and trained masons through classroom and practise sessions. The master mason training session benefitted 60 local masons across three flood affected districts. In response to Hudhud and Phailin, 348 masons were trained out of which 102 were women.

Cash Transfers for Shelter:

Post cyclone Hudhud, shelter intervention across 690 households in 13 villages, Andhra Pradesh included provision of safe shelters to the communities through unconditional cash transfer. For transferring of cash, accounts were opened in the name of women which positively impacted in addressing gender inequalities. A total of 626 women were direct recipients of the funds for shelter construction.

Water, Sanitation and Hygiene

Drinking Water: CARE India responded to drought affected areas in Maharashtra and Madhya Pradesh in 2016, reaching out to 2,140 households. In consultation with *Gram Sevaks*, village representatives installed a 2,000 litres plastic water tank in drought-stricken district of Solanpur in Maharashtra. Majority of participant belong to Scheduled Caste communities, from Below Poverty Line, women headed households, elderly persons whose children have migrated out and physically challenged persons. The intervention reduced the distance women needed to walk to fetch water thereby getting more time to attend to their farm and non-farm activities.

Water Purification Tablets and Jerry Cans: To ensure safe and clean drinking water during drought and floods, relief interventions included distribution of aqua tablets and jerry cans for affected communities. In Maharashtra drought, 4,500 purification tablets were provided to 1,900 households.

Hygiene-Cum-Dignity Kits: Hygiene and dignity kits are an important part of gender sensitive approach of disaster relief and recovery by CARE India.

- During Nepal earthquake, 4,900 hygiene kits were distributed.
- In Assam floods, 2,622 women and girls among 5,331 participants across 1,000 households received hygiene-cum-dignity kits.
- 2,248 households were provided hygiene kits in response to floods in Assam and Uttar Pradesh, and cyclones in Odisha.

Hygiene-and-Dignity Kit Items:

Water Purification Tabs-100, Bathing soap bar (100g)-5 pcs, Washing powder (500g) – 1 packet, Toothpaste - 100g – 2, Toothbrush – 5, Bucket for washing- with lid – 1, Disposable razors – 1 pack of 5 pieces, Ladies underwear (3 large), Sanitary napkins – 3 packet of 10 each, Detergent soaps – 2, Combs – 2, Washable baby napkin – 3 pieces, Two packets of safety pins, Bathing towel – 2, Hand towel – 2, Nail cutter – 1, Draperies / cloth – 2pcs of size of 100 cm x 100 cm, Thread and Sewing Needle, An old newspaper.

WASH awareness campaigns have been an integral part of the disaster response and recovery process. CARE India has conducted awareness campaigns in two severely affected districts of Andhra Pradesh and in 61 villages hit by Cyclone Phailin in Odisha. The campaign covered issues related to access to drinking water, sanitation facilities, personal hygiene, prevalence of diseases and food hygiene using IEC materials on WASH. A total of 122 wall paintings were made and covered messages on hand washing, use of toilets, water testing and preparation of ORS. Moreover, folk dances and street plays were organised to sensitise people.

Livelihoods and Food Security

Cash Transfer: In the aftermath of disasters, livelihood options are very limited for a majority of people, especially socially and economically marginalised communities. In response to this, CARE India has made conditional and unconditional cash transfers to recover income assets and generate livelihood opportunities.

- 150 households benefitted from unconditional cash transfer of ₹164 per day, for 25 days during flood response in Odisha and Tamil Nadu.
- 1,000 worst affected households in West Bengal floods received ₹2,160 per household under unconditional cash transfer.

- Unconditional cash transfers provided as part of relief response to 75 households for 25 days at the rate of ₹164 per day during cyclone Phailin in Odisha. It benefitted 359 individuals including 159 women. Conditional cash support was also provided through cash for work approach, which benefitted 1,522 households including 54 persons with disability.
- For reviving livelihood sources, conditional cash transfers provided to 500 households affected by Cyclone Hudhud and 75 households affected by Cyclone Phailin, to start petty businesses like vegetable retailing, fruit vending and handicraft making. 130 community members including 76 women and 54 men provided with 15 days of wage labour opportunities at ₹183 wage rates.

Dry Ration: To meet the immediate food requirements dry ration food packages were provided to 2,554 households during floods in West Bengal and Jammu & Kashmir. The dry ration kit in West Bengal flood response contained 75.5 kg of different items that included- *rice, dal, turmeric, salt, sugar, lentils* per family per month for the period of two months.



Sexual and Reproductive Health

Recognising the need for access to SRH services as an important need of women and girls in disaster situations, CARE India provided 100 clean delivery kits to women in the flood affected areas and 1,700 households were provided with Hygiene Kits in districts of Baramulla and Pulwama in Jammu & Kashmir foods.

Clean Delivery Kit Items:

Two clean cloth, one new blade, 2 cord clamps or suture, gloves, 1 bed sheet and 1 soap.

Guided by SRH interventions, CARE India's initiatives focussed on creating awareness among women and girls on proper menstrual waste disposal. In response to Cyclone Hudhud, 30 women and adolescent girls were trained to abandon the practice of using and reusing cloth and proper disposal of menstrual waste. This was well-received by the community and as a feedback there were many participants who expressed their willingness to spend ₹30 to ₹50 per month on menstrual hygiene management and thought to be a worthwhile expenditure to take care of their personal hygiene and health.

Jayamani lives with her father and sister in Veeranthan, Tamil Nadu. After floods destroyed her village, CARE India came with relief items and distributed. "Even if my mother was alive, we would not have had access to these items like sanitary pads, cloths for women and innerwear of very good quality," she says.

*Jayamani, Programme Participants
Cuddalore District*

Key Approaches

Social Monitoring Committees

Social Monitoring Committees (SMCs) were promoted as a vehicle for participatory monitoring mechanism by the community in disaster preparedness, early recovery and reconstruction projects. SMCs are village level committees for supporting effective participatory, transparent and accountable conflict resolutions, recommending and authorising the release of funds, management of the projects with agreed procedures. It includes representation of all castes, marginalised communities, PRI members, constituting at least 50 percent women representation and with representation from persons with disabilities. Establishment of SMCs has ensured local collective engagement and strengthening the facilitation between community and service providers.

SMCs played key roles in recovery phases of Andhra Pradesh, Odisha and Tamil Nadu by:

- Acting as facilitating bodies between community and service providers.
- Playing vital role in participants selection for shelter repair and cash transfer programme, site identification for community toilets and dump yards.
- Providing handholding support and coordination during assessment and estimation.
- Handling complaints and issues at village level, information sharing at various levels.

- Supporting organisation of training and capacity building programmes

In cyclone Hudhud, 60 trained SMC members, including 45 women and 15 men, played active role in ensuring linkages between government agencies and vulnerable individuals. During Tamil Nadu floods, SMCs in 3 villages, comprising of 21 women and 16 men led cleanliness drive through awareness generation campaigns and planting of trees.

Integrating Gender

- Gender analysis for relief and recovery is undertaken to explore gender specific needs during emergencies.
- Gender leadership and their voice is promoted.
- Ensuring sole or joint ownership of property and assets
- Enhancing women's role in disaster preparedness, participation of women in preparedness meetings and share responsibilities
- Targeting the specific needs of women in all phases of relief, recovery and rehabilitation across sectors

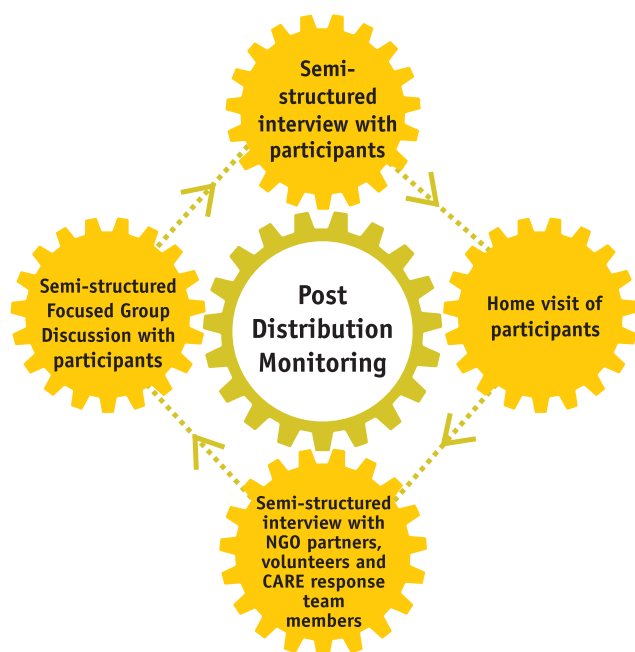
Quality and Accountability

Accountability is both a means for CARE to improve the relevance, quality and impact of our work, and an end in itself, as our stakeholders have a right to hold CARE to account. Our approach places the emphasis on our accountability to participants and non-participants that make up the disaster affected population, rather than stakeholders such as staff, donors and media that are easier to reach.

Programme quality during an emergency response means effectively addressing immediate needs in a timely way and in a way that helps disaster-affected communities take control of their lives and promotes equity and justice and secures livelihoods over the longer term. Accountability is about CARE fulfilling its responsibilities in meeting the needs of different groups in its decision making and activities. Accountability means making sure that the women, men, and children affected by an emergency are involved in planning, implementing, and judging our response to their emergency. This helps ensure that a project will have the impact they want.

Post Distribution Monitoring: This is integral to the emergency response project which checks that the intended participants got their correct relief provisions. It also seeks community feedback to assess quality and accountability standards. CARE India conducts post distribution monitoring following all relief operations.

Post Distribution Monitoring Methods



A post distribution monitoring after emergency response in flooded regions of West Bengal, Tamil Nadu and Andhra Pradesh brought forth opinions of participants.

- It showed that relief distribution was positively received through CARE India team members along with NGO partner and local panchayat leaders.
- The monitoring showed that relief distribution was carried out in an organised manner, with proper participants identification and validation. Many instances showed how special attention was paid to people with special needs.
- Through the post distribution monitoring process, CARE India was able to ascertain if the relief items were used by participants themselves. No cases of trading of particular items were mentioned by participants.
- Field observations and interactions with the community revealed which materials were most useful, quality of materials distributed, damages or breakages of any items and how unconditional cash transfer at timely situation helped meet specific needs of affected families.
- Community feedback was collected to understand satisfaction level of participants and improve future response efficiency for disaster affected communities. Community has acknowledged CARE India for its participants selection process and mock drills during distribution processes as an effective mode of preparation prior to relief distribution.

After Action Review: CARE India conducts internal *emergency response lessons learned exercise* through After-Action Review (AAR) workshops. This takes place within the first 3-4 months of an emergency response.

Participants who reported satisfaction on humanitarian assistance by CARE India in flood affected districts of Tamil Nadu

Cash for work: More than 4/5th of the participants expressed cash for work was a boon to get additional income. 2/3rd were satisfied with the wages they received as part of cash for work.

1/3rd of the participants referred to the location of work being nearer to their homes, or within the village. They reported this as very helpful for them.

Masons training: 1/3rd of the participants mentioned that they are practicing what they have learned from the training programme. More than 4/5th of the participants reported that they would adopt the learning from the training programme in future construction works they are involved in.

SMC training: 80% felt they were able to discharge their roles completely.

59% felt that SMC acceptance by community was high. 25% felt that SMC acceptance level was moderate. 16% felt that SMC acceptance level was low.

70% SMC believed that the SMCs will function even after completion of the project.

A detailed debrief and analysis is undertaken of the entire emergency relief operation, by dividing the timeline into weeks. To evaluate CARE India's response, surveys are conducted by the staff. Performance areas identified include leadership, initial rapid assessment, relief distribution, procurement and logistics, coordination and preparedness and so on aligning to our commitment to Core Humanitarian Standard. Alongside these, CARE India also conducts group exercises to know challenges faced by response teams and accordingly work on recommendation. Taking learnings from this phase changes are made to subsequent response and recovery projects.

The review captures successes and failures with the goal of improving future performances. It also helps as a knowledge management tool and a way to build a culture of accountability. It begins with a clear comparison of intended vs. actual results achieved. It is focussed on team member's own action, team member and group reflect on a project, activity, task etc. – learning from the review is taken forward by the organisation.



CHAPTER 7

GENDER-BASED VIOLENCE

The Context

Violence Against Women and Girls (VAWG) is pandemic. In India, women and girls continue to face multiple forms of violence based on their gender, caste, class, age, marital status, ethnicity, religion, disability and sexuality. According to National Crime Records Bureau (NCRB), between 2005 and 2015, over 10,00,000 cases were filed by women across the country under sections pertaining to 'cruelty by husband' and dowry. As per a recent World Bank study, more than 1 billion women lack legal protection against domestic sexual violence. Over the years, various legislations for addressing gender inequality and VAWG have been enacted in India.

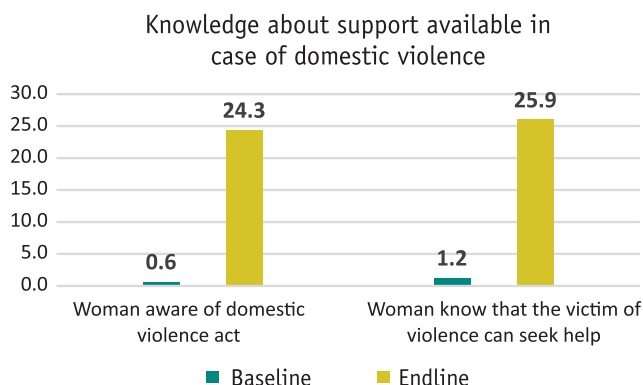
Ending gender-based violence involves social change work at deepest levels and commitment of community, government, civil society organisations and may others to transform deep rooted norms. As part of its GTC approach, CARE India's Women Empowerment Framework focusses on the holistic improvement and empowerment of women and girls. At the core, the framework aims to generate gender transformative change where men and other influential members of the society pave the path for women to be equal participants in all walks of life.

Changing Gender Norms

CARE India's commitment towards sensitising and tackling gender-based violence issues can be seen through programme interventions across different sectors. Project JMV in Barabanki district of Uttar Pradesh has worked at individual and community levels to bring about significant change in gender attitudes and behaviour changes regarding gender-based violence. While aiming to improve sexual and reproductive health of women, the project organised collectives of newly married men as well as women. The intervention reported an increase from baseline to endline in awareness on domestic violence act and knowledge that the victim can seek help in case of domestic violence.

Pathways project in Odisha worked towards changing the attitudes of both men and women regarding tolerance of violence and helped strengthen women to stand up against gender-based violence. By the end of project, women took steps against alcohol misuse including shutting down alcohol production facilities in their area.

Participation of women in water rights, farmer and water groups increased by the end of the project with women reporting greater involvement in decision making at local platforms. Endline findings of the project showed that women disagreeing on the statement "most decisions should be made by men" increased from 47% to 67% from baseline to endline. Gender progress marker study in Pathways project showed that a higher proportion of women have adopted roles that are traditionally in the domain of men, over the period of time (14% in 2015 to 40% in 2016).



K-LEAP project created an atmosphere for women to be confident and mobile to venture out frequently for meetings, as evident from 45% of women members joining SHGs on their own. The endline data of WtRF project showed that 58.5% women in the intervention areas were more confident in raising issues for discussion in a public forum, than the comparison group where only 35.2% of the women respondents believed that they could speak up in public forums. This is further substantiated by the qualitative findings, which highlight that not only had social solidarity improved, but that both men and women respondents equally felt that women's decision making had improved. Data on individual decision making with regards to various aspects of finance and agricultural practices also showed that women were dealing directly with the buyers and sellers of agricultural commodities. Among the key approaches adopted by CARE India to address patriarchal norms was men's engagement strategies toward empowering women. The interventions focussed on addressing the structural barriers as part of the project design.

One of CARE's pioneer programmes is the multi-country regional project EMPHASIS. CARE India worked with cross-border migrants, addressing multiple vulnerabilities they experience. Recognising that migrants are prone to instances of violence and harassment; the project played a significant role in establishing linkages with local organisations at transit points to address violence against women and barriers to decision making related to migration and sexual and reproductive health. The project intervened to support 83 reported cases of different forms of violence and harassment at the Indo-Nepal border including sexual harassment, gender-based violence and physical abuse.

Advocacy for Implementation of PWDV Act in Bihar

CARE India has integrated strong advocacy efforts against domestic violence through creating evidence of domestic violence and implementation of PWDV Act and advocating for effective implementation of the law in the state of Bihar and at National level. In the past one decade, Bihar has recorded the highest incidence of reported spousal violence. As per NFHS-4 data (2015-16), 43% of married women in Bihar reported experiencing domestic violence, as compared to 29% at the national level. Since the last few years, CARE India has been actively engaged in advocating for effective implementation of PWDV Act 2005 in Bihar.

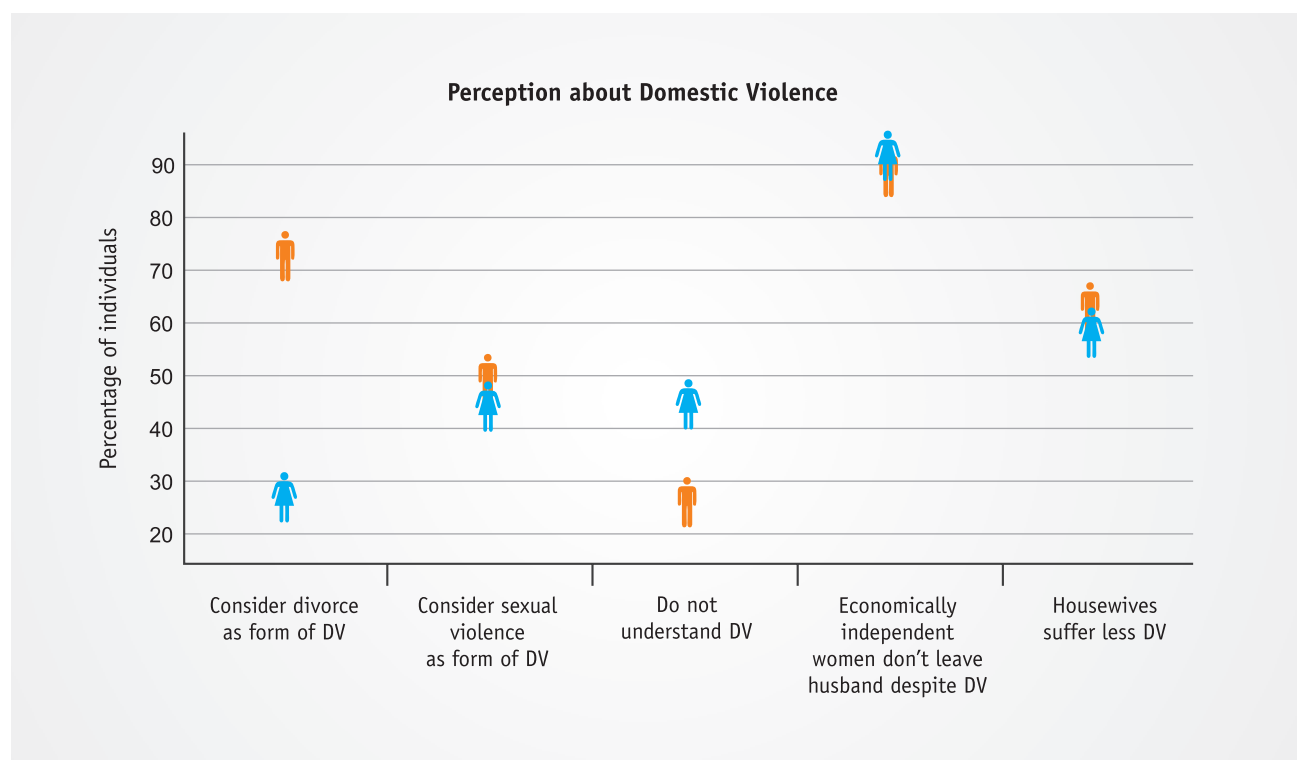
CARE India partnered with a local NGO to implement key community level interventions and sensitise various stakeholders at community, district and state level on domestic violence. In order to strengthen and gather evidence on the issue of domestic violence and the status of implementation of PWDV Act in Bihar, two research studies were conducted across 9 districts in Bihar. Findings from the action research are as follows.

Perception and awareness on domestic violence:

- There is lack of awareness and understanding about domestic violence and its different forms among both men and women.
- 82% respondents are dissatisfied with complaint redressal by government institutions such as help lines and police stations.
- All respondents did not have knowledge about various provisions of the Act.

Impact of domestic violence on social well-being of women:

- 61% female and 43% male respondents reported that violence has a direct bearing on the birth of underweight child, maternal death and abnormal childbirth.



Awareness on PWDV Act and its supporting infrastructure:

- Almost 50% respondents did not know that violence against women is a legal crime.
- 80% respondents have no knowledge about institutions to which survivors of domestic violence can complain to.
- 86% respondents have no information about existence of women help line in their district.
- 28% stakeholders associated with PWDV Act such as protection officers, rehabilitation and training officers at short-stay homes, police, advocates and Child Development Project Officer (CDPO) do not know all provisions under the PWDV Act.

In view of the above, CARE India and its partners advocated to revisit awareness generating mechanism for PWDV Act in the state; adequate allocation of budget to ensure efficiency and effectiveness of the enforcement of the law; evolve strategies to improve access to these services by the survivors; and train service providers on provisions of law and their accountability towards the survivors. CARE India's project contributed to the identified gaps by delving into the existing institutional capacity to handle instances of domestic violence. Significant attention needs to be paid to promote the trust of survivors in the system.





CHAPTER 8

CONCLUSION

CARE India's projects implemented in the past in the areas of health, education and livelihoods made positive changes in the life of poor and most marginalised women, girls and their households by contributing towards living with dignity and securing resilient lives. The impact that CARE India has been able to make largely relates to eight SDGs such as eradication of poverty, ending hunger, ensuring good health and well being, inclusive and equitable quality education, gender equality, water management, decent work and economic growth, and combating climate change.

The lessons coming from the implementation, leading to positive changes in the projects, can be associated with programming which is grounded in the identification of grassroots realities and opportunities and responding to the underlying causes for poor outcomes. The deliberate strategy of working with communities, systems and institutions at multiple levels, combining varied approaches, has made a difference to achieve the impact. Projects that integrated gender transformative approach and inclusive governance to address unequal powers, and resilience to deal with coping and adaptation has shown lasting and positive changes.

Health portfolio of CARE India contributed in improving maternal and reproductive health, child health and nutrition, and reducing prevalence of communicable diseases such as TB, *Kala-azar* and HIV. In the bottom of pyramid states of Bihar, Uttar Pradesh and Madhya Pradesh, by working with the system and strengthening service provisions, CARE India has been able to contribute to improve health and nutrition outcomes of the communities. Innovative solutions such as facility quality improvement, nurse mentoring, incremental learning approach, team-based goals and incentives, low-birth weight newborn tracking, and technology driven monitoring systems, developed by CARE India has been adopted and scaled up by the government.

The education intervention working at four levels – individuals, community, schools and policy, has resulted in accelerated learning outcomes and strengthening of institutions. The major contribution of CARE India

in strengthening the education system include teacher development, bi-lingual reading materials, quality school improvement, and development of leadership curriculum for adolescent girls. These have been taken up by relevant stakeholders as the key innovative approaches for rolling out into the ongoing state government programmes.

In the domain of livelihoods, CARE India's project's impact cover sustainable and resilient livelihoods, food and nutrition security, income generation and diversification, expansion of asset base and control over resources, and financial inclusion of poor and marginalised. The livelihood interventions adopted multi-pronged strategies by integrating women's economic empowerment across its key focus areas of work viz. improving income, nutrition security and climate change resilience, that contributed to lasting change at the household level. This has been possible to achieve by enhancing women's access and control over productive resources, engagement with multi-stakeholders, market actors, public and private service providers and men in households. Strengthening of SHGs, federations and value chains via working with collectives has impacted lives of women in the areas of improved leadership, decision-making, control over resources, participation and negotiation, and challenging traditional social norms.

CARE India has made a foot print in all the major disasters that have struck in India during the past. By being involved in emergency relief distribution and recovery, CARE India played an important role in meeting the immediate needs of disaster-affected families in key priority areas such as food and nutrition security, livelihoods, WASH and SRH. CARE India's disaster response and recovery efforts have proved to be valuable for the affected communities in reducing poverty, sustaining livelihoods, empowering women and providing secure and dignified lives. Harnessing the local capacities and partnering with government, CARE India has been able to deliver timely and as per the humanitarian mandate. Building emergency preparedness capabilities both at the organisational and at community level were instrumental in responding to disasters appropriately.

There are many lessons from our work that has been learned, which can produce significant and remarkable impact for the poor and marginalised. Working with communities is imperative for catalysing demand and leadership of individuals as well as collectives to achieve fundamental changes, though it takes long-term effort. The intent of helping the marginalised segment of the population to reap the benefit of developmental intervention equitably requires a system to ensure equitable opportunities to grow and develop human potential. CARE India's work on strengthening system has delivered quality services to the impact population, which point to a significant lesson for our future interventions. For sustaining impact on a large-scale, working with the system is found to be of strategic importance. A strong system can deliver quality services equitably. The roles played by CARE India and other institutions towards facilitating system-level changes in the areas of health, education and disaster management reinforced this conviction.

In compiling the evidences from multiple projects, not every project had a clear evidence of impact. At times achievements are captured at the level of project outputs or outcomes without a clear view of long-term change in the key indicators. Since a wide range of indicators has been used across different projects, aggregation of impact has also posed challenges. More consistent methods for measuring and analysing achievements would have helped to consolidate and present contributions to the impact.

The effort to synthesise different evaluation reports help us understand the areas that needs improvement in impact measurement systems, standardisation of reporting along important indicators and adoption of innovative evaluation methods. This would help future reporting of achievements and long-term impact.



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PROJECT PORTFOLIO

CARE India's Health Sector Reach: 2014–16

Project name	States	Districts	Participants reached	Women participants
Join My Village (JMV)	Uttar Pradesh	1	1,212,71	55,552
Urban Health Initiative (UHI)	Uttar Pradesh	6	1,341,702	678,651
Bihar Technical Assistance and Support Programme (BTAST) ¹⁴	Bihar	38	39, 264,749	29,248,110
Technical Support Unit (TSU)	Bihar	38	23,141,162	20,823,928
Integrated Family Health Initiative (IFHI)	Bihar	8	2,060,696	1,360,059
Improved quality of community and low-level facility management of childhood pneumonia and diarrhoea (TCH)	Bihar	2	199,561	95,893
Leveraging the Village Health, Sanitation and Nutrition Days to improve the reach of Community Health Workers in Bihar (VHSNDs)	Bihar	14	1,443,123	1,102,362
Madhya Pradesh Nutrition Project (MPNP)	Madhya Pradesh	3	200,712	122,789
New Born Survival Project (NBS)	Madhya Pradesh	1	20,291	17,812
Treatment Adherence and Follow-Up of MDR TB Patients	West Bengal	5	7,497	3,280
<i>Axshaya</i>	Madhya Pradesh, Chhattisgarh and Jharkhand	16	1,94,391	122,098
Enhancing Mobile Populations Access to HIV and AIDS Services Information and Support (EMPHASIS)	Maharashtra, Uttar Pradesh, Uttarakhand, Delhi/NCR, West Bengal	5	1,94,076	39,867
Strengthening <i>Kala-azar</i> Elimination Project	Bihar, Jharkhand	33	6,549	2,751
Total	9	65+	41,351,238	30,290,910

CARE India's Education Sector Reach: 2014–16

	Project name	States	Districts	Schools/Centres	Children reached	Girls reached
1	Early Childhood Care and Development (ECCD)	Chhattisgarh, Odisha	3	220 Anganwadi centres	14,412	6,053
2	Start Early: Read in Time (SERT)	Uttar Pradesh, Odisha	8	996 Schools	158,802	77,804
3	Kutch Livelihood and Education Advancement Project (KLEAP)	Gujarat	1	132 Schools + 5 Adolescent girls learning centres	23,313	13,017
4	Teacher Resource Lab (TRL)	Uttar Pradesh	1	52 Schools	5,368	2,630
5	<i>Pragati</i>	Bihar	4	15 Special training centres	750	750
6	<i>Udaan</i>	Uttar Pradesh, Haryana, Bihar, Odisha	4	4 Centres	837	837
7	<i>Agrani</i>	Bihar	2	100 Schools	21,397	11,274
8	Join My Village (JMV)	Uttar Pradesh	3	480 Schools	65,285	32,069
Total	8 Projects	6 States	18	1,500+	224,879	112,365

¹⁴Bihar Technical Assistance and Support Team (BTAST) supported implementation of Sector-Wide Approach to Strengthening Health (SWASTH) programme of Government of Bihar, which was funded by DFID. BTAST was a consortium comprising of CARE India, IPE Global and Options Consultancy, where CARE India was the prime.

CARE India's Livelihood Sector Reach: 2014-16

Project name	States	Districts	Participants reached	Women participants
Banking on Change (BoC)	Tamil Nadu	3	181,807	109,259
Dairy Value Chain (DVC)	Tamil Nadu	1	2,645	2,645
Enhancing the Sustainable Farming Initiative by Integrating Gender and Nutrition (EnSIGN)	West Bengal	1	504	504
Kutch Livelihood and Education Advancement Project (KLEAP)	Gujarat	1	10,697	5,024
Climate change adaptation for resilient small-scale tea production (CCA)	Tamil Nadu	1	500	169
Empowering Poor Smallholder Farmers and Enhancing Maize Productivity	Odisha	1	1018	1018
Pathways	Odisha	2	13006	13006
Women Leadership in Small and Medium Enterprises (WLSME)	Tamil Nadu	2	240	210
Where the Rain Falls (WtRF)	Chhattisgarh	1	7,167	7,167
Total	5	9	217,584	139,002

CARE India's Disaster Management and Response Sector: Support and Coverage 2014-16

Type of disaster	Participants reached	Thematic response areas
CYCLONE Odisha Phailin Response and Recovery Andhra Pradesh Hudhud Response and Recovery	Household: 5,367 Individuals: 27,583 Women: 13,536	Shelter: Shelter Non-Food Item kit, shelter repair and construction WASH: Hygiene-cum-dignity kit, jerry cans, water purification tab, hand pumps and community toilet construction, solid & liquid waste management equipment, WASH awareness campaign Livelihood: Unconditional cash transfer, conditional cash transfer and mason training
FLOODS Uttarakhand Flood Response Uttarakhand Flood Recovery Odisha Flood Response Uttar Pradesh Flood Response Jammu & Kashmir Flood Response West Bengal Flood Response Assam Flood Response Tamil Nadu Flood Response	Household: 20,624 Individuals: 119,660 Women: 58,734	Shelter: Shelter Non-Food Item kit, winterized items, raincoats, tarpaulins and mosquito nets WASH: Hygiene-cum-dignity kit, jerry cans, water purification tab, drinking water and water bottles SRH: Delivery Kits Food & nutrition: Local food items and dry ration Livelihood: Unconditional cash transfer and mason training
DROUGHT Madhya Pradesh Drought Maharashtra Drought	Household: 2,610 Individuals: 14,496 Women: 7,530	WASH: Drinking water, Water purification tab Jerry cans, Water tanks
EARTHQUAKE Nepal Earthquake	Household: 2,500 Individuals: 12,500 Women: 6,354	Shelter: Shelter Non-Food Item kit WASH: Hygiene-cum-dignity kit, jerry cans
CONFLICTS Assam Conflict Muzaffarnagar Conflict	Household: 1,170 Individuals: 6,138 Women: 2,996	Shelter: Winterised items, Blankets





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