CARE-India
(1950-2009)

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Kutiti and Mohan Mondal had just finished their chores on the morning of 29 October 1999. It had been raining and strong winds had been blowing for 24 hours. Their three children had been forced to stay in their thatched hut because of cyclone warnings. The weather improved a little and bright sun beamed warmth on the landscape, the children were allowed to come out and play. Cattle were grazing in the fields and fishermen were preparing to go out to sea. But within minutes the sky grew dark and there was an ominous roar, the likes of which had not been seen before. Everyone ran to their huts as winds whipped up to 155 miles an hour and a 20 foot high wall of water that rose like a giant monster from the sea hit the village and moved inland some 18 miles leaving a trail of death and destruction. This was the second cyclone to have lashed coastal Indian state of Orissa in a span of 12 days. The Mondal family and the 3000 residents of the village were washed away. Hundreds of children were orphaned by the cyclones and people's sources of livelihood, whether as farmers or fishermen, were decimated.

Over 10,000 people were killed in the worst affected districts of Jagatsinghpur, Kendraparal Puri, Baleshwar and Bhadrak of Orissa state. Some 12.5 million people and thousands of villages were ravaged by the fury of the cyclone. By the end of January 2000, CARE-India had distributed over 10,000 metric tons of food to over 425,000 families, along with plastic sheets to 149,000 families so that they could create temporary shelters. To counter the threat of cholera and other water borne diseases, CARE India provided water purification equipment to ensure safe drinking water.

All the boats of the 3000 fishermen of the village of Nuagaon and Noliasahi had been smashed by the strong winds and their fishing nets were washed away. The boats had been the lifeline for the villagers who had survived the storm. Care–India helped the fishermen rebuild their lives by providing fishing nets and building new boats. It helped them to construct small new wooden fishing boats at a cost of Rs 10,000 a boat, which was shared by a group of five fishermen who each contributed Rs. 800 with the remaining funds contributed by Care-India. Some 300 such groups were formed and 1500 families were able to resume their livelihood.

INTRODUCTION

CARE (originally "Cooperative for American Remittances to Europe", and later the "Cooperative for Assistance and Relief Everywhere") was founded in 1945 in the US where twenty two American organizations came together to provide food aid and basic

supplies in the form of 'CARE packages' to survivors of World War II in Europe. Later it expanded its aid to Asia and other parts of the developing world. As the economies of the wartime nations developed and improved, the focus of CARE's work shifted to the problems of the developing world.

Today CARE is one of the world's largest private humanitarian organizations, working in poor communities of 72 countries reaching more than 59 million people around the world. The secretariat is based in Geneva. There are more than 12,000 staffs -- most of whom are citizens of the countries where it works. CARE USA, headquartered in Atlanta, Georgia, is a part of an international confederation of eleven member organizations committed to helping communities in the developing world to reduce poverty. The board of directors of CARE- International is the organization's governing body, elected by the members at an annual meeting. Currently there are 22 members. All of the board members are volunteers and serve without compensation. The main responsibility of the board is to understand and initiate action in support of CARE's mission, goals and programs including assistance to expand CARE's outreach and increase its visibility and donor support.

CARE-India started its operation in 1950 as a part of CARE USA. It is a multi-sector social development and emergency humanitarian agency operating in twelve states and two union territories of India reaching 16 million people through a team of more than 500 people and strategic partnerships with the government of India, civil society organizations and international agencies. The mission in CARE-India is to facilitate lasting change in the well-being and social position of vulnerable groups. The organization focuses on working with the very poor, especially women and girls belonging to marginalized groups from lower classes, tribal groups, religious and cultural minorities and sex workers.

Having made a conscious shift from need-based food and related services to rights-based programming aimed at addressing underlying causes of poverty, CARE’s programs for vulnerable and marginalized communities have helped to develop solutions to poverty by strengthening the most vulnerable populations related to health, education, disaster relief and rehabilitation, HIV prevention, livelihood and holistic development.

HISTORICAL EVOLUTION

As the Cooperative for American Remittances to Europe (CARE) was sending CARE Packages® of food, clothing, medicine and other relief supplies to people in Europe and Asia after the war in 1946, the newly independent nation of India took its first steps toward self-governance following the uniting of severed independent states. In addition to creating national unity from diverse cultural and linguistic groups, the new sovereign republic also faced important challenges, including an uncertain economic future and the need to build up social services.

In 1950, students at Vassar College in Poughkeepsie, New York sent a shipment of CARE packages to students at Indian universities. It was part of the official Indo-CARE agreement, which was signed between CARE and the Government of India (March, 1950). Initially the focus was food commodities and expanded in the 1960s to provide food to twelve million primary school students and six million preschoolers annually. The Food-for-Work program in India was one of the first of its kind in the world and grew to encompass eleven States. The program included water harvesting, flood control and road rehabilitation.

The famine in the Bihar state of India prior to the establishment of the country of Bangladesh in 1970, during 1960s prompted CARE to begin managing the delivery of massive amounts of food commodities, while the refugee crisis led CARE to work with the United Nations to set up and maintain camps for displaced persons. This helped the organization evolve its response to humanitarian crises. Since then CARE has provided relief to several natural disasters: the flood relief in West Bengal in 1979, cyclones in Andhra Pradesh in 1977 and 1996, earthquake relief in Latur district of Maharashtra in 1993 and Chamoli district in Uttar Pradesh in 1999 and Orissa cyclone in 1999.

Gradually agriculture, health and education projects were added to CARE's range of activities. The agriculture support extended to the supply of hand tools, specially designed steel ploughs, construction of roads and irrigation canals. In the health sector, the emphasis was on the training of medical staff and the supply of mobile medical units and other equipment, books, midwifery kits and surgical instruments. To promote education, CARE provided adult literacy material, book cases, school kits and equipment for vocational training.

Until the mid 1980s, the primary objective of CARE India's activities was to provide food to vulnerable groups, especially children in the age group of 6 to 11 years. In 1984, with food aid from USAID, CARE began to support a portion of the Integrated Child Development services (ICDS) program, one of the largest mother and child survival program in the world, through its supplementary nutrition program. In early 1990s, CARE identified certain significant inter-related problems facing the poor in India related to increasing population, retaining children in school, health problems of women and children, food security, and degradation of natural resources. Care re-oriented its goals for serving poor women and children by expanding its program for increasing women's access to education, livelihood and control over their productive and reproductive lives.

In 1995 CARE-India launched its first educational initiative with the Girls' Primary Education (GPE) Project. During the same year, Integrated Nutrition and Health Project (INHP) was launched to reach population in the ten poorest states with multiple health related needs. These included the Better Health and Nutrition Project, Maternal and Infant Survival Project (MISP), the Child Survival Project, the Linkages for Improved Maternal and Infant Health Project and the Anemia Control Project. In the end of the 1990s, micro-finance projects were being launched through the grassroots mobilization and organization of self-help groups in six states (Bihar, Madhya Pradesh, Andhra Pradesh, Maharashtra, Orissa and west Bengal). In 1999, CARE India set up agriculture

and natural resources unit to bring about sustainable agriculture and natural resources management practices using a participatory development approach. In its new vision and goals for 2000 and beyond, CARE-India sought to promote sustained economic security for one million women belonging to low income households by 2005 through its Small Economic Activities Development Programs in nine states.

Since 2000, CARE programs are oriented towards addressing unequal power relations related to strengthening women's representation and participation in local governance and community institutions, and building strategic alliances and networks.

PROGRAMS AND APPROACHES

CARE–India implements programs by establishing partnerships between the government and local non-government organizations (NGOs) and community-based organizations (CBOs) seek to promote well-being and social position of women and girls. CARE-India provides capacity building assistance and funds to the partners to promote well-being. The government of India is another strategic partner to whom CARE-India provides technical assistance to implement services. The partnerships with the NGOs / CBOs are in the form of projects that are based upon addressing the needs of the community. The duration can vary between 3-5 years or even longer. Currently there are about 250 outreach partners which are either local non-government organizations (NGOs) or community based organizations (CBOs).

CARE uses a livelihoods approach within a rights-based framework to address women's poverty. The approach attempts to increase women's security in their work and lives by increasing their ability to control the conditions of their lives and enhancing their position in society. The common strategies of the economic empowerment programs include:

- Organizing of poor and marginalized communities of women
- Capacity building and promoting women's access to and control over resources and assets
- Promoting women as advocates and making governance structures more responsive to and inclusive of the voices of women

Health & Nutrition

CARE-India is committed to improving the health status of women and girls, as well as other vulnerable populations. The interventions are designed to increase access to family healthcare, nourish expecting mothers and young children, boost their resistance to infections and help prevent and/or reduce vulnerability to HIV/ AIDS. Since its inception, CARE has been working closely with the government of India to provide health and nutrition program to poor and marginalized communities. Since 1982, CARE has been actively supporting the government's work related to the Integrated Child Development Scheme (ICDS), one of the largest public health programs in India that reaches 15.5

million pregnant and breast-feeding women as well as children under the age of six, with a particular focus on children under two. The different health programs include

- RACHNA is a public health and family welfare program that focuses on basic family healthcare, including reproductive healthcare and HIV / AIDS prevention for poor rural and urban families in ten states. It is among the largest NGO public health programs in the world. The program seeks to catalyze existing public health programs by mobilizing communities to focus on a set of evidence-based preventive interventions and measurable outcomes designed to reduce malnutrition and mortality in children, increase the use of reliable, modern contraception and reduce the risk of HIV transmission in high-risk groups.
- SAKSHAM_ is a leading national technical assistance program supported by the Bill and Melinda Gates Foundation that focuses on HIV prevention work in India. The objective of the program is to strengthen awareness, knowledge, skills for HIV/AIDS management amongst non-governmental organizations in India.
- Sustainable Tribal Empowerment Project (STEP) is a process-oriented and multi-sectoral project that aims to achieve sustainable livelihood for marginalized tribal communities in four districts of northern Andhra Pradesh state of India covering 20% of the tribal population in the state. It is a seven year project, funded by European Commission, is implemented in partnership with ITDAs (Integrated Tribal Development Agencies) under the Department of Tribal Development, Government of Andhra Pradesh, local partner NGOs and community-based organizations (CBOs) targeting 200,000 tribal households. The main objective of the project is to raise community awareness and build capacity through access to information and improve the quality of service delivery. It focuses on five areas: 1) social mobilization and institution building, 2) education attainments, 3) health attainments, 4) economic attainments and 5) enabling environment and local self-governance.
- The project for Strengthening Awareness, Knowledge and Skills for HIV/AIDS Management (SNEHAL) seeks to improve the health and nutrition, education and livelihoods of women and girls working in the saltpans of Kutch in Gujarat state of India – as well as other marginalized communities facing livelihood insecurity like fishery or farming communities.

HIV/AIDS
CARE's SAKSHAM program, is a unique capacity-building effort designed to increase the understanding and skills of organizations participating in the fight against HIV/AIDS using innovative strategies that prevent the spread of HIV amongst vulnerable populations. SAKSHAM uses a Community-Led Structural Interventions (CLSI) approach to mobilize communities, build access to and utilization of services, and develop an enabling environment for community empowerment and decreased vulnerability to HIV/AIDS.

The SAKSHAM program involves sex workers, men who have sex with men, injecting drug users, truck drivers and others most vulnerable to HIV. To build an enabling

environment it also includes medical caregivers, suppliers and the community at large to improve the health services and reduce the stigma.

In 2009, the Program focused on six high-prevalence states that include Andhra Pradesh, Maharashtra, Tamil Nadu, Karnataka, Manipur and Nagaland as well as along the nation's highways.

Education

The education program addresses the causes of the denial of education to girls by promoting greater life opportunities through formal and alternative education. The Girls Education Program works to improve the formal education system through: 1) teacher training and curriculum development; 2) increase access of girls to educational services through gender awareness; 3) reduce dropouts; and 4) strengthen the abilities of communities to advocate for their right to education. CARE-India has helped more than 100,000 children, mostly girls, through increased participation in formal and alternative education.

CARE coordinates its efforts with two important national education efforts that support the development of girls in India. These are the *Kasturi Bai Balika Vidyalaya* and the National Program of Education for Girls at the Elementary Level in the states of Uttar Pradesh and Gujarat. It is also working to strengthen the preschool education (0-3 yrs) component of a large-scale national maternal and child health program known as the Integrated Child Development Services in the union territory of the Andaman and Nicobar Islands. In Andhra Pradesh, CARE-India works with the Integrated Tribal Development Agency to bring quality education to more children from tribal families who live on the fringes of mainstream society. It focuses on young children at state-run daycare centers, school-going children in rural and tribal settlements, teenage dropouts, girls who have never been to school, and semi-literate and illiterate youth and women. It incorporates three major tribal languages into the training curriculum for teachers, so that the children no longer needed to struggle to understand their teacher's instructions in the mainstream language in that state

CARE is also expanding its efforts to provide technical support to marginalized communities in order to reach adults and adolescents girls with the opportunity for education.

Livelihoods

CARE works to ensure that some of the most vulnerable communities in India (e.g. women and girls working in the saltpans, charcoal-making families, fishing communities, rural communities and subsistence farmers) are able to acquire viable and resilient livelihood through its microfinance program known as CASHE (Credit and Savings for Household Enterprise). The program not only encourages poor women to save, but also educates federations of women's groups about repayment to become more credit worthy in order to gain access to mainstream finance.

CASHE has far exceeded its targets since start up in 1999. Its clientele soared to 3, 74,000 in March 2006, nearly four times as many as targeted. By 2009, the total number of clients was over half a million, for the four Indian states of Andhra Pradesh, Madhya Pradesh, Orissa and West Bengal where client savings exceed 943 million Indian rupee and client loans total 1,219 million Indian rupees. CASHE has nurtured 33 microfinance institutions and 109 federations of self-help groups. Loans leveraged from banks stand at 520 million Indian rupees, and 11 mainstream banks have now become interested in poor women as a promising market for expanding their microfinance products, including micro insurance.

Disaster Management

CARE's disaster management and response program builds the capacity of communities to cope with natural and man-made disasters by working with local partners to alleviate human suffering and rehabilitating lives and livelihoods over the long term. The program includes disaster preparedness, disaster response and post-disaster recovery. Disaster preparedness involves mapping community resources by involving local government bodies and residents communities in planning for disasters as well as conducting disaster drills. The first phase of disaster response is to meet people's basic needs that include providing food, water, sanitation, shelter and basic health care to save lives. By conducting a rapid assessment of the damage done and the response of communities, CARE-India also examines how the UN, NGOs and the government have responded in order to determine CARE's response. The relief and rehabilitation includes activities that range from infrastructure repair and agricultural rehabilitation to small business assistance. The goal is to rebuild livelihoods in ways that reduce the vulnerability of communities to future disasters.

When it comes to ensuring that people can live their lives with dignity, after a disaster CARE-India uses the Sphere standards that emerged in July 1997, when a group of humanitarian agencies (including CARE-India) launched the Sphere Project with the aim of improving the quality of assistance provided to people affected by disasters and to promote the accountability of humanitarian agencies. These disaster relief standards relate to water supplies, sanitation, food, shelter and health.

The organization provides training for communities to conduct social audits and monitor relief and rehabilitation activities that promote transparency and equity. Where needed, CARE advocates for changes in rehabilitation policy and practice. CARE's program promotes empowerment, works in local partnerships, ensures accountability, promotes responsibility, addresses discrimination, promotes the non-violent resolution of conflicts and seeks sustainable results.

GOVERNANCE

CARE-India, part of CARE-USA, is governed by a board of 12 members. However CARE-India is in the process of becoming an independent affiliate of CARE International. It has now been registered in India with three national board members and

will soon be expanded to eleven members. The role of the board is to provide governance for the organization.

FINANCES

CARE-India receives funds from multilateral and bilateral donors, as well as from individuals, foundations, trusts and corporations. The annual budget for the organization for 2009 is approximately $35 million.

The major donors to CARE-India are:

- The UK Department for International Development
- The United States Agency for International Development
- The United States Department of Agriculture
- The European Union
- The Canadian International Development Agency
- The Gates Foundation
- The Michael and Susan Dell Foundation
- The Government of India

FUTURE VISION

During the next five year (2010-2015), CARE-India plans to become independent from Care USA and becoming the twelfth member to Care International and changing its strategy from a project-oriented need-based approach to a program-oriented integrated-approach focused on the poverty reduction in targeted populations.

CONCLUSION

The case describes a partnership model of service delivery between an international non-government organization and the government as well as with local non-government organizations and community-based organizations. CARE-India focuses on the underlying causes of poverty, gender inequality through community-based efforts to address the needs of those who are on the margin of society primarily women, children and minorities. The transition from a food distribution organization to an integrated community-based service delivery organization has been challenging, especially given the regional disparities, the social obstacles of the caste systems, gender inequality and different community responses. In spite of the challenges CARE-India continues to bring lasting sustainable change to the lives of millions while it becomes an independent affiliate to CARE-International and changes its implementation strategies.

DISCUSSI0N QUESTIONS

1. What are the organizational challenges to working in partnership with the government and other organizations?
2. What is the process of becoming an independent affiliation to the international organizations?
3. What are the common challenges caused by the regional disparities in India? How can they be addressed?

SOURCES

Care International (2009), Retrieved Oct 09 from http://www.care.org/about/index.asp

Country Profile-Care India (2008) , Asia Regional Office, Bangkok, Thailand Retrieved Oct 09 from http://www.careaustralia.org.au/Document.Doc?id=33

Celebrating a 50 Year Partnership CARE India 1950-2000, Retrieved Oct 09 from http://careindia.org/ManagePublications/VisitPublicationDetail.aspx?SectionID=59

Women and Economic Empowerment, CARE (2006), Retrieved Oct 09 from http://careindia.org/ManagePublications/VisitPublicationDetail.aspx?SectionID=74

Care India (2009), Financials-Donor, Retrieved Oct 09 from http://careindia.org/ManageFinancial/VisitFinancialDetail.aspx?SectionID=65

Rachna program (2001-2006); Executive summary: what we have learnt so far; Retrieved Dec 09 from http://www.careindia.org/DocumentLibrary/Executive%20Suummary%20What%20we%20have%20learnt%20so%20far11.pdf

Interview with R. N. Mohanty, Chief Operating Officer, Care-India.