





CARE is an international humanitarian organisation fighting global poverty and social injustice, with a special focus on working with women and girls to bring lasting change in their lives and communities. As a non-religious and non-partisan organisation, CARE works with communities to help overcome poverty by supporting development and providing emergency relief where it is needed most. In 2011, CARE was implementing programs in 84 countries worldwide, reaching some 122 million people in Africa, Asia, Eastern Europe, the Middle East and Latin America and the Caribbean.

Since its founding in 1946, CARE has worked to improve the lives of the poorest and most excluded populations around the world. CARE's operations are supported by the 12 members of the CARE International confederation – Australia, Austria, Canada, Denmark, France, Germany and Luxemburg, Japan, the Netherlands, Norway, Thailand, the United Kingdom (UK) and the United States of America (USA). India and Peru are affiliate members of the confederation.

CARE seeks to address the underlying causes of poverty and social injustice, working at different levels to improve material conditions and wellbeing, improve social positions and create a sound enabling environment to achieve lasting change. CARE works with communities to increase their income, improve health and education services, increase agricultural production, protect the environment, build appropriate water supply and sanitation systems, and address child malnutrition. It seeks to increase access to essential services by the most excluded populations and to foster sustainable and equitable development for all. CARE cooperates with local partner organisations and government agencies, seeking to build capacity at all levels.

Because poverty disproportionately affects women and girls, CARE is particularly focused on gender equality. From its program experience and research, CARE knows that supporting women and girls, ensuring their voices are heard and helping to remove barriers to their development is the best way to bring lasting change to poor communities.

OUR DONORS

CARE's work in the Asia-Pacific region is made possible by the contribution of many donors. We are grateful for their support and the trust placed in CARE. The main donors to CARE's work in Asia in the past five years were:

Bilateral

Governments of Australia, Austria, Canada, Denmark, France, Germany, Ireland, Japan, Luxembourg, the Netherlands, New Zealand, Switzerland, the UK and USA as well as the European Union (EU).

Multilateral Cooperation

Asian Development Bank, The Global Fund, the United Nations and its specialised agencies, and the World Bank.

Foundations and private sector

AIDS Trust, AmeriCares, Barabar Jack Reis, Barclays Bank, Bill and Melinda Gates Foundation, BMZ, Boston Foundation, Botstiber Foundation, Cargill, The Charitable Foundation, Christies Foundation, Count Charitable, Collins Trust, Computershare, Daimler financial services, Dave Matthews Band, Deutschland Bank, Elton John Foundation, Ford Foundation, Fry Foundation, GAP, George Leader, Green Light Foundation, The Harold Simmons Foundation, Henley, Howard G Buffet Foundation, HSBC & ABC Banking CIUK Marketing Funds, Japan Post, Jason Yam, Jean Peter's Foundation, Jolan Nagy Bequest, Kresge Foundation, Levi Strauss & Co., Maitri Trust, Mallesons, Michael & Susan Dell Foundation, Mundango Foundation, Northwest Community for CARE (NWCC), Oak Foundation, Patsy Collins Trust Fund Initiative, Robert. E. Field, Salmat, SHO, Sony, Stern Foundation, Taisei-Kajima-Nippon Steel Joint Operation, Timberland, TOSA Foundation, United Business Media & Souter Charitable Trust, Walmart.



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EXECUTIVE SUMMARY



Timor Leste © Jane Dempster/CARE



In publishing this review of our work in Asia over a five-year period, CARE seeks to provide greater accountability to those with whom we work and to those who entrust CARE with resources, as well as contribute to global discussion on assessing the impact of development efforts. We aim to improve our knowledge and evidence base to make our future programming, partnerships and advocacy more effective, and to identify where we should improve our internal systems.

CARE regularly reviews the effectiveness of its programs as part of its commitment to learning and accountability. Like all agencies working in development, CARE needs to learn from the challenges we face and our possible failings. This report does not set out to present the totality of CARE's work in Asia, or to synthesise all lessons captured in program evaluations, both positive and negative. Rather, the purpose is to better understand the impact of CARE's work in the region over the past five years, as a basis upon which to build in the future.

This report is an analytical review of CARE's programs and projects undertaken with partners and allies in 16 countries over the period 2005–2010. It explores CARE's principal strategies for achieving positive impact by drawing on a broad range of evaluations and other assessments produced over the period. The report methodology follows three strands: a desk-based analysis of project and program impact, which collated quantitative and qualitative project-level impact and outcome information against defined global impact categories; a survey of external stakeholders to elicit their perception of CARE's impact and contribution in the region; and a Value For Money Analysis (VFM) to assess a sample of four projects. Our statistical analysis of the desk-based impact analysis was also subject to independent technical review. Limitations of the process include the difficulty of synthesising higher-level outcomes from a diverse range of activities and indicators, and the inability of a desk-based review to capture and interpret every change achieved in varying dynamic contexts.

The analysis shows that CARE's work has made a positive impact on the lives of millions of poor, marginalised and vulnerable people across Asia. Our programming – underpinned by a common vision and principles, but adapted and grounded in local realities and opportunities – works directly with poor and marginalised communities to support their priorities, and has helped achieve impact in many different settings.

Feedback from CARE's partners across the region confirms this, although partners also suggest how CARE's impact could be greater.

Looking at different themes and sectors in each chapter, the report includes a number of aggregated achievements, and provides selected examples to illustrate CARE's approach and contribution in different countries, where different approaches and activities have improved lives, empowered women and men and achieved remarkable changes. Illustrative highlights include:

- Reaching nine million people across the region through initiatives addressing income poverty, including increasing the average annual income of almost 2.7 million poor and marginalised people on average by 117% in Bangladesh, India, Sri Lanka and Vietnam
- Reaching ten million people through food and nutritional security initiatives, including reducing average malnutrition rates by 21.5% in target communities in Bangladesh, India and Nepal, benefiting over 2 million children
- Reaching almost two million people through education initiatives, which contributed to raising overall primary enrolment rates on average by 74% for target communities in Afghanistan, Cambodia, India, Nepal and Timor-Leste
- Providing emergency relief to over 4.3 million people, including shelter, water and sanitation, food and health support, along with measures to reduce future vulnerability .

Lessons from the report will inform our future directions. CARE should continue to explore ways to effectively scale-up its work to reach larger numbers of people. NGOs like CARE are already capable of operating at a large scale: for example, the report includes detail on significant impacts in child nutrition and women's empowerment from one project which worked with more than two million of the poorest people from the most disadvantaged areas of Bangladesh. To ensure greater impact, CARE should continue to identify and document effective models of working that can be replicated by others, and advocate for their adoption.

The report provides examples of where CARE's work with particular vulnerable groups or communities can contribute to changes at the societal level: whether working with partners to change domestic violence laws in Bangladesh, demonstrating a successful model of ethnic minority education in Cambodia now replicated by government, or building the capacity of partner NGOs in India who in turn support multiple self-help groups in their own communities. Such examples show how successful advocacy is a key part of long-term sustainable change at scale.

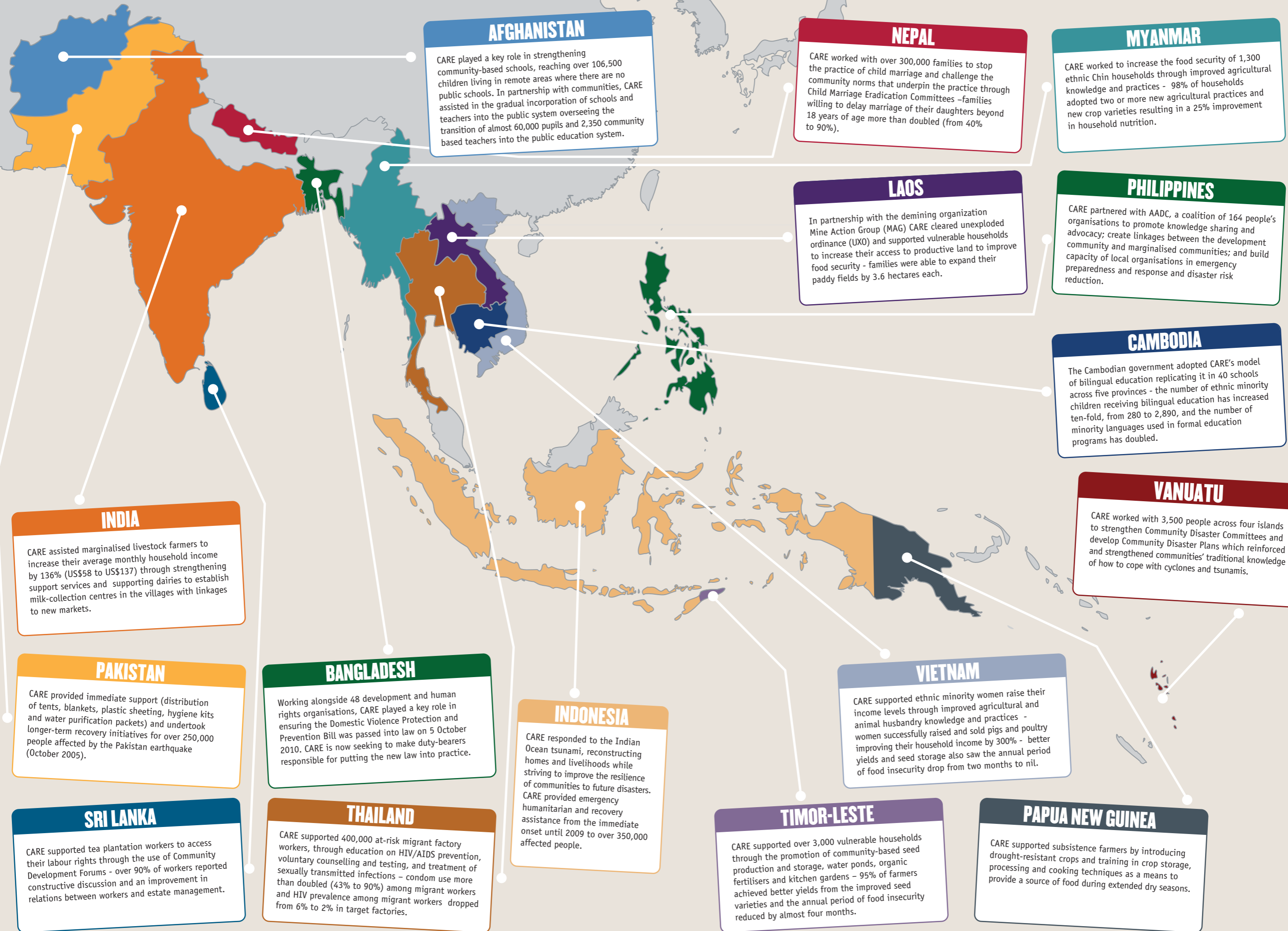
Looking ahead, CARE will make better use of evidence from programs to work towards broader change in policy or practice, through better integration of advocacy into program strategies, informed by clear understanding of the underlying causes of poverty. More innovative approaches to partnership will also be important, so that CARE can link with and support like-minded organisations, social movements, the private sector, government and others to build the capacity of civil society, pursue progressive visions of development, and work for positive change.

Experience from the report shows there is room for improvement in CARE's impact measurement systems: capturing whether long-term change has been achieved, rather than just focusing on project outputs or outcomes. More consistent methods for measuring and analysing achievements would also assist better aggregation of data. CARE is addressing this through strengthening its systems, methods and practices in monitoring and evaluation and knowledge management, including through more consistent indicators and

methodical approaches to building impact information over the life of the project. As CARE builds its longer-term programs, methods to track impact over the longer-term are being developed, such as longitudinal approaches to assess outcomes of empowering women and girls. Better impact measurement will also help build a clearer articulation of how CARE achieves value for money in its work. There is also room for better integration of CARE's humanitarian emergency and development programs. This is being addressed through stronger integration of disaster risk reduction activities and incorporating climate change considerations in long-term programs.

Many lessons from this report confirm directions CARE has already identified as part of continuing learning and improvement, such as our recent moves to long-term program approaches as our main framework, and development of a new Project/Program Information and Impact Reporting System, as a single, authoritative CARE-wide platform. CARE has also begun reviewing operations in each country in which it works, to ensure our presence is relevant and appropriate to the local environment. This is also contributing to internal dialogue about CARE's future role and leading CARE to develop stronger capacity in areas such as research, facilitation, alliance building, developing local capacity, documenting evidence, policy analysis and advocacy, to ensure our work has the widest possible reach and impact.

Analysis shows that CARE's work has made a positive impact on the lives of millions of poor, marginalised and vulnerable people across Asia.



AFGHANISTAN
 CARE played a key role in strengthening community-based schools, reaching over 106,500 children living in remote areas where there are no public schools. In partnership with communities, CARE assisted in the gradual incorporation of schools and teachers into the public system overseeing the transition of almost 60,000 pupils and 2,350 community based teachers into the public education system.

NEPAL
 CARE worked with over 300,000 families to stop the practice of child marriage and challenge the community norms that underpin the practice through Child Marriage Eradication Committees – families willing to delay marriage of their daughters beyond 18 years of age more than doubled (from 40% to 90%).

MYANMAR
 CARE worked to increase the food security of 1,300 ethnic Chin households through improved agricultural knowledge and practices - 98% of households adopted two or more new agricultural practices and new crop varieties resulting in a 25% improvement in household nutrition.

INDIA
 CARE assisted marginalised livestock farmers to increase their average monthly household income by 136% (US\$58 to US\$137) through strengthening support services and supporting dairies to establish milk-collection centres in the villages with linkages to new markets.

LAOS
 In partnership with the demining organization Mine Action Group (MAG) CARE cleared unexploded ordnance (UXO) and supported vulnerable households to increase their access to productive land to improve food security - families were able to expand their paddy fields by 3.6 hectares each.

PHILIPPINES
 CARE partnered with AADC, a coalition of 164 people's organisations to promote knowledge sharing and advocacy; create linkages between the development community and marginalised communities; and build capacity of local organisations in emergency preparedness and response and disaster risk reduction.

PAKISTAN
 CARE provided immediate support (distribution of tents, blankets, plastic sheeting, hygiene kits and water purification packets) and undertook longer-term recovery initiatives for over 250,000 people affected by the Pakistan earthquake (October 2005).

BANGLADESH
 Working alongside 48 development and human rights organisations, CARE played a key role in ensuring the Domestic Violence Protection and Prevention Bill was passed into law on 5 October 2010. CARE is now seeking to make duty-bearers responsible for putting the new law into practice.

CAMBODIA
 The Cambodian government adopted CARE's model of bilingual education replicating it in 40 schools across five provinces - the number of ethnic minority children receiving bilingual education has increased ten-fold, from 280 to 2,890, and the number of minority languages used in formal education programs has doubled.

SRI LANKA
 CARE supported tea plantation workers to access their labour rights through the use of Community Development Forums - over 90% of workers reported constructive discussion and an improvement in relations between workers and estate management.

THAILAND
 CARE supported 400,000 at-risk migrant factory workers, through education on HIV/AIDS prevention, voluntary counselling and testing, and treatment of sexually transmitted infections - condom use more than doubled (43% to 90%) among migrant workers and HIV prevalence among migrant workers dropped from 6% to 2% in target factories.

INDONESIA
 CARE responded to the Indian Ocean tsunami, reconstructing homes and livelihoods while striving to improve the resilience of communities to future disasters. CARE provided emergency humanitarian and recovery assistance from the immediate onset until 2009 to over 350,000 affected people.

VANUATU
 CARE worked with 3,500 people across four islands to strengthen Community Disaster Committees and develop Community Disaster Plans which reinforced and strengthened communities' traditional knowledge of how to cope with cyclones and tsunamis.

VIETNAM
 CARE supported ethnic minority women raise their income levels through improved agricultural and animal husbandry knowledge and practices - women successfully raised and sold pigs and poultry improving their household income by 300% - better yields and seed storage also saw the annual period of food insecurity drop from two months to nil.

TIMOR-LESTE
 CARE supported over 3,000 vulnerable households through the promotion of community-based seed production and storage, water ponds, organic fertilisers and kitchen gardens - 95% of farmers achieved better yields from the improved seed varieties and the annual period of food insecurity reduced by almost four months.

PAPUA NEW GUINEA
 CARE supported subsistence farmers by introducing drought-resistant crops and training in crop storage, processing and cooking techniques as a means to provide a source of food during extended dry seasons.

GLOSSARY

AADC	Agri-Aqua Development Coalition
AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
AusAID	Australian Agency for International Development
BCC	behaviour change communication
CBO	community-based organisation
CHV	community health volunteer
CF	community forestry
CFW	cash-for-work
COME	Centre of Mother Education
CmSS	Community Support System
CSO	civil society organisation
DAC	Development Assistance Committee
Dalit	the lowest caste in the Hindu system
DFID	Department for International Development
DRR	disaster risk reduction
EU	European Union
GBV	gender-based violence
HIV	human immunodeficiency virus
MDG	Millennium Development Goal
MFI	microfinance institution
MIC	Middle Income Country
MMR	maternal mortality rate
NGO	non-government organisation
NSEP	Needle Syringe Exchange Program
OECD	Organisation for Economic Co-operation and Development
PNG	Papua New Guinea
SALT	Sloping Agriculture Land Technology
SHG	self-help group
SROI	Social Return on Investment
UK	United Kingdom
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USA	United States of America
VAW	violence against women
VDC	Village Development Committee
VFM	Value for Money
WHO	World Health Organization

NOTES

- 1 Unless otherwise stated, currencies are expressed in US\$ at the May 2012 rate of exchange.
- 2 Pseudonyms have been used to respect the privacy of those individuals who kindly shared their personal testimonies with CARE.



Afghanistan ©Kate Holt/CARE

FOREWORD

Why an Asia Impact Report?

International development organisations like CARE work in dynamic and demanding environments, engaging with the complexities of social change. It is seldom a straightforward process to measure the impact of this work. Nevertheless, CARE believes it is important to demonstrate its achievements and tell the story of where and how its work has made a difference.

Fundamentally, CARE sees impact as lasting, positive change in the lives of poor and vulnerable communities. By working with women, men, girls, boys, community groups, local organisations, partners and governments CARE seeks to address the underlying causes of poverty and social injustice. CARE's efforts to improve the effectiveness and efficiency of its programs seek to maximise their impact in the lives of those for whom the agency works.

As one of the initiatives underway to better measure CARE's overall impact, in 2010 the Regional Office for Latin America and the Caribbean (LAC) produced its first Regional Impact Report.¹ This provided a consolidated analysis of CARE's overall achievements in the LAC region over a five-year period, based on aggregating data and analysis from projects and programs in 10 countries, with impacts grouped against indicators broadly consistent with the Millennium Development Goals (MDGs).

This CARE Asia Impact Report provides a similar analysis of the impact of CARE's work in Asia and seeks to:

- Ensure CARE is **accountable** to those with whom it works, and to the donors and agencies who entrust CARE with resources to do this work, as well as to its own staff.
- Provide a strong **evidence base** for CARE's future programs, partnerships and advocacy, and understand where successful approaches can be promoted or expanded.
- Provide insights into **issues facing the region** and how CARE can contribute beyond the country level, where common approaches may work, and where programs can benefit from experience elsewhere.
- Contribute to the **development of improved internal systems** for knowledge management and impact measurement, helping to understand the role CARE has played and how to make a greater contribution in the future.

Number of people in the Asia-Pacific region in extreme poverty

(living on less than the equivalent of US\$1.25 a day)



Despite this impressive reduction of relative poverty, in absolute terms Asia accounts for some two-thirds of the world's poor.



INTRODUCTION

The Asia-Pacific region

The countries that make up the Asia-Pacific region are enormously diverse.² Home to 4.2 billion people, or some 60% of the world's population,³ the region encompasses wide geographic and cultural differences as well as varying approaches to socio-economic development and poverty reduction. As a result, aggregate data at the regional level may tell one story while the experiences of individual countries, or communities within those countries, present contrasting narratives.

Asia's overall economic performance has been strong in recent decades. Many countries have experienced more sustained economic growth than the OECD average. The rapidly expanding economies of China and India, and increasing regional integration into the global economy, have helped millions of people to overcome poverty. At the same time this increasing interdependence exposes the region's economies to fluctuations in global markets, particularly those countries with a narrow export base or whose macroeconomic policies are fragile. Growth forecasts for the region, while high, may decline in the face of global financial uncertainty.⁴

The World Bank estimates that the number of people in the region in extreme poverty (living on less than the equivalent of US\$1.25 a day) dropped from 1,543 billion in 1990 to 856 million in 2008. The region as a whole is therefore on track to meet the Millennium Development Goal (MDG) of halving income poverty by 2015. But despite this impressive reduction of relative poverty, in absolute terms Asia accounts for some two-thirds of the world's poor.⁵

The region also includes five of the world's seven most populous nations – Bangladesh, China, India, Indonesia and Pakistan – four of which are now Middle Income Countries (MICs). The fact that many millions of poor people live in countries whose per-capita income has become relatively high⁶ means that CARE and other agencies must re-think traditional approaches to aid and development to suit these environments.

Looking towards social indicators, composite measures of poverty and vulnerability such as the Human Development Index show significant improvement in relation to life expectancy, literacy and infant and child mortality rates.⁷ Despite this progress, the region is unlikely to reach even half of the MDG indicators.⁸

Global statistics or regional trends conceal major variations among and within countries across the region. Such disparities mean that despite positive national statistics, many communities experience extreme poverty, deprivation and vulnerability. For example:

- There are sharp contrasts in the mortality rates of rural and urban children, and between boys and girls.⁹
- Progress in reducing maternal mortality rates (MMR) is uneven. Although estimates for 2010¹⁰ show that Asia as a whole compares favourably with the global average (150 and 210 per 100,000 live births, respectively), some countries, such as Afghanistan (estimated MMR 460 in 2010), Laos (470) and Timor-Leste (300) are comparable with some of the world's poorest countries.

Women are seriously disadvantaged in terms of poverty, education, nutrition and health. Owing to widespread male preference, the region has the world's highest ratio of boys to girls – 110 boys per 100 girls (the natural ratio is 105).¹¹ Sex-selective abortion, infanticide or neglect of girls results in 'missing millions' of women and girls, especially in China and India.¹² Discrimination against women and girls means that they have fewer educational opportunities and are more likely to suffer hunger and malnutrition than men and boys. Of the region's 518 million non-literate adults, 65% are women, a proportion that has barely changed in 20 years. Women's economic opportunities are also limited. Women comprise only two-thirds of the formal labour force and are clustered in unpredictable and/or low-paid employment; indeed, most work in the informal economy. Women's ownership of or access to land, property and credit are also very limited.¹³





Many countries in the region are particularly vulnerable to natural catastrophes. Extreme events such as the 2004 Indian Ocean tsunami, Cyclone Nargis in Myanmar, and earthquakes and floods in Pakistan disproportionately affect the poorest communities. Women are at particular risk. For instance, four times more women than men were killed in the Indian Ocean tsunami, partly because so few women could swim, and were unable to climb to safety due to restrictive clothing and cultural restrictions on their mobility. Finally, climate change is expected to intensify existing poverty and vulnerability as changing weather patterns such as prolonged droughts, shorter and more intense rainy seasons and unpredictable cyclones may have devastating effects on small farmers and people living in precarious conditions.

For CARE, an organisation focused on fighting poverty and social injustice, the region presents continuing challenges and needs – but also opportunities.

CARE's presence in Asia

Between 2005 and 2010 CARE undertook development activities in 17 countries throughout Asia: Afghanistan, Bangladesh, Cambodia, India, Indonesia, Laos, Myanmar, Nepal, Pakistan, Papua New Guinea (PNG), Philippines, Sri Lanka, Tajikistan, Thailand, Timor-Leste, Vanuatu and Vietnam. CARE currently has development, emergency and rehabilitation programs in 16 countries.

CARE's financial investment in the region for the five year period (FYs 2006-10) amounted to \$909.4 million. Figures 1 and 2 following show the shares of funding across the 17 countries, and the proportion of development programs to emergency and rehabilitation programs.

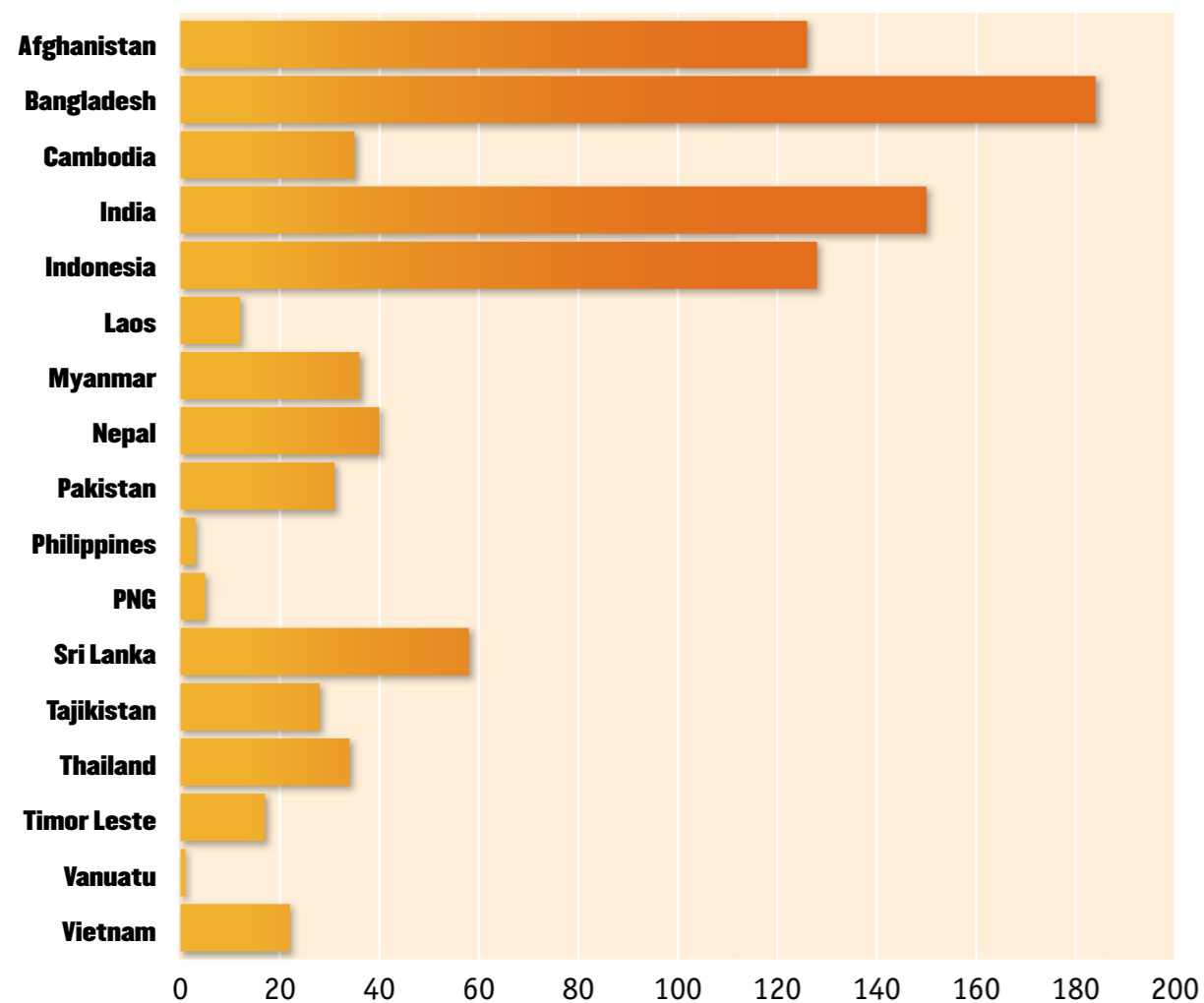
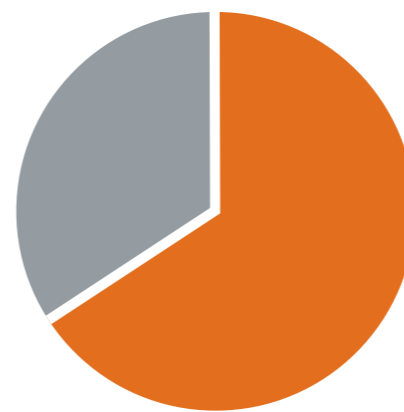


Figure 1: CARE programming in Asia, FYs 2006–10, by country in \$ million



- 66% Development Programs
- 34% Emergency and Rehabilitation Programs

Figure 2: Focus of CARE programs in Asia, FYs 2006–10

Despite diverse operational environments, CARE's approach is underpinned by six core principles:

- promoting the empowerment of poor and marginalised people
- working in partnership to maximise program impact and sustainability
- ensuring accountability to those with whom we work
- addressing discrimination and the denial of rights
- promoting non-violent means for prevention and resolution of conflicts
- seeking sustainable results for lasting and fundamental improvements in the lives of the poor and marginalised

CARE believes that the empowerment of women and girls is crucial, first and foremost, as a human right, but also as a way of achieving lasting change for communities living in poverty, and therefore mainstreams its commitment to gender equality and the empowerment of women and girls in every aspect of its work and relationships.

Development is a difficult and slow process and not everything goes according to plan. Achievements built up over many years can be literally swept away in a few minutes, as in the case of the Indian Ocean tsunami. They can be seriously eroded by slow onset events such as drought, or when conflict erupts. CARE, like all agencies working in development, needs to learn from the challenges we face and our possible failings. It is not always easy to isolate the causes of change, and CARE is usually only one actor among many. For these reasons, monitoring and evaluation of activities is particularly important, as CARE uses information gathered to understand what is working and what is not, and adapts its approach as necessary.

CARE is committed to learning and accountability to others through regularly reviewing the effectiveness of its programs and publishing program evaluations. This report draws upon these reports but does not set out to synthesise all the lessons captured in these evaluations. Rather, the purpose is to better understand the impact of CARE's current work in the region, as a basis upon which to build in the future.

Learning from its own and others' experiences and research, CARE is moving towards a long-term program approach as a means to enhance its impact. Taking this forward means developing a deeper understanding of what kinds of change particular groups of people need in the immediate and broader context, and of the partners and allies with which CARE must collaborate in order to achieve a lasting impact in its fight against poverty and social injustice.



Some projects have continued over 10 years and the impact that can be achieved through making such long-term commitments is evident.



CHAPTER 1: METHODOLOGY

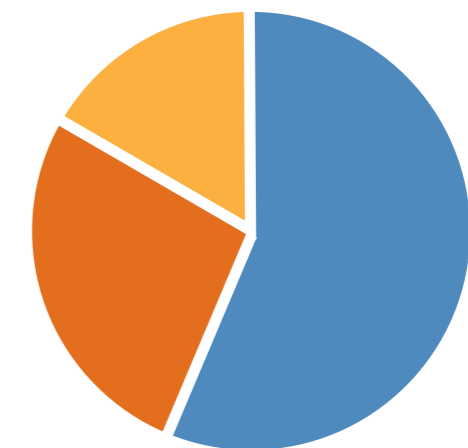
This report is an analytical review of CARE's programs and projects undertaken with partners and allies in the Asia region over the period 2005-10. It explores CARE's principal strategies for achieving positive impact by drawing on a broad range of evaluations and other assessments produced over the period. The report aims both to support learning and accountability within CARE and beyond, and to contribute to developing better systems for monitoring and measuring impact.

Scope

The review is based on the following countries: Afghanistan, Bangladesh, Cambodia, India¹⁵, Indonesia, Laos, Myanmar, Nepal, Pakistan, PNG, the Philippines¹⁶, Sri Lanka, Thailand¹⁷, Timor-Leste, Vanuatu¹⁸ and Vietnam.

The study team reviewed all 399¹⁹ initiatives that concluded between June 2005 and June 2010 as well as current projects that had been running for at least three years during this time and had conducted mid-term evaluations. Some projects began before 2005 but were included if the final or mid-term evaluation was undertaken during the study period. Some projects have continued over 10 years and the impact that can be achieved through making such long-term commitments is evident. In other cases, such as CARE's response to emergencies, the immediate outcomes were evaluated, but the impact of longer-term rehabilitation and recovery remains to be seen.

The documents reviewed include program evaluations, mid-term reviews, end-of-project reports, completion reports, case studies and donor progress reports. Of the interventions identified for analysis, 235 (or 59%) had an evaluation or final report with sufficiently robust data to provide impact-level information; 109 (or 27%) provided information about outcomes and outputs and 55 (or 14%) were found to have incomplete reporting records (see Figure 3). The analysis in this report focuses primarily on the first category of projects, but it is clear that even when the evaluation reports did not include impact-level information, many of the projects had in fact made significant achievements. In order to ensure integrity and consistency, however, such projects were excluded from the analysis.



- **59%** Impact-level data
- **27%** Outcome and output-level data
- **14%** Incomplete reporting

Figure 3: Percentage of projects analysed by data classification

Three methods were used:

1. A **desk-based analysis of project and program impact**, based on CARE's global impact indicators (which are broadly aligned with the MDGs)²⁰ using standardised tools (matrices) and current documentation. This involved collating quantitative and qualitative project-level impact and outcome information against the defined global impact categories. Our statistical analysis of the desk-based impact analysis was also subject to independent technical review. In addition to quantifiable changes, information was collated on CARE's contribution to changes in government policy or implementation as an indication of broader social change and sustainability. Chapters 2 to 8 present an analysis of CARE's approach in different fields, with illustrative examples.
2. An **online survey of external stakeholders** to elicit their perception of CARE's impact and contribution to reducing poverty and social injustice in the region. The survey was conducted primarily online to ensure confidentiality and there were over 250 respondents. These included local partner organisations, peer organisations, donors, national governments, research institutions and the private sector. The survey yielded a rich array of feedback and findings for reflection and action, some of which is reflected in Chapter 9.

3. A retrospective **Value For Money Analysis (VFM)** using a modified Social Return on Investment (SROI) methodology to assess four projects that met the necessary data requirements. The study sought to quantify the additional value CARE's work created in these different contexts, and to inform an understanding of how CARE achieves a return on its investment in supporting vulnerable communities. The exercise is summarised in Chapter 10.

The main strength of the review process is that it took a consistent and comprehensive approach across countries and programs, based on (a) reviewing existing performance data on project implementation and evaluations; (b) using both qualitative and quantitative measures; and (c) looking beyond CARE to incorporate the views of external stakeholders. The main limitations of the process include (a) a lack of wider quantitative data to help in assessing the influence of CARE's interventions alongside other agents of change; (b) the difficulty of synthesising higher-level outcomes from a diverse range of activities and indicators; and (c) the inability of any desk-based review to capture and interpret every change achieved in a range of dynamic contexts. In terms of gaining the direct perspective of project beneficiaries, the external stakeholder survey did not directly seek their opinions, however, many of the project evaluations did reflect processes of consultation with beneficiaries, including interviews.

CHAPTER 2: GENDER EQUALITY AND WOMEN'S EMPOWERMENT

Women and girls suffer disproportionately from the burden of extreme poverty – UN Women highlights estimates that they make up 70% of the world's poor.²¹ For these women and girls, poverty does not only mean scarcity and want, it means rights denied, opportunities curtailed and voices silenced.

Gender equality is the equal enjoyment of rights, opportunities, resources and rewards by women and men, girls and boys. These cannot be determined by biology; gender equality is an explicit, internationally recognised human right.²²

Throughout Asia, women and girls continue to face significant barriers to achieving equality with men and boys. Early and/or forced marriages, particularly in rural areas, high maternal mortality rates (MMR) and gender gaps in education, employment and income continue to limit women's prospects of a better life. Entrenched cultural norms often restrict women's mobility, which reinforces their lack of access to basic services and to employment. Gender inequality intensifies social and political exclusion. Statutory and customary laws restrict women's access to land and other types of property in about half the countries in Asia.²³ Moreover, women typically work in insecure and poorly paid sectors, such as domestic labour and in the non-formal economy, where they have few if any employment rights or legal protection. Restrictions on women's equal participation in the workforce across Asia cost the regional economy an estimated US\$89 billion every year.²⁴

CARE's analysis of the underlying causes of global poverty and social injustice demonstrates that gender discrimination – or the denial of women's basic human rights – is one of the most significant, reinforcing other aspects of poverty and exclusion. CARE seeks a world of hope, tolerance and social justice, and to eradicate poverty – this vision cannot be realised without addressing gender inequality. Gender equality is, first and foremost, a human right. But it is also a cornerstone of development and the eradication of poverty. This is why working for gender equality and women's empowerment is mainstreamed as a cross-cutting goal in every aspect of CARE's work.²⁵

Empowering women and engaging men

Gender equality and women's empowerment cannot be achieved by working with women in isolation. Gender inequality is about *relationships*, which means engaging men and boys as well as women and girls to challenge power imbalances that diminish everyone's full enjoyment of human rights. CARE believes that the empowerment of women will empower men too, and so recognises the importance of changing attitudes and fostering mutually supportive relationships.

Working on gender equality means tackling the social and cultural norms that diminish everyone's human potential. Gender norms are always specific to each society because they are rooted in cultural beliefs and practices. Social and cultural norms often differ even within the same country.

This is why CARE makes every effort to gather context-specific information and to ensure that the different needs and priorities of local women and men inform program design, implementation and evaluation.

In more gender-equitable societies, men as well as women tend to be healthier, wealthier and better educated – in other words, women's empowerment benefits everyone.²⁶

Restrictions on women's equal participation in the workforce across Asia cost the regional economy an estimated US\$89 billion every year



CARE's women's empowerment framework

CARE's current approach to women's empowerment grew out of research and reflection undertaken during a multi-year Strategic Impact Inquiry (SII).²⁷ This organisation-wide examination to deepen CARE's understanding of factors contributing to women's empowerment and gender equality led to a definition of women's empowerment as the **combined effect of changes** in three interlinked domains:

1. women's own knowledge, skills and abilities (agency)
2. social norms, customs, institutions and policies that shape women's choices in life (structures)
3. power relationships through which women negotiate their paths (relations)

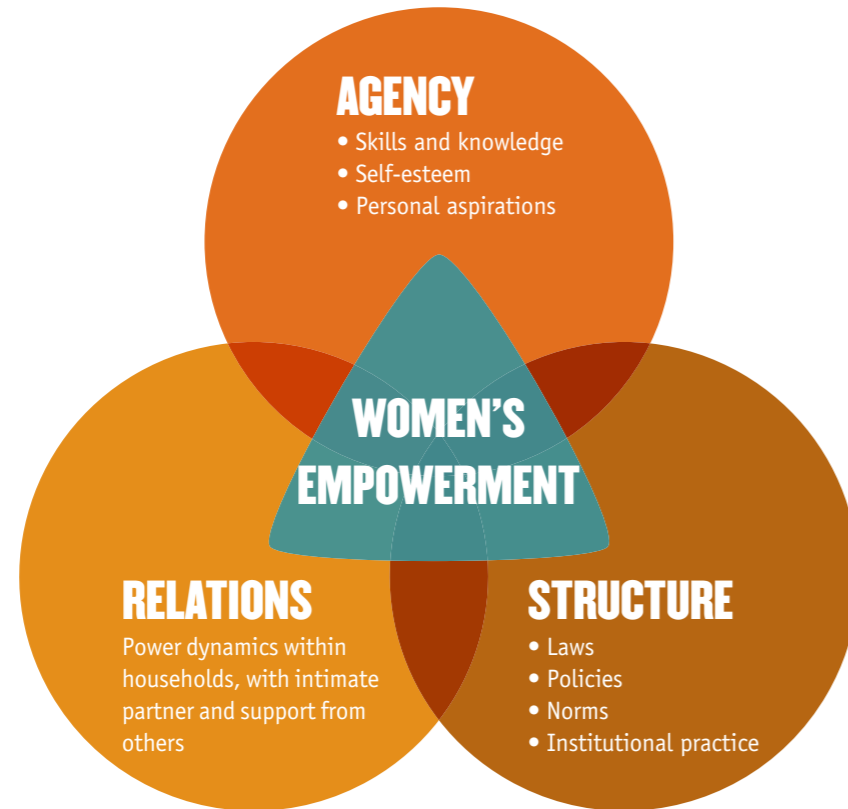


Figure 4: Three domains of women's empowerment

This comprehensive understanding of empowerment means not only increasing women's individual agency (knowledge, skills and confidence) but also changing deeper structural barriers in order to shift social and cultural norms, policies and key relationships in ways that allow women – and men – to assume more equitable gender roles.

The SII process confirmed CARE's belief that achieving gender equality by empowering women and girls constitutes the greatest and most predictable 'return on investment' in development interventions. Women represent the greatest proportion of the poor and vulnerable but in overcoming barriers to equality they are also most likely to contribute to sustainable change in their family, in their community and wider society.

CARE's program impact

Promoting gender equality and empowering women is Millennium Development Goal 3 (MDG3), whose main target is to end gender disparity in primary and secondary education. Other targets include cutting the maternal mortality rate (MMR) by 75%, ensuring universal access to reproductive health, achieving full and decent employment and equality of political participation and decision-making in all sectors. CARE strives to go beyond these targets to make a difference to marginalised girls and women at all points in their lives. Its programs seek to reach girls, adolescents and women of all ages, tailoring its empowerment framework to meet the needs of the age group(s) in question.

The following section provides selected examples to illustrate CARE's contribution towards achieving gender equality and women's empowerment and key strategies for achieving that impact.

In **Afghanistan**, CARE has assisted vulnerable women, including widows and their families, since 1994. Starting with providing food aid to 13,000 widow-headed households, CARE's work now fosters women's empowerment by supporting their livelihoods, the provision of health services and literacy classes, the organisation of widows' associations, and research, documentation and advocacy. CARE worked with women to form 580 widows' solidarity groups with a total membership of 11,000 across five districts of Kabul. The groups provided a collective voice for



women's needs, aspirations and rights. With support from CARE, members effectively advocated for women's human rights and their claim to entitlements such as being permitted to own land and to use public transport. Other successes include preventing forced marriages in their communities and working with religious leaders to reduce gender-based violence (GBV) and uphold inheritance rights.

In **Bangladesh**, in partnership with the government, CARE supported SHOUHARDO, a major program on child malnutrition. SHOUHARDO ('Strengthening Household Ability to Respond to Development Opportunities') also means 'friendship' in Bangla. SHOUHARDO was characterised both by its ambitious scale – a budget of US\$126 million over four years, reaching 2 million of the country's poorest people – and by its integrated and holistic approach. The project revolved around the belief that addressing gender and other structural inequalities is vital to reducing child malnutrition and increasing food security, and combined the provision of food aid with improving hygiene and sanitation and reducing vulnerability to recurrent natural disasters. The health achievements were impressive, with the stunting rate among children under the age of two in the target population declining by 15.7% in the four years of SHOUHARDO's operation. The impact on women's empowerment and gender equality was equally impressive (see Box on SHOUHARDO: Putting Women at the Centre).

Also in **Bangladesh**, CARE supported 3,500 'natural leaders' (more than half of them women) to solve community issues ranging from road repairs to concerns about livestock, poor sanitation and unfair wages. Women and men jointly negotiated higher wages at harvest time and also successfully pressured the local health service provider to improve its performance – an unprecedented advocacy action. Women and men said they felt better able to influence power structures and that it was more effective to approach authorities as a group rather than as individuals. Women also attributed reduced GBV to CARE's activities with male 'natural leaders', fostering their willingness to work alongside women. The project benefited 49,000 people.

In **India**, CARE sought to assist and support women sex workers to protect themselves from HIV infection. The project provided assistance in the form of providing condoms and ensuring access to testing facilities. More importantly, it encouraged the women to become organised to build mutual support and take joint action to counter abuse by clients, pimps and also the police. These women now run their own drop-in centres and health clinics, and are more confident in reporting and demanding action be taken in cases of abuse. As a result of their greater self-esteem, the sex workers experienced a major decline in violent abuse, and a restored sense of dignity with police and other authorities now treating them with more respect. Running from 2004 to 2010, CARE reached 1,700 women in its final year.

In **Nepal**, CARE supported mothers of young children in highly marginalised areas to increase their demand for and access to health services, and to adopt healthier practices in their own lives. CARE found that filling service-delivery gaps – such as enhancing access to information and providing outreach support – was not enough to bring about sustainable improvements in health. In response, CARE supported women, including Dalit women, to establish 70 Dabi ('pressure') groups to analyse problems and develop and plan organised advocacy through interaction, rallies, press meetings and dialogue with different authorities. Dabi groups achieved improvements in community health structures and health services, and children's health also improved. Over time, Dabi groups tackled other issues such as violence against women (VAW), alcoholism, and the practice of Chaupadi, which confines women to special huts during menstruation and childbirth. By the end of the project, new alcohol regulations had been passed, there was a decline in the incidence of VAW and about 70% of households in the program had stopped Chaupadi and 255 huts had been dismantled. Overall, CARE reached about 200,000 women of reproductive age and 153,000 children under the age of five.

Also in **Nepal**, CARE worked with over 300,000 families from poor and socially excluded communities to reduce the practice of child marriage. CARE supported peer educators, young women leaders, community-based organisations (CBOs) and schools to challenge community norms that underpin child marriage through a behaviour change communication (BCC) campaign and the establishment of Child Marriage Eradication Committees. As a result, the number of families willing to delay marriage of their daughters beyond 18 years of age more than doubled (from 40% to 90%).

In **Vietnam**, gender norms reinforce systems of discrimination in some ethnic minority communities, meaning women are largely excluded from community activities, services and decision-making processes. In partnership with the local Women's Union, CARE established 100 Women's Livelihood and Rights Clubs (LARC), involving around 5,000 rural women. LARC supported women to analyse their legal entitlements and address issues affecting their livelihoods. As a result of their

participation in the Clubs, women became sufficiently confident to make themselves heard in their families and communities. By creating a space for women to share and discuss their own issues, gain awareness of gender equality and women's rights, make decisions and, importantly, have fun together, the women have established solidarity and the ability to take development initiatives. LARC have enabled women to gain formal rights to forest land, influence banks to provide user-friendly information to give women easier access to credit, and participate in local development decision-making and negotiation in accordance with grassroots democracy laws. Issues that were previously taboo, such as domestic violence, are now discussed openly with reference to the law. LARC members have gained respect at home and in the community and have successfully challenged GBV in both spheres. These changes also made a positive change in their families, indirectly benefiting 32,000 people.

The program's empowerment strategies ranged from assisting women to start up small businesses to supporting self-help groups (SHGs) where women and girls could take on taboo subjects such as early marriage, dowry and violence against women. Once reluctant to leave their homes because of harassment in the streets, the women and girls of SHOUHARDO started travelling to markets to buy and sell goods. They began challenging men who harassed women and girls in the streets. And they played a larger role in traditional village courts, driving decisions like never before.

Average incomes more than doubled, as many of the women began pooling their money, forming village savings and loan associations (VSLAs) and converting their collective funds into loans for group members to start small businesses. With their increased financial contributions, more women began participating in household purchasing decisions. At the beginning of the project, less than a quarter of women had a say in decisions about buying or selling household assets such as land, livestock and crops. By the end, nearly half of the women did. There also was a 46% increase in the portion of women who participated in decisions about the use of loans and savings. Their priorities, which often included nutritious foods and school supplies for their children, were no longer being brushed aside (see Figure 6).

CASE STUDY | SHOUHARDO: putting women at the centre

The word SHOUHARDO means 'friendship' in Bangla and represents the *Strengthening Household Ability to Respond to Development Opportunities* program implemented by CARE in partnership with the Government of Bangladesh and funded by the US Government.

Focusing on maternal and child health, nutrition, sanitation, homestead food production, income generation, village savings and loans groups, institutional strengthening and climate change adaptation, the program aimed to reduce child malnutrition, poverty and food insecurity for more than 400,000 of the poorest households in Bangladesh.

At the completion of the first phase of the project in 2010, significant gains had been made to reduce food insecurity. In less than four years, the stunting rate among children aged 6–24 months in the target population had fallen from 56% to 40%. **These figures reflect an annual stunting reduction of 4.5 percentage points, dwarfing the 0.1 percentage point decline in Bangladesh as a whole and the 2.4 percentage point annual decline seen in the average food security program (see Figure 5). Upon analysis of the program, no single intervention reduced child stunting more than women's empowerment.**

ANNUAL DECREASE IN THE PREVALENCE OF STUNTING AMONG CHILDREN

The SHOUHARDO project resulted in unusually large reductions in "stunting", a measure of malnutrition in children, between February 2006 and November 2009.

SHOUHARDO's annual stunting reduction of 4.5 percentage points dwarfed the national average during that period (0.1 percentage points) and was nearly double the average USAID project of its kind (2.4 percentage points).

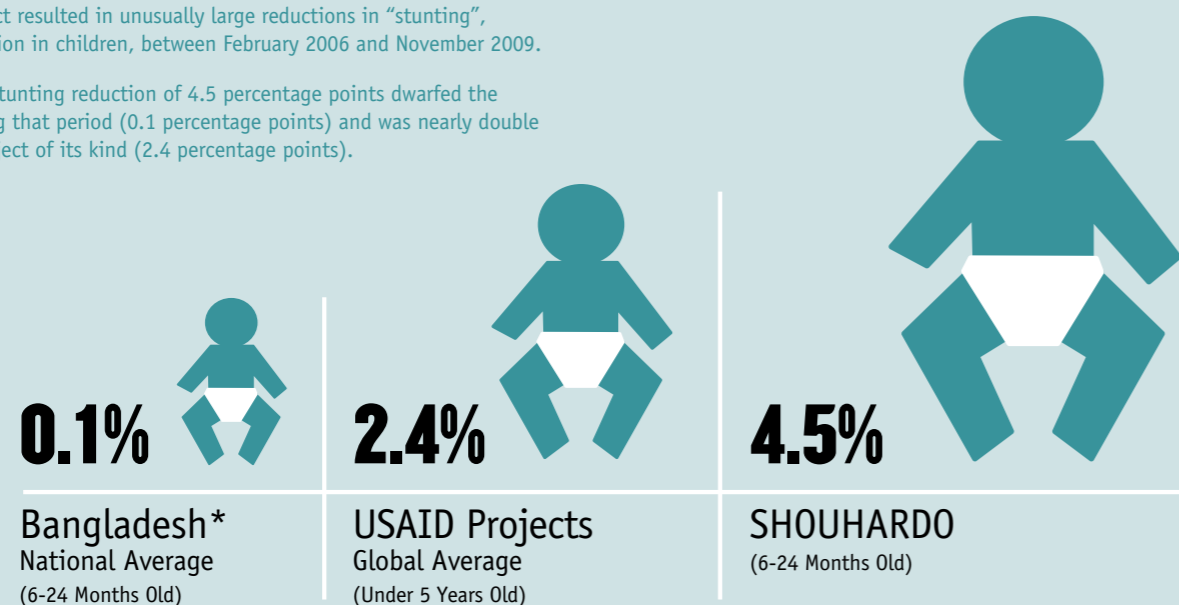


Figure 5: Annual decrease in the prevalence of stunting among children

*2001-2010

BIG GAINS IN WOMEN'S DECISION-MAKING POWER

The percentage of women reporting that they participate in various types of decisions rose sharply in several categories during the course of SHOUHARDO.

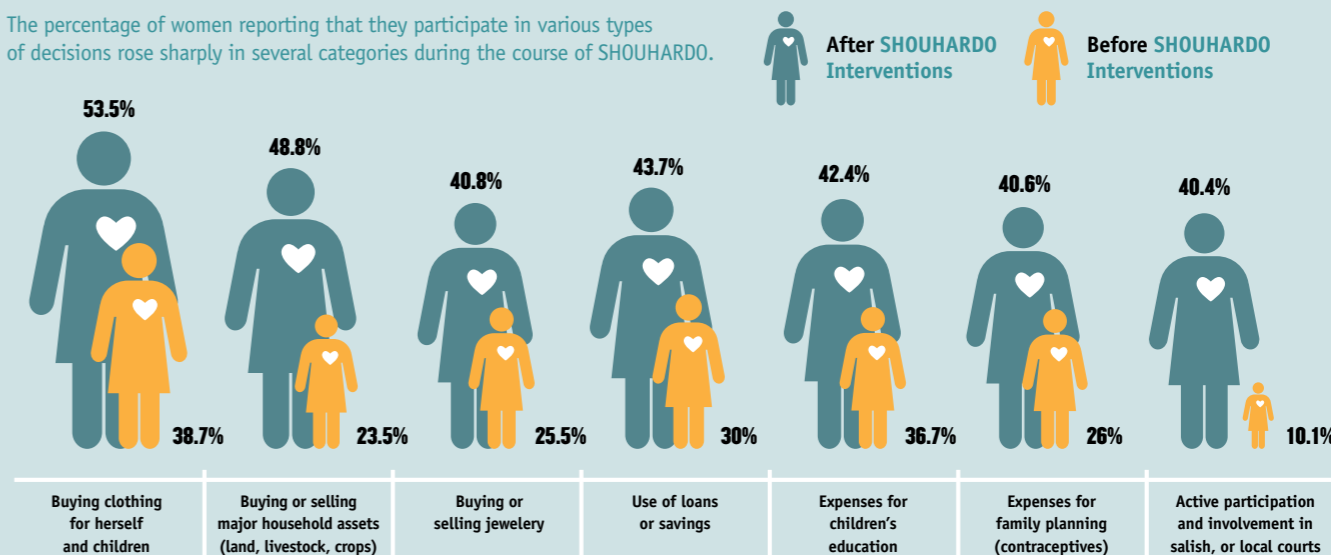


Figure 6: Big gains in decision-making power

WHAT CAUSES THE REDUCTION IN STUNTING?

The findings show that women's empowerment was the single biggest contributor to reducing malnutrition and child stunting when compared to the project's other interventions, even those that include the direct provision of food to mothers (see Figure 7).

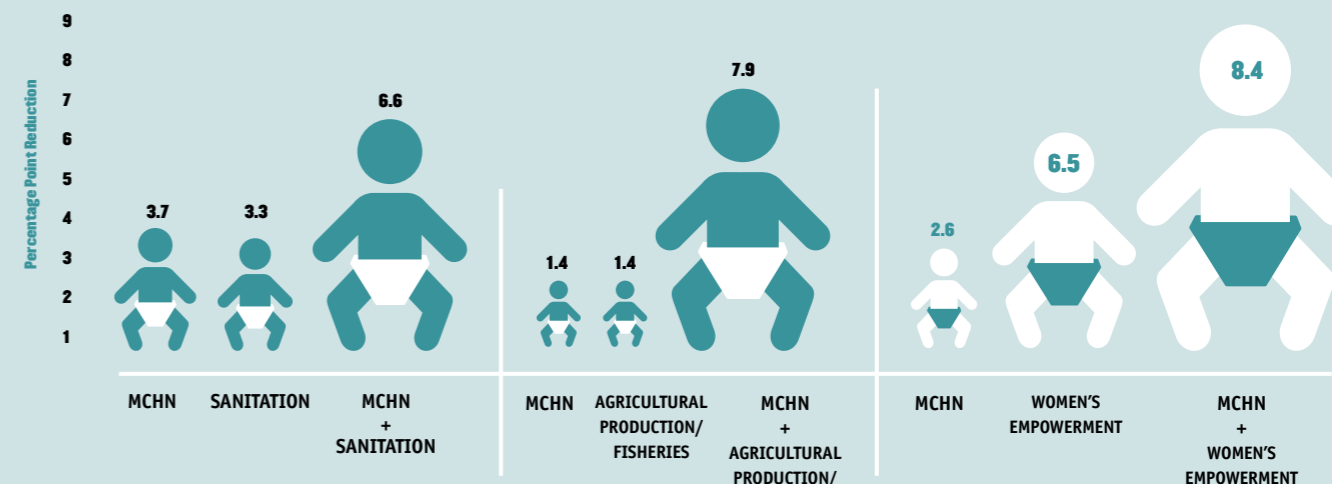


Figure 7: What caused the reduction in stunting?

There is no doubt that SHOUHARDO spectacularly achieved its quantitative goal to reduce child malnutrition and stunting. But the answer to sustaining that success was women's empowerment. As SHOUHARDO's director, Faheem Khan, put it: 'If we are able to significantly reduce stunting, we are able to change a population for the better for the rest of their lives. The children will grow up more healthy and intelligent, enabling them to be more productive members of society. Their households are more likely to graduate out of poverty, and the positive effects are felt widely in their communities and beyond'.

Across every aspect of CARE's work, governance can either inhibit social justice and block change, or it can facilitate broad-based and sustainable social transformation.

CHAPTER 3: GOVERNANCE

Governance is the sum of the many ways in which citizens and institutions, public and private, manage their common affairs within a given society and internationally. It is a dynamic, political process through which decisions are made, conflicts are addressed – and ideally resolved – diverse interests are negotiated, and collective action is undertaken. The process can be influenced by formal written codes (such as laws or policies), informal but broadly accepted cultural norms, the leadership of an individual or group, the use of patronage, coercion or force – or often, a combination of these. Across every aspect of CARE's work, governance can either inhibit social justice and block change, or it can facilitate broad-based and sustainable social transformation.

Ranging from single-party states to parliamentary democracies, Asia is as politically diverse as it is geographically, culturally and economically varied. This means that the governance challenges are equally diverse, ranging from inequitable delivery of public services, bureaucratic cultures, weaknesses in parliamentary oversight or corruption to lack of equality and justice for all, and the social, economic and political exclusion of women and indigenous peoples or other minorities. Security concerns – including conflicts, political unrest and other disruptions that threaten the viability and effectiveness of government institutions – are becoming more prevalent in the region.²⁸ Fragile states in Asia are characterised by poor governance, including a lack of policy direction, weak institutions, limited financial and human capacities, under-representation of women and other marginalised groups, civil conflict and corruption. They are unable to provide basic services to and ensure the security of their citizens.²⁹ The effects of climate change and increasing pressure on natural resources are likely to result in more frequent and increasingly complex emergencies (the combination of both natural and social causes such as conflict and drought and food insecurity) further straining their resources and endangering their citizens.

Throughout Asia, research shows a positive correlation between effective governance and human development – and, conversely, between poor governance and poverty.³⁰ Improving democratic governance means ensuring citizens' participation in decision-making processes, in particular marginalised groups such as women and ethnic minorities, and ensuring that governing institutions are more accountable and responsive to society as a whole.

CARE's approach to governance programming

CARE's Governance Programming Framework (GPF)³¹, illustrated as follows, builds on its research and experience in governance.

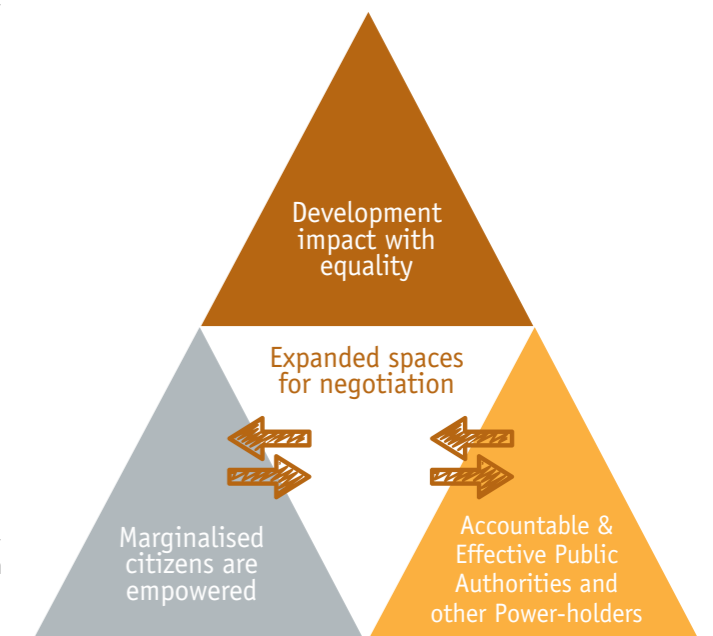


Figure 8: CARE's Governance Programming Framework

To achieve equitable and sustainable development, CARE's work in the area of governance aims to achieve changes within the three domains depicted in Figure 8:

- **Enabling citizens to become more active and engaged**, particularly women and girls, so that they can exercise their rights and communicate their needs more effectively.
- **Working with public authorities and other power holders** so that they can be more effective, and increasing accountability between public authorities and communities.
- **Promoting more and better spaces for communication and dialogue** between communities and public authorities.





CARE's program impact

CARE's governance programming in Asia focuses on enabling poor and marginalised people to become more active and empowered citizens. This is both an end in its own right and also contributes to stronger development outcomes. CARE seldom promotes 'governance projects' as such. But its work in the areas of livelihoods, education or health, for example, implicitly adopt a 'governance approach' in tackling the power inequalities that underpin poverty, injustice and the lack of access to resources. In this sense governance, like gender equality, is a cross-cutting issue.

The following sections provide selected examples to illustrate CARE's contribution to improving governance in the Asia region and key strategies for achieving this impact.

Active citizens

Not all individuals have equal capacities to participate as citizens. They may lack awareness of their rights and responsibilities or have limited ability to articulate and act on their needs and aspirations. Discriminatory social structures – such as gender, ethnicity, class and

caste – may prevent them from participating. The barriers to and costs of participation are often particularly high for women. Women who have not been encouraged to express their views, or who are expected to defer to men, face significant challenges in speaking and acting confidently in public. CARE believes that if poor and marginalised people, including women and girls, are able to participate actively and communicate their views, priorities and aspirations, then they will be able to engage more effectively in governance processes and influence decisions that affect their lives.

In **Afghanistan**, CARE worked with the Ministry for Rural Rehabilitation and Development (MRRD) to establish and train Community Development Councils (CDCs) and Women's Sub-Committees (WSCs). These placed community members at the centre of decision-making processes and assisted them to prioritise their needs and interact with the relevant authorities, thus helping to give a voice to the marginalised rural population. CARE and the MRRD jointly managed the election and formation of 1,700 CDCs and 1,500 WSCs totalling almost 20,000 members, training them in project management, book-keeping, administration and procurement, warehouse management, gender awareness and conflict resolution as well as good governance. Through CARE's training and support, CDCs and WSCs learned to assess and prioritise community needs, develop proposals, seek funding and manage projects. Each CDC developed a Community Development Plan and received block grants for priorities such as road gravelling, power and water supply and sanitation, protection walls, parks and public spaces and irrigation. In total, almost 2 million people benefited from these initiatives.

In **Sri Lanka**, in partnership with the Plantations Human Development Trust, CARE supported plantation workers in 13 tea estates in the country's central region. The overall aims were to improve the traditionally tense relationships between the mainly Tamil plantation workers and estate staff and managers, to enhance labour rights and community wellbeing and to promote ethical standards within the tea industry. The principal mechanism for achieving these goals was Community Development Forums (CDFs) – effectively 'mini parliaments', within which different stakeholders could learn to discuss and negotiate issues in a non-confrontational way. The CDFs also provided a way to link up with government services, such as health workers, and also the police, who worked on how to identify and defuse potential conflicts. Women in particular were encouraged to take up leadership roles within the community and were supported in setting up small businesses and vegetable gardens. Surveys conducted before and after the project found that even those who had not been directly involved agreed that relationships had seen a real improvement, based on dialogue and more responsive management. Over 90% of plantation workers felt that there had been a significant improvement in inter-personal relationships between workers and estate management, whilst 84% of management and estate staff reported they had better dialogue with plantation workers and found it easier to deal with labour unions. Over 38,000 people benefited from these improvements in local governance.

Accountable and effective public authorities

When public authorities and other power-holders are capable, accountable and responsive to poor and marginalised people, then services and other public resource allocation is more transparent and equitable. For this reason CARE works with a range of power-holders, including governments and other duty-bearers, to improve their ability to fulfil their obligations.

In **PNG**, many citizens have only limited access to resources and services. There is a strong correlation between geographical remoteness and extreme poverty in PNG. CARE formed a partnership with government agencies to strengthen the capacity of remote and impoverished communities to identify, prioritise and address their development needs. Demand for good governance was created through supporting communities to participate in local planning processes, and working with local administrators, faith-based organisations and civil society organisations (CSOs) to address constraints to the delivery of public services. Activities that had a direct impact on governance included the training of trainers for over 60 members of village courts in good governance and leadership, community administration of conflict-resolution and legal processes; and strengthening community and institutional capacity through Ward and Community Development Planning Activities. Over 31,000 people benefited from these improvements in local governance. The Ward Plans are now feeding into local government planning and budget processes outlined in the PNG Organic Law.

In **Vietnam**, CARE worked with Khmer women to improve their living conditions and enable them to develop the confidence to participate actively in community development initiatives. In the Mekong Delta, although Khmer form only 7% of the population they represent 16% of the region's poor. CARE supported the establishment of 330

Women's Development Groups (WDG), 68% of which were poor Khmer women. The WDGs took a participatory approach to not only identifying problems but also their solutions. This led to significant changes in women's position in the family and community as they learned about family health, financial management, business start-up and savings. The WDGs also offered solidarity and mutual support. As WDG members gained the confidence to express their concerns and ideas they began to speak out at home and in public. District and commune authorities were supported and therefore willing to use participatory methods to prepare Community Development Action Plans and to incorporate them in the Socio-Economic Development Plan. The governance impacts include changes in the thinking and behaviour of relevant stakeholders regarding poverty-reduction initiatives, and making a significant contribution to improving civil society and grassroots democracy at commune and district levels.

Space for negotiation between citizens and authorities

CARE focuses on building opportunities and spaces for interaction between citizens and public authorities, with an emphasis on rights and responsibilities. These may be formal spaces created by the government, such as local development and participatory budget committees and roundtables on poverty issues. Or they may be informal spaces in which CSOs come together to channel unrecognised demands, provide services and generate solidarity. CARE works to strengthen existing formal and informal spaces for participation and representation, and to create new ones.

In **Bangladesh**, CARE sought to strengthen national collective action to press for legislative change in favour of equal rights for women. Working with 48 development and human rights organisations for the enactment of the Domestic Violence Protection and Prevention Bill, CARE played a central role in ensuring the bill was passed into law on 5 October 2010. Although this was a major breakthrough, its implementation on the ground remains difficult, so CARE is now seeking to make duty-bearers responsible for putting the new law into practice. Besides promoting an understanding of the law and its implications at the community level, CARE works both with the Ministry of Women's and Children's Affairs (MOWCA) and with grassroots organisations to encourage changes in the beliefs and attitudes that underpin discrimination against women.

Also in **Bangladesh**, CARE worked to strengthen the relationship between local government and citizens, in particular the ultra-poor and marginalised. By creating opportunities for dialogue and encouraging citizens' participation in the processes of governance and development, the initiative has amplified the voice of the most marginalised, particularly women. CARE's support enabled citizens to mobilise around demands for access to productive resources (such as land), fairer wages, and for local government to generate employment and business opportunities. The ultra-poor now participate in managing government safety-net schemes, which has served as a way to mobilise citizens around other claims for rights and entitlements. Communities have become more resilient, accessing support by drawing on their own resources such as savings or their new relationships with local authorities. Even in a context of very limited devolution of power and authority to the local level, inclusive governance has yielded important changes in people's lives.

CASE STUDY

Supporting women's empowerment through local governance initiatives

Relationships among people working in Sri Lanka's tea estates have traditionally been tense and confrontational. Most of the plantation workers are women, yet they tend to get the worst-paid jobs as pickers, working long hours outside, even in the rainy season. Although 90% of women in Sri Lanka are literate, this drops to around 68% among women plantation workers. Poor education and an inadequate diet during pregnancy contribute to relatively high rates of maternal mortality, and gender-based violence is also a major problem – though it tends to be concealed as a domestic issue. These factors combine to make it even harder for women to challenge their subservience to men and other forms of discrimination.

Tanya has lived these problems first-hand. Her father started drinking heavily and everyone knew they should keep out of his way, as he would often become violent. Eventually her father was killed in a brawl with another worker, leaving the family almost destitute.

Tanya felt angry that her mother had to work for such meagre earnings, but she knew that it was useless to approach the union, and she could never go to ask the estate managers for help. But then her friend Srilatha told her about the Community Development Forums, which had provided loans for sewing machines so that women could earn a living from dressmaking rather than as tea pickers. The two young women decided to go along. At first they were shy. Although everyone was seated in a circle, they found it hard to speak out – especially in front of the estate managers. They were afraid of being branded as 'trouble makers'. But they saw that other women like them were doing so, and gradually gained the confidence to raise their concerns about the lack of employment opportunities for women and the importance of making sure that girls had the chance to attend school rather than joining their mothers in low-paid jobs. After a few sessions, Tanya asked straight out why the women were paid less than men for similar work, or had only the worst-paid jobs on the estate.

One of the CARE community development workers approached Tanya after the Forum and suggested that she join a leadership training program. This was the boost Tanya needed to become a special union representative for women workers: 'I am no longer scared to talk with the estate management. I speak freely now'. Her friend Srilatha became a volunteer outworker, going outside the estate to establish communication between Tamil and Sinhalese communities, which have traditionally remained separate and mutually suspicious. 'Our two communities face the same challenges, now we participate in each other's cultural activities and help each other out in times of need.' These different expressions of non-confrontational engagement in tackling deeply ingrained cultural prejudice and discrimination are a microcosm of good governance at the grassroots level.

CHAPTER 4: INCOME POVERTY REDUCTION

The World Bank estimates that 1.3 billion people worldwide live on US\$1.25 or less a day and that 856 million of these live in Asia.

At the same time it points out that Asia almost halved the number of people living in extreme poverty between 1990 and 2008, thanks largely to sustained economic growth. It notes that the region is therefore likely to achieve MDG1, to halve poverty and hunger by 2015 – although in absolute terms poverty and hunger or food insecurity remain unacceptably high.

The communities with which CARE works have scarcely benefited from economic growth. They tend to live in remote areas and are often poorly equipped to participate even in the local or regional economy. They lack significant assets to use as collateral, such as land, livestock or savings, and are heavily reliant on subsistence farming or agricultural wage labour.

Women and girls may spend much of the day maintaining and managing the household, such as fetching water and fuel, cooking meals and caring for children, and for sick and elderly relatives – activities that generate no income and limit women's earning potential. Women are more likely than men to be illiterate, and may accept inferior working conditions simply to ensure that their families survive. The call on women's unpaid labour often increases with external shocks, such as those associated with natural disasters.

When women and men have equal opportunities and freedoms, economic growth accelerates and poverty declines more rapidly. Moreover, research shows that women re-invest on average 90% of their income in their families and communities, while on average men re-invest 30%–40%. To increase women's economic opportunities and the economy overall, women need access to more and better employment, an environment that supports them in starting and doing business, a financial sector that gives them access to services that are tailored to their needs, and greater livelihood security in times of crisis. This is especially true for women living in rural areas and in vulnerable environments.

CARE's work on reducing income poverty in Asia focuses on the poor and marginalised, including socially excluded groups such as women-headed households, ethnic minorities and smallholder or landless farmers. Its programs aim to strengthen the capacity of individuals, families and communities to ensure that women and men have secure and sustainable livelihoods. CARE's support for sustainable livelihoods focuses on tackling the underlying causes of poverty and economic and social injustice, in order to promote greater participation by marginalised communities in broader movements of social and economic change.

CARE'S PROGRAM IMPACT

Between 2005 and 2010, CARE reached an estimated 9 million people through initiatives whose primary focus was to reduce income poverty.

HIGHLIGHTS OF CARE'S CONTRIBUTIONS INCLUDE:

Increasing the average annual income of almost 2.7 million poor and marginalised people on average by 117% in Bangladesh, India, Sri Lanka and Vietnam.

Increasing the asset and savings base by approximately 60% (either in terms of cash savings, crops or productive assets such as livestock) for target communities in Cambodia, India, Laos and Timor-Leste.

Diversifying the income sources of over 117,000 people in Cambodia, India, Nepal, Pakistan, Timor-Leste and Vietnam so that they no longer solely rely on agriculture.

Training over 20,000 people in small business management in Afghanistan, Nepal, Pakistan, PNG, Timor-Leste and Vietnam enabling them to enhance their economic capacities and opportunities.



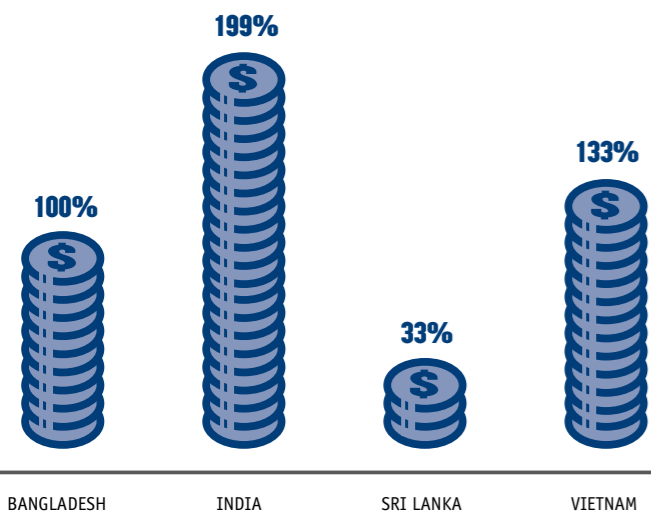


Figure 9: Percentage increase in average annual income per capita in target communities

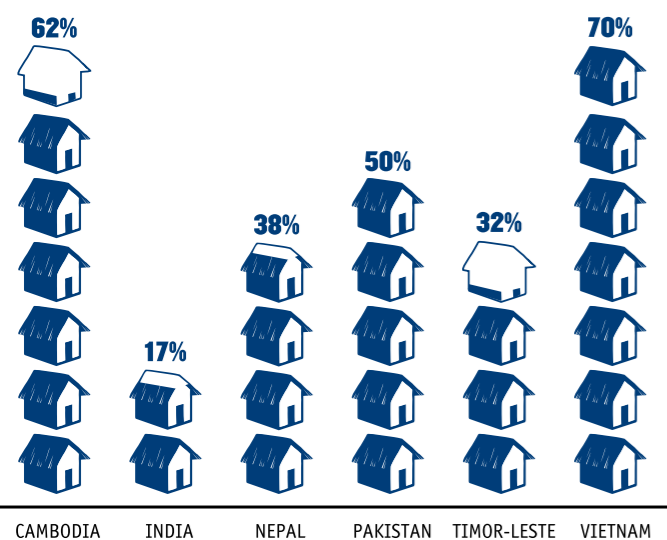


Figure 10: Percentage of target households reporting diversified sources of income

The following section provides selected examples to illustrate CARE's contribution to reducing income poverty and key strategies for achieving this impact.

Strengthen access to and control over natural resources and other assets

In **Myanmar**, CARE supported 3,200 landless or land-poor Rohingya households in Northern Rakhine State (NRS) to establish and manage community forestry (CF) plots, and facilitated the issuance of land-use certificates to plot holders. These certificates are valid for 30 years and may be renewed. This was a major achievement both in terms of the immediate livelihood benefits and in enabling the Rohingya to advance their rights as citizens. The CF plots constitute significant assets: 62% of households who had plots for four or more years reported 'substantial' or 'very substantial' increases in household income and assets as a result³⁶, and income is expected to grow considerably in the years to come. There were also environmental improvements such as streams continuing to flow during dry spells. Non-project communities in NRS have established their own CF plots after seeing the success of project-supported plots. CARE's advocacy with the Ministry of Forestry could lead to the replication of – or at least learning from – CARE's CF approach.

In **Nepal**, CARE enabled 8,800 people to increase their earning power by participating in agricultural skills training and receiving support for livestock (goats) and vegetable farming. As a result households could sell between eight and 15 goats a year, generating an annual income equivalent to between US\$145 and US\$190. Through developing skills in agriculture and livestock production, poor farmers have both doubled their daily income and increased their linkages to local movements related to agricultural production.

Increase sustainable agricultural production

In **Vietnam**, women from ethnic minorities in rural areas are disproportionately poor, experiencing the combined effects of social exclusion and gender inequality. CARE used Farmer Field Schools (FFS) to improve women's knowledge of and practices in agriculture (cultivation of rice and soybeans) and small animal husbandry. FFS proved successful in improving women's understanding about production and yields. For instance, pig husbandry in Hoa Binh Province produced a 490% increase in household income over a three-year period, while poultry raising improved overall incomes by 245%. Furthermore, FFS members reported better yields and the ability to keep seeds for the next season, positively impacting food security and health. For example, women in Lac Son district said they used to experience food shortages for an average of two months each year, but these had become a thing of the past thanks to increased yields. There was also sufficient food for livestock, securing an important household productive asset as the pigs now reached maturity and the ideal sale weight more rapidly, which therefore increased sales.



Strengthen farmers' access to and control over markets

In **Cambodia**, CARE supported small-scale farmers and producers to buy and sell produce at fair prices and avoid exploitation by intermediaries. CARE promoted the dissemination of market information by introducing village information boards and radio announcements. These helped to clarify the market prices of cash crops and increased the bargaining power of farmers and producers vis-à-vis buyers and intermediaries. Two-thirds of beneficiaries reported listening to the radio announcements, including to obtain market information (around 90% of households), followed by news and advertisements. Nearly all (96%) beneficiaries were aware that information was published on the village notice board and 78% reported making regular use, mainly for the prices of agricultural products and inputs, while others gathered health and other general information.

In **India**, CARE supported small and marginal livestock owners to increase their income by establishing village milk-collection centres and developing linkages with the National Dairy Development Board (NDDB) and other dairies in order to reach new markets. Before this initiative, the household monthly income from selling milk averaged US\$58, but by being able to sell more milk at better prices to collection centres and expanding their market, this rose to US\$137, an increase of 136% in average household income.

Create access to microcredit and other financial services

In **Cambodia**, CARE sought to increase access to credit and savings in poor and disaster-prone communities. Within four years over 4,500 people, almost 60% of them women, were able to obtain loans from community-based facilities established by the program. These included 75 Village Cash Banks, 38 Village Rice Banks, 78 Village Savings and Loan Associations, and 17 Commune Council Development Funds. Typical activities for which loans were sought were agricultural inputs, household consumption and trading.

In **India**, CARE's strategy of building the capacity of partner NGOs to run microfinance institutions (MFIs) led to the formation of almost 43,800 self-help groups (SHGs) and over 120 federations. These MFIs independently manage savings worth US\$625,000. Meanwhile the partner NGOs have used the US\$270,000 in revolving loan funds to leverage funds worth over US\$3.3 million.

Strengthen women's leadership and decision-making on livelihoods

In rural **Afghanistan**, where women do not generally work outside the home, CARE worked with 2,000 women-headed households and their adult children living on incomes of US\$1 or less a day. CARE provided business and life skills training as well as community-based sessions on gender equality and women's rights to increase employment and self-employment for women or their unemployed adult children, and to enhance local acceptance of women in the workplace. As a result, 46% of former trainees are employed or self-employed and over 32% have seen a significant increase in earnings. More employers are willing to hire women and more families accept that women may seek work – 75% of adult family members now support women in finding employment. Although women usually find it easier to find jobs as home-workers, 94% of women who underwent the training felt more confident about finding outside employment. In addition, CARE supported the establishment of 110 savings and loan groups to provide resources for women to support their livelihoods and other household needs. These groups had total savings worth US\$21,000 and 145 loans were issued to women to set up a small or micro-enterprise.

In **Nepal**, CARE supported marginalised Dalit women to establish 255 savings and credit groups, whose total savings amounted to the equivalent of US\$33,280. The savings contributed to their economic empowerment, and the groups also played a crucial role in promoting gender equality and changing gender roles. Group members said that as a result of their regular meetings, they gained in confidence and solidarity, learned about issues of gender-based violence (GBV), and developed better negotiating skills at the household level over financial and material decisions, such as purchasing food, paying for school fees, and meeting health needs. Some women also reported a change in domestic relations thanks to their improved financial knowledge.





CASE STUDY

CARE's engagement with the private sector in Asia

The private sector's impact on economies across Asia is undisputed. Whether this is through the rapid expansion of multinational corporations or, on a different scale, the increasingly significant role played by small and medium enterprises. In both cases, the private sector has the potential to either facilitate sustainable economic growth and development, or to reinforce unequal and uneven wealth distribution. In Asia, CARE has seen that strengthening the livelihoods of poor and vulnerable communities through positive private sector engagement (PSE) can also contribute to improving overall living standards.

In many countries, CARE has a long history in creating access to markets for poor farmers and offering agricultural extension services. In some cases, CARE has helped to create social enterprises, while in others CARE has worked directly with companies on their labour policies and practices. The aim is to encourage businesses and industry bodies to address poverty and social injustice and so produce a 'return' for the partners, communities and groups on whose behalf CARE works.

CARE's beneficiary groups typically fall into three categories – workers, producers and consumers – and interventions are therefore designed to encourage responsible practice on the part of the private sector in ways that will make positive changes to the lives of these people.

CARE aims to engage with the private sector in ways that ensure fair and transparent interactions and which take into consideration the unique assets, perspectives and needs of local communities. Although it may challenge certain business practices, CARE's approach is to influence business priorities through

constructive engagement as a means to improve the long-term situation of poor and marginalised people and communities, whether as workers, producers or consumers.

Impact on workers

CARE has developed expertise in training garment factory workers, working closely with factory owners, CBOs and women's groups, as well as international brand names such as Gap, Walmart, Timberland and Levi Strauss & Co., in providing in-service training courses and replicating this experience across the region. In all, CARE has provided training to over 100,000 garment workers in factories in Bangladesh, Cambodia, Indonesia and Vietnam who are now better equipped with life skills that help them achieve more at work or improve their ability to achieve, and be aware of, future employment opportunities. In Bangladesh, a country that has become one of the world's main garment exporters, over 42,000 garment factory workers have now received training and mentoring on issues ranging from health and nutrition to business development and management.

Impact on producers

CARE has a global commitment to facilitating and designing market-linkage initiatives for smallholders and subsistence farmers and local producers. In Asia, CARE has experience across a range of 'value chains' – from vegetable harvesting in Nepal, to crab production in India and poultry farming in Vietnam.

Typically, CARE's focus is on improving people's access to market information on pricing and demand, as well as providing training and mentoring on farming techniques, joining cooperatives, and household financial management.

In India, CARE has partnered with Walmart on a cashew value chain initiative to train, federate and organise over 1,000 women cashew processors, responsible for the roasting, aggregation, packaging, marketing and sale of the produce. This initiative has also leveraged financial assistance from the Indian government and other stakeholders to purchase land, procure machinery and construct three cashew processing factories. The factories are supported by 15 centres, which provide community educational services on livelihood activities. In 2011, Walmart began purchasing cashews from these processing factories.

Impact on consumers

From 1999 to 2006, CARE managed a major program in India to enhance women's savings and access to microfinance services. The program created and then operated through a vast network of self-help groups (SHGs) working with 27 implementing partners. This experience of working in financial services, along with a long background in livelihoods, gave a platform for establishing post-tsunami recovery initiatives. With a focus on training and employing marginalised women in different enterprise ventures, this work represented a lifeline to many of the coastal communities deprived of their livelihoods by the 2004 Asian tsunami.

CARE also helped to strengthen microfinance institutions that were serving tsunami-affected communities in India (Tamil Nadu and Andhra Pradesh), as well as engaging with the global insurance company, Allianz, in the co-design and distribution of an innovative micro-insurance product, which was sold to over 250,000 households in three districts of Tamil Nadu. This provided hundreds of thousands of people with access to new health and life assurance products.

In **Vietnam**, CARE worked with poor, rural households in the Mekong Delta to address the needs and interests of marginalised Khmer women, who make up a disproportionate percentage of the subregion's poor. Women in particular suffer harsh living conditions – illiteracy rates are high, many do not speak Vietnamese, and their weak understanding of markets limits their access to and competitiveness in rural markets. CARE established 327 Women's Development Groups (WDGs) comprising a total of 5,000 members.

Through these groups, the women became more independent by being able to obtain credit (70% of women took out loans through the WDGs) and by strengthening other sources of income, such as agriculture and animal husbandry. Women increased their income by up to 20%, improved their financial skills by participating in savings groups (reaching 44% of women), and also adopted better farming techniques as well as sharing land for growing crops. Women also reported gains in confidence through taking on leadership roles both within the WDGs and in their communities.

CARE aims to engage with the private sector in ways that ensure fair and transparent interactions, taking into consideration the unique assets, perspectives and needs of local communities.

Create employment and skills-development opportunities

In **Bangladesh**, widows and married women who are abandoned, separated or divorced face multiple forms of marginalisation and violation of their rights, which limit their social, economic and political opportunities to lead a life of dignity. CARE supported 42,000 marginalised women and their families through a cash-for-work initiative which over four years guaranteed women a regular salary and training in road maintenance, human rights and gender equality, health and nutrition, numeracy and small business management. Over the period, women's income rose by over 40%, which translated into a 30% reduction in the proportion of families living in extreme poverty. Women used the extra money to increase household food security, with a 15% increase in expenditure on food items.

In **Nepal**, CARE assisted poor and socially excluded women to increase their access to income-generating opportunities. Forty-four per cent of women reported that skill-development training gave them the confidence and skills to set up small enterprises and to earn more. Of these women 67% also believed that this led to greater gender equality at home since they largely decided how to spend their earnings. Most of this work was achieved through mobilising women's groups and offering training in how to make financial transactions and assess household expenditures. This also fostered solidarity among group members. In addition, CARE worked to raise awareness of women's families regarding the support and value provided by the women's groups in order to ensure their participation and through encouraging public group discussions about issues usually regarded as belonging to the 'domestic' sphere.

In **Timor-Leste**, CARE increased employment opportunities and reduced the isolation of rural communities by involving them in the construction and rehabilitation of rural feeder roads. Using cash-for-work with a mandatory savings scheme, CARE provided the work teams (60% of whom were women) a regular salary and training in road construction and maintenance, bio-engineering techniques to prevent landslides and small-scale business management. This significantly enhanced women's livelihood security with 32% of

women using their savings accounts as start-up capital to set up small businesses. In addition, almost 50% of women were able to provide for their basic needs (food, salt, oil, soap) and increase their livestock holdings as a result of having a regular income. Greater economic security meant that people could make long-term investments in the form of education, as shown by the fact that 23% more families were in a position to send their children to school.

Strengthen workers' organisations and improve labour rights

In **Bangladesh**, CARE used a community-mobilisation and solidarity-building approach to address social exclusion, injustice and marginalisation. This resulted in a better rate of pay for rice paddy labourers, particularly for women, who were starting from a lower base (66% more for women and 20% for men). The 180 communities involved succeeded in accumulating the equivalent of US\$10,000 in collective savings and eight tonnes of rice. A total of 7,000 families experienced positive changes as a result of CARE's work.

In **Nepal**, CARE raised awareness of fair working conditions and helped women and men to acquire the skills to lobby for higher wages and equal wages for both sexes. CARE also provided training and support for on-farm and off-farm income-generating activities. As a result 45,000 labourers doubled or even trebled their wages.

CARE combines a rights-based approach to development with practical support to enable communities, especially women, to deal with food insecurity and its consequences.

CHAPTER 5: FOOD SECURITY AND NUTRITION

The United Nations Food and Agriculture Organization (FAO) estimates that some 950 million people worldwide experience hunger³⁷, of whom over 60% live in the Asia-Pacific region.

Social exclusion reinforces food insecurity – women-headed households, ethnic minorities, orphans, those who are HIV-positive or are living with AIDS, people with disabilities and the elderly, for example, are also more likely to suffer hunger. Marginalised groups often live in poor housing and have few productive assets and few opportunities to earn a living wage. Each of these factors heightens vulnerability to food insecurity, which may be triggered by other variables such as the loss of employment or the inability to work, a natural disaster, crop failure or volatile food prices on the global market.³⁸

In most of the world, women-headed rural households tend to be among the poorest because women are less likely to own land, or be able to farm it, and because of a historical neglect of the subsistence sector in favour of cash crops – which tend to be produced by men.³⁹ Women farmers are responsible for up to 80% of staple food production in most developing countries, yet face more difficulties than men in contributing to decision-making processes and have less access to land, credit, agricultural inputs, training, services and appropriate technology.⁴⁰ Women experience chronic hunger and food insecurity more often than men⁴¹ with far-reaching consequences because malnutrition affects the health of mothers and children and so contributes to an inter-generational cycle of poverty and malnutrition.

CARE combines a rights-based approach to development with practical support to enable communities, especially women, to deal with food insecurity and its consequences. CARE addresses all four dimensions of food security: access, availability, use and stability of supply. Key strategies include increasing food reserves; increasing and diversifying sources of income; promoting health and hygiene; improving access to clean water and sanitation; improving technologies; and conserving natural resources, linked to disaster risk reduction (DRR) measures. In the context of food security, CARE's commitment to gender equality means striving to transform the lives of women, girls and their families, building on their own capabilities and aspirations, in order to ensure that they have secure access to enough nutritious food.

In the context of nutrition, CARE works closely with communities, local civil society organisations (CSOs), governments and the private sector to develop programs that both meet immediate food needs and also promote long-term solutions. To do this, CARE focuses on monitoring and promoting children's growth; behaviour change and communication (BCC); and home- and community-based nutrition programs to rehabilitate moderately malnourished children.

CARE's work on food security and nutrition contributes to the achievement of both MDG1, which aims to eradicate extreme poverty and hunger, and MDG5, which aims to improve maternal health.



CARE'S PROGRAM IMPACT

During the study period CARE reached an estimated 10 million people – 70% of whom were women and girls – through initiatives focused on improving the food and nutritional security of marginalised and vulnerable households. These included chronic and transitory food-insecure households, small-scale and subsistence farmers, people affected by environmental degradation and/or drought, ethnic minorities and widows.

HIGHLIGHTS OF CARE'S CONTRIBUTIONS INCLUDE:

Reducing average malnutrition rates (stunting, wasting and underweight) by 21.5%⁴², benefiting over 2 million children in target communities in Bangladesh, India and Nepal.

Reducing the average number of food-insecure months by an average of three months in target communities in Bangladesh, Cambodia, Timor-Leste and Vietnam.

Increasing the average crop yield of subsistence farmers in target communities by 84% in Afghanistan, Bangladesh, Cambodia, Myanmar, Timor-Leste and Vietnam.

Training 105,530 subsistence farmers in conservation agriculture techniques (such as terracing, mixed farming, crop rotation, manuring and mulching) in Cambodia, Laos, Myanmar, PNG, Timor-Leste and Vietnam. Over 90% of farmers with whom CARE worked in Laos, Myanmar, Timor-Leste and Vietnam adopted one or more of these techniques.

Enabling 110,600 people in Bangladesh and Cambodia to achieve a more diverse diet (including vegetables, fruits, meat and fish).

Promoting and increasing the practice of breastfeeding immediately after birth by 59% on average across target communities in Bangladesh, India and Cambodia.

Promoting and increasing the practice of breastfeeding from birth to six months by an average of 40% in target communities in Cambodia, India and Nepal.

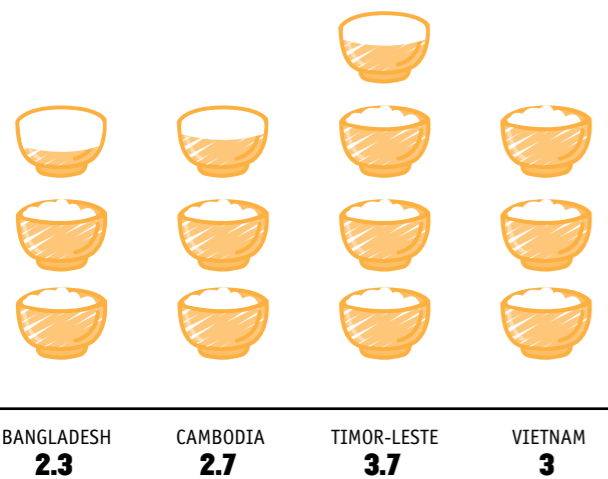


Figure 11: Average reduction in number of food-insecure months for target communities

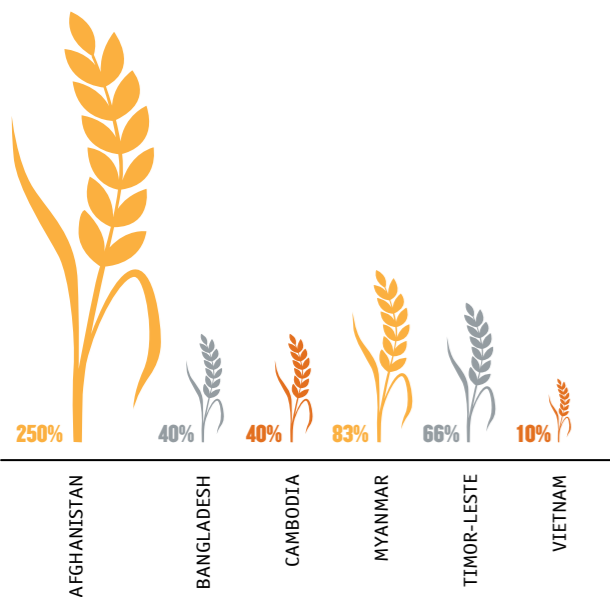


Figure 12: Percentage increase in crop yield for target communities

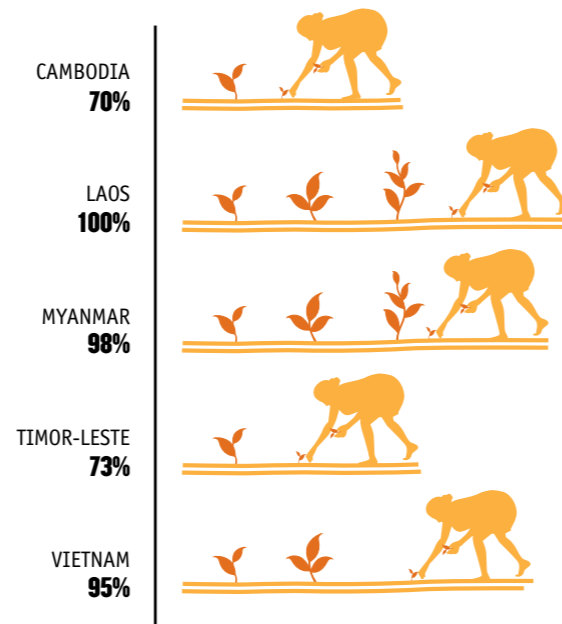


Figure 13: Percentage of farmers adopting improved agricultural techniques in target communities

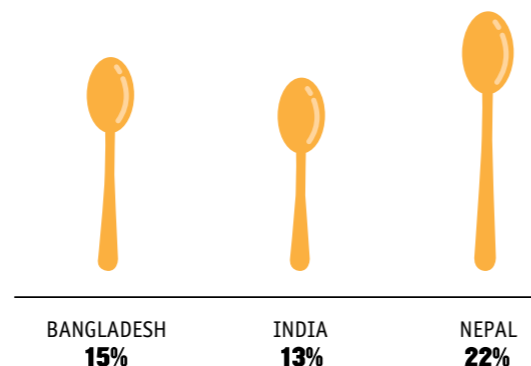


Figure 14: Percentage reduction in child malnutrition for target communities

The following section provides selected examples to illustrate CARE's contribution to improving food security and nutrition key strategies for achieving this impact.

Strengthen resilient livelihoods to improve food security

In **Bangladesh**, CARE supported low-income, food-insecure rural households to improve their production and income by adopting new technologies and crop varieties and linking them up with market opportunities. This enabled farmers to increase their income from rice production by 40%, aquaculture by 28%, crop diversification by 24% and kitchen gardens by 59%. These improvements benefited over 308,000 people.

In **Cambodia**, CARE supported vulnerable households to construct and maintain water-storage ponds for home-based economic activities such as maintaining kitchen gardens, cultivating mushrooms, and raising fish and frogs. Forty-two per cent of these households reported increased earnings and vegetable production because of the ponds, and 50% stated that having ponds meant they spent less time and effort on fetching water – primarily the responsibility of women and girls. CARE also provided training in post-harvest techniques and supported farmers in building over 80 facilities to store maize and rice in order to reduce losses and fetch the best price for their crops. One hundred per cent of households reduced post-harvest losses and obtained higher prices for their produce, which was also of a better quality. CARE helped local people to improve their diets by providing a better understanding of nutrition and hygiene. Eighty per cent of households improved their diets and more than 60% of women reported eating more vegetables and animal protein, such as fish and meat. These improvements benefited almost 4,500 people.

In **Myanmar**, CARE worked to increase the food and livelihood security of ethnic Chin households in 44 remote villages. Previously, only 30% of these households enjoyed even a minimum standard of nutrition, and CARE's work saw this rise to 55%. Almost all (98%) households adopted two or more new agricultural practices, including 20 new crop species. Examples of improved farming practices included contour planting and other methods to reduce soil erosion, the production and use of compost and crop rotation to improve soil fertility, home gardening such as fruit trees and vegetables for domestic consumption and sale, livestock breeding and spring catchment protection. CARE also facilitated the transfer of land: 80 landowners transferred some 380 hectares to 163 landless households, 12 of which were headed by women, for farming, spring catchment protection and community forestry. These improvements benefited over 1,300 households.

In **Laos** CARE worked with the demining organisation UXO Laos to clear unexploded ordinance (UXO) and expand paddy fields to improve the food security of vulnerable households. On average families were able to expand their access to productive land by 3.6 hectares and were supported to increase their crop yield through new rice seeds and training on improved paddy rice production techniques. CARE also provided training in animal raising techniques in six villages and vaccination training for 42 village volunteer veterinarians – as a result livestock holdings increased: buffalo increased by 25%, cattle by 30%, pigs by 10% and poultry by 60%.

Reduce vulnerability and enhance food security through integrated risk reduction and management

In **PNG**, CARE supported subsistence farmers by introducing drought-resistant crops as a means to provide a source of food during extended dry seasons. CARE distributed drought-resistant seedlings and provided training in crop storage, processing and cooking techniques. CARE also worked with the Department of Agriculture and Livestock on preparedness programs to encourage seed banks and the adoption of resistant crops – three communities developed Community Seed Banks as a result of this effort.

In **Timor-Leste**, CARE supported food-insecure households that were highly vulnerable to drought, crop pests, flood and soil erosion, strong winds and post-harvest losses because of poor storage. CARE addressed these problems in a variety of ways, including the promotion of community-based seed production and maize storage, water ponds, organic fertilisers and kitchen gardens. Ninety-five per cent of farmers achieved better yields from the improved seed varieties and used storage containers to increase their own seed stocks and to sell to other farmers. Yields of maize, peanuts, cassava and sweet potato increased by 66%, and crop diversity and consumption increased with the number of vegetable varieties more than doubling to an average of 21 per household. Training in new agricultural techniques and technologies proved popular, with 36% of farmers changing some aspect of their previous practices – 75% adopted the metal seed-storage bin, 70% started kitchen gardens and almost 60% adopted the new maize and peanut varieties.

Farmers attributed the high adoption rates to CARE's holistic approach to training, which included the piloting of technology in Farmer Field Schools, exposure visits, training and mentoring. The project reduced by almost four months the annual period of food insecurity. CARE also worked with community organisations to develop and implement Disaster Risk Mitigation Plans in six villages. These plans led to training in techniques such as Sloping Agriculture Land Technology (SALT), planting of grasses and trees to reduce erosion and the introduction of seed varieties that are more resilient to less predictable seasons. These improvements benefited over 3,000 households.

In **Vietnam**, CARE worked to improve the food security and livelihoods by providing training in soil-conservation practices and the use of improved seed varieties. SALT models were established as a means to prevent soil erosion and land degradation. Within only one year of adopting these approaches over 60% of farmers harvested two crops of maize rather than one, and 40% of farmers applying SALT practices observed better retention of topsoil. These successes led to the district governments of two provinces to adopt SALT in their Socio-Economic Development Plans, stating that 'the SALT method has been successfully piloted and evaluated by CARE and therefore this advanced technique will be applied with assistance from district line agencies'. These improvements benefited over 26,000 people.



CASE STUDY

Supporting families through enhanced food security

Rosalina has seven children, all under the age of 15. Such a large family can be cause for worry – a third of the people in the remote district in Timor-Leste where Rosalina lives experience periods of hunger and most Timorese survive on less than a dollar a day. ‘In the past my husband and I could not afford to send our children to school’, Rosalina explains. ‘Education is so important for our children and our country to have a better future but the fees are US\$60 a year. We sold all our animals and used any extra money we made to pay the fees but we didn’t have enough. It wasn’t easy for me to do but I pleaded with the Director of the school to let them attend. It was only because of his generosity that I was able to send them ... and we still couldn’t afford to pay for uniforms or books.’ When CARE staff came to Rosalina’s district to ask villagers what improvements

they would most like to see, the answer reflected the basic but all-important challenges they faced: ‘we need to grow more food so we can feed our families and earn an income from any surplus we sell at the market ... but to do that we need water to grow the vegetables ... and a road from the village to the main road so we can take our produce to the market’.

CARE began to work with Rosalina and other villagers to remove the barriers to better livelihoods and development in a way that reflected local priorities. A team of villagers was trained in road construction and set about building a vital link that would allow them to transport goods and trade more easily with other villages. Others, including Rosalina, learned how to create rainwater-collection systems to see them through the dry season and grow crops all year round. Next, a member

of Rosalina’s community generously set aside some land adjacent to the rainwater-collection area for a group of villagers to create a kitchen garden. CARE provided seeds, tools and training in more efficient farming techniques, including the construction of raised beds and the preparation of natural pesticides. When Rosalina speaks about the future now, it is with optimism, and a restored sense of dignity. ‘The profits from this garden allow us to buy goats, pigs and chickens, which we raise and sell to pay for school costs. When my children ask about money for education now I can tell them we have a plan for the future.’

Promote good governance and rights to ensure equitable food security

In **Myanmar**, CARE used community forestry (CF) as a means to support marginalised households to improve their income and food security and to enhance social cohesion. A total of 92 CF user groups were formed, who established over 2,020 hectares of community forestry with technical inputs from the Forest Department and support from CARE. The program was developed within the framework of the Community Forestry Instructions (CFI), which permit CF user groups to use land for 30 years, which can be renewed if they observe the CFI. CARE helped the user groups and the Department

to understand and apply the CFI and created spaces in which to build trust and relationships, enabling user groups to raise any concerns they might have about the fair distribution of benefits from the CF program. Around 60% of the users made at least one harvest of wood products and all of the users doubled their assets in relation to the value of the land and the forests. In terms of sustainability, the user groups continue to work with the Department on CF plantations. These improvements have benefited over 5,000 households.

Improve nutritional status

In **Bangladesh**, CARE implemented a comprehensive program in the country’s poorest communities, including maternal and child health and nutrition, sanitation, kitchen gardens, village savings and loans groups, and activities geared to generating an income and improving resilience to climate change. Taking a rights-based approach that focused on women’s empowerment was essential to tackling the structural causes of hunger and malnutrition. If mothers go hungry during pregnancy, they tend to produce underweight babies who do not grow normally. Stunting not only inhibits cognitive and physical development but also reduces children’s immunity to diseases. At the start of the project, over 55% of babies and toddlers were stunted, which had dropped by 16% four years later in project areas, compared to no change at the national level. This success was due to synergies among a range of factors, in particular improved food production, higher incomes and better hygiene and sanitation. These improvements directly benefited over 400,000 households or almost 2 million people.⁴³

In **Timor-Leste**, 10% of children are acutely malnourished and 50% of under-fives are chronically malnourished. Poor nutrition among under-fives inhibits children’s cognitive and physical development. CARE provided training and support for community health volunteers (CHVs) in measuring and monitoring babies and children under five years of age. Ninety-eight per cent of CHVs who completed the training were able to effectively measure and record children’s growth patterns and identify children who are underweight and/or show other symptoms that require intervention. Armed with this knowledge, 94% of CHVs in 40 communities were then able to provide guidance and support to mothers and carers on nutrition and hygiene – promoting, for instance, a more diverse diet, proper preparation of appropriate foods and ways to encourage children to eat new foods. To ensure that mothers and carers could obtain foods needed to support more nutritious diets and improve food security at the household level, CARE also assisted over 300 mothers to develop agricultural skills and establish community kitchen gardens.

In **India**, CARE worked to achieve sustainable improvements in health and the nutritional status of 6.6 million women and children in partnership with the Government of India. CARE’s program targeted pregnant and lactating women and children less than two years of age - strategies included supplementation with food, vitamin A, iron and folic acid, immunisation, antenatal care and improved practices for safe delivery and newborn care, and breastfeeding and complementary feeding. As a result the proportion of pregnant women who received iron and folic acid tablets more than doubled from 21% to 50% and the total number of tablets consumed increased by 58%; in addition supplemental nutrition assistance reached 68% of these women compared with only 47% previously. Household visits to pregnant women by community health and nutrition workers, delivery in a health facility, and use of clean delivery practices at home also all improved significantly. Newborns were better cared for with delayed bathing (44% vs 2%), early breastfeeding (23% vs 19%) and not feeding pre-lacteals (67% vs 33%). Among older infants, more infants began to receive other liquids in addition to breast milk between 6–8 months (51% vs 18%). Most importantly, there was an overall decline in malnutrition rates among children in target districts of 8%. CARE worked to ensure these successes were sustainable by transitioning management of all program activities to the relevant government agencies over the following three years (2006–09).



India © Ami Vitale/CARE

Removing barriers to education helps girls prepare for the future and acquire the skills they need to build better lives for themselves, their families and wider community.



CHAPTER 6: EDUCATION

Improving access to basic education – in line with MDG2 on universal primary education and MDG3 on eliminating gender disparity in primary and secondary education – is one of the best ways to invest in efforts to eradicate poverty.

Receiving a good primary education can help poor girls and boys to improve their life chances, yet some 75 million children worldwide miss out on school – 34 million boys and 41 million girls.⁴⁴ Millions of children drop out of school before they have learned to read and write – whether because school fees and other costs (such as books and uniforms) are too expensive, because their families need them to work, because the quality of education is poor or seems irrelevant – or perhaps a combination of these factors. Adults are also missing out: more than 790 million people over the age of 15 years are functionally illiterate (which means they lack basic reading and writing skills) and almost two-thirds of them are women. West and South Asia are home to 52% of the world's illiterate adults.⁴⁵

The effects of poverty and inequality are passed down to future generations in a cycle that is difficult to break without benefiting from a good education. Research shows a positive correlation between education, healthy families and greater earning potential.⁴⁶ In keeping with its commitment to gender equality and women's empowerment, CARE particularly focuses on improving girls' access to education. Over generations, many millions of women have been denied the right to a basic education and girls still represent 54% of the children missing out on school. Removing such barriers helps girls prepare for the future, acquiring the skills they need to build better lives for themselves, their families, communities and their wider societies. Educated women tend to delay marriage and pregnancy and to have healthier children, partly because they are more likely to be able to earn a decent living – the World Bank claims that for every extra year a girl spends in school, as an adult she raises her family's income by 10%–20%.⁴⁷ Educated women are more likely to seek antenatal care, which also reduces the likelihood of complications in pregnancy or childbirth. In terms of long-term impact, education helps to create a virtuous circle, because educated mothers are also far more likely to send their own daughters to school with the result that the fertility rate begins to decline.

Improving access to quality education is a national priority in almost all of the countries in Asia where CARE works. However, despite progress in increasing the proportion of children in school, developing more effective national plans and policies, and implementing large-scale training for teachers and administrators, many countries still struggle to provide universal primary education. Common challenges include inadequate school buildings and transport infrastructure; curriculum may be in a national language not spoken by different ethnic groups; shortage of qualified teachers, especially in remote areas, compounded by a lack of teacher training institutions or facilities; lack of good textbooks and other educational resources, particularly in remote schools; disparities in educational opportunities between areas depending on population density (particularly urban versus rural areas); and poor health and unsanitary living conditions which impede children's educational performance. Some 'traditional values' may result in the exclusion of women and girls and of ethnic, language and religious minorities from educational opportunities. Natural disasters and conflict can also lead to population displacement and/or to a disruption in schooling.

CARE's work includes training teachers, building schools and improving school facilities, fostering community involvement in school management and supporting bilingual inter-cultural education. CARE seeks to ensure that disadvantaged and marginalised girls and boys complete their primary schooling, and that women and men who missed out also have the chance to receive a sound basic education. CARE's role includes providing services in the absence of government provision, technical assistance to national education departments, and a range of partnerships, including with CBOs.





India © Valenda Campbell/CARE

CARE'S PROGRAM IMPACT

During the study period, CARE reached an estimated 2 million people through initiatives focused on improving access to and the quality of education.

HIGHLIGHTS OF CARE'S CONTRIBUTIONS INCLUDE:

CARE contributed to raising overall primary enrolment rates on average by 74% for target communities in Afghanistan, Cambodia, India, Nepal and Timor-Leste.

CARE contributed to improving adult literacy for approximately 103,500 adults through community education support groups in India, Nepal, PNG and Sri Lanka.

CARE promoted and enabled safe learning spaces through the construction and reconstruction of 673 schools, and improved 906 school facilities through the provision of science equipment, drinking water systems, libraries and school furniture, such as bookshelves and desks, in Afghanistan, Pakistan, Sri Lanka and Nepal.

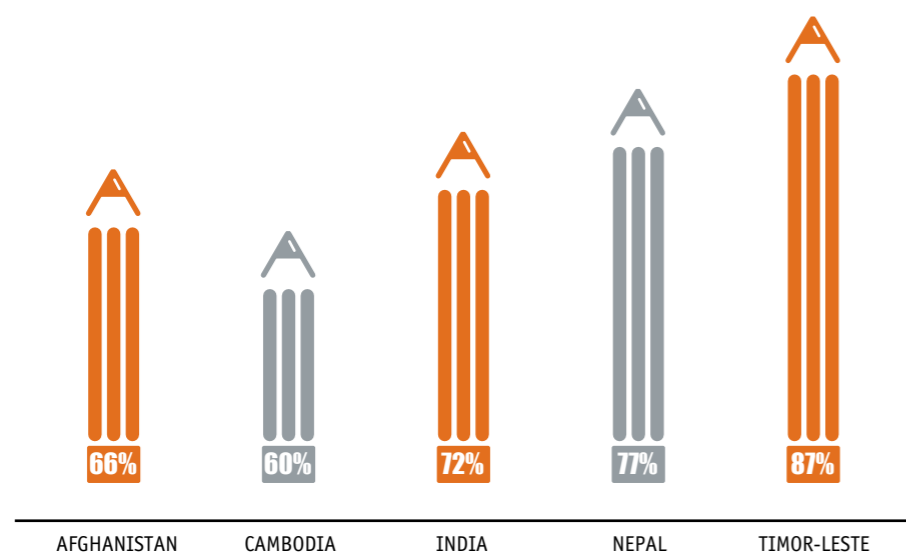


Figure 15: Percentage increase in primary enrolment rates for target communities in selected countries

The following section provides selected examples to illustrate CARE's contribution to improving access to and quality of education and key strategies for achieving this impact.

Increase basic educational attainment, with a focus on school enrolment and completion rates

In **Afghanistan**, the lack of financial resources at both government and community level presents a major challenge to the provision of education for children living in remote areas where there are no public schools. By promoting and strengthening Community-Based Education (CBE) schools, CARE reached 106,510 children (two-thirds of them girls) in 11 provinces. CARE and its partners mobilised 6,740 members of local communities who formed 1,930 School Management Committees (SMCs) with the support of the Ministry of Education (MoE). Some 4,240 CBE teachers were trained by the project, 36% of them women. Once the MoE was ready to assume ownership of the CBE schools, CARE, in close collaboration with communities, assisted in their gradual incorporation into the public system. Between 2005 and 2010, CARE oversaw the transition of almost 60,000 pupils and 2,350 CBE teachers into the public education system. Working in a NGO consortium, CARE helped establish a CBE Unit in the MoE, and supported the development of a CBE policy. CARE also advanced the introduction of a system for the accreditation of CBE schools and professional certification for CBE teachers.

In **Cambodia**, CARE piloted a bilingual education model in six schools in the remote north-east of the country, working closely with ethnic minority communities who are marginalised from mainstream Khmer society. The model covered training of locally recruited teachers, curriculum and materials development in four languages, community management of schools, improvements in school infrastructure and support for teachers. The pilot significantly improved enrolment and retention rates among ethnic minority

children, especially girls. The Ministry of Education, Youth and Sport (MoEYS) was sufficiently impressed to adopt CARE's model of bilingual education, replicating it in 40 schools across five provinces in the north-east, with technical support from CARE. To date, the number of ethnic minority children receiving bilingual education has increased ten-fold, from 280 to 2,890, and the number of minority languages used in formal education programs has doubled. Under the aegis of the Education Law, MoEYS has developed and approved Guidelines for Education of Ethnic Minorities, which describe the model of bilingual education and the conditions for its implementation in community and state schools.

In **India**, CARE focused on issues of quality and equity in classroom processes, teaching capacity and practice, learning materials, assessment and community engagement. CARE's activities included onsite technical support to primary schools (e.g. facilitating classroom processes that affect the learning of languages, mathematics and social skills), community mobilisation (e.g. involving community members in issues of school performance and plans for improvement) and engagement with the state education system, by seeking to enhance the government teacher-training program. The project was based on the premise that the adoption of learner-centred methods and approaches, better use of existing resources and strengthening of community-school relationships would lead to enhanced educational performance. An average 68% (70% for girls) completion rate was achieved in CARE-supported state primary schools.



Afghanistan © Kate Holt/CARE



Enhancing the quality of basic education

The quality of education is the key to student retention and achievement, as well as to continued community involvement and ownership of the school system.

In **Timor-Leste**, CARE developed an essential classroom resource in the form of a set of magazines called Lafaek (meaning 'crocodile' in Tetun). Lafaek was the only educational material published in Tetun, the country's national language. The magazine covered topics ranging from geography, language, health, culture and science to issues such as peace, international affairs and women's rights. Lafaek provided children a forum in which to voice their opinions and submit their own original stories and artwork. The magazine took three forms: Lafaek (for grades five to nine), Lafaek Prima (for grades three and four) and Lafaek Junior (for grades one and two). The Lafaek team also produced Lafaek Educator, a professional magazine distributed to 8,000 teachers. The magazines were produced in partnership with the Ministry of Education and Culture and have become part of the national primary curriculum.

Five times a year between 2004 and 2009, CARE distributed 327,000 copies, reaching over 280,000 students nationwide. Throughout Timor-Leste, every class and teacher in grades one to nine received issues of Lafaek from 2005 to 2009 thanks to an exceptional distribution network including field officers on motorbike and horseback reaching the remotest of regions. Ninety-six per cent of teachers attested to the importance and popularity of the Lafaek magazines and reported using them to teach, emphasising that they were the only locally created, locally relevant, consistent curriculum support – and the only educational materials 'that work'; 99% stated that Lafaek supported children's learning in basic literacy, languages, natural and social sciences, health, geography, history and civic education. Eighty-six per cent of teachers used Lafaek Educator for lesson plans, curriculum content, ideas for activities and their own professional development. As for the children, 91% in grades five to nine said they were learning from Lafaek and the younger children agreed that they also benefited and learned from the magazine; and 79% said they also used the magazines at home. Parents were equally enthusiastic, saying that the magazine helped them to increase their knowledge and to have a better grasp of what their children were learning.

Over 85% of women involved in Mother Support Groups in Timor-Leste changed their behaviour to enhance their children's wellbeing in the areas of health and protection, and 50% encouraged their children to attend school, and were more willing to listen to what their children had to say.

Reduce cultural and economic barriers to children's education

In **India**, CARE's work in girls' education was especially successful in engaging out-of-school adolescent girls aged from 10 to 14 years, giving them the chance to complete an accelerated primary education in less than a year at Udaan (meaning 'to soar') residential camps. Each year 100 girls enrolled, of whom 98% stayed the full year. About 95% graduated by passing the government fifth-grade examination, 80% continued formal education in grade six and some 30% of the initial class completed grade 12. To date 1,200 girls have been educated through Udaan. This extraordinary success led the Indian Government to seek CARE's input in the Kasturba Gandhi Balika Vidyalaya (KGBV) program, which offers boarding-school education for minority and/or scheduled caste (Dalit) adolescents from communities where female illiteracy is especially high. CARE's contributions included a bridging semester to prepare the newcomers to succeed academically and socially, and innovative curriculum elements – tested in Udaan camps – that developed skills and challenged girls to re-imagine themselves and their position in society. Udaan camps and KGBV schools continue to be extremely successful. The KGBV model both cuts dropout rates and reduces the gender gaps in learning and measurable skills attainment.

Udaan and KGBV graduates emerge with an expanded vision of their future, the options available to them, and their right to make choices about their relationships, livelihoods and reproductive health. CARE's education program in India has reached more than 700,000 children.

In **Timor-Leste**, CARE worked with children, teachers and mothers' groups to promote knowledge, understanding and protection of children's rights. Seventy-one per cent of participating children, could name and discuss least at least two rights, including a child's right to education and to play. One thousand primary teachers were better able to identify, facilitate and provide guidance regarding children's rights and welfare, with 86% reporting that they conducted classroom activities on children's rights and 92% saying that they had observed positive changes in their teaching methods, with less reliance on punishment. Over 85% of women involved in Mother Support Groups changed their behaviour to enhance their children's wellbeing in the areas of health and protection, and 50% encouraged their children to attend school, and were more willing to listen to what their children had to say. CARE's activities had an impact on women's ability to communicate on these topics, with 72% of the respondents saying that they sometimes or often discussed children's rights with their friends, family and neighbours.



Timor-Leste © Jane Dempster/CARE

CASE STUDY

Reaching ethnic minorities through innovative education programs

Being unable to attend school is not the only obstacle for children living in poverty. Khmer – Cambodia's national language – is the only language of instruction in public schools, but few speak or understand it in the north-east provinces. 'We had a school, but no teachers came to teach here, so nobody could read or write. All the children worked on the farm', explains a grade five teacher in the indigenous village of Lung Khung, where the local language is Tampuan.

One of the first to enrol in CARE's teacher training program, 22-year-old Tving Sen is bringing bilingual education to the indigenous children of Cambodia for the first time. 'The Tampuan children cannot speak the Khmer language, but they can learn it and then learn to read and write in the national language.

It is very important for the Tampuan minority. Now they can write in Khmer, and some children go on to secondary school, which is a big change for them. I hope all children in my village finish the community school and go to high school. After that, they can get a good job', he said. Commencing from 2002, CARE established six community-run schools for 280 children in Ratanakiri so they could begin learning in their own language, with Khmer introduced over three years, so that it eventually becomes the sole language of instruction.

Despite initial scepticism regarding the educational potential of ethnic minorities, the government adopted the approach in 40 state schools in five provinces in the north-east and two new indigenous languages have been

added. The model is now part of the country's formal education system. With the help of local communities and teachers, CARE developed bilingual teaching materials and also provided a number of scholarships and other support to enable rural children to attend secondary school. Scholarships provide the support needed for children from rural areas to study and stay in boarding houses based in secondary schools.

Sophal won a scholarship and stays in a boarding house. She is determined to study to help her community. Instead of travelling hours to and from school, and spending what little time she has at home doing chores, she reads and studies alongside her peers after class. 'When I finish school, I would like to be a teacher in my village', she says, beaming.

CHAPTER 7: HEALTH

Health promotion is a critical part of CARE's work to help people overcome poverty. CARE promotes healthy practices, enables communities to prevent and manage health risks and supports health systems, particularly at the community and first-line facility levels, in providing sustainable, quality and affordable health services. CARE works to foster health-related improvements at multiple levels, from the individual to national policy.

CARE's health programs focus on reproductive and maternal health (MDG5), child health (MDG4), halting the spread of HIV and AIDS, malaria and other major diseases, and providing access to treatment for those who need it (MDG6). CARE is committed to helping individuals and communities become informed and organised in demanding decent health services, and working with them to address social and cultural practices that hinder good health.

CARE recognises the right of every mother to experience a safe and healthy pregnancy and delivery. Maternal health is fundamental to overcoming poverty and injustice: a healthy mother is more likely to earn an income, raise healthier children and be involved in public life. Although global maternal mortality rates (MMR) are generally improving, this remains the most challenging of all the MDGs. Whilst Asia overall has reduced the MMR by 61% between 1990 and 2010, South Asia still accounts for almost 30% of all deaths in pregnancy and childbirth.⁴⁸ Maternal deaths are both caused by and cause poverty. Poverty is widespread and persistent throughout Asia, and is strongly associated with living in remote rural areas or being from a marginalised ethnic group or caste. The prevention of maternal deaths very much depends on pregnancy and birth being attended by skilled health personnel, effective referral systems and access to emergency obstetric care.

There is a clear link between the health of the mother and that of her newborn child – for instance, women who are malnourished, anaemic or suffer malaria or other major diseases, who have had multiple pregnancies or are not fully adult themselves – are more likely to experience one or more complications and to produce underweight babies, who are more fragile. Interventions to reduce MMR therefore address perinatal and infant mortality. Other factors affecting the health of babies and infants include not exclusively breastfeeding for the first six months of life, inadequate complementary feeding practices, lack of access to safe water and sanitation and poor access to health services – or to services that are of a decent standard.

Despite great progress in the adoption of modern methods of family planning over the last several decades, millions of women worldwide are not accessing reliable forms of contraception to help plan their families, space births and prevent unplanned pregnancies. The need for family planning services will increase as the number of women and men of reproductive age continues to rise. Rather than increasing to keep pace with population growth, however, funding for family planning programs has actually decreased over the past decade. Access to sound information and accessible family planning services can make a major impact on reducing poverty and injustice. When a woman can choose whether and when to have children, she is likely to have fewer, healthier, better educated children, and she is far less likely to die or experience the debilitating consequences of multiple pregnancies. In fact, an analysis of data from 1990 to 2005 suggests that more than 1 million maternal deaths were averted by increased use of contraception.⁴⁹

CARE understands that offering access to good quality family planning information and services is not sufficient in itself to enable women to overcome poverty – programs must also address the wider social and cultural issues affecting women's empowerment and gender equality. Inequitable gender and social norms that accord women little decision-making power within their families, or a woman's fear of social disapproval or her partner's or mother-in-law's opposition to family planning may prevent women from using any contraception. A woman may be concerned about negative health or other side-effects, or perhaps not know about or understand the available options. CARE works to increase access to and use of high-quality family planning information and services by women and men, through an integrated approach that includes understanding – and addressing – underlying causes of poor reproductive health. CARE also works to strengthen health systems and collaborate with governments and other partners to ensure that the most vulnerable women can better plan their lives, be more productive and participate more fully and equally in society.



In terms of MDG6, new HIV infections are declining worldwide, although in East Asia the rate remained relatively unchanged between 2001 and 2009.⁵⁰ The use of condoms by youth and rural people who engage in high-risk sexual activity is still relatively low however, and young women and rural youth are even less likely to know that using a condom can reduce the chances of HIV infection.

The risk of future pandemics in Asia lies not only in its large population and migration patterns and its concentration in mega-cities but also in the close contact between animal and human populations, which facilitates the emergence of zoonotic diseases (infectious diseases

that can be transmitted from animals to human beings). CARE recognises the need to make the concept of disaster risk reduction (DRR) more explicit in relation to reducing the vulnerability of the poorest to a range of health-related threats, including HIV and AIDS and potential pandemics such as avian influenza (bird flu). CARE's strategy is to build communities' capacity to prepare for, respond to and mitigate risk. In the case of avian influenza or similar outbreaks, this means addressing poor living conditions, poor hygiene, inadequate sanitation and lack of early-warning systems, all of which can accelerate the spread of viruses.

CARE'S PROGRAM IMPACT

During the study period CARE reached over an estimated 10 million people through initiatives focused on improving access to health services as well as strengthening the quality of these services.

HIGHLIGHTS OF CARE'S CONTRIBUTION INCLUDE:

Improving immunisation rates for children by an average of 51% in target communities in Cambodia, India and Nepal.

Helping to double the proportion of births delivered by trained attendants in target communities in Cambodia, India and Nepal, exceeding by about 30% the national average in Cambodia and India.

Helping to more than double the number of women who attended two or more antenatal check-ups in target communities in Cambodia and Nepal, in both cases significantly exceeding the national average.

Improving access to and supply of safe drinking water for households by an average of 30% in target communities in Bangladesh, Cambodia, Myanmar and Nepal.

Improving sanitation facilities for almost 2.3 million people in Bangladesh, Myanmar, Nepal, PNG, Sri Lanka, Timor-Leste and Vietnam.

Increasing knowledge of how to prevent the sexual transmission of HIV and AIDS among almost 700,000 people in India, Nepal, Thailand and Vietnam.

Improving women's access to contraception and ensuring informed decisions about which method to use in target communities in Cambodia, India and Nepal where women's use of contraception increased by an average of 22%.

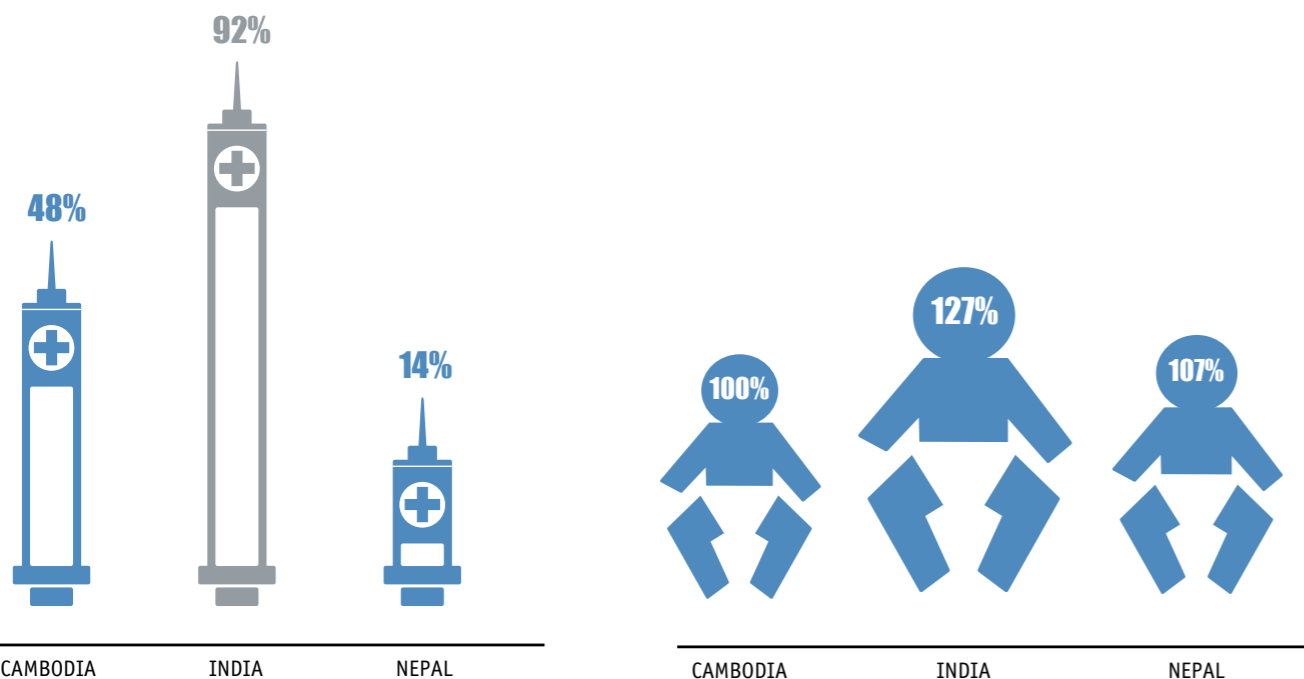


Figure 16: Average improvement in immunisation rates for target communities in selected countries

Figure 17: Percentage increase in deliveries attended by trained personnel for target communities in selected countries

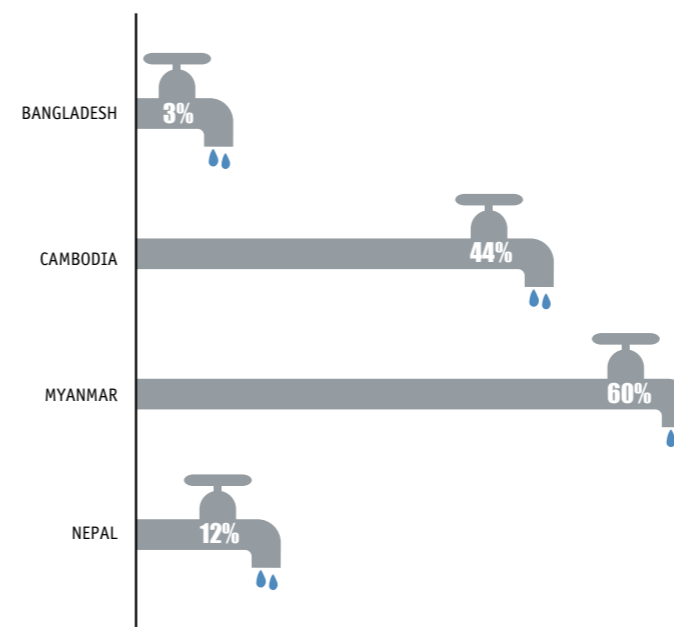


Figure 18: Percentage increase in access to and supply of safe drinking water for target communities in selected countries. (Note: the smallest change occurred in Bangladesh, where the majority [97%] of households already had access to safe water at baseline)

The following section provides selected examples to illustrate CARE's contribution to improving access to and quality of health care services and key strategies for achieving this impact.

Improve maternal health

For women who live in remote, rural areas, being able to recognise danger signs and reach a skilled birth attendant in time can mean the difference between life and death in pregnancy, and during and immediately after giving birth.

In **Bangladesh**, CARE helped establish a Community Support System (CmSS) to increase knowledge about and use of maternal health care and to facilitate transport and access to emergency obstetric services for women with complications in pregnancy or childbirth. Communities formed CmSS groups to monitor women during their pregnancy, help women and others in their family to make preparations, support the provision of antenatal care (ANC) and skilled birth attendance, and collect small amounts of money to pay for emergency transport and care if needed. Approximately 330 CmSS groups were established in the Narshingdi district. Women in CmSS areas were significantly more likely (76%) to attend ANC appointments than women in non-CmSS areas (49%). CARE's program had the greatest impact among the poorest women: whereas in a nearby area, the wealthiest 20% were more than twice as likely as the poorest 20% to receive ANC, in the CmSS area there was no difference across the economic spectrum. In CmSS areas, 97% of women knew about two or more danger signs during pregnancy and childbirth compared to 79% in non-project areas. Pregnant women in CmSS areas were also better prepared for the

birth of their child: 55% made three or more arrangements (e.g. deciding where to give birth, saving money for an emergency, identifying transport) versus 14% of women in non-project areas. In total 125,600 women were supported by this program. The government of Bangladesh decided to scale up CmSS nationwide in association with a network of over 13,500 community clinics, and in July 2011, signed a Memorandum of Understanding (MoU) with CARE to provide support for that process.

Antenatal Care

Although there has been an overall increase in the number of women receiving ANC and skilled birth attendance, marginalised populations and ethnic or religious minority communities still lack access to adequate care.

In the province of Koh Kong in **Cambodia**, before CARE's program, 42% of women received no ANC and 71% of deliveries took place at home. Moreover, 70% of women reported at least one problem in obtaining access to health care and rural women were twice as likely as women living in cities to have problems related to distance and transport. Following CARE's work to strengthen the capacity and knowledge of health professionals at government clinics, as well as strengthening community-based organisations (CBOs) and emergency-referral systems, such as village health volunteers and village support groups, 80% of pregnant women had two or more ANC visits, resulting in safer pregnancies.

In **Nepal**, as part of the decentralisation of public services, CARE supported the transfer of the management of 39 health facilities in Chitwan District to Village Development Committees (VDCs) and supported participatory local governance through Health Facility Operations and Management Committees that included local women and Dalit representatives. By increasing community participation and the accountability of service providers, poor, vulnerable and socially excluded communities had better access to maternal health care, enabling 66% of pregnant women to receive at least four ANC visits.

Postnatal Care

Given the high rate of newborn deaths, and of women who die from complications after giving birth, postnatal care is just as important as antenatal care.

In **Afghanistan**, as a result of CARE's training and support on maternal health, 78,500 women and their family members demonstrated better knowledge of danger signs during pregnancy, childbirth and the postpartum period, and among newborns. They also knew where the health facilities were and what types of service they provided. Mothers whose babies were born by Caesarean section learned how to prepare for the next pregnancy. Furthermore, CARE ensured that 85% of mothers diagnosed with postnatal depression received proper counselling.

In **Nepal**, CARE's worked to strengthen the capacity of community health volunteers (CHVs) with the result that in target communities there was an increase from 6% to 27% in the proportion of women who received postnatal care from health workers and female CHVs within 72 hours of delivery. CARE also increased awareness among 8,630 married adolescents of the need for at least four ANC visits during pregnancy.

In **Pakistan**, CARE worked to address sexual and reproductive health needs and rights in 60 villages, reaching about 50,460 villagers, mainly women and youth. This resulted in a significant increase in the use of public health facilities. Ninety-four per cent of women received antenatal check-ups during their last pregnancy, 32% higher than before the project started. The percentage of home births dropped from 57% to 41%, with a strong preference for giving birth in the public health facilities. In addition, 17% more women had postnatal check-ups compared to before the project. Male attitudes to women's use of the facilities also became more positive. By the end of the project, 90% of male respondents said they would allow their wife to go to the health facilities in an emergency, accompanied by any family member, compared to 56% previously. Knowledge of contraceptive methods also improved: by the end of the project, over 97% of female respondents knew about oral pills and depo-provera injections while 95% knew about the intra-uterine contraceptive device or coil, and 80% knew about condoms and 61% about natural methods.

Universal Access To Reproductive Health

In **India**, the state of Uttar Pradesh accounts for a large percentage of newborn and maternal mortality. The state also ranks below the national average on many indicators of gender-based inequality and women's empowerment, such as women's mobility, autonomy of decisions and control over household resources. Men and women who participated in a CARE project using gender-transformative approaches to health promotion reported greater gender equality at home, with 15% more women reporting an increased role in decision-making and husbands undertaking household chores. Men living in nuclear families said that they took on the task of fetching water and carrying cattle feed while their wife was pregnant. Several mentioned that they had accompanied their wife to the health facility at least once as a part of her antenatal and postnatal care. Moreover, 20% more women reported being able to go out alone, 42% more women felt able to express their physical or sexual wishes and 58% more women felt able to refuse sex. The project resulted in a 34% increase in the number of families using contraception. Compared with a neighbouring district where there was no 'gender transformative' program, there also was a significant increase in women who reported planning for childbirth and being attended by a skilled health worker.

In the northern states of **India**, there is a 25% unmet need for family planning, and sterilisation accounts for around 90% of contraceptive methods used. Against this backdrop, CARE's family planning interventions focused on birth-spacing methods such as condoms and oral contraceptive pills and improving access to and the availability of contraceptives at the community level. The focus was on strengthening contacts and counselling for couples and on making contraceptives more available through supporting free supplies and social marketing. As a result of CARE's activities there was an increase of 5% in the contraceptive prevalence rate for spacing methods over a three-year period (2003–06) in the four high-fertility states of Chhattisgarh, Jharkhand, Rajasthan and Uttar Pradesh.⁵¹

Child health

Reduce Infant And Child Mortality

Each year approximately 1 million newborns die within the first month of life because of largely preventable severe infections. Neonatal deaths account for about 40% of mortality among children who die before the age of five. The provision of good ANC, skilled birth attendance and essential newborn care (including clean cutting of the umbilical cord,



management of breathing complications, ensuring the baby stays warm and early breastfeeding) can reduce deaths. Improved hygiene, reduced exposure to life-threatening bacterial infections particularly in the first week of life, and medical care for sick infants are also critical in saving lives.

In **Asia**, child deaths tend to occur at home or in the community, not at a health facility. This is why CARE and its partners focused on supporting the community-based application of integrated management of newborn and childhood illnesses, an approach that helps improve family and community health and nutrition practices and facilitates the early detection and appropriate management in the community or facility of major childhood conditions including malaria, acute respiratory infections, diarrhoea and severe malnutrition.

In **India**, CARE focused on improving childbirth practices, particularly on proper cutting of the umbilical cord in order to prevent infection, not bathing the newborn immediately, early and exclusive breastfeeding and the avoidance of pre-lacteal products. There was a 30% rise in the hygienic treatment of the umbilical cord, a 15% increase in the proportion of parents who waited before bathing the baby for the first time, and a 50% reduction in the use of pre-lacteals.

In **Indonesia**, CARE focused on improving village-level health and nutrition services in low-income communities where many children are malnourished. The main strategy was to form mothers' groups to advise women about optimal infant and young child feeding, with women from the community whose children were healthy and well-nourished demonstrating successful strategies ('Positive Deviance'). Almost 2,000 pregnant and breastfeeding women enrolled in one of 80 Centres of Mother Education (COME) established by CARE. Group members learned about the importance of early and exclusive breastfeeding and applied that knowledge, as demonstrated by an increase from 13% to 53% in the proportion of participants who began breastfeeding their baby within one hour of birth. Rates of exclusive breastfeeding for six months also increased from 9% to 22%. In three years, the project succeeded in reducing the incidence of chronic malnutrition among young children, from 32% to 28%. CARE developed a strong collaborative relationship with the Tangerang District Department of Health, which is now planning to adopt and scale up some of CARE's models and approaches, using modules and training from CARE.

Immunisation

Effective immunisation programs can dramatically improve children's health and prevent killer diseases such as measles. Vitamin A supplements are important as deficiency exposes small children to an increased risk of severe infectious illnesses, such as measles and diarrhoea.

CARE supported immunisation and vitamin A supplementation programs across several countries in **Asia**. In **Cambodia**, there was a 27% increase in the proportion of infants in target communities fully immunised at 11 months, and the number of under-fives who received vitamin A supplements tripled since the CARE project began.

In **India**, CARE strengthened immunisation services and introduced Village Health and Nutrition Days providing monthly outreach sessions for immunisations, maternal health care and growth monitoring and nutrition education. In areas where CARE supported improved service delivery, the percentage of children aged between 12 and 23 months who received the measles vaccine rose from 37% to 71%. There was also a fivefold increase in the percentage of children between 18 and 23 months who received at least two doses of vitamin A, exceeding the national average by 10%.

HIV and AIDS

CARE works with vulnerable communities to raise awareness and promote changes in behaviour to prevent communicable diseases, reduce the negative social and economic effects of disease, and protect the rights of people who are stigmatised such as those living with HIV and AIDS.

In **Bangladesh**, CARE worked to reduce the risks of HIV infection and AIDS and helped to contain the epidemic through advocacy at the national and local level. CARE focused on reducing the spread of HIV among at-risk populations (primarily intravenous drug users), developing the knowledge and skills of 60 NGOs and CBOs in HIV prevention and providing technical support for the development of a National HIV Policy and Strategy. CARE provided information about behaviour change and harm-reduction advocacy for injecting drug users for policy-makers and funding agencies. As a result, a Best

Practices Training Manual in the Needle Syringe Exchange Program (NSEP) was developed and used by policy-makers on issues of harm reduction in the HIV program. The Manual was supported by the United Nations Office on Drugs and Crime (UNODC) and adopted at national and local levels, serving as an important resource for similar interventions.

In **Thailand**, CARE focused on groups most vulnerable to HIV and AIDS infection such as migrant workers, intravenous drug users and sex workers. The program reached more than 400,000 migrant workers, providing education on prevention, voluntary counselling and testing, and treatment of sexually transmitted infections. CARE also worked under a new Thai law that allows NGOs to hire migrant workers, training them as social workers for their communities and as Migrant Health Assistants to provide translation and counselling in hospitals in provinces with significant migrant populations. Condom use more than doubled among migrant workers who engaged in sex with a non-regular partner (from 43% to 90%). Particularly encouraging was the reduction of HIV prevalence among migrant factory workers in Chiang Mai and Tak in Thailand from 6% to 2%.

In **India**, CARE worked with sex workers, establishing and strengthening CBOs, which served as a focus for education and empowerment. Group members engaged in peer education and support, building capacity and confidence to access services and engage in collective action to reduce exposure to violence and intimidation by clients or the police. CBO participants were much more likely than non-participants to report always using a condom with clients (97% as opposed to 72%); being tested for HIV (80% as opposed to 40%); and having the confidence to manage clients and the police.

Malaria

Malaria is prevalent in **Timor-Leste**, which has a high social and economic cost both for the people and for the country. There is little understanding of the danger and the impact of malaria and only limited proactive prevention, health-seeking behaviour and treatment. To address this, CARE worked with the Ministry of Health (MoH) to develop tools for implementing its behaviour change communication (BCC) strategy. These included a flipchart about malaria developed by CARE in collaboration with the health promotion and malaria unit in the MoH, and community health volunteers and district-level MoH staff training on how to use it. CARE also supervised community campaigns on environmental health clean-ups to reduce mosquito breeding sites.

These campaigns included training about malaria and environmental health for communities and schools, community walks to observe breeding sites, problem-identification and consensus-building on a plan of action for each community, and environmental health clean-up days. As a result, 97% of pregnant women, 92% of breastfeeding women and 91% of children under the age of five who participated in the training sessions used an insecticide-treated bed net. More than 42,000 such nets were distributed through health facilities across three districts, which encouraged women to attend clinics, receive ANC and have their children vaccinated, and promoted sustainability by making the distribution of bed nets a routine part of MoH activities.

CASE STUDY

Maternal and neonatal health – couple communication brings change

Meeta, who lives in a small village in Uttar Pradesh, India did not realise that her married life could turn out so differently within the space of two years. At the time CARE started working in Meeta's village, Meeta had a one-year-old daughter and was expecting her second child. She had become pregnant a few months after she got married, and her second pregnancy had followed only four months after the birth of her daughter. Both times she felt it had happened too soon but had no one with whom she could talk about it.

She overworked to make ends meet, and was weak despite taking tetanus injections and receiving nutrition supplements. Rashmi, one of CARE's fieldworkers, spoke to Meeta and her mother-in-law about the need for rest and support. The mother-in-law said that when she was young she had worked to feed 15 members of her family, while Meeta had only four to cater for. Rashmi immediately realised that she needed to talk with Meeta's husband, Ramkishore, who worked as a wage labourer or was jobless and stayed at home.

Meeta and Ramkishore were motivated to participate in the meeting for couples where the question of women's needs during pregnancy and following childbirth was discussed. During the meeting, issues related to pregnancy and care were addressed, including how the couple felt when they first knew they were expecting a baby. It touched topics of how couples can express their feelings about the arrival of a new baby, changes in a woman's body during pregnancy, sex during pregnancy and respecting women's feelings. This discussion introduced Ramkishore to new ideas: 'I did not know that with the physical changes during pregnancy a woman also goes through such emotional changes and I know about her nutrition needs, need for sharing workload and good environment at home'.

Ramkishore promised to not only help out at home, but also to convince other men to do so. He became active in organising the community media shows like puppet shows, community theatre and film shows for addressing issues of social change. He became a positive role model

and never hesitated to discuss the changes he had undergone in a public forum. Ramkishore also revealed that his mother was very reluctant about him helping to bath his daughter and working in the kitchen with his wife. He was able to convince her this was not shameful and that she should feel good that her son is enjoying the little things he does at home, which has ultimately made for a happier family environment.

His wife Meeta said her life had changed. Although she was still the first one to get up, she now had help with care for her daughter and the household chores. They cook together, eat together and go out for work together. She is also able to go out on her own and makes her own decisions.

CARE checked on Meeta two years after the end of the program – she had two children, the second of whom was born in a health facility. She exclusively breastfed the new baby, was using contraception and was living a happy and healthy life.

REGIONAL CASE STUDY

Combating avian influenza

In 2003, the Highly Pathogenic Avian Influenza, commonly known as bird flu, captured global attention when more than 100 cases occurred in human beings with a case-fatality rate of over 30%. In many Asian countries, outbreaks of the virus initially affected poultry, and spread to farmers and others who had come into contact with infected chickens, ducks, geese and other birds. In 2006, when more than 76% of confirmed cases of human infection were in South-East Asia, CARE began a four-year program, funded by AusAID, to pilot models and approaches for strengthening community-based recognition, control and prevention of the virus in communities in **Cambodia, Laos, Myanmar and Vietnam**. This example shows a regional response by CARE to a cross-border health threat.

The program

CARE supported local organisations to pilot community models aligned with national strategies and international frameworks that sought to raise community awareness, teach small-scale poultry farmers about how to reduce risk for their flocks and themselves, improve hygiene in wet markets and slaughterhouses, and establish community-based early detection and response systems. Lessons from pilots were documented and successful models were disseminated among CARE's partner organisations throughout the region to influence their policy and approach to conducting community-level activities.

PROGRAM IMPACT

A total of 12 community-based models were piloted in Cambodia, Laos, Myanmar and Vietnam. Nine achieved sustained behavioural change and evaluations – internal and external – judged them to be worthy of replication. There were three key areas of impact.

1 Positive behavioural change in target communities:

- Improved response capacity of local authorities, with outbreaks contained following early detection and response by program-trained community workers (Laos, Myanmar)
- Compliance by traders and farmers with pilot-led hygienic and bio-security practices (Cambodia, Laos, Myanmar)
- of extension workers who received community awareness training, 80% went on to conduct health education sessions in their communities (Myanmar)
- Community surveillance systems were used in the response to the 2009 outbreak of the H1N1 virus (so-called 'swine flu') (Cambodia, Laos), showing that lessons had been assimilated and could be applied to a different situation.

2 Partners adopted and replicated successful models using their own resources:

- Community surveillance model was adopted in four communes (Vietnam)
- Laos Health Ministry adopted the Healthy Markets guidelines and conducted training in four provinces
- Markets model adopted in two provinces (WHO and Hygiene Department, Laos) and the slaughterhouse model in 10 provinces (Livestock Department and World Bank, Laos)
- Avian Influenza package training occurred in six districts (UNICEF, Laos).

3 Program outputs influenced partners' own policies and plans:

- Laos Health Ministry adopted National Healthy Markets guidelines
- Bio-secure farming model included in socio-economic development plans (Vietnam)
- Behaviour Change Communication Strategic Frameworks developed for each province (Vietnam).

How sustainable was this impact?

The completion and transfer of community-based models to partner organisations was a major achievement. The program was also praised for its success in maximising opportunities for regional learning. The lessons shared benefited the piloting of specific models – for home-based poultry farming and community-based surveillance in particular – and also influenced the way in which national partner organisations approach these issues. In Vietnam, local authorities now fund public outreach activities (newspaper, TV and radio spots) and workshops to promote bio-secure farming, while in Cambodia and Laos household visits and awareness activities continue to be conducted and monitored using local resources. Slaughterhouse and markets models are being expanded by government agencies in Laos, with donor support. In all of the countries, volunteer-based surveillance structures show strong signs of ownership and commitment by the volunteers themselves and recognition by communities.



Between July 2005 and December 2010, CARE responded to over 45 emergencies in 17 countries across the region, which affected more than 100 million people.

CHAPTER 8: EMERGENCY RESPONSE AND DISASTER RISK REDUCTION

The Asia-Pacific is the world's most disaster-prone region.⁵² Natural disasters cause more deaths and damage each year than in any other single area, in part because of the number of people who live in precarious conditions or are otherwise vulnerable.

CARE has worked in the Asia-Pacific region for over 65 years, and has a long-term presence in many of Asia's poorest and most disaster-prone countries. Its comprehensive three-pronged approach to emergency response involves:

- 1 **Disaster risk reduction (DRR)**, working with communities to prepare for and mitigate the impact of disasters.
- 2 **Partnering** with local groups to provide immediate assistance when a crisis hits.
- 3 **Assisting** survivors in their post-crisis recovery.

Between July 2005 and December 2010, CARE responded to over 45 emergencies in 17 countries across the region, which affected more than 100 million people. Examples of emergencies to which CARE responded include:

- Earthquakes (Afghanistan, Indonesia and Pakistan)
- Cyclones, tropical storms and typhoons (Bangladesh, Cambodia, India, Laos, Myanmar, Papua New Guinea, Pakistan, the Philippines, Sri Lanka and Vietnam)
- Floods (Bangladesh, India, Indonesia, Nepal, Pakistan, Papua New Guinea, Thailand and Vietnam)
- Cold wave (Tajikistan)
- Volcanic eruption (Indonesia)
- Conflicts (Afghanistan, Pakistan, Sri Lanka and Timor-Leste)
- Rodent infestation (Laos)
- Tsunami (India, Indonesia, Sri Lanka and Thailand).

CARE gave emergency relief to over **4.3 million people**, providing shelter, water and sanitation, food and health support, along with measures to reduce vulnerability to future disasters linked to ongoing development programs.



Measuring the impact of emergency and humanitarian assistance

In 2010, CARE began to pilot a Humanitarian Accountability Framework (HAF)⁵³ to integrate its emergency work with existing quality and accountability commitments, including both its internal programming principles and compliance with inter-agency standards such as Sphere. For example, CARE is part of the Emergency Capacity Building (ECB) project that produced a Good Enough Guide⁵⁴ on impact measurement and accountability in rapid-onset emergencies. This uses a livelihoods approach to measuring 'contributions to change', while at the same time acknowledging the efforts and coping mechanisms already used by local populations.

Central to these standards is a commitment by humanitarian organisations to being accountable for the quality of their response by ensuring that affected populations have a say in planning, implementing and judging

their work. To ensure this is happening in practice, and to use the experience to improve future performance, CARE currently measures the impact of its humanitarian assistance through a series of monitoring activities, After Action Reviews (AARs) and external evaluations.

This is not to suggest that measuring the impact of humanitarian assistance is simple. Challenges include the lack of baseline data, problems of attribution and donors' emphasis on real-time reporting and evaluation. Moreover, since DRR aims to avert negative change and build up resilience to future disasters, it is difficult to measure with any certainty what might have happened in the absence of an intervention.

When emergencies strike: CARE's emergency response

Of the many emergencies to which CARE responded in the Asia region, four stand out for their magnitude and significance: the Indian Ocean tsunami (December 2004)⁵⁵, the Pakistan earthquake (October 2005), cyclone Sidr in Bangladesh (November 2007), and cyclone Nargis in Myanmar (May 2008). CARE responded with lifesaving relief and recovery operations reaching over 2.8 million people, of whom more than 75% were women and children.

Indian Ocean tsunami

The Indian Ocean tsunami of 26 December 2004 was triggered by one of the most powerful earthquakes ever recorded. It affected more than 12 countries, an estimated 250,000 people died and millions were left homeless. Some coastal villages in Indonesia lost around 70% of the population. The debris from fishing boats, businesses and homes was strewn across thousands of kilometres of shoreline, and millions of people were left to reconstruct their lives after having lost everything.

CARE was among the leading organisations in responding to the tsunami, and continued to work with affected communities over the next five years, reconstructing homes and livelihoods and promoting socio-economic development while striving to improve the resilience of the affected communities to future disasters. In India, for example, CARE coordinated with local NGOs and government to establish community-based disaster planning in 60 communities that were vulnerable to natural hazards. Efforts included promoting grain banks and emergency funds and securing government and community support to develop infrastructure. The 65,000 people who live in these communities are now better informed and have more resources to prevent and mitigate the effects of future emergencies.

CARE was able to build on its long-term presence and existing relationships in the affected countries – in particular, India, Indonesia, Sri Lanka and Thailand – making it possible to respond quickly and to reach some of the most vulnerable, marginalised and worst-hit communities.

CARE provided emergency humanitarian and recovery assistance from the immediate onset until 2009 to over 1,205,000 affected people in India, Indonesia, Thailand and Sri Lanka.

Impact: Examples of impact from evaluations undertaken during the emergency response phase help to shape forward programming. A joint evaluation undertaken in 2005 during the emergency response in Indonesia and Thailand noted that control of diarrhoea is one of the most critical factors for reducing malnutrition in the aftermath of a disaster. While the 31% incidence of diarrhoea initially doubled with the distribution of milk powder combined with unsafe water, the CARE program which provided safe water supplies, toilets with septic systems, Vitamin A capsules, and micro-nutrient sprinkles contributed significantly to its reduction. CARE's diarrhoea monitoring program was particularly commended, given its relevance to especially vulnerable young children.

The evaluation also found that community members said that livelihood recovery was their highest priority and lack of money their greatest problem. The evaluation noted that although 'the various initiatives involving cash-for-work – mostly environmental clean-up and road repairs – have been extremely useful for the communities, they have not made

a large contribution to personal recovery. The work is not seen as "real work", and provides no security for the future, as most projects lasted a month or less'. Findings like this helped to shape further responses towards more comprehensive approaches to livelihood recovery and development as the program evolved.

Pakistan earthquake

On 8 October 2005, an earthquake measuring 7.6 on the Richter Scale rocked northern Pakistan, causing an estimated 87,000 deaths and significant destruction of and damage to houses and infrastructure. The earthquake affected some 4 million people in Azad Jammu and Kashmir and North-West Frontier Province. Working closely with local partners, government agencies and affected communities, CARE provided support and the basic supplies needed to survive the freezing winter months (known as 'winterisation' support). This included the distribution of tents, blankets, plastic sheeting, hygiene kits and water purification packets to 75,000 people, and winterisation packages for 50,000 people in the Allai Valley.



Pakistan © Warrick Page/CARE

CARE later helped to rebuild infrastructure and livelihoods and assisted people in regaining a sense of normality. During the reconstruction and rehabilitation phase, CARE focused on providing earthquake-proof housing as well as safe shelter for those who had been displaced. People living in affected communities were enrolled in cash-for-work (CFW) programs to rebuild damaged infrastructure, such as roads, culverts, bridges, community centres and schools. In affected villages, CARE helped to repair water systems, and established community-based health clinics and safe temporary schools.

CARE's relief and recovery work following the Pakistan earthquake built on existing local capacities and focused on sustainability and greater resilience to future earthquakes.

CARE provided immediate shelter, winterisation assistance and support for longer-term recovery initiatives for 250,000 people affected by the Pakistan earthquake.

Impact: An independent evaluation of CARE's response found that the winterisation program appeared to have contributed to arresting permanent migration to the lowlands, which could have meant that villages in the valley would no longer have been able to support the remaining residents.

Although the goal was to save lives and livelihoods, the impact was to maintain the occupation and development of the area, in line with CARE's long-term commitment. The winterisation process also maintained community health: while this cannot be quantified, despite evidence of respiratory infection there was no significant increase in mortality or morbidity.

CARE's winterisation program enabled people to continue to regard the valley as their home as the risk was that large-scale disaster-related exodus, particularly of the men would trigger a loss of confidence in the long-term habitability of Allai. In fact the population is now thought to be higher than before the earthquake.

Cyclone Sidr in Bangladesh

On 15 November 2007, cyclone Sidr ravaged the south-west coast of Bangladesh. High winds and flooding caused extensive damage to housing and public infrastructure. Drinking water was contaminated by debris and saline water from the storm surge, and sanitation facilities were destroyed. Sidr killed over 3,400 people and affected over 11.5 million people, 1 million of them severely.

CARE provided emergency food and non-food items and hygiene education, repaired and constructed water supply and sanitation facilities and provided cash-for-work (CFW) in parts of Barguna and Bagerhat districts. In the immediate aftermath 336,260 people received food aid and over 285,000 received other relief items. CARE provided safe water to over 150,000 people and medical care to more than 63,500. When CARE shifted from immediate relief to recovery activities, it provided food packages to almost 462,000 people and other relief items to over 137,000. In all, CARE reached about 134,000 cyclone-affected people in Barguna and almost 111,300 in Bagerhat.

The worst-hit communities received relief and recovery assistance from various sources. The rapid response from CARE and others included the provision of safe drinking water and hygiene education, which helped to avert outbreaks of diarrhoeal and water-borne diseases. In addition to distributing food and basic shelter materials, CARE placed complaints boxes in the distribution centres and invited affected communities to provide feedback.

CARE assisted almost 1,140,000 people affected by cyclone Sidr in Bangladesh.

Impact: The 2008 CARE Bangladesh cyclone Sidr evaluation reported several positive impacts, including averting epidemics of diarrhoea and water-borne illnesses that often follow such a disaster. The reasons for the limited outbreak of such diseases are due in part to the efforts to provide safe water quickly, combined with rapid distribution of relief food and basic shelter materials.



Before emergencies strike: disaster risk reduction

A major emergency can wipe out the hard-won development gains made by poor, vulnerable communities. Good planning and preparedness can save lives, reduce the impact of disasters and help people to recover more quickly. By incorporating disaster risk reduction (DRR) methods and emergency preparedness plans into long-term development programs, CARE supports people to develop sustainable coping mechanisms and strengthen community resilience to prepare for and respond to disasters – which may include anything from rapid-onset events such as cyclones and floods to longer-term problems such as droughts and food shortages.

As a low-lying country, **Bangladesh** is vulnerable to seasonal cyclones and storms, which often cause heavy flood damage and loss of life. Effective early-warning systems and shelters are critical in minimising such devastation, and the government was already able to provide 72-hour warning of pending storms. CARE facilitated the introduction of new technology that extended the warning period to 10 days, which allows communities to take pre-emptive action such as early harvesting of crops and aquaculture, and to take measures to protect livestock and other household and community assets and infrastructure. Longer-lead forecasting (of 20 to 25 days and even to six months) is still in the piloting phase, but it is anticipated that improved forecasting developed in Bangladesh may be adopted in other Asian countries, assisted by better regional flood forecasting capacity.

In the **Philippines**, CARE worked with its local partner AADC on community-based DRR activities in Mindanao, part of a broader package linking with the work of partners in three other provinces. The program involved participatory community risk assessments, training and workshops on community-based DRR, disaster preparedness and contingency planning. Other activities included school drills to test the effectiveness of contingency plans, public awareness raising and small-scale mitigation projects. Overall 32,430 people directly benefited from the project, as well as 15 local organisations, 30 civil society organisations (CSOs), 40 corporations and corporate foundations and 14 member agencies of the National Disaster Coordinating Council (NDCC). As a result, communities, schools and local government units in Mindanao have

developed and strengthened capacities in community-based early warning, evacuation and contingency planning. In 2009, the municipality of Maragusan received a NDCC award for best DRR practices.

In **Vanuatu**, CARE contributed to increasing local DRR capacity and strengthening national institutions, in support of the National Action Plan on DRR and Disaster Management. CARE worked with 19 communities across four islands to help them establish and consolidate their own Community Disaster Committees, which resulted in Community Disaster Plans, especially in relation to cyclones and tsunamis. CARE also undertook awareness-raising exercises with communities. Feedback indicated that CARE's work reinforced and strengthened communities' traditional knowledge of how to cope with cyclones and tsunamis. CARE also worked with the National Disaster Management Office to strengthen technical and coordinating capacity, provide training for peer organisations, develop training materials (since adopted by other organisations), and improve coordination by developing a standard DRR glossary.

In **Vietnam**, CARE worked with poor communities in the Mekong Delta to reduce their vulnerability to floods and typhoons, which cannot only destroy homes and essential infrastructure, but also damage crops, fields and livestock. This both impedes people's capacity to recover and intensifies their vulnerability. Mangrove forests planted along the shoreline provide physical protection by slowing down winds and storms before they make landfall, providing a filter system against salinisation and soil erosion, and also provide an environment for aquaculture both for subsistence and as a source of income. CARE therefore supported a community-based mangrove reforestation project across six highly vulnerable coastal villages in Thanh Hoa province, where 1,070 households established a local mangrove management system to plant and maintain 150 hectares. These initial efforts have since expanded and their continued success is attributed to CARE's investment in community participation and training, which ensured the level of ownership and engagement that are critical to long-term sustainability. A total of 30,000 people to date have benefited from better protection from storms and flooding.

Cyclone Nargis in Myanmar

On 3 May 2008, cyclone Nargis hit **Myanmar** with winds of up to 190 kilometres an hour. Yangon and four other zones were badly affected, primarily in the Irrawaddy delta. The cyclone devastated entire towns and villages and affected 2.4 million people. Almost 140,000 people were killed or remain missing.

In addition to immediate emergency relief, CARE's response contributed to the overall disaster-response system in Myanmar.

CARE delivered emergency food assistance to over 183,200 people both in partnership with the World Food Program (WFP) and through direct funding. CARE also distributed over 17,000 tarpaulins, 5,000 family kits and 3,000 toolkits. In the immediate aftermath, CARE provided agricultural support in the form of rice seed, hand tractors, pumps and fuel, so that farmers could recover flooded agricultural land for planting crops.

In an effort to meet minimum transitional shelter needs, CARE used traditional materials such as bamboo. CARE also rehabilitated drinking ponds and cleaned wells.

In addition to this immediate assistance, CARE's emergency response to the effects of cyclone Nargis achieved a sustainable impact by replacing assets. CARE provided durable goods and constructed buildings that could resist harsh climates and natural disasters.

Communities to which CARE delivered food aid consistently said that distribution was regular, that the food was acceptable and of good quality and that it had been critical in preventing serious malnutrition and suffering. Communities also reported that agricultural inputs helped families to engage in seasonal planting.

CARE assisted almost 288,500 people affected by cyclone Nargis in Myanmar.

CARE'S MAJOR EMERGENCY CONTRIBUTIONS IN NUMBERS: AN OVERVIEW

The following figures provide an overview of how CARE's emergency assistance was distributed in the four emergencies described in this chapter.

- **Food:** CARE provided emergency food rations for 1,642,000 people in Bangladesh, Myanmar, Sri Lanka and Indonesia.
- **Shelter:** CARE provided temporary shelter and household packages for 945,600 people in Bangladesh, India, Indonesia, Myanmar and Pakistan and permanent shelter for 7,000 people in Bangladesh, India, Indonesia and Sri Lanka.
- **Water and sanitation:** CARE provided clean water and appropriate sanitation facilities for 1,235,400 people in Bangladesh, Myanmar, India, Indonesia, Pakistan and Sri Lanka.
- **Health:** CARE provided essential health services for over 98,500 people in Bangladesh, Indonesia and Pakistan and also built four health clinics in Indonesia.
- **Livelihoods:** CARE provided a total of 181,000 days of 'cash-for-work' in India, Indonesia and Pakistan, as well as seeds and fertilisers for 70,000 farmers in Pakistan. In addition, CARE assisted 11,000 women to develop small businesses in India and Thailand, and 105,000 families benefited from livelihood initiatives in Indonesia, Myanmar, Sri Lanka and Thailand.
- **Education:** CARE provided 21 temporary school buildings in Pakistan, enabling 3,000 children to continue their education following the earthquake, and 2,500 women graduated from adult literacy programs in India.



CASE STUDY

Rebuilding livelihoods in Aceh

It is noon in Banda Aceh, Indonesia, a city that was devastated by the 2004 tsunami. Nearly five years later, Eri, aged 26, is making coffee at his café. The noisy lunch crowd will later give way to afternoon coffee drinkers enjoying Aceh's famous brew.

Eri and his family lived in a small coastal village. He had just started a computer class after graduating from high school. The tsunami swept away almost everything Eri had: his home, souvenirs of his childhood and, most painfully, his mother.

Unable to continue his schooling, Eri became an unskilled construction worker like his father.

In October 2008, he joined a CARE program offering training in the hotel industry.

'I was excited when I first joined the program and very keen to learn new knowledge and skills. It turned out to be a bright decision.'

Trained by a professional chef, Eri learned how to handle food – from the preparation of various local and international dishes to meeting basic hotel standards in serving customers. After four months, he did an internship in a reputable hotel to get firsthand experience. With his new knowledge and a small amount of capital, the young man started up a roadside food stall. Not long after, his friends joined the business and

brought in more capital. After receiving additional assistance from CARE which helped him secure a refrigerator, dining furniture and cutlery, Eri and his colleagues rented a house and started the café and catering service, delivering food to students from outlying towns. Eri now makes a decent living and no longer depends on his father.

'Sometimes at night, I think about my mother. It is still very hard, even after five years, but I try to move on with my life. Five years ago, I lost everything. I never thought I would have anything again. Now, I am living my life to the fullest.'



CHAPTER 9: EXTERNAL VIEWS ON CARE IN ASIA

As part of this review, CARE conducted an external stakeholder survey in order to gain a better understanding of how its partners and allies perceive its work in the Asia region. This chapter presents the findings.

The survey

CARE invited representatives of CBOs, multilateral agencies, donors, national and international NGOs, officials of national and municipal governments, members of social movements, academics from local universities and research institutions as well as the private sector across 14 countries to participate in an online survey. A fully offline option in Myanmar and a partially offline option in India enabled respondents to complete the survey in English, Burmese, Dari or Tantung.

Respondents were coded by location and category, but to ensure confidentiality their opinions and comments were recorded on an anonymous basis.

CARE's partners

Half of the 500 invited stakeholders completed the survey, mainly CBOs, multilateral agencies, international NGOs, government officials, academics, social movements and the private sector. Two-thirds of CARE's partners or allies (mainly government organisations, local NGOs, multilateral agencies and private companies) rated the relationship as well established and 23% as recently developed. The former are mainly project-based relationships with local and international NGOs and CSOs while CARE's longer-term relationships and strategic alliances are predominantly with host governments and donor agencies. This balance will shift as CARE adopts longer-term program-based commitments (approximately 15 years) and further develops partnerships and alliances to sustain them.

Views on the quality and impact of CARE's programs

One in three respondents rated CARE's programs as excellent and 61% as of good quality. Ninety-five per cent of partners and allies in the sample said that CARE's programs were very relevant or relevant to country-specific issues.

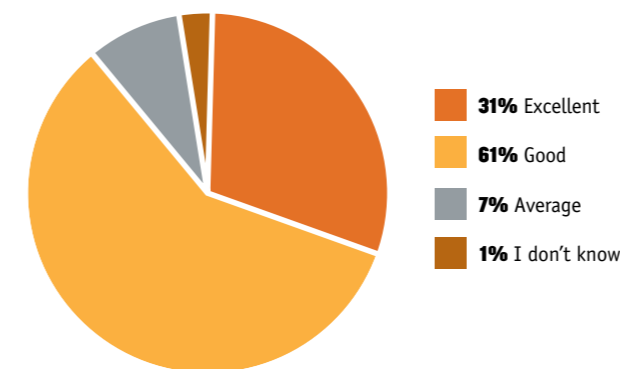


Figure 19: How would you rate the quality of CARE's programs?

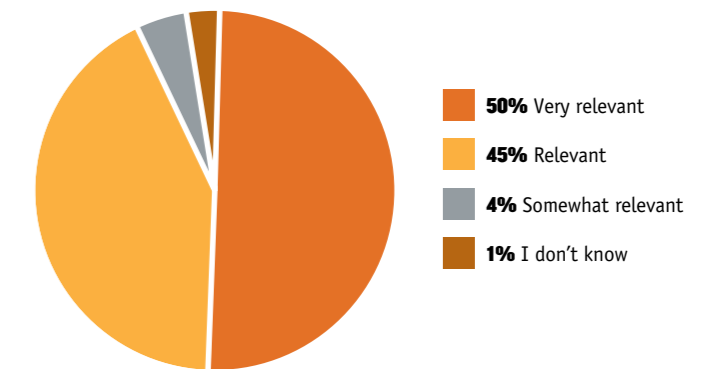


Figure 20: CARE's relevance to country-specific issues

Three-quarters of the respondents believed that CARE is working with others to address poverty well or very well, and 20% rated its performance in this respect as medium.

When asked about CARE's impact on poverty and inequality in their country, 26% of respondents regarded it as significant and 55% as moderate. Moreover, 62% of partners and allies believed that CARE had improved its program over the year prior to the survey, while only 9% saw no improvement.

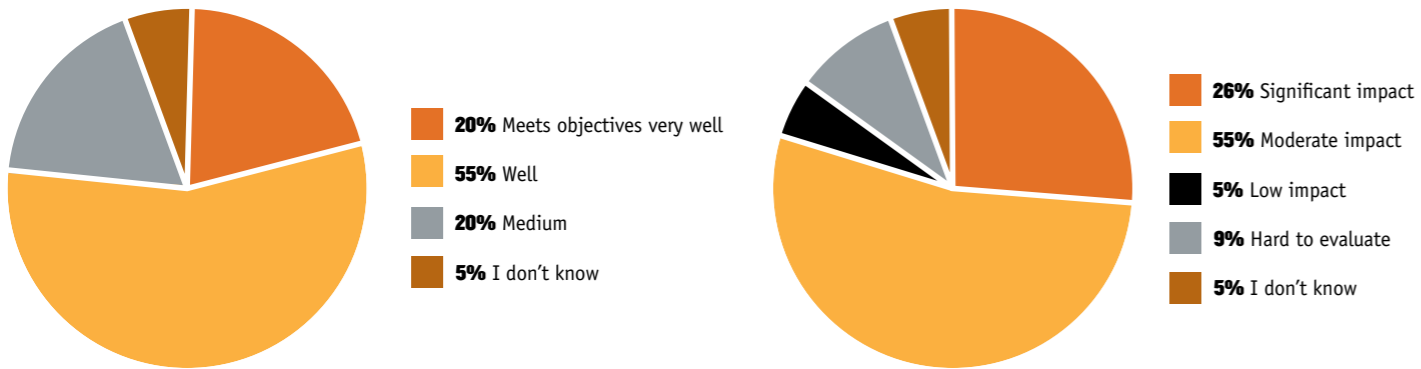


Figure 21: How well does CARE meet its objective of working with others to make an impact on poverty and inequality?

Figure 22: How would you describe CARE's ability to reduce poverty and inequality in your country?

Wider opinions

The survey asked partners and allies about their interaction with CARE. The questionnaire included a list of statements which respondents were asked to rate on a three-point scale from agree, neither agree nor disagree, to disagree. The feedback is represented in the following graph. Overall, respondents agreed on the importance of their relationship with CARE to their organisation and that CARE staff valued their work. There was broad agreement that CARE complements their efforts and generally works in a participatory manner. The responses also suggested that CARE needs to devote more attention to receiving and accepting constructive criticism, sharing information and adopting more agile and responsive internal processes.

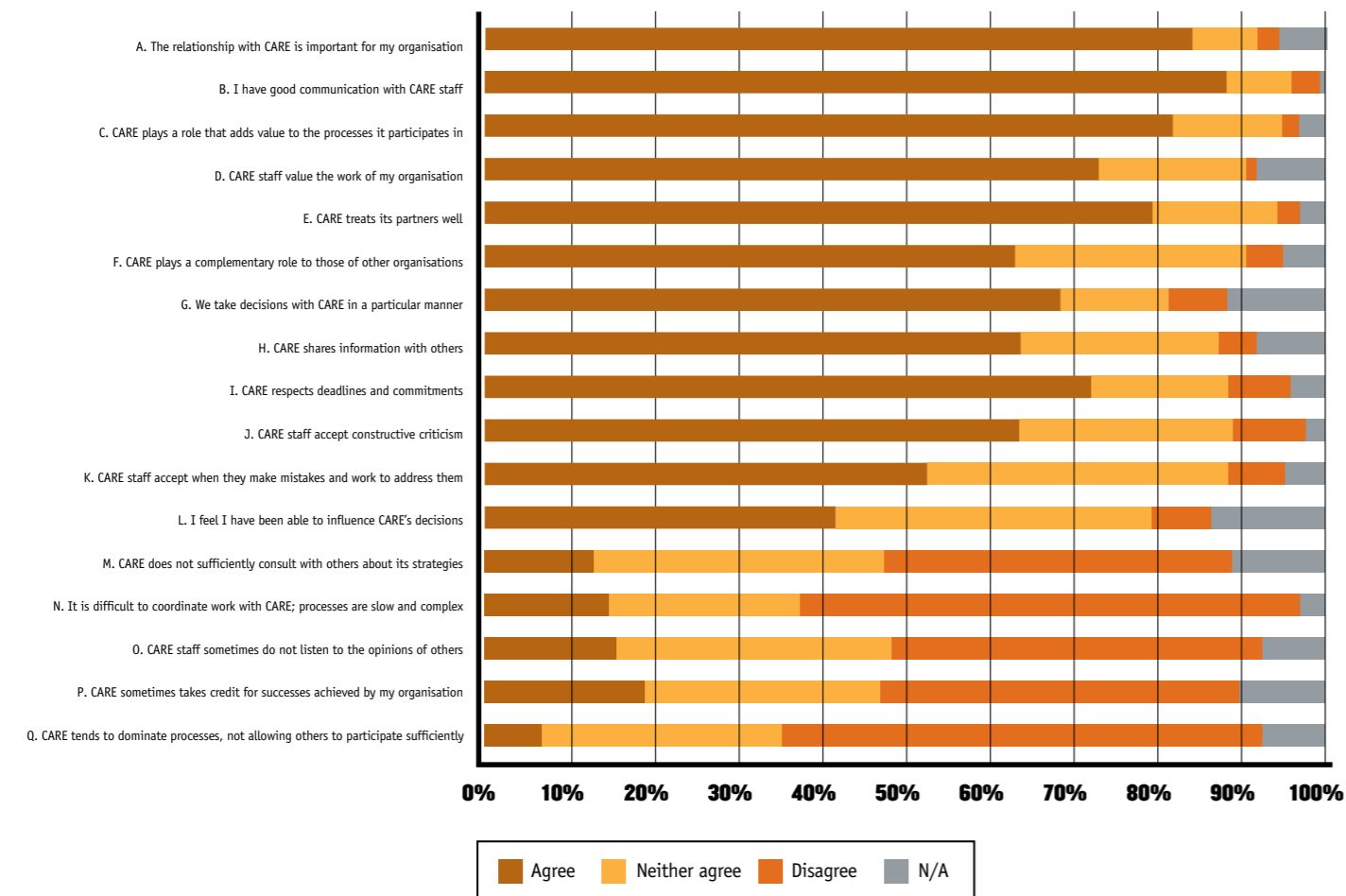


Figure 23: Wider opinions of CARE



The final part of the survey included open-ended questions intended to elicit suggestions and recommendations on how to improve the quality of CARE's work and communication with stakeholders.

The feedback was concentrated in six areas:

- 1 move towards long-term interventions
- 2 coordinate better with others
- 3 engage in more policy and advocacy work
- 4 review internal procedures and capacities (HR, technical)
- 5 document progress and achievements and share successes
- 6 continue to refine, disseminate and build on lessons learned, especially in relation to difficult contexts.

The three statements below illustrate some of the views expressed in this section of the survey:

'I have a great deal of respect for my CARE ... colleagues. They are smart, efficient, focused, make excellent contributions to the team, deliver on time and think strategically. I believe CARE delivers strategic initiatives, which will have positive impacts on poverty and inequity issues. CARE has demonstrated leadership and commitment in providing senior staff to engage in these initiatives and they in turn have taken a high level of responsibility in ensuring that the quality of the work/outputs is good. My only comment would be that these key staff are incredibly busy. Most often they are doing work on these initiatives on weekends etc. as they have very heavy commitments with CARE work (a problem not particular to CARE!).'

'I somehow feel that CARE is losing its focus ... it seems confused and too much donor-driven ... it has to speak the donors' language, which changes as the donor changes. CARE has a very good impact at the community level, but hardly any influence at the policy level. The activities it does [are] mostly project-based. I humbly request CARE to limit its focus area, generate some core resources to push on what it believes and move towards upstreaming its efforts ... Work more strategically by switching from project to program orientation.'

'CARE's strength is its field presence. However, in my experiences with CARE it struggles to learn from its field experiences. Translating CARE's sometimes complex policies and frameworks does not happen effectively, leaving both field and staff and HQ frustrated. CARE needs to be more attuned to local politics and social contexts. These are factors that largely influence development practice and CARE needs to recognise this.'

Overall respondents were broadly positive regarding CARE's achievements and ways of working across the Asia region. Given the different history of CARE's involvement in individual countries, and of course their own diverse contexts and characteristics, this is naturally reflected in the different emphases placed, for example, on community-level versus national-level policy and advocacy work. Common messages are to make long-term strategic commitments and thus be relatively independent of donor influence, to deepen relationships with relevant and like-minded organisations and agencies, while also retaining sufficient flexibility to respond to needs and opportunities as they arise.

CARE has developed many diverse relationships in Asia over the last 60 years, working in partnership with others to provide a sustainable response to the complexity of poverty and social injustice. More recently, CARE has developed a strategic partnership with a national organisation in the Philippines, which will contribute to its thinking about different operational and country models in moving to long-term programs.

CARE began working in the Philippines in 1949, starting with relief efforts and gradually including development initiatives. Over the decades, there has been enormous progress in the social, economic and development landscape of the Philippines. It became a MIC, built a vibrant local civil society and developed an open democracy. Despite these achievements, the country still faces important challenges. This raised questions about whether CARE should maintain a traditional Country Office, which would compete for funding with local

organisations, or whether to look to alternative ways of working.

With the decision to close its Country Office in 2007, CARE opted to enter into a strategic partnership with Agri-Aqua Development Coalition (AADC), a coalition of 164 people's organisations working in Mindanao. CARE was attracted to AADC's clear lines of accountability as well as its ability to engage with its constituency, which enabled CARE to hear and interact directly with the poor. So, in July 2007, CARE and AADC signed a formal agreement on ending poverty and supporting vulnerable groups. The mutual commitments included knowledge sharing and joint advocacy; AADC linking CARE to the development community and representing impoverished communities to CARE; and CARE building the capacity of AADC in the areas of program quality and emergency preparedness and response and disaster risk reduction.⁵⁶

This partnership reflects CARE's strategy to include more Southern constituencies in its membership, while it is also an opportunity for AADC to grow and become more influential. An external review found that the partnership included an excellent level of knowledge and expertise sharing, especially with regard to program quality and DRR, and was a valuable means of connecting CARE directly to vulnerable communities. Areas for improvement include defining AADC's place within the CARE family; collaborating on advocacy and regional issues; detailing emergency response plans; and promoting the partnership among stakeholders.

CARE and AADC are committed to optimising the potential of the current partnership. CARE is also keen to learn about new ways of working in striving to become a more diverse and inclusive organisation.

CHAPTER 10: VALUE FOR MONEY – INVESTING IN SOCIAL CHANGE

While the previous chapters have focused on CARE's contribution to changing the lives of vulnerable communities across the region, this chapter explores how CARE's financial 'investment' in vulnerable communities creates social value and demonstrates the effective use of resources – known in shorthand as 'Value For Money'.

This chapter is based on a 2011 desk review of four CARE projects undertaken in Asia since 2006, using an adapted version of Social Return on Investment (SROI) methodology.⁵⁷ SROI is a form of cost-benefit analysis that seeks to quantify the social and environmental effects of projects as well as their economic effects. This is done through a participatory approach which aims to develop an understanding, from the perspective of those affected, of how a development intervention contributes to changes in people's lives. This analysis forms the basis upon which to measure outcomes. All outcome values are quantified in dollar terms using a variety of techniques and financial proxies, with adjustments made which seek to isolate the contribution of the individual project. These monetised outcomes are then compared with the financial investment to establish a SROI ratio, which expressed the value achieved for each dollar invested.⁵⁸

The desk review aimed to explore how SROI might be applied to CARE's activities and ways of working. By definition, it did not undertake primary research or direct consultation with stakeholders

but relied upon existing sources and project documentation. There was, however, a degree of consultation via interviews with CARE program staff. In addition, much of the internal project documentation was based on direct consultation with beneficiaries and other stakeholders. The review addressed any major gaps in information necessary for the analysis by making supplementary assumptions and relying on secondary sources to estimate outcomes.

A profile of the four selected projects is presented below, with an overview of their key achievements and SROI ratios. It was beyond the scope of the exercise to assess all of the outcomes and activities for each project, which means that its SROI ratio shows only whether it represented 'Value For Money' in its own terms – it does not provide a basis upon which to compare cost-effectiveness across the sample. In addition, some of the interventions are part of long-term programs and their value cannot be viewed in isolation from the broader set of activities. Nevertheless, for indicative purposes the analysis provides useful evidence of the value created through CARE's approaches and ways of working with the poor and marginalised in Asia.

1 Bangladesh: social and economic transformation of the ultra poor

Initiated in 2009, Social and Economic Transformation of the Ultra Poor (SETU) is a six-year project that aims to address the underlying causes of extreme poverty in four districts in north-west Bangladesh, which are characterised by severe seasonal food insecurity.⁵⁹ By building solidarity and empowering poor and marginalised communities the project aims to support 40,000 households (around 128,000 people) in the Unions of Nilphamari, Lalmonirhat, Gaibandha and Rangpur.

SETU defines the underlying causes of poverty as powerlessness in the three interconnected domains of social, economic and political change. Empowerment therefore means achieving change across these domains, so that extremely poor people can find their own development solutions. From a social perspective, SETU aims

to address exclusion and marginalisation and reduce exploitation by, and dependence on, others. From an economic standpoint it seeks to enable the poor to gain better access to, and use of, resources and services including market and employment opportunities. From a political perspective it seeks to empower the poor by facilitating the creation of spaces for them to participate in local government and development processes.

To date, SETU's key achievements include implementation of community-led sanitation programs for 960 communities comprising some 52,000 households, an 80% reduction in households forced to take out high-interest loans, and more than 12,000 households benefiting from support for their livelihoods.



Philippines © Jes Eznar/CARE

The SROI analysis involved combining primary project data collected by CARE with assumptions based upon secondary literature concerning the size of the affected population and the level of change experienced against identified project outcomes. This permitted the analysis to incorporate and value outcomes relating to communities' increased revenue and school attendance as well as more social and gender-related factors such as reduced early marriages and gender-based violence.

A particular challenge lies in how to assess the value of socio-political empowerment, which is both an end in itself and a means by which to achieve better outcomes in other areas.⁶⁰ It is no simple task to measure empowerment as an outcome in its own right and for the purposes of this exercise, no attempt was made to do so. It was, however, possible to estimate value created by empowerment as a means to achieve broader socio-economic change. SETU's approach enables communities to improve their capacity to organise themselves and express their needs and concerns to local and regional authorities. This results in marginalised

communities being better able to engage in local and regional political structures, which can lead to broader change, such as access to public services. For SETU, the value of such access was estimated through secondary research that uses what communities would be 'willing to pay' as a proxy for how much they value the services, and adjusting this for the Bangladesh context.⁶¹

Another characteristic of SETU is its multi-level approach, addressing household and community empowerment as well as broader social institutions – not least local government structures. Although this holistic approach can amplify the anticipated impacts⁶², the complex nature of these linkages, and their potential direct or indirect impacts on livelihoods, would be very difficult to measure and were not addressed in the SROI analysis.

The SROI ratio suggests that for the assessed outcomes, every US\$1.00 invested in SETU generated a return of approximately US\$8.70 in social value to the communities.



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Cambodia © Josh Estey/CARE

2 Cambodia: integrated rural development and disaster mitigation

Integrated Rural Development and Disaster Mitigation (IRDM) was a two-phase poverty-reduction project with poor and chronically food-insecure populations in rural Cambodia that began in 2006 and ended in 2011.⁶³ These vulnerable populations lacked sufficient food reserves to see them through to the next harvest. Climate contributes to food insecurity through flood and drought cycles, and vulnerabilities are exacerbated by the lack of infrastructure in the region. In addition, in Prey Veng and Svay Rieng provinces the pressure of a growing population means that land ownership is becoming increasingly fragmented, and intensive agriculture is degrading soil fertility and quality. Rice yields are below the national average and 83% of farming households cannot subsist on their production.

IRDM sought to reduce poverty in Prey Veng and Svay Rieng in two main ways. First, enhancing the livelihood security of vulnerable households by improving access to resources, markets and appropriate technologies, and developing technical, operational and management capacity. And second, reducing exposure to natural disasters by strengthening local governance, social capital and local networks, and also strengthening government capacity to respond to disasters by documenting and sharing lessons learnt.

IRDM took a holistic approach to supporting livelihoods, combining efforts to improve agricultural productivity with measures to improve farmers' access to market information and to obtain loans through community saving schemes. Other project outcomes included better standards of education and increased assets among participating communities. Most households adopted safer practices regarding drinking water – an increase of 21% – and the duration of annual food shortage dropped from almost four months to just one, with 25% more households harvesting more than one rice crop per year. As a result of diversifying their livelihood activities, by the end of the project 90% of the households had at least three sources of income – up by 55%. Increased access to market information also contributed to farmers' incomes via the sale of rice products, which increased by an average of 44% over the lifetime of the project.

The SROI analysis combined primary data with assumptions based on secondary literature. This allowed the analysis to incorporate and value project outcomes relating to communities' economic and social resilience as well as gender equality. A range of outcomes including more savings, better education and access to safe water were factored into the calculation by using appropriate financial proxies.

The SROI ratio suggests that for the assessed outcomes, every US\$1.00 invested in IRDM generated a return of approximately US\$13.50 in social value to the communities.

3 Laos: poverty alleviation in remote upland areas

Implemented between 2008 and 2012, Poverty Alleviation in Remote Upland Areas (PARUA II) was a follow-up project supporting sustainable livelihoods in northern Laos.⁶⁴ The region is inhabited by vulnerable and marginalised communities with high rates of poverty, inadequate infrastructure, poor linkages to national or regional markets and therefore little access to both services and production inputs.

The project area of Saysathan district in Xainyabouli province comprises 19 villages, all of which benefited from PARUA activities to varying degrees. The local population is almost exclusively from the Phrai ethnic group. Ethnic groups in Laos often experience deeper poverty and deprivation, which can in part be explained by the relatively low investment in the areas where they live. The region is also prone to unreliable weather and to natural calamities such as flooding and pest infestation. For such vulnerable communities, even a small adversity can be catastrophic.

PARUA's overall objective was to 'sustainably increase livelihood security among poor ethnic groups in remote upland areas' by (a) ensuring economic livelihood by investing in livestock/agriculture; (b) improving infrastructure within communities; (c) enhancing regional infrastructure investment linking these communities to urban centres of the country; (d) empowering communities from a social/participatory perspective; and (e) improving resource management of the surrounding ecological system, notably water, both to promote economic sustainability and as part of disaster risk reduction (DRR).

Specifically, PARUA focused on safe drinking water, roads, livestock vaccination, livestock banks as a social safety net, and income-generating activities including mushroom growing, selling eggs and managing tea gardens. In addition PARUA provided scholarships for Phrai students, and funded the development of almost 14 kilometres of roads in the area.

The SROI analysis for PARUA assigned financial proxies to outcomes relating to economic, social and political empowerment, as well as ecological sustainability and gender equality. These outcomes included higher income, better access to health services and participation in community structures. The PARUA data were the most comprehensive of the sample, which facilitated measuring the size of the affected population as well as the magnitude of change for numerous outcomes. The example following demonstrates how improved access to clean water created value for the women in the participating communities, and serves to illustrate the process undertaken for all projects in the desk review:

- 1 Women are often disproportionately affected by inadequate infrastructure, such as the lack of safe water or affordable and reliable transport facilities. Improved infrastructure, e.g. related to water-distribution systems, is therefore a means both to address gender inequalities and to improve health outcomes.
- 2 PARUA aimed to reduce women's domestic workload. According to the project data, 26% of women said that since the start of the project they had more time available because their workload had declined. The data did not show the exact amount of time saved, so a modest reduction of an hour per day was assumed.
- 3 The value of time saved on household chores was calculated in relation to what women were able to undertake as a result, including childcare and income-generating activities in tended to increase women's autonomy. A 'willingness-to-pay' exercise conducted in Bangladesh, Ghana and Tanzania provided an estimation of value for the time women saved, which was on average 57% of their income.⁶⁵ This was converted to a percentage for Laos, based on another study on rural household incomes⁶⁶ and gave a financial proxy of US\$ 0.16 per hour saved.
- 4 Finally, the standard SROI processes for estimating deadweight, attribution, benefit period and application of net present value using a 3.5% discount rate were incorporated into the analysis.

The SROI ratio suggests that for the assessed outcomes, every US\$1.00 invested in PARUA generated a return of approximately US\$6.90 in social value to the communities.

4 Sri Lanka: plantation community empowerment project

Implemented between 2008 and 2012, the Plantation Community Empowerment Project (PCEP) worked with over 26,400 workers and members of vulnerable and marginalised communities, particularly women and youth in 13 tea plantation estates in the Nuwara Eliya district in Sri Lanka. Focusing on Tamil-speaking communities from Southern India, who often face discrimination and have lower average living standards compared to other ethnic groups in Sri Lanka, the project contributed to a broader CARE program of work with plantation communities in the country.⁶⁷ It worked in partnership with the Sri Lankan Plantation Human Development Trust and in association with three Regional Plantation Companies.

PCEP's overall objective was to create systems to support the socio-economic and political rights of women, men and children living and working on the tea plantations. This was based on the need to address their poor socio-economic conditions, which repeatedly gave rise to conflicts in the plantations, thus reducing productivity and consequently affecting the tea companies' profits. The project aimed to find a 'win-win' outcome by improving working conditions through the establishment of collective-bargaining structures and Ethical Tea Partnerships. These Partnerships required tea companies to support their workers' socio-economic empowerment, from which the companies also benefited through increased productivity and reduced labour-related conflict. While the main intended beneficiaries were the workers and their families, and the tea companies operating in these plantations, the government and the wider society also stood to benefit.

The principal action was the establishment of 13 CARE-designed Community Development Forums (CDFs) on each participating estate, bringing together representatives of plantation workers and management,

trade unions, local government officials and other community members. CDFs are in effect 'mini-parliaments' or participatory spaces.

The results of these and other interventions were overwhelmingly positive, as demonstrated both by feedback from all stakeholders and partners during the project period and by the findings of independent assessments. The workers achieved better working conditions, a greater say on estate conditions, improved access to government services and a renewed sense of dignity. In the final evaluation, 95% of participants judged the project benefits as 'high' or 'extremely high'.⁶⁸ Furthermore, the estates spent on average 16 weeks less time on labour disputes per year; saw a 25% increase in productivity in terms of the number of hectares plucked by the same size workforce; and a 10%–20% increase in their yield of good quality tea.

The SROI analysis combined primary data with assumptions based upon secondary literature to calculate the size of the affected population and the degree of change experienced for identified project outcomes. This allowed the analysis to incorporate and value outcomes relating to communities' autonomy and control over their livelihoods, gender equality, and health and education-related improvements. For example, the calculations took into account the value of benefits to community members achieved via increased access to training and education as well as the value of higher productivity to tea companies.

The SROI ratio suggests that for the assessed outcomes, every US\$1.00 invested in PCEP generated a return of approximately US\$42.60, including US\$11.20 in social value to the communities, US\$26.70 to the tea plantations and estates, and US\$4.70 to the government and wider society.

Implications for CARE

In the context of the broader accountability agenda, CARE and other development organisations are experimenting with different ways to measure and demonstrate both the effectiveness of their work and also estimate value for money to help ensure we make the best choices about what we support. For CARE, this means developing **the most appropriate approaches** for assessing the complex work it undertakes with women and their communities – as described in earlier chapters – in order to allow more consistent and systematic measurement of outcomes and impact. Cost-benefit analyses can tell one part of the story; but CARE also needs to develop a range of qualitative as well as quantitative approaches, indicators and methodologies to demonstrate the value and impact of its work in addressing poverty and social injustice.

The application of SROI to international development programs is still in its infancy. Organisations like CARE therefore need to build experience around the challenge of **measuring the less tangible outcomes** of their work. For example, as noted in the afore-mentioned SETU example, the empowerment of women is an end in itself as well as a vital means to achieving other improvements. Understanding the full picture is the key to being able to present credible evidence on both aspects. This in turn means that CARE must build its assessment tools on **solid foundations** including robust systems for analysing and understanding complex local circumstances; developing clear Theories of Change to understand how impact is expected to occur, which in turn can inform program design; and consistent, effective monitoring and evaluation of interventions in order to understand what has been achieved. Community participation in this process is critical since it is the only way to ensure that local perspectives on value are fully integrated into CARE's ways of working.

CARE's focus on **working with the most disadvantaged people** needs to be taken into account when demonstrating value for money and effectiveness. Working with the poorest is invariably more complex and costly than working with those who are less poor – for example, working in remote locations entails higher transport costs and it tends to take more time to establish trust with marginalised communities. The challenge for CARE is therefore to weigh and measure the benefits of its programs and overall approach to those in most need, as well as understanding the wider social benefits.

CARE is increasingly moving towards **long-term programs** and away from a project-based approach. As highlighted in previous chapters, CARE uses its Theories of Change to achieve long-term sustainable change for identified groups through a range of initiatives rather than through isolated interventions. Working in this way will present two new challenges. First, to define what 'value for money' looks like at the overall program level, because project-level assessments such as those featured in this chapter may tell a different story. And second, to understand how best to measure long-term changes, the degree of change (or 'distance travelled') by the relevant population groups, and the durability of benefits and value created by CARE's intervention.

CARE emphasises accountability as part of ensuring that its resources are used to achieve maximum impact – and communities, partners and donors also expect CARE to use funds as efficiently and effectively as possible. Thus, value for money is not a new concept for CARE, but is inherent in its accountability to others. As part of deepening its accountability, CARE will work to improve its systems for information and knowledge management, monitoring and evaluation, impact measurement and long-term programming.

CONCLUSIONS – WHERE TO FROM HERE?

The preparation of this report has been a valuable opportunity for learning and reflection: for CARE to understand what has been achieved and to identify what can be done better.

What does the report tell us?

Overall, it is clear that CARE's work has had many successes and made a positive impact on the lives of millions of poor and vulnerable people in Asia. The previous chapters capture a diverse range of approaches and activities that have improved lives, empowered women and men and achieved remarkable changes. The case studies on value for money indicate that CARE has invested resources in a way that brings significant benefits to communities.

CARE's programming is underpinned by a **common vision and principles**, but in adopting these approaches CARE makes an effort to be **grounded in local realities and opportunities**. CARE takes the time to work with communities to identify the particular issues they face and develop responses to these, based on an understanding of the underlying causes of poverty and social injustice. This flexible and responsive approach has helped to achieve impact in many different settings. The feedback from CARE's partners and allies across the region generally bears this out – although partners also suggest ways in which CARE's impact could be greater.

Program impact can – and should – be multiplied beyond the groups with whom CARE is working directly. It is a sign of success when pro-poor approaches trialled by CARE are picked up by local authorities and applied more broadly within their own programs, or when communities follow the lead of those who are adopting new

approaches, or when CARE is successful in advocating with partners and communities for policy changes, or when women who have been empowered through CARE interventions provide an inspiration or role model which others then follow. These achievements help to sustain and expand the benefits from CARE's work. This dynamic can be seen in examples presented throughout the report: whether working with partners to change domestic violence laws in Bangladesh, or demonstrating a successful model of ethnic minority education in Cambodia which the government is now replicating in other provinces, or building the capacity of partner NGOs in India who then begin to work in their own communities to form and support multiple savings and self-help groups, or seeing communities in rural Myanmar adopting community forestry practices from neighbouring communities supported by CARE.

Many examples from the report reinforce the **value of CARE working in close partnership with others** – local community groups, government agencies, NGOs. What CARE can provide through its own efforts and resources is limited, compared with what can be achieved when CARE can facilitate and leverage stronger connections which will help poor communities and vulnerable women and men improve their situation on a long-term basis – and which will be sustained after CARE's intervention has ended.



Looking back, where can CARE do better?



In compiling the evidence from multiple programs, there has also been a sense that only a partial picture has been captured: not every program or project has had a strong information base or clear evidence of impact. Sometimes, achievements are captured at the level of project outputs or outcomes, but without a clear view of whether long-term change has been achieved. There is room for **improvement to CARE's impact measurement systems**, which would make it clearer what has or has not been achieved. CARE should address this through further developing its systems and processes for knowledge management, and continuing to test, challenge and improve its methods and practice in monitoring and evaluation, including through more consistent indicators, operational definitions and methodical approaches to building impact information over the life of the project, and beyond. As CARE moves towards longer-term programs, it should also develop innovative ways to track impact over the longer term, such as longitudinal approaches to better assess outcomes of empowering women and girls.

Because a wide range of indicators has been used across different projects and countries, aggregation of impact at the regional level has also posed challenges. **More consistent methods for measuring and analysing achievements** would help paint a clearer regional picture, and develop a better understanding of where CARE has contributed to impact. It would also help in understanding where CARE's impact may have been less than expected, and how to adjust approaches to do better next time.

CARE needs to continue to explore ways to effectively **bring the impact of its work up to a broader scale**. In the past, much of CARE's work was through isolated projects. CARE can deliver direct benefits on the ground for communities where it has a presence, but project coverage will be geographically limited and time-bound, with limited opportunity to address the underlying causes of poverty. For more sizable and sustainable impact, CARE needs to improve its strategies for scaling up. This means **identifying and documenting effective models** or ways of working that can be replicated by others, and can attract support and resources for larger-scale adoption; or using evidence from programs to work for broader change in policy or practice.

A key challenge for CARE is to ensure that its work on the ground with hundreds or thousands of people in a given community or group can also be used to contribute to positive impact and transformational change for thousands, or even millions, more people who face similar circumstances. In this context, **advocacy** needs to be seen as an integral part of programming strategies; and approaches for monitoring the impact of advocacy work should be developed. CARE needs to ensure that its work with particular vulnerable groups or communities can contribute to changes at the societal level. The experience from project implementation yields valuable insights and evidence on the underlying causes of poverty and this can be used to inform advocacy by CARE or by others for new approaches or broader change that will benefit the poor and vulnerable. More innovative approaches to **partnership** will also be important, so that CARE can link with and support like-minded organisations, social movements, the private sector, government and others to identify and work for the changes needed to overcome poverty.

There is also room for better integration of CARE's **humanitarian emergency and development programs**. Approaches such as stronger integration of DRR activities and incorporating climate change considerations in long-term programs will help build more sustainable approaches and hence more resilient communities.



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Looking ahead – what is CARE doing?

CARE seeks to promote a culture of learning. Past research and analysis, linked with program monitoring and evaluation, have provided lessons which have flowed through to change the way CARE works. In the past five years, analysis, learning and reflection have led to CARE adopting various new approaches, such as long-term programming and women's empowerment. This report provides a further important opportunity for learning and improvement.

It is encouraging that many lessons arising from this report confirm forward directions that CARE has already identified as part of its continuing improvement and evolution. Key steps include:

Programming explicitly focused on long-term impact: CARE is moving from a reliance on short-term, standalone projects to long-term program approaches as its main implementation framework. Essentially, this looks to strengthen the impact and sustainability of CARE's work at the country-level by defining its programs through the long-term impact (over a 10 to 15-year period) sought for a particular group of people (for example, marginalised women, ethnic groups, the urban poor). This shifts the focus of CARE's work directly towards people, rather than focusing on change in a particular sector or location. Program design will increasingly be based on an analysis of the underlying causes of poverty for the impact group, with a Theory of Change developed outlining the assumptions about what is required to achieve and sustain impact, and what role CARE can play. This framework then guides CARE's choices for project interventions, advocacy and strategic partnerships and collaboration. As a result CARE Country Offices are now moving to organise around two or three long-term programs, rather than having systems solely geared to project implementation, and are developing approaches to monitoring program-level impact.

Improved knowledge management: work is underway on developing a new Project/Program Information and Impact Reporting System (PIIRS). As a single, authoritative CARE-wide platform for collecting relevant project and program information, this is intended to enable all parts of the organisation to have access to timely, up-to-date and relevant information on CARE's work and what it is achieving. The PIIRS is currently in a development phase involving stakeholder consultation and a pilot of some aspects of the system. Once a preferred option is identified and approved, introduction of the full system is planned to commence from mid-2013.

Reviewing country models: in 2012 CARE began a rolling review of its operations in each country in which it works, to ensure that its presence is relevant and appropriate to the local environment. This is also contributing to internal dialogue about what CARE's role should be, and how best it can achieve impact. Traditionally, CARE and its staff have played roles such as community workers, project managers and implementers. New thinking about how best to achieve impact may also lead CARE to develop stronger roles in areas such as research, facilitation, alliance and coalition building, developing local capacity, documenting evidence, policy analysis and advocacy; not just doing things for other people, but also stimulating and enabling action by others.

CARE believes that understanding and measuring impact is crucial in moving towards overcoming poverty and social injustice, and in being accountable to the societies in which it works. Overall, this report and the process of preparing it has been a valuable step for CARE. While it offers useful pointers as to how CARE can improve its own approaches, it aims to contribute to the wider dialogue on improving development effectiveness, transparency and accountability.

CREDITS

Donors

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FOOTNOTES

- Available at: http://www.care.org/newsroom/specialreports/latinamerica/LAC_impact_report-English.pdf/
- This Asia Impact Report is based on CARE's programs in 16 countries in Asia and the Pacific, although to date involvement in the Pacific subregion is limited to Papua New Guinea (PNG) and Vanuatu.
- UNESCAP (2011) *Statistical Yearbook for Asia and the Pacific 2011*, Bangkok: UNESCAP.
- World Bank (2012) *Global Economic Prospects: Uncertainties and Vulnerabilities*, Washington, DC: World Bank.
- World Bank (2012) *Poverty and equity data*, available at <http://povertydata.worldbank.org/poverty/home/>
- Sumner, A. (2011) *Poverty and Aid in Middle Income Countries*, Brighton: Institute of Development Studies; Sumner, A. (2010) *Global Poverty and the 'New Bottom Billion': Three Quarters of the World's Poor Live in Middle-income Countries*, IDS Working Papers 349, Brighton: Institute of Development Studies.
- UNDP (2010) *Human Development Report 2010*, Basingstoke: Palgrave Macmillan and UNDP. Available at: <http://hdr.undp.org/>
- UNESCAP/ ADB/UNDP (2010) *Achieving the MDGs in an Era of Global Uncertainty*, available at: <http://mdgasiapacific.org/>
- See <http://mdgasiapacific.org/> for details.
- WHO/UNICEF/UNFPA/World Bank (2012) *Trends in Maternal Mortality: 1990 to 2010*, Geneva: WHO.
- UNESCAP (2011) *Statistical Yearbook for Asia and the Pacific 2011*, Bangkok: UNESCAP.
- Sen, A (1990) 'More than 100 million women are missing', *New York Review of Books* 37(20).
- UNESCAP (2011) *Statistical Yearbook for Asia and the Pacific 2011*, Bangkok: UNESCAP.
- Based on annual figures calculated on an annual average USD exchange rate.
- CARE India has been an Affiliate Member since 2010, before which it was a CARE Country Office.
- CARE closed its Philippines office in 2007, since then it has supported the development work of a strategic partner, the Agri-Aqua Development Coalition (AADC), and other partners in emergency response and disaster risk reduction (DRR) efforts.
- In 1997, CARE Thailand ceased to be a CARE Country Office and became a national entity, Raks Thai Foundation, which is a member of CARE International.
- CARE established a Project Office in Vanuatu in 2008.
- Where multiple project grants contributed to a common project framework and were covered by common reporting these were counted as a single project intervention.
- The MDGs and progress reports are available at: <http://www.un.org/millenniumgoals/>
- UN Women refers to this frequently cited figure at: http://www.unifem.org/gender_issues/women_poverty_economics/
- CARE International Gender Policy, available at: <http://gender.care2share.wikispaces.net/CARE+Car+International+Gender+Policy/>
- See <http://unstats.un.org/unsd/demographic/products/Worldswomen/Executive%20summary.htm>
- UN Women (2011) *Progress of the World's Women 2011-2012: In Pursuit of Justice*, available at: <http://progress.unwomen.org/>
- For an overview of CARE's extensive research and analysis of women's empowerment in its programs, see CARE (2010) *Strong women, strong communities: CARE's holistic approach to empowering women and girls in the fight against poverty*, available at: <http://www.care.org/downloads/womens-empowerment-report-201005.pdf>
- This is illustrated in the Gender Inequality Index (GII) presented in UNDP (2011) *Human Development Report 2011*, Basingstoke: Palgrave Macmillan and UNDP. An explanation of the GI is available at: <http://hdr.undp.org/en/statistics/gii/>
- CARE (2010) *Strong women, strong communities: CARE's holistic approach to empowering women and girls in the fight against poverty*, available at: <http://www.care.org/downloads/womens-empowerment-report-201005.pdf>
- Moktan, K. and Nicoll, S. (2008) *Governance and Sustainable Development, The Asian Development Bank Perspective*, ADB Sustainable Development Working Paper Series No. 3, December, Metro Manila: ADB.
- ibid.
- See successive Asia-Pacific Human Development Reports as well as national Human Development Reports at: <http://hdr.undp.org/xmlSearch/reportSearch?y=&c=r:Asia+and+the+Pacific&t=&lang=en&k=&orderby=year/>
- Available at: <http://governance.care2share.wikispaces.net/GPF/>
- World Bank (2011) *Poverty Picture 1990-2008*, available at <http://web.worldbank.org/>
- World Economic Forum (2011) *The Global Gender Gap Report 2011*, available at: <http://www.weforum.org/issues/global-gender-gap/>. See also the Gender Inequality Index in UNDP (2011) *Human Development Report*, Basingstoke: Palgrave Macmillan and UNDP.
- OECD DAC (2008) 'Guiding Principles for Aid Effectiveness, Gender Equality and Women's Empowerment', Paris: OECD DAC.
- Results for this and subsequent sectors refer only to those countries in which programs were classified as contributing to reducing income poverty. In many cases, lack of baseline or final data meant that a country program was not included, although it is often clear that change occurred.
- The mean estimate of the value of the trees grown on CF plots of over four years of age was Kyat 923,343 (US\$1,100), and the mean household income from CF plots in the previous 12 months was Kyat 84,706 (US\$100, or approximately 11% of the average annual household income reported in the Final Evaluation survey).
- Food and Agriculture Organization (2010) *The State of Food Insecurity in the World 2010*, Rome: FAO. Available at: <http://www.fao.org/docrep/013/i1683e/i1683e.pdf>
- Food and Agriculture Organization and World Food Program (2009) *The State of Food Insecurity in the World: Economic crises - impacts and lessons learned*, Rome: FAO. Available at: <http://www.fao.org/publications/sofi/en/>; Diouf, J. (2008) 'An Era of Unprecedented Opportunity?', *UN Chronicle* No 2/3.
- Food and Agriculture Organization (no date) 'Gender', available at: www.fao.org/gender/en/
- IFAD (no date) 'Learning about strengthening women's decision-making', available at: <http://www.ifad.org/gender/learning/lessons/decision.htm>
- Food and Agriculture Organization (2009) *The State of Food Insecurity in the World 2009: Economic crises - impacts and lessons learned*, Rome: FAO; Von Braun, J. and Pandya-Lorch, R. (1991) *Income sources of malnourished people in rural areas: Microlevel information and policy implications*, Washington, DC: IFPRI.
- Nutrition indicators varied by country. Three indicators were used: percentage of stunting, wasting and underweight children from birth to the age of four years (Bangladesh); percentage of children aged between 12 and 23 months whose weight-for-age is more than two standard deviations below the median (wasting) (India); and percentage of underweight children from birth to 23 months (Nepal).
- For further information, please see box titled 'SHOUHARDO: Putting Women at the Centre', Chapter 2: Gender Equality and Women's Empowerment.
- See UNDP's MDG Monitor, available at: <http://www.mdgmonitor.org/goal2.cfm>.
- UNESCO Institute for Statistics (UIS) (2011) *UIS Factsheet September 2011, No. 16*, Montreal: UIS. Available at: <http://www.uis.unesco.org/FactSheets/Documents/FS16-2011-Literacy-EN.pdf>
- UNESCO (no date) 'Eight reasons why education is important to achieve the MDGs', available at: <http://www.unesco.org/new/en/education/themes/leading-the-international-agenda/education-for-all/education-and-the-mdgs/eight-reasons-to-achieve-the-mdgs/>.
- <http://www.worldbank.org/children/costs/invest.htm>
- WHO/UNICEF/UNFPA/World Bank (2012) *Trends in Maternal Mortality: 1990 to 2010*, Geneva: WHO.
- Stover, J. and Ross, J. (2010) 'How increased contraceptive use has reduced maternal mortality', *Maternal Child Health Journal* 14(5): 687-695.
- UNAIDS (2011) *Regional Fact Sheet*, available at: http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2011/20111121_FS_WAD2011_regional_en.pdf
- CARE (2006) Working papers 8: Deepening Access to Spacing Methods, Rachna Program 2001-2006 Women and Child Health Program at Scale, available at: http://www.basics.org/documents/Deepening_Access_to_Spacing_Methods.pdf
- See OCHA's Regional Office for Asia and the Pacific (ROAP), available at: [http://ochaonline.un.org/roap](http://ochaonline.un.org/Default.aspx?alias=ochaonline.un.org/roap)
- Available at: <http://www.care-international.org/Download-document/489-CI-Humanitarian+Accountability-Framework-Pilot-version.html>
- Available at: <http://www.ecbproject.org/the-good-enough-guide/the-good-enough-guide/>
- Although the Indian Ocean tsunami occurred at the end of December 2004 and therefore fell outside the study period, because the response and recovery for affected communities occurred from 2005 onwards it was included.
- AADC operates only in Mindanao, so CARE collaborates with others in emergency response and disaster risk reduction elsewhere in the country.
- The New Economics Foundation developed SROI as a means for 'Third Sector Organisations', including international NGOs such as CARE, to demonstrate 'value for money', and undertook the desk review in late 2011 on behalf of CARE International.
- Space does not permit full presentation of the methodology and workings here, but the detailed report is available on request. For a guide to the general SROI methodology, see Brouwers, Jan; Prins, Ester and Salverda, Menno (2010) *Social Return On Investment: A practical guide for the development cooperation sector*, Utrecht or available online at http://contextinternationalcooperation.files.wordpress.com/2010/11/sroi-practical-guide_context_international-cooperation.pdf
- Between 2009 and 2012, SETU received the equivalent of about US\$5.5 million from DFID via the Shiree Economic Empowerment Program. See www.shiree.org
- Sen, A. (1999) *Development as Freedom*, Oxford: Oxford University Press.
- See Gertler, P. and Van der Gaag, J. (1988) 'Measuring the Willingness to Pay for Social Services in Developing Countries', *Working Papers from World Bank - Living Standards Measurement*, Washington, DC: World Bank; Littlefair, K. (1998) 'Willingness to pay for water at the household level', *MEWEREW Occasional Paper* No. 26, Water Issues Study Group, London: School of Oriental and African Studies (SOAS), University of London; Torroero, M., Chowdhury, S.K. and Galdo, V. (2002) 'Willingness to Pay for the Rural Telephone Service in Bangladesh and Peru', *ZEF Discussion Papers on Development Policy* No. 54, Bonn: Center for Development Research, University of Bonn.
- Hinton, R. (2010) 'Promoting inclusive governance in Bangladesh', CARE International: *Learning and Policy Series*, Issue 1, London: CIUK.
- IRDM received the equivalent of over US\$5 million from AusAID over the period.
- PARUA received a grant from the Swiss Agency for Development and Cooperation (SDC) from 2008 to 2012, amounting to approximately US\$1.5 million.
- DFID (2009) 'Valuation of travel time savings: empirical studies in Bangladesh, Ghana and Tanzania', *Brief ITT Transport Ltd*, London: Department for International Development. Available at: <http://www.ittransport.co.uk/documents/R8307%20VoT%20Brief%20Final%20July%202005.pdf>
- Komoto, G. and Stone, S. (2009) 'Determining Poverty Impacts on Lao People's Democratic Republic and Cambodia: Reconciling Household and GTAP Data', *ADB Working Paper 141*, Tokyo: Asian Development Bank Institute. Available at: www.adbi.org/workingpaper/2009/07/21/3228.povstudy.lao.pdr.cambodia.gtap/
- PCEP received a three-year grant from the European Union (EU) between 2008 and 2012. Its total budget was approximately US\$1.3 million.
- PCEP final evaluation, unpublished.



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