2005-2010 Impact Report
LATIN AMERICA AND THE CARIBBEAN
Introduction:

why this report?

For more than 50 years, CARE has worked in Latin America and the Caribbean in programs to combat poverty and inequality. During these years, we have published a number of reports on our programs in the countries where we work, most of them focused on project activities and the resources we have invested in development.

However, this report goes beyond CARE’s activities and investment; it is intended to analyze the extent to which the projects and programs we implemented achieved - or not - an impact on poverty and inequality. The best intentions and substantial resources are not always enough to obtain positive changes in the lives of the most excluded and marginalized groups. It is only by conducting a deeper and more thorough analysis that we will be able to assess the impacts achieved. Learning from what went right and from the challenges that remain is an essential step for better contributing to development and social inclusion.

This report is intended to increase CARE’s accountability to governments and civil societies in Latin America and the Caribbean, based on the evidence of the impacts that CARE has contributed to in the region. In earlier decades, non-governmental organizations (NGOs) were given legitimacy simply because they existed. Today, it is necessary to go much further. We believe strongly in the importance of transparency regarding our achievements as well as our limitations. We feel that this openness will enhance our relevance and legitimacy.

The first chapter of this report presents CARE’s strategy in Latin America and the Caribbean; the second, the methodology used for identifying impacts; and the third contains the results of the analysis. The fourth chapter emphasizes our emergency response and disaster risk reduction efforts; the fifth chapter describes the results of an external survey we conducted about CARE’s work in the region. Finally, in the last chapter we reflect on what we have learned over the last five years and on issues that will require our attention and commitment in years to come.

It is our desire that this analysis will enrich dialogues with governments, other NGOs, communities, universities, the private sector and other institutions. We look forward to receiving recommendations from all of you about how to enhance our strategies in order to contribute to impacts that lead to greater social inclusion and equality.

We also hope that this report will foster the debate on how to measure the impact of initiatives supported by NGOs and encourage greater accountability. The changes in reducing poverty and social injustice that we aspire to will only be possible with more openness, responsibility and dialogue among all stakeholders.

Sofía Sprechmann
Deputy Director
CARE Latin America and the Caribbean
Haiti
We assisted more than 300,000 survivors of the devastating earthquake in Haiti with safe water and sanitation, hygiene kits and education, mattresses, cooking utensils, birth kits, tarps, as well as psycho-social support.

Guatemala
We contributed to a significant increase in access to preventive and curative health care services for 88,225 people.

Cuba
With the support of CARE Canada, we supported the development of a national strategy for agricultural diversification.

El Salvador
We contributed to reducing domestic violence for 2,400 people, as well as reducing the abuse of children and adolescents.

Peru
We contributed to a 49% reduction in the maternal mortality rate in the Ayacucho region. The model developed will be used by the government at national scale.

Brazil
Based on CARE’s successful model, the municipal government of Duque de Caxias in Rio de Janeiro, with a population of 870,000, adopted an environmental education policy.

Bolivia
We supported an average increase of 239% in the annual incomes from agriculture of 45,757 people (from US$0.40 to US$1.36 per capita per day) in the poorest regions of the country.

Nicaragua
We contributed to providing access to safe water and sanitation services for 18,065 people who previously lacked those services.

Ecuador
We attended over 40,000 women and 20,000 men in HIV prevention. We supported 20% of the country’s health centers which provide counseling for voluntary HIV testing.
**Haiti**
We assisted more than 300,000 survivors of the devastating earthquake in Haiti with safe water and sanitation, hygiene kits and education, mattresses, cooking utensils, birth kits, tarps, as well as psycho-social support.

**Guatemala**
We contributed to a significant increase in access to preventive and curative health care services for 88,225 people.

**El Salvador**
We contributed to reducing domestic violence for 2,400 people, as well as reducing the abuse of children and adolescents.

**Honduras**
We worked to withdraw or prevent 4,600 children and adolescents from engaging in exploitative child labor.

**Brazil**
Based on CARE’s successful model, the municipal government of Duque de Caxias in Rio de Janeiro, with a population of 870,000, adopted an environmental education policy.

**Nicaragua**
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**Bolivia**
We supported an average increase of 239% in the annual incomes from agriculture of 45,757 people (from US$0.40 to US$1.36 per capita per day) in the poorest regions of the country.

**CARE’s programs: examples of our impact**
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CARE’s strategy in Latin America and the Caribbean
From its founding in 1946, CARE has worked to improve the lives of the poorest and most excluded populations around the world. In 2009, CARE was implementing programs in 72 countries with the support of the 12 members of the CARE International federation - Australia, Austria, Canada, Denmark, France, Germany and Luxemburg, Japan, the Netherlands, Norway, Thailand, the United Kingdom and the United States. Last year, these programs reached nearly 60 million people in Africa, Asia, Eastern Europe, the Middle East and Latin America and the Caribbean.

In Latin America and the Caribbean, CARE supported approximately 100 projects in 2009, with a total budget of $84 million for programs in Brazil, Bolivia, Cuba, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Nicaragua and Peru. The funding for the programs that CARE carries out come from a variety of sources, such as multilateral and bilateral aid, private and corporate donors, foundations and governments of host countries. It should be noted that in two of the countries where we work in the region - Brazil and Peru - steps are being taken to convert these offices into full members of the CARE International confederation.

CARE works on a number of different issues in the region: micro-credit, agriculture and natural resource management, nutrition, health, HIV/AIDS, education, water and sanitation, and democracy and governance, aiming to reduce the barriers that prevent access to essential services for the most excluded populations and to foster sustainable and equitable development. For this purpose, one of the key strategies of CARE’s programs is to build capacities at all levels.

In recent years, there have been important changes in CARE’s strategy in Latin America and the Caribbean. We would like to highlight the six most significant changes.

First of all, we have made a shift to concentrate our efforts on the structural causes of poverty, rather than focusing on its consequences. This has meant putting issues like discrimination, the inequitable distribution of power, inadequate public policies and exclusionary economic development strategies at the center of our work. Through our programs, we are addressing these complex but crucial issues.

Secondly, we looked at the roles that we play in the countries where we work and selected those that allow us to make a more significant contribution to reducing poverty and inequality. Even when there are important differences in the roles CARE plays in each country - they are not the same in Brazil, Guatemala and Haiti - there are some commonalities:

CARE’s Vision

We seek a world of hope, tolerance and social justice, where poverty has been overcome and people live in dignity and security. CARE will be a global force and partner of choice within a worldwide movement dedicated to ending poverty. We will be known everywhere for our unshakeable commitment to the dignity of people.
Innovate and influence to take successful solutions to scale. One of the most important roles for an NGO like CARE is to develop and promote innovative strategies for reducing poverty. These strategies are developed together with other actors, never in isolation, and generate evidence of the impact that they have on poverty. Based on this evidence, we advocate for changes in public policies and/or their implementation at local, national and international levels. We also promote the scale up of these innovative and successful strategies – primarily by the State – so that they can benefit a larger number of people.

Support the demands of the most excluded groups of the population. Another role that we prioritize is ensuring that the demands and interests of the most marginalized sectors are taken into account by governments and the private sector. For this purpose, one fundamental strategy is to work in solidarity with social movements that represent these groups.

Influence the most privileged sectors of the population. Without a change in the attitudes and actions of the most privileged sectors of the population, both in developed countries as well as in developing countries, it is difficult to conceive a better world. Influencing these sectors is one of the roles that we play in Latin American and Caribbean countries, as well as in developed countries.

It should be noted that in all of these roles, we work with a broad spectrum of partners and allies. A decade ago, we implemented many of our projects directly. Today, this is the exception for CARE. We are part of a wide range of networks and alliances with which we share the same vision and objectives.

Thirdly, we have incorporated a human rights approach in our programs. We seek to contribute to the fulfillment of human rights as established by the Universal Declaration of Human Rights and other international instruments. This approach has not only meant a change in CARE’s actions, but also in how we analyze the problems we address. Therefore, we advocate so that those who have responsibilities related to the exercise of human rights fulfill their duties. On the other hand, we strengthen the most excluded populations so that they can voice and negotiate their own demands. In our programs, we promote principles derived from human rights, like non-discrimination and equality, participation and inclusion, as well as responsibility and accountability.

In the past five years, we have placed a priority on women and girls in our programs and projects. Based on the incorporation of a human rights-based approach and a strong belief in the principle of equality, we promote opportunities for women and girls in our programs, and work so that they can take control of their own lives. However, as we are aware that this is not enough, we also support measures to compensate for the historical and social disadvantages women and girls have suffered. For example, a woman who gains access to resources to improve her income through a micro-credit program could find that her initiative
generates friction, fear or domestic violence. For that reason, we support actions at various levels, working both with women and men in order to promote greater equality.

We want to highlight a final point regarding our strategy in the region: **accountability and the measurement of significant impacts.** This report is an example of this change and an effort to widely share our contributions to the fight against poverty as well as the challenges we have faced in our work. We know that we still have a lot to learn and a ways to go in terms of measuring our impact and ensuring mechanisms by which we are accountable for them. It is our commitment, starting with this publication, to do so in a more systematic and regular way.

**The CARE that we want to be in Latin America and the Caribbean**

- A CARE that puts dignity and equity at the center of its work.
- A CARE that better understands the context in which it works and defines its relevance with respect to this context, based on dialogue with others.
- A CARE that explicitly addresses the structural causes of poverty.
- A CARE that learns from and works intensely with others, and which is accountable for the impacts of its programs.
Methods for the impact analysis
The analysis on the impact of CARE’s programs in Latin America and the Caribbean took into account a five-year period, between July 2005 and June 2010. We used three methods to do the research: a) a quantitative and qualitative analysis of CARE’s contributions to reducing poverty and social injustice, within the framework of Millennium Development Goals (MDGs); b) a qualitative analysis about the impacts on the structural causes of poverty; and c) an external survey on the opinions of partners and allies about CARE’s work and its capacity to contribute to generating significant impacts. Below we will explain each of these methods in more detail.

Analysis of CARE’s contributions to Millennium Development Goals

In order to analyze CARE’s contributions in the region, we used as a framework of reference MDGs, which have become the main development agenda for the United Nations as well as for most governments in the region and for many other organizations. As MDGs are a reference point for joint action, we chose to analyze and summarize our contributions to impacts in relation to them.

Nevertheless, as do many others, we feel that MDGs have limitations. They omit some elements that we consider to be crucial, especially in regard to equity, gender equality, governance and climate change. As can be observed in the following chapters which present the results of the impact analysis, we have broadened our reflections to include issues that go beyond MDGs, issues that we feel are fundamental in the fight against poverty and inequality.

In order to analyze CARE’s contributions, we took the following main steps: First, we listed all projects that concluded between 2005 and 2010, as well as solid programs that had an intermediate evaluation in this period. Second, we reviewed all external evaluations conducted of those projects within the study period, as well as internal evaluations or final reports that contained substantiated evidence of impact. It is important to note that some of these projects began before 2005, but we included them in the study if their final evaluation was conducted during the study period. It should also be noted that some projects were funded by more than one donor, and therefore the impacts generated are attributable to all them.

A total of 461 CARE program initiatives concluded during the period analyzed for this study. However, not all of them had an external or internal evaluation or a final report solid enough to provide evidence of impacts – only 334 (or 72%) of them had solid information. In the final chapter of this report we reflect on the elements of our work that we need to improve, and without a doubt this is a point that deserves attention. It is fundamental that we properly document our actions and that we establish mechanisms to share the contributions that they make. Moreover, we are aware that many of the projects for which we do not have a sound evaluation had significant achievements. However, we are not presenting information on them in order to ensure a minimum level of rigor in the way in which we show our contributions.

Another aspect to take into account is that not all evaluations reviewed contained information on impacts. A number of them described the activities and direct results of these actions, but omitted references to impacts in terms of poverty reduction or the various manifestations of inequality. This is also an issue that we explore more deeply in later chapters.
One challenge that we faced when doing the analysis was the diversity of indicators that projects used to measure their impacts, depending on what the CARE teams and their partners involved in project design had agreed with donors. For example, to measure the increase in household income, projects used a variety of indicators that cannot be aggregated.\(^1\) This is why we are including only the most consistent information in this report, and not all information that was found.

In addition to the quantitative impacts, we reviewed CARE’s contributions related to changes in public policies and the implementation of those policies. We influenced ad total of 126 public policies at the municipal or national level to better respond to the demands and the rights of the most excluded populations. This report does not include all but some examples of these public policy changes, especially where we have evidence of their sustainability.

In summary, keeping in mind all of these aspects, we decided to present in this report the main achievements that were adequately documented and supported, but these are certainly not all of CARE’s contribution in the region. We know that we have a long way to go in terms of measuring impact.

**Number and percentage of initiatives analyzed for the impact report**

<table>
<thead>
<tr>
<th>Initatives that concluded between 2005 and 2010</th>
<th>461</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiatives with an external or internal evaluation or final report that adequately substantiate impacts</td>
<td>334</td>
<td>72%</td>
</tr>
<tr>
<td>Initiatives that contributed to a change in a public policy or its enhanced implementation</td>
<td>126</td>
<td>27%</td>
</tr>
</tbody>
</table>

**Qualitative impact analysis on structural causes of poverty**

For this report, we used the Most Significant Change (MSC) methodology, as well as qualitative information from the evaluations, to analyze example of CARE’s influence on the structural causes of poverty.

MSC\(^2\) is a qualitative methodology that consists of gathering testimonies of changes occurred over a specific period of time attributable to the interventions of a project. The methodology is useful for learning what has changed and reasons for the change, for understanding the impact of project activities on people, and for exploring what people think about the change: is

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\(^1\) We understand poverty as a multi-dimensional concept, subject not only to an economic point of view.

\(^2\) See http://www.mande.co.uk/docs/MSCGuide.pdf
it positive or negative? It also helps identify which changes are seen as significant and which not, and promote learning on how project activities can be improved.

Following this methodology, we identified a total of 65 examples in which we addressed structural causes of poverty through our programs, causes like discrimination based on sex, race and social class; public policies – in some contexts – that do not take into account the rights of excluded populations; weak citizen participation and apathy of some sectors of the population; as well as extraction-based and unsustainable economic models and their multiple consequences, such as climate change.

The most significant changes were documented through interviews with members of the communities with whom we work, government officials, members of NGOs, participants in social movements and other stakeholders. For each of the changes, at least one interview was conducted. This report does not present all of these changes, but rather those that best illustrate CARE’s contributions.

We recognize that the descriptions of these changes are limited to the experiences of the people interviewed, and do not always represent the totality of views of the stakeholders with whom we work. Nonetheless, these stories are important for demonstrating impacts from the point of view of key actors and their experiences.

**The external survey**

Even though many of the evaluations of CARE projects were external, for this report it was essential to conduct a survey of partners and allies, as well as other stakeholders, in order to learn how they perceive our contributions in the region. The survey was conducted online to ensure the confidentiality of responses and answered by 200 people. It seemed to us that obtaining this round number of responses was a good sign!

Chapter 5 of this report presents the results of the survey, which was answered by members of community organizations, international and national NGOs, multi-lateral institutions, officials from national and municipal governments, participants in social movements, donors, academics from universities and other research centers, as well as representatives of private companies from all of the countries in the region where we work.

There are, without a doubt, different forms, instruments and tools which an organization like CARE can use to hold itself accountable for its actions. By describing the methodology employed for the impact analysis, we would like to transmit our intention to conduct an assessment which is sufficiently solid. We would also like to encourage dialogue about what the best methodologies are for measuring the contributions of a NGO such as CARE. For the future, it is fundamental to achieve more agreement among different stakeholders about how to evaluate their actions in the fight against poverty and inequality. Such an agreement will promote greater transparency.
Advancing toward Millennium Development Goals: CARE’s contribution
Eradicate extreme poverty and hunger

This section presents the contributions of CARE to MDG 1 - eradicate extreme poverty and hunger. The first part shows the impact of our programs on income poverty and inequality; the second part reports on our contribution to reducing hunger.

Reducing extreme poverty and inequality

The indicators related to this objective include, among others, the proportion of the population below US$1 per day, the share of poorest quintile in national consumption, and the proportion of employed people living below US$ 1 per day.

Even when it is necessary to have some measurements for comparison, which can also be collected worldwide, these indicators have certainly their limitations. The concept of living on less than US$1 per day excludes poor people who survive with little more than this amount per day, but who still live in conditions of extreme vulnerability and exclusion. That is why in our work we also use the indicators that governments use to measure economic poverty (extreme poverty and total poverty). In addition, the MDG indicators link wealth to consumption and do not take into account the effects of production on people and on the environment.

It is also important to mention that CARE works with sectors that fall into the category of the poorest 20% of the population of Latin America and the Caribbean. That is why we think we are contributing to reducing inequality with our efforts to combat poverty.

Therefore, in the programs that are aimed at reducing income poverty and increasing income, we have used indicators which go beyond those contained in MDG 1. However, we believe that we still have a lot of room for improvement in measuring the impact of these programs; in the future we want to put much more emphasis on critical issues like measuring income inequality and other types of inequality. In chapter 6, where we synthesize the lessons learned, we have included a reflection on this subject.

In the past five years, we have implemented initiatives intended to reduce economic poverty in eight countries in the region – Brazil, Bolivia, Ecuador, El Salvador, Haiti, Honduras, Guatemala, Nicaragua and Peru - impacting on the lives of 885,145 people in areas of extreme poverty, especially in rural and peri-urban environments.

Economic development programs have stimulated the production and marketing of agricultural and agro-industrial products, livestock, forest products, crafts and textiles. We have placed special attention on promoting economic activities with low environmental impact, like organic farming and the generation of new technologies that enable appropriate natural resources management, for example bio-digesters. In addition to strengthening the technical and management capacities of the producers to improve productivity and competitiveness, we have fostered their linkages with new and better markets, like in Honduras and Nicaragua, where

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3 The official United Nations indicator is US$1 per day and the official measurement is US$1.25. It is recommended to use national poverty lines.
we supported the production and export of organic coffee. We promoted sustainable models of access to technical assistance at the community level, given the fact that in many countries in the region, governments have withdrawn these services in the past decade. Our emphasis on economic development programs has also centered on organizations of small producers, to build up solidarity among them and their capacity for negotiating with others. We have promoted alliances with business sectors with corporate social responsibility initiatives.

The graph shows the most significant impact for 94,283 households, which is the equivalent of 471,415 people, in some of the countries where we have implemented economic development programs. It shows the increase in the average income per household obtained during the period of analysis in the most marginal areas of the Andean highlands in Bolivia and Peru, in northeastern Haiti and in areas with high poverty rates in Honduras.

In total, CARE programs in these countries contributed to an average increase of 112% in the annual incomes from agriculture of 94,283 households, which works out to an average annual increase from US$1,130 to US$2,398 per household (or from US$0.62 per capita to US$1.31 per capita per day), with which it could be expected that the majority of these households have crossed over the poverty line.

One of the factors that explains the increase in impact is the change in the practices of producers. We cite here some examples:

- In Bolivia, 56,580 producers employed new farming or livestock practices, using the production chains approach (textiles, cheese, peanuts, peaches, peppers, etc.). Another 1,585 people built their capacities in non-agricultural productive activities, like handicrafts and textiles.

- In Honduras, 17,000 households improved their access to markets from 33% to 46%.

- In Guatemala, in the departments of Sololá and Quiché, we supported the linkage of the Adiska Association with La Fragua, the main suppliers of produce to the largest supermarket chains in the country.

- Peru appears twice in this graph because data belongs to different time periods.

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### Annual income of 94,283 households in Bolivia, Haiti, Honduras and Peru

<table>
<thead>
<tr>
<th>Country</th>
<th>Before the program</th>
<th>After the program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolivia</td>
<td>US$ 735</td>
<td>US$ 2490</td>
</tr>
<tr>
<td>Haiti</td>
<td>US$ 939</td>
<td>US$ 3596</td>
</tr>
<tr>
<td>Honduras</td>
<td>US$ 489</td>
<td>US$ 2406</td>
</tr>
<tr>
<td>Peru</td>
<td>US$ 755</td>
<td>US$ 2501</td>
</tr>
<tr>
<td></td>
<td>US$ 1427</td>
<td>US$ 2297</td>
</tr>
</tbody>
</table>

*Peru appears twice in this graph because data belongs to different time periods.*
• In Guatemala, 10,420 producers used three or more sustainable agriculture practices.

• In Nicaragua, 400 farmers produced and sold organic coffee.

• In Peru, 48,367 producers in the highlands, from 8 regions with the highest poverty rates, built their agricultural management capacity to improve their productivity and marketing.

One of the biggest impediments to overcoming income poverty for broad sectors of the population is the access to credit in line with their characteristics and capacity. These groups generally remain excluded from formal credit systems. The CARE experience with the greatest impact has been EDYFICAR in Peru, a financial entity established by CARE in 1998 to provide financial services to low-income sectors.

In 2007, the Inter-American Development Bank ranked EDYFICAR as ninth among the top 100 micro-finance institutions in Latin America. In 2009, its portfolio reached US$194 million, serving people in 13 regions in Peru. Also in that year, the Banco de Crédito del Perú – the most important bank in the country - reached an agreement with CARE to acquire the majority stake in EDYFICAR. Since then, it has operated under the model of financial services aimed at the lowest income segments of the population.

In Brazil, CARE has developed community banks providing services to 8,000 people in the states of Bahia and Piauí. The model it promoted together with partners has shown significant impacts on poverty and due to its success was adopted by municipal governments.

Another important line of work, in addition to those already mentioned, has been supporting municipal governments for local economic development processes. The investments of these governments in productive infrastructure, organizing exhibitions and events to promote and sell local products, as well as facilitating linkages with new markets, are central for fostering economic development.

Some examples of CARE’s support to municipal governments are:

• In border towns of Bolivia, we supported the inclusion of traditionally excluded sectors in municipal economic development agendas, by supporting the establishment of 5 oversight committees so that 34 productive organizations could participate actively and incorporate their demands in municipal development plans. A total of 40 municipal officials improved their capacity to support an inclusive process.

“With the new seed I have been able to produce a lot more. I invested the surplus in raising animals. I will store the seeds for the next farming season.”

Aniel Dorestan, Haiti

EDYFICAR, a micro-finance entity founded by CARE Peru, in 2008 provided access to credit to 182,310 people of the lowest-income sectors. The total amount loaned was US$194 million.
• In Ecuador, we supported the design of participatory budgets in areas near the Colombian and Peruvian border, as well as the Ecuadorian Amazon region, to stimulate economic development.

• In Peru, we worked with 80 local governments to formulate consensual development plans and develop participatory budgets, and thereby strengthen production chains for increasing household income.

Beyond the local level, we have also encouraged the adoption of innovative models in national-level public policies, in order to help strengthen public administration and ensure the inclusion of excluded sectors of the population in development programs promoted by governments, as in the case of Peru.

Reducing hunger

This section shows the impacts of CARE programs on reducing chronic malnutrition. Most of our work related to this goal was focused in Bolivia, Ecuador, Guatemala, Haiti, Honduras and Peru. We primarily used six strategies to combat malnutrition:

• Influencing public policies and investments at the municipal and national level to reduce chronic child malnutrition.
• Building the capacities of community members in the areas of food production, child care and feeding practices.
• Promoting hygiene education and access to water and sanitation. This strategy is presented with more detail in the MDG 7 section. Even though it appears in relation to that MDG, it is central for reducing child malnutrition.
• Encouraging exclusive breastfeeding until the sixth month.
• Supporting health outreach services and actions at the local level, to ensure better attention to children suffering from malnutrition.
• Providing food rations to children less than five years of age at risk of malnutrition.

In the past five years, we achieved significant impacts in contributing to reducing chronic child malnutrition from 25% to 19% for a population of 2,226,371 children under five years of age in Bolivia, Honduras and Peru. This means that 132,885 children overcame chronic malnutrition.

The contribution to reducing chronic child malnutrition was particularly significant in Peru, because of the role that CARE and its partners played in supporting the development and implementation of national and regional strategies.
CARE contributions to reducing chronic malnutrition in children under five years in Bolivia, Honduras and Peru

<table>
<thead>
<tr>
<th>Country</th>
<th>% malnourished before</th>
<th>% malnourished after</th>
<th>Population of children in programs</th>
<th># of children no longer malnourished</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolivia (0 to 2 years)</td>
<td>46</td>
<td>28</td>
<td>14,104</td>
<td>2,539</td>
</tr>
<tr>
<td>Bolivia (3 to 5 years)</td>
<td>51</td>
<td>42</td>
<td>4,603</td>
<td>414</td>
</tr>
<tr>
<td>Honduras (2 to 5 years)</td>
<td>61</td>
<td>50</td>
<td>12,750</td>
<td>1,403</td>
</tr>
<tr>
<td>Peru (0 to 2 years)</td>
<td>42</td>
<td>50</td>
<td>34,000</td>
<td>3,196</td>
</tr>
<tr>
<td>Peru (0 to 5 years, public policy)</td>
<td>24</td>
<td>18</td>
<td>2,160,914</td>
<td>125,333</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>19</td>
<td>2,226,371</td>
<td>132,885</td>
</tr>
</tbody>
</table>

Influencing national policies to combat chronic child malnutrition: the case of Peru

In 2006, CARE Peru supported, together with other organizations, the creation of the Initiative Against Child Malnutrition in Peru. The Initiative convinced the 10 candidates for President of Peru in the 2006 elections to sign a memorandum in which they committed to making chronic child malnutrition a priority of their government should they win the elections, and to achieve a reduction of 5 percentage points during their 5-year term, while closing the urban-rural gap. By mid-August, the Prime Minister of the newly elected government confirmed this commitment in his first address to Congress.

Since then, the Government of Peru carried out comprehensive interventions to address chronic child malnutrition. Demographic surveys report a nationwide reduction of this indicator from 23% to 18% between 2005 and 2009. CARE Peru was an important part of this achievement, and together with its allies in the Initiative, supported the creation and implementation of the National Strategy Crecer (Grow), especially in Apurímac, Ayacucho and Huancavelica, regions which are home to approximately 170,000 children under five years of age. The strategy includes local malnutrition assessments, monitoring systems and pro-nutrition public investment plans.

For the national, regional and local elections in the 2010-2011 cycle, the Initiative is working to ensure that the next administration remains committed to fighting chronic malnutrition and maintains this goal as a national priority.

“We supported the mobilization of civil society groups and organizations to impact chronic child malnutrition. It is with efforts of this kind that we will achieve a more significant contribution in Peru.”

Milo Stanojevich, Director of CARE Perú
In countries like Bolivia and Honduras, CARE also influenced public policy. We can highlight the following examples:

- **In Bolivia**, CARE supported the implementation of the national Zero Malnutrition program, by training 1,350 health volunteers and 469 staff members of Ministry of Health clinics in monitoring malnutrition among children under the age of five. In addition, we contributed to the establishment of Nutrition Units in municipalities with high levels of food insecurity.

- **In Honduras**, CARE contributed to the creation of a network of volunteers who are working with the Health Units of the Ministry. This network was recognized by the government as ‘the right arm of the Health Units’.

In the more direct work with populations affected by malnutrition, we implemented a number of strategies at community level. One of these strategies was to train promoters and committees in communities to monitor food security locally. In Guatemala, 211 committees were established in order to monitor malnutrition in their communities.

Promoting family gardens in order to feed families in the areas most affected by malnutrition was another one of CARE’s priority activities. In Ecuador, we supported a traditional way of organizing the family garden in the Amazon region of the country, the Aja Shuar, in order to not only encourage proper household nutrition, but also support rescuing ancestral cultures and conserve the environment.

In Peru, we contributed to strengthening the capacities of 1,358 health promoters in eight regions of the country, and to creating local coordination councils and community-based systems for monitoring activities intended to promote food security. Another CARE strategy used in its community-based work was to encourage **exclusive breastfeeding** until six months, along with appropriate complementary feeding after that time.

Through community-level efforts to reduce malnutrition, CARE was able to widely promote women’s participation. Mobilizing women to improve the nutrition of their children, as observed in the evaluations of CARE programs in Bolivia, Haiti, Honduras and Peru, where they participated in preparing municipal plans to reduce malnutrition, was fundamental in achieving impact.

Even though this is a strategy that CARE has since discontinued, during the period covered in this report we provided food rations for the most critical cases of chronic and severe malnutrition. In Bolivia, we distributed a total of **148,385 rations** to children under five and mobilized communities to identify cases of child malnutrition, improve practices as a means of prevention and take action in conjunction with health staff. In Guatemala, **23,891 households** received rations.
Achieve universal primary education

In this section, we present the impacts that CARE has contributed to in relation to MDG 2 on achieving universal primary education. It should be mentioned that analyses carried out from various perspectives indicate that indicators for this MDG encompass school access and completion rates, but do not take into account educational quality. In addition to measuring the net enrollment ratio in primary education and the proportion of students starting grade one who reach the last grade of primary schooling, it is essential to measure the levels of learning and competency of students. We know that there are children who complete primary school without the necessary knowledge and skills for their futures. We also know that education management capacities are still limited in their ability to generate innovative classroom curricula, to incorporate elements of equity and interculturality, and to respond to the specific contexts of the student population.

School tests in subjects like mathematics and language provide – more than the years of schooling – very valuable information on educational quality, and therefore express the extent to which children can face the challenges of the future. The fact that there is great heterogeneity in the region in terms of the education provided in schools, justifies even more the need to focus on educational quality. Attendance numbers at these schools do not provide sufficient information. It should be mentioned that there are various countries in the region which, through their Ministries of Education, measure indicators that are more relevant than those contained in MDG 2. With regard to gender equity in education, that issue is addressed in the analysis of MDG 3, as this goal includes an indicator about the proportion of boys and girls in primary school. Given all of the above, in this part of the report we have focused on indicators of educational quality rather than quantity.

In its education programs, CARE has focused on three main approaches:

• Incorporating innovative methodologies in the classroom
• Supporting strategies for bilingual and intercultural education
• Promoting educational improvements that prevent and eliminate child and adolescent labor

In these programs, we always worked at three levels: in the communities, with the children and their parents; in the schools with teachers and administrative staff; and at the public policy level with policy makers from the education sector at local and national levels.

Incorporating innovative classroom methodologies

In this line of work, CARE’s programs have aimed at seeking alternative and innovative ways to improve the quality of the learning process in formal or alternative education. For this purpose, the strategy has focused on promoting the capacities of teachers or education authorities in managing the educational process; in encouraging and strengthening intercultural education experiences and proposals in public and private schools, facilitating improved administration of educational establishments; encouraging the inclusion of student governments in schools; facilitating linkages between teachers and students through play, in order to generate more trust and interaction with local realities; as well as to raise awareness and promote greater participation and engagement of the educational community – parents, teachers, local authorities – for guaranteeing a better quality of learning for children and adolescents. These strategies have helped retaining students in school and build their capacities.
CARE and its partners have worked in the past five years directly with a total of 44,491 children and adolescents in Ecuador, Guatemala, Haiti, Honduras, Nicaragua and Peru, to develop innovative models that involve the entire educational community and to improve the quality of education. In addition, CARE has contributed to ensuring that 10,763 children and adolescents reached higher levels of schooling, from preschool to primary school, primary to secondary, and from secondary to university.

As examples of impacts obtained, we present here results from Ecuador. The graph shows the average results of standardized tests in schools where an innovative model was applied in rural areas in the province of Loja, compared to national averages. It should be noted that in the program target areas, the percentage of the population considered poor was higher than the national average.

Beyond the improvements achieved in schools with innovative models supported by CARE and its partners, out of these experiences we participated in processes to influence public policies, using successful experiences to benefit a larger number of girls, boys and adolescents. In these policy advocacy experiences, the participation of indigenous, rural and community organizations was very important, as well as of other civil society organizations, which helped ensure that the formulation and implementation of these policies were in accordance with their reality and identity, and that they responded to their community’s learning needs.

CARE Ecuador participated in civil society networks and alliances to support the implementation of Ecuador’s ten-year Education Plan. One of the most significant contributions was to promote the construction of a citizen’s agenda to help implement the plan. This agenda was developed by the Social Contract for Education, an alliance in which CARE participates. We have learned that for an educational policy to be successful, it is essential to involve the entire educational community: girls, boys, adolescents, parents, teachers, as well as local and national authorities.
The improvement of alternative education has also been part of CARE’s efforts in the past five years. Innovative learning methodologies have been promoted like child tutors, reading circles, and education for teenage mothers in a total of 320 schools in the region.

Again, in these programs, CARE’s biggest contribution - beyond the implementation of specific projects – was the use of the lessons learned. We were able to take the learning form these experiences and influence public policies to reach a greater number of children and adolescents, as was the case in Brazil.

With regard to achievements in improving teacher capacities, CARE has supported the training of 4,861 teachers in Bolivia, Ecuador Honduras and Peru in innovative teaching methodologies in subjects like math and language, as well as in how to work with didactic elements and improve teacher-student relations.

The experiences of the actions carried out in training teachers were used to influence public policies in various countries. In Haiti, based on successful strategies proposed by CARE and its partners, inspectors began to assume more responsibility in controlling the quality of education in their visits to schools in two regions of the country, the Artibonite and Northwest regions. In addition, parent associations significantly increased their participation in schools, in order to improve the quality of the teaching that their children were receiving.

Supporting strategies for bilingual and intercultural education

CARE’s support for bilingual and intercultural education has had significant impacts in Ecuador, Guatemala and Peru. For example, in Ecuador, based on a study facilitated by CARE and a cooperation agreement with the Ministry of Education and the National Directorate of Bilingual Education, a methodology was approved to allocate resources for bilingual education.

In Peru, CARE supported regional education authorities in developing a curriculum for intercultural bilingual education in the Puno region, through a highly participatory process of gathering social demands for education in 13 provinces. The application of this curriculum, which regional authorities and the civil society in Puno feel is theirs and not a product of an NGO project, is going to impact the education of more than 400,000 children and adolescents in coming years in this region.

“I have experienced the transformation potential of education: It can only be achieved with a closer relationship between students and the teacher. This has been an experience in expressing affection.”

Testimony from a participant in the teacher training project, Bolivia
The curriculum is intended to foster education for human and collective development; an education for intra-culturalism and inter-culturalism; a decolonizing and liberating education; and a productive and business-minded education. It promotes the four principles of the Andean philosophy of *Allin Kawsay* (Living Good), *Allin Munay* (Wanting Good), *Allin Yachay* (Learning Good) y *Allin Ruray* (Doing Good).

Promoting educational improvements to prevent and eliminate child and adolescent labor

The initiatives promoted by CARE in this area have sought to have an impact in preventing and eliminating child labor in sectors like mining, manufacturing and agriculture. They have also promoted the retention and graduation of working students in schools with programs specially designed for the context and needs of these populations.

The analysis shows that over the past five years we have worked in **Ecuador, Bolivia, El Salvador, Guatemala, Honduras and Nicaragua** with 370 schools for supporting a population of **15,740 working children and adolescents** and those at risk of starting to work between 6 and 17 years of age.

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**I experienced it with Sarita, a student. She was unmotivated. I didn’t know what child labor was. When I saw a quiet child I thought that they were lazy. Now I know that they were working. The change that we have achieved has to do with the way we work. Remember that before we told kids ‘sit down and shut up’. Not now; we have another opinion about what children need and another way of treating them and relating to them.**

Testimony from a first grade teacher, participant in an education initiative in Honduras
With respect to child and adolescent labor, one of CARE’s most important contributions over these five years was its influence on public policies, with the intent of developing innovative educational models that incorporate the problem of child labor. The most significant example of this was that of CARE Central America, where we worked not only in the countries where we have a presence – El Salvador, Guatemala, Honduras and Nicaragua – but also in Costa Rica and the Dominican Republic. With the backing of the Ministers of Education of those countries, 14 educational models were validated for preventing and/or eliminating child labor. A number of these models were adopted when their positive impact was demonstrated, for example:

- The incorporation of the ‘leveling classrooms’ and ‘holistic attention to working children’ models in programs of the Ministry of Education in El Salvador for 134 schools.
- The adoption of the ‘child tutor’ model in programs of the Secretariat of Education of Honduras in 6 of the country’s 18 departments.
- The incorporation of the ‘spaces to grow” model in programs of the Ministry of Education of the Dominican Republic for 100 schools in areas with populations at risk of dropping out of school and beginning exploitative work.

**Impacts on child and adolescent labor eradication and prevention by CARE and partner programs**

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>El Salvador, Ecuador, Guatemala, Honduras and Nicaragua</td>
<td>Number of children and adolescents withdrawn from work in various sectors.</td>
<td>4,905</td>
</tr>
<tr>
<td>Bolivia</td>
<td>Number of children attending schools with a curriculum that is contextualized to regions with a high prevalence of child and adolescent labor in mines.</td>
<td>6,250</td>
</tr>
<tr>
<td>Honduras</td>
<td>Number of working children who stay in school.</td>
<td>2,312</td>
</tr>
</tbody>
</table>

The CARE Guatemala program worked with 3,355 boys and girls in second and third grades. It was able to increase the percentage of students with sufficiency in mathematics and technology from 52% to 68%, by incorporating Mayan mathematics.
There has been much criticism of the limited vision regarding gender equality and women’s empowerment that is reflected in MDG 3. The indicators focus on measuring the ratios of girls and boys in primary, secondary and tertiary education; the share of women in wage employment in the non-agricultural sector; and the proportion of seats held by women in national parliament. Women’s organizations and movements throughout the world agree that this is a very narrow angle through which to define gender equality in society and the empowerment of women.

In our work at CARE, we have prioritized equality between women and men and the empowerment of women. We agree with the view of women’s organizations with respect to the critique that they have formulated regarding this MDG. Equality between women and men should not be limited to one single goal, but rather has to cut across all of them – income, nutrition, education, environment and participation. All of the indicators used to evaluate progress toward MDGs should be broken down by gender, not only those that are included in MDG 3. This is an aspect that we also want to improve in CARE programs. It should also be noted that none of the goals include an indicator regarding women’s empowerment.

There are a number of key issues that have to be addressed in order to achieve gender equality which do not appear in any MDG. We are referring to fundamental aspects like the elimination of all forms of discrimination, exclusion and violence against women, as well as the sexual division of labor. We are convinced that equality between women and men is both an end and in and of itself and an indispensable factor for development and social justice.

Taking into account all of these aspects, this section presents our contributions in relation to:

• Issues that are part of MDG 3 and also other MDGs (even though a gender equality perspective may not have been included in all MDGs); and
• Issues that are not included in MDGs but which we consider essential for promoting equality between women and men.

At the end of this section, we will refer to the regional CARE program to promote gender equality. This is a new program and therefore has not yet generated the impacts that we are hoping for. Nonetheless, we are mentioning it here in order to share the changes that we are experiencing as an organization, in pursuit of equality, as well as to commit ourselves from this point on to make even more significant contributions to increasing women’s autonomy.

CARE contributions to MDGs from a gender perspective

In recent years, we have made considerable progress in ensuring that CARE programs in all of the sectors in which we work – education, health, economic development, water and sanitation, governance and emergency response – put emphasis on an equitable distribution of power between men and women. We know that this approach is important but not sufficient, and that is why we have also worked on other issues, as will be seen later. However, including
A gender equity perspective has been a cross-cutting strategy of our work. This perspective is included from the program design stage, where we make a rigorous analysis of the discrimination suffered by women in various contexts. Some examples of our work in specific areas from a gender perspective are the following:

- In Bolivia, the education program promoted training in the rights of girls and women in night schools in La Paz and El Alto. It also encouraged the inclusion of sexual education in the curriculum, along with other subjects which - if they are not addressed - contribute to the marginalization of young people. In Ecuador, Honduras and Guatemala, our programs broadly supported girls’ education, as well as their participation in student governments. In Peru, our contribution was that 2,862 teachers, municipal government officials and community authorities promoted the importance of educating girls. We helped to reduce dropout and grade repetition for a population of 29,922 girls.

- In Nicaragua, in a water and sanitation program which supplied nearly 9,000 people with basic services and strengthened local water management committees, 43% of committees were led by women. Various testimonies by women leading these groups show that based on their involvement in managing potable water, they were able to enhance their leadership capacity in other areas of their lives.

- In Peru, we supported citizen participation in health, by training women in Puno to monitor the services provided by hospitals and health centers. In Nicaragua, we promoted family planning and provided information on reproductive health to 6,515 women.

- In Ecuador, we supported associations of recyclers in the city of Cuenca to increase their incomes, but also to reinforce their organizations and to build up women’s self-esteem. In Honduras, we contributed to the active participation of women in rural businesses; in Peru, we worked with 13,298 women producers in the rural highlands, and supported increasing their incomes by 217%.

- In Ecuador, the democracy and governance program strengthened the leadership and citizen participation capacities in 10 municipalities, with a focus on gender equity and interculturality.

We have learned that in order to promote an equitable distribution of power between women and men, it is fundamental to analyze the political dimension of discrimination at all levels – households, communities, countries. This means that, as an organization, we have to have clear and consistent responses when we witness abuses of power. This also implies promoting greater participation and democratization in our own organization.

**Contributions beyond MDGs to promote gender equity**

In addition to the issues mentioned above, which are part of MDGs, we have worked on some elements that we feel are fundamental in the fight for gender equality, like violence against women and the sexual division of labor.
In El Salvador, CARE worked with the Ministry of Education, women’s organizations and parents’ associations, to ensure that schools are safer for girls. Each month, the Ministry reports an average of eight cases of violence, sexual harassment or abuse of students – primarily females – in public schools. Most of these cases are not reported and the perpetrators remain unpunished. CARE supported 80 communities with high rates of violence in designing violence prevention initiatives, and in making decisions to resolve conflicts and to monitor the safety and quality of schools for young and teenage girls. This program – which worked directly with 2,400 girls, boys and adolescents – supported the government’s policies to prevent abuse and discrimination in schools.
In Peru, we worked with commercial sex workers, a group which is highly vulnerable to HIV as well as exploitation. We encouraged the consistent use of condoms and strengthened associations of sex workers. We were able to demonstrate, through an extensive study, that one of the factors that is strongly associated with the use of condoms is membership in an association of sex workers, which clearly underlined the importance of strengthening these groups.

Working with men is a fundamental strategy in the pursuit of greater equality. In Peru, we promoted environments for the development of responsible masculinity, primarily with adolescents in Huancavelica. The process of training adolescent leaders led to transformations in the way of thinking and the behavior of teenage boys. These transformations are expressed in improved gender equity in the distribution of roles with regard to household chores, relationships characterized by more cooperation, respect and horizontality between girls and boys, a reduction of violence among boys and against women, and a reduction in alcohol consumption. The leaders who were trained developed a capacity for reflection which allowed them to be more critical with respect to expressions of hegemonic masculinity (machismo), and violence in its many forms.

In the last two years, we have put special emphasis on the issue of the sexual division of labor. Even though it is too early to report impacts, we are currently implementing a program to support five initiatives of the women’s movement who are carrying out concrete actions to generate co-responsibility within the family, the community and the State in relation to unpaid reproductive work and the care of dependents, in countries like Bolivia, Ecuador, El Salvador, Nicaragua and Peru. We believe that this issue is at the core of inequality, and – if it is not addressed – progress toward equality between women and men will be slow and limited.

Our role in this program is to support some initiatives led by the women’s movement and civil society organizations. We want to avoid fragmenting our pro-equality efforts in sectors which have lost sight of more strategic issues like the sexual division of labor and discrimination against women.

“Now we know how to deal with situations of sexual harassment and abuse in schools. We know our rights and we know who to turn to.”

Miriam Edelmira Santamaria, estudiante, El Salvador
The target for this MDG is to reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. In Latin America and the Caribbean, it is estimated that 23 children out of every 1,000 live births die before reaching their fifth birthday. In the past five years, CARE has worked on programs to reduce the mortality rate of children under five in Bolivia, Ecuador, Haiti, Honduras, Nicaragua and Peru. At the community level, these programs directly reached 113,492 children. The models employed, as will be explained further on, were used to promote improvements in public policy.

Given the complexity of measuring child mortality, only one of CARE’s programs in the region, the one in Nicaragua, measured this indicator. The program achieved significant impacts in reducing the under-five mortality rate. The evaluation also showed that the percentage of women who identified at least three warning signs in newborns increased from 43% to 57%.

We do have information from our program evaluations about two of the illnesses that contribute to child mortality in Latin America and the Caribbean: pneumonia and diarrhea.

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Management of diarrhea in children under 5 years of age in programs in Bolivia, Honduras and Nicaragua

- **Bolivia**, 2,282 mothers: % that managed correctly the diarrhea episode of their child: 65%
- **Honduras**, 1,796 children under 5 years: % of children for which their diarrhea episode was managed correctly: 29%
- **Nicaragua**, 60,150 children under 5 years: % of children under 5 for which their diarrhea episode was managed correctly: 36%

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5 UNDP report on progress in fulfilling MDGs (2010)  
The increase in immunization coverage, another key factor in reducing child mortality, has also been a goal of our programs in the region over the past five years.

In developing models to reduce child mortality, our main strategy was to facilitate greater access to quality integrated health services, for the most marginalized and excluded communities. This included actions at the community level and at the level of the health services themselves, for example:

- Supporting Ministries of Health in the implementation and monitoring of strategies to reduce child mortality. In Peru, we provided technical assistance to the Ministry of Health in developing clinical guides for comprehensive child health care, with a human rights approach. Together with our allies from the Neonatal Health Collective, we helped the Ministry to develop guidelines to better address neonatal mortality, which accounts for nearly two-thirds of child deaths in the country. In 2008 and 2009, the Ministry introduced national standards to achieve more effective interventions to reduce infant mortality, and to strengthen epidemiological monitoring. Currently, we are supporting the government in implementing these standards at the national level.
Building the capacities of health service staff to provide quality care, based on a human rights approach. In Nicaragua we worked with 16 municipalities in the department of Matagalpa, in order to train staff of health care centers.

Training community-level volunteers on monitoring the health of children, and to connect them with health care services. In Bolivia, we contributed to the training of 538 community health agents, of a total of 1,583 trained in cooperation with other organizations. We also worked to facilitate the implementation of “Intercultural Community Family Health”, which was instituted as a national policy.

Supporting outreach campaigns to disseminate information for parents about caring for their children. In Ecuador, we reached 9,450 households with radio messages about children’s health.

One of the structural causes of poverty and inequality that we address through our programs is citizen apathy with regard to social problems. We feel that more participation of all sectors is crucial for achieving the transformation that we seek.

In order to achieve significant changes in Peru, CARE and its partners worked with the Ministry of Health, Congress and with civil society organizations to pass the Co-Management and Participation in Health Law. This law seeks to consolidate a system of participation by the population in administering health care establishments. CARE supported the Ministry of Health in formulating the regulations for this law, which was developed through a participatory process that was unprecedented for the country.

As a community health agent, I accompany families with sick children to the hospital. The doctor supports me and that motivates me because he values my work. For me it is a responsibility and I don’t expect anything from people. I want to work for the health of our neighborhood and people.

Carlos Poñe, Bolivia.
MDG 5 includes targets for reducing maternal mortality and births attended by skilled health personnel, as well as for universal access to reproductive health (the use of contraception, coverage of antenatal care and the adolescent birth rate). Our work to support MDG 5 has been focused in six of the countries where we work in the region: Bolivia, Ecuador, Guatemala, Haiti, Honduras, Nicaragua and Peru. Our more direct actions have reached a population of 779,223, for which we have supported improvements in obstetric and reproductive health services (access to prenatal care and family planning).

In our work to improve maternal health, we use an approach based on human rights which encompasses the following principles: no regression and adequate progress, non-discrimination and equality, participation, and responsibility. We work at being faithful to those principles and to be accountable for of objectives and targets.

CARE’s program in Peru had significant impacts on the reduction of maternal mortality and its model was approved by the government to be replicated and scaled up to the national level. We supported the Regional Department of Health of Ayacucho in improving the quality of managing obstetric emergencies, with regard to timely access to health services through a referral system, as well as in the referral of obstetric and neonatal emergencies. Throughout this process, we promoted a focus on interculturality and human rights, as well as the participation of civil society, to ensure safe and healthy maternity. The program was evaluated jointly by the Ministry of Health and CARE, and given its success, was used in 2007 to develop standardized guides for handling obstetric emergencies in the country. Based on its significant impacts, the model has been used beyond Peru, specifically in advising the Ministry of Health of Bolivia.

Other experiences also demonstrate CARE’s contribution to reducing maternal mortality:

- We helped train 2,043 health care staff in managing obstetric and neonatal emergencies in Bolivia, Ecuador, Guatemala, Nicaragua and Peru.

- We supported 33,813 people from poor and marginalized communities by advising them of the danger signs which require immediate hospital attention, in Bolivia, Ecuador, Guatemala and Nicaragua. In Ecuador, in Otavalo, we also supported the establishment of a radio system to communicate between rural communities and obstetric emergency services.

In Peru, we contributed to a 49% reduction in the maternal mortality rate in the Ayacucho region. The percentage of obstetric emergency care needs satisfied increased from 30% to 76%. The model developed will be used by the government nation-wide.

In the areas where we supported efforts to reduce maternal mortality, a total of 54,375 deliveries were attended by qualified personnel.

6 See the report by Physicians for Human Rights
• In Guatemala, we supported health care services for a population of 88,225 people, helping to strengthen obstetric care, as well as encouraging the communities to use these services. The model used for establishing contact between health care services and midwives was scaled up to the national level.

In terms of access to prenatal services, we contributed to ensuring that a total of 230,051 pregnant women had access to quality antenatal care in the first five months of pregnancy in Bolivia, Haiti and Nicaragua.

<table>
<thead>
<tr>
<th>% of pregnant women that attended antenatal care in the first 5 months of their pregnancy (programs in Bolivia, Haiti and Nicaragua)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolivia</td>
</tr>
<tr>
<td>68%</td>
</tr>
<tr>
<td>73%</td>
</tr>
<tr>
<td>Before</td>
</tr>
</tbody>
</table>

Our work also focused on promoting contraceptive methods for women and men.

• In Bolivia, a total of 26,320 women and men made use of family planning services supported by CARE; 77% of a population of 54,636 women knew at least three modern family planning methods, and 56% discussed sexually transmitted infections at least once with their spouse.

• In Bolivia and Honduras, we contributed to the training of 9,314 health care staff to provide family planning counseling services.

MDG 5 includes an indicator regarding birth rates among adolescents. Even though we have not measured this indicator in our more direct work, we have worked on various initiatives with young people. In Bolivia, we worked with 232 adolescents to develop their capacities as change agents to disseminate information, education and communication regarding sexual and reproductive health among peers. In Honduras, we worked in 12 schools and coordinated workshops with adolescents regarding sexuality, in close coordination with the Departmental Directorate of Education.
In addition to supporting changes to the changes and/or implementation of public policies already mentioned, CARE contributed to others in the area of maternal, sexual and reproductive health.

- In Bolivia, we supported departmental health services in the implementation of the Sexual and Reproductive Health Program 2004-2008, in 92 health care centers in two departments of the country. We also contributed to the implementation of Supreme Decree No. 26873 for establishing municipal pharmacies. We helped to disseminate National Standard No. 381 of the Ministry of Health, on patient counseling, informed choice and consent.
- In Ecuador, based on our experiences in Otavalo, we supported the Ministry of Health in designing a national policy to improve access to quality obstetric services.
- In Haiti, we supported departmental health services for the implementation of the 2002-2007 Sexual and Reproductive Health Program.
- In Honduras, we contributed to the National Strategy to Reduce Maternal and Child Mortality of the Health Secretariat, which identifies family planning as the most important component in reducing maternal deaths. We developed an approach to understanding the social conditions of sexually active adolescents between 15 and 24 years of age, in order to identify the challenges in promoting family planning among young people, in 6 municipalities of the department of La Paz.
- In Nicaragua, the strategy to strengthen community health associations was adopted by 16 municipal governments of the department of Matagalpa.

You can’t come into my house because its private, but this health care service is public. I have been trained and I have the right to be here. These are my credentials.

Nilda Chambi, maternal health monitor, Peru

In Peru, CARE supported a health care monitoring and citizen participation program, supporting the coordination of groups comprised of rural women and civil society networks. These groups and networks created alliances to work together to fulfill the rights of women. Through these oversight efforts, the initiative achieved a greater commitment to women’s rights on the part of health care services staff and local authorities. The initiative was recognized by the government as a key mechanism in improving the quality of health care services.

It is important that young people are aware of their reality and that we can talk about issues that are considered taboo. We have to build up trust in order to be able to talk about sexual and reproductive health, identity and self-esteem.

Teacher, Bolivia
In this section we will present our contributions to MDG 6. The first part will focus on the impacts on HIV/AIDS, while the second part will describe our work to reduce the prevalence of tuberculosis.

**HIV/AIDS**

This MDG, unlike others, includes indicators to measure specific data for women, like the HIV prevalence rate among 15 to 24 year old pregnant women. The emphasis on women is fundamental for this MDG, given the fact that the inequalities and violence that they suffer contribute to a greater vulnerability and risk of HIV. The document that resulted from the 2005 global summit to review the progress made in achieving MDGs, “energetically condemns the violations of the human rights of women and girls in situations of armed conflict and sexual exploitation, acts of violence and abuses against them” (United Nations, 2005).

In the past five years, CARE has worked on HIV/AIDS prevention and treatment, primarily in **Ecuador** and **Peru**. In these two countries we have served as the Principal Recipient for programs funded by The Global Fund to Fight AIDS, Tuberculosis and Malaria, in actions carried out at **national scale** to prevent and treat HIV/AIDS. We also implemented programs in **Haiti** and **Honduras**. In the four countries we have contributed to HIV/AIDS prevention or treatment programs for a total of **2,160,974 people**.

In **Ecuador** and **Peru**, given the fact that CARE worked on a national scale, the contributions and impacts were large-scale. We want to emphasize the fact that these actions – as well as all those presented in this report – are implemented together with partners and allies, and never in isolation. It is important to reiterate that all of the impacts described are the result of processes carried out with various partners.

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7 The Principal Recipient is selected by the Country Coordination Mechanism, which includes representatives of the government, civil society and people affected by HIV, tuberculosis and malaria to administer the funds. The Principal Recipient is responsible to the Global Fund for ensuring that the projects that its finances meet their objectives.
Using an approach based on human rights and non-discrimination, our work to combat HIV/AIDS focused on reducing the incidence of HIV among high-risk and highly vulnerable populations, on reducing vertical HIV transmission from mother to child, and on reducing the prevalence of HIV among the general population through broad-based strategies of communication and education.

The graph illustrates impacts at the level of prevalence, behavior and knowledge.

In Ecuador, we supported 20% of the health centers in the country that provide counseling for the voluntary HIV test.

In Ecuador and Peru, we helped to strengthen 469 health care centers in the provision of HIV/AIDS counseling services. More than one million people made use of these services.

**People reached with HIV counseling and/or testing services (Ecuador and Peru)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women</td>
<td>414,820</td>
</tr>
<tr>
<td>Women aged 15 to 49</td>
<td>653,665</td>
</tr>
<tr>
<td>People who received HIV counseling</td>
<td>46,693</td>
</tr>
<tr>
<td><strong>Total number of people</strong></td>
<td><strong>1,068,485</strong></td>
</tr>
</tbody>
</table>
We have employed a variety of strategies for combating HIV/AIDS, and they have been implemented in a coordinated way at the national and sub-national level. Among the most important of these strategies were:

- Guaranteeing timely treatment for people living with HIV/AIDS.
- Facilitating access of the population to counseling and voluntary testing centers.
- Improving access, quality and use of basic services related to HIV/AIDS, as well as the availability of condoms.
- Raising awareness and build the capacities of health care personnel in order to improve the quality of care and treatment of people living with HIV/AIDS.
- Developing awareness raising and mass communication campaigns to reduce the stigma and discrimination against people living with HIV/AIDS.
- Developing initiatives focused on populations with risk behaviors (men who have sex with men, transsexuals and commercial sex workers).
- Involving the private sector in HIV/AIDS in order to develop non-discriminatory human resources policies.
- Strengthening mechanisms to demand participation and citizen monitoring for people living with HIV/AIDS and for the population at risk.
- Encouraging the incorporation of HIV/AIDS in the public agenda, and promote public policies and budgets for this issue.
- Developing public spaces of accountability to provide information about progress made and to receive feedback in order to improve processes.

People reached with information and education regarding HIV prevention

<table>
<thead>
<tr>
<th>People reached with information and education efforts on HIV/AIDS (Ecuador)</th>
<th>数目</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>707,967</td>
</tr>
<tr>
<td>Adolescents reached with outreach activities regarding HIV prevention (Ecuador, Honduras, Peru)</td>
<td>279,368</td>
</tr>
<tr>
<td>Women from grassroots organizations trained on how to lead a healthy sexual life (Peru)</td>
<td>10,331</td>
</tr>
<tr>
<td>Men who have sex with men reached with HIV prevention activities (Ecuador and Peru)</td>
<td>56,832</td>
</tr>
<tr>
<td>Commercial sex workers reached with HIV prevention activities (Ecuador and Peru)</td>
<td>50,325</td>
</tr>
<tr>
<td>Staff of health care centers and teachers trained on eliminating stigma and discrimination against people living with HIV (Peru)</td>
<td>2,716</td>
</tr>
</tbody>
</table>
In terms of public policies and their strategic importance, we would like to mention some of the contributions that we have made to strengthen policies in order to help improve the lives of various sectors of the population.

In Ecuador, we contributed to the Multi-Sector Strategic HIV/AIDS Plan in Guayas, Manabí, Esmeraldas and El Oro. We also supported the approval of ministerial accord 436, which prohibits demanding any kind of health tests or examinations related to detecting HIV/AIDS as a requirement for enrollment in schools. We helped revising the HIV/AIDS law presented to the National Assembly, which includes a broader framework of rights of people living with HIV/AIDS, as well as a review of the legal framework regarding sexual diversity and non-discrimination.

CARE Peru has actively supported the process of designing and implementing the Multi-Sector Strategic Plan for the Prevention and Control of Sexually Transmitted Diseases and HIV/AIDS. We also supported the approval of ordinances by the Regional Governments of Ica, Tumbes and Ucayali so that adolescents over 14 years of age could have access to HIV counseling services without prior permission from their parents or legal guardian. The successful negotiations that CARE engaged in with the Peruvian government and the Global Fund to acquire generic medications for antiretroviral treatment, have contributed to reducing the cost of medications in future years. Together with other members of the CARE International Confederation, CARE Peru participated in the global campaign against the efforts of the company Novartis to promote a change in patent laws in India, which would have put at risk the possibility of acquiring generic medications manufactured in that country.

Previously, there were many difficulties in providing care to people living with HIV/AIDS. The patients did not know that they could file a complaint if their rights were violated. Now there is a monitoring plan. This is not easy because people living with HIV/AIDS do not want to disclose their status.

Celina del Pilar Dioses Piedra, Director, Asociación por la Vida, Peru
Tuberculosis

In two of the region’s countries, Ecuador and Peru, over the past five years CARE has served as the Principal Recipient of programs to fight tuberculosis financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria. As in the case of HIV/AIDS, in these two countries our contributions to reducing the prevalence of tuberculosis, a disease which involves discrimination and stigma, and which is closely related to poverty, have been at national scale.

We have also supported tuberculosis detection and treatment services in Haiti.

In Peru, we have contributed to the program led by the Ministry of Health for the treatment of people with tuberculosis at national level, working also with people deprived of their freedom in 27 of the country’s penitentiaries. A total of 10,906 people with multiple drug resistant tuberculosis received treatment.

The main strategies of the tuberculosis program were the following:

* Providing treatment to patients with tuberculosis. In Peru, in addition to providing tuberculosis treatment, we contributed to 9,960 tuberculosis patients receiving HIV/AIDS counseling and testing.
* Improving the tuberculosis information and diagnosis system. In Ecuador, we helped to equip a national laboratory, two regional laboratories and 24 provincial laboratories. We also supported the consolidation of a computerized information system.
* Strengthening health centers and hospitals in the detection and treatment of tuberculosis, as well as in managing bio-safety units. In Peru, we supported four centers of excellence for hospital care for tuberculosis patients. A total of 4,598 health care professionals were trained on how to manage this disease.
Strengthening social participation, monitoring and organization of people living with tuberculosis. In Peru, we supported 30 organizations of people affected by tuberculosis. A total of 540 community outreach workers were trained on preventing and controlling multiple drug-resistant tuberculosis.

- Supporting social mobilization in order to position tuberculosis on the public agenda. In Haiti, we promoted a social support system for people affected by tuberculosis.

- Strengthening social support and rehabilitation for those affected by tuberculosis. In Peru, 670 patients with tuberculosis benefitted from a social employment and housing program; 752 highly vulnerable people received food baskets.

CARE also made contributions to public policies. In Ecuador, we helped to update the national law for tuberculosis prevention and control. We assisted the Ministry of Health in regulating the free sale of anti-tuberculosis drugs.

In Peru, we presided over the health commission in charge of preparing an assessment on health problems in jails. We supported the creation of a food basket program for people with tuberculosis. We played an important role in designing the Multi-Sector Strategic Plan for Tuberculosis, which was done with the participation of civil society and the government. The plan indicated the importance of providing a multi-sector response to this disease; the supreme decree approving the plan was signed by the President of the Republic and the Ministers of Defense, Justice, Labor, Women and Health, in May 2010.

“... I changed the way I look at things. There are social determinants that lead to tuberculosis. Luz today is not the same person she was when she was told she had tuberculosis. We have received training on human rights, monitoring and social mobilization. Now we participate in decision-making fora.”

Luz Estrada González, Perú.
Ensure environmental sustainability

In this section, we present CARE’s contributions to MDG 7. We believe that in order to reverse the current trend of deployment of natural resources, is essential to encourage changes such as promoting renewable, non-polluting energy sources, the appropriate and measured use of natural resources, and a re-thinking of the economy so that it can serve the well-being of humanity and the environment.

In all countries where we work in the region, we have carried out actions to contribute to the sustainability of the environment. We have organized this information into two parts. The first refers to the first two targets of this MDG, that is, to integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources (Target 7A); and to reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss (Target 7B). In the second part of this section, we will present our impacts in contributing to halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation (Target 7C). In the future, we will organize our measurements in such a way that we can also show our contributions to target 7D, regarding improving the lives of slum dwellers.

It should be mentioned that the indicators of this MDG do not include the issue of climate change, nor aspects related to the appropriate management of natural resources beyond forest cover.

Environment and biodiversity

In the past five years, we have worked directly with 109,165 people in Bolivia, Ecuador, Guatemala, Nicaragua and Peru in specific processes to foster sustainable development and to reduce the loss of biodiversity. Many of these processes led to changes in public policies or to a better implementation of those policies.

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In Brazil and Nicaragua, 14,366 people participated in ecological brigades or community clean-up workdays.

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**Contribution to conservation in several countries**

- **153,044 hectares**
  - Bolivia, Ecuador, Guatemala, Haiti and Nicaragua
  - (76,497 people): number of hectares with improved plans and conservation practices

- **222,000 hectares**
  - Ecuador: number of hectares legalized for conservation in ancestral land of the Shuar people
We used **five main strategies** to contribute to environmental sustainability and biodiversity. For all of these strategies, we also made public policy contributions.

- **Protecting agro-forestry systems.** This strategy included providing support to reforestation plans, agro-forestry systems, as well as demonstrative plots or forest management plans at the household, community and sub-national level. Some of these systems combined the production of traditional consumer crops like teak, mara, chestnuts, shiringa, couazú, citrus trees, alders, and sage; at the same time allowing farmers to face climate and market risks. In total, we supported 2,087 hectares with agro-forestry systems at the household and community level, for **5,161 households in Bolivia, Brazil, Guatemala and Peru**. In indigenous territories in **Guatemala**, CARE supported the reforestation of an area with a population of **7,983 people**.

- **Contributing to natural resource conservation.** With regard to the conservation of natural resources, primarily soil and water, we facilitated planning processes to establish conservation areas and to build capacities to manage these areas in **Bolivia, Ecuador, El Salvador, Guatemala, Haiti and Nicaragua**. In the case of Ecuador, we worked to support the recovery of ancestral knowledge of the Shuar nationality in the Amazon region, in order to promote sustainable resource management and agriculture. In Bolivia, CARE built the capacities of the communities to define their own rules for managing natural resources. These rules were then included in land use plans in five micro-watersheds in Chuquisaca, Potosí and Tarija.

- **Raising awareness and promoting action.** For water and soil management and conservation, we developed awareness-raising campaigns among various sectors of the population. We trained a total of **1,234 leaders in Bolivia, Ecuador, Guatemala and Nicaragua** on sustainable natural resource management. We also contributed to community efforts to care for the environment.

- **Mitigating climate change.** The strategy in **Brazil, Ecuador and Peru** was focused on promoting pilot climate change mitigation projects, using in all of them an approach involving equitable development for the most marginalized populations. In Ecuador, we supported the payment of environmental services for forest protection and management, while in Peru we encouraged the use of improved stoves that reduce carbon emissions.

- **Supporting climate change adaptation.** In **Bolivia, Ecuador and Peru** we built community capacities for identifying, validating and implementing climate change adaptation measures, focused primarily on agricultural production and the availability of water resources for consumption or production in a context of climate change.

> **Before, there was nothing that brought all of us together.** We gave to our children a few hectares of forest and they did an inventory of flora and fauna. This became a project to care for the environment in a living classroom, where children could learn by co-existing with their surroundings. They have raised their awareness and if their parents don’t take care of the forest, they are the first ones to point it out.  
> Santiago Jofré Vaca and Margarita Ramona Quete, Bolivia

> **In Haiti, we supported 8,278 families in planting 979,000 fruit trees to prevent soil erosion and to increase their incomes.**
Education for environmental conservation in Brazil

In Brazil, we worked on promoting educational activities to conserve the environment in marginal neighborhoods in Rio de Janeiro, fostering young people’s pride in their neighborhoods. In 10 schools, we supported selective garbage collection units. The model was adapted as an environmental education policy by the municipality of Duque de Caxias, which has a population of 870,000.

“Before, in schools we treated environmental education without any direct relation to the problems of our neighborhood. Now, public schools have young people and teachers who are trained as environmental agents to facilitate recreational activities and reflect on environmental issues. In 2009, we negotiated with the municipality and were able to guarantee a waste collection route to collect the materials separated in schools. An abandoned shed is used to receive recyclable materials and is run by a cooperative.”

Varner Medeiros Simas Filho, environmental education monitor, Brazil

Water and sanitation

Our most direct work to increase access to water and sanitation supported the mobilization of communities and local governments to improve access to water and sanitation systems in rural or peri-urban communities, whose needs for access to basic services was unsatisfied. We contributed to the construction or rehabilitation of systems for a total of 701,754 people in rural and peri-urban areas with high poverty rates in Bolivia, Ecuador, El Salvador, Haiti, Honduras, Guatemala, Nicaragua and Peru. As we have seen in previous sections, improving access to safe drinking water is crucial to reducing severe diarrhea and child malnutrition.

Number of people with access to new or improved water and sanitation systems

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolivia, Honduras,</td>
<td>384,575</td>
</tr>
<tr>
<td>Nicaragua and Peru</td>
<td></td>
</tr>
<tr>
<td>Bolivia, Ecuador, El</td>
<td>595,110</td>
</tr>
<tr>
<td>Salvador, Guatemala, Haiti</td>
<td></td>
</tr>
<tr>
<td>Nicaragua and Peru</td>
<td></td>
</tr>
</tbody>
</table>

In Bolivia, we supported an increase in potable water coverage from 44% to 90% in rural program areas. In Haiti, this percentage rose from 30% to 55%. In Honduras, sanitation coverage increased from 38% to 73% in areas where we worked.
In addition to improving or building water and sanitation systems, CARE supported the training of communities and local governments in managing water and sanitation systems, and provided hygiene education for encouraging changes in practices. Some examples of these results are:

- In **Ecuador**, **El Salvador**, **Nicaragua** and **Peru**, we contributed to training 3,854 members of water management organizations (709 organizations).
- In **El Salvador**, we raised the awareness of a population of 19,445 people in the rational use of water and in measures to prevent water pollution.
- In **Ecuador**, we supported 27 local governments in taking action to reduce pollution from solid waste in rivers, air and soil.

Beyond the populations directly supported by CARE to improve their access to water and sanitation, we also used the models promoted by the programs to support governments in introducing public policy changes to favor the most excluded populations, both at the national and local levels. These are some examples:

- In **El Salvador**, we contributed to the design of a rural potable water strategy, within the framework of the Solidarity Network, in order to respond to the needs of extremely poor families in the country. We also helped to design and carry out an assessment of the water and sanitation subsector.
- In **Honduras**, we supported the decentralized management of water and sanitation by the municipal governments of Mercedes, Lempiras, Yamaranguita Intibucá, Guajiquiro and Nacaome. These municipalities serve as examples for the rest of the country.
- In **Peru**, we contributed to the ratification of Directorate Resolution 007-2006-GR CAJ -DRVCS and to the approval of regional water and sanitation policies, through Regional Ordinance 004-007-GRCAJ -CR of the Regional Government Council of Cajamarca. This led to the formal establishment of a training program on the management of sanitation services in rural areas.

“Before, the water system was chaos and we only had one or two hours of water service per day. With the project, citizen organization was strengthened and an oversight committee formed, which was the link between the municipality and the users. The system was rehabilitated. The population chose to install meters and agreed on the rates. We don’t need subsidies anymore. Now we have water 24 hours per day, without cuts or interruptions. Our management capacities have been strengthened and the authorities feel supported by the residents.”

Saul Ruiz Lezama, Mayor of the District Municipality of Ichocán, Peru

In Honduras, among a population of 2,267 households, the percentage of improvement in hygiene practices increased from 24% to 41%.
Develop a global partnership for development

MDG 8 about the development of a global partnership for development is far-reaching and includes various targets and indicators. The targets aim at developing an open, non-discriminatory trading and financial system; attending to the special needs of the least developed and landlocked countries; and addressing the problems of developing country debt.

There have been many criticisms of this MDG given the ambiguity of the title and the number of issues it includes. Members of Southern organizations say that a partnership for development must have terms that guide relations between countries based on equality – which is still far from being the case in the world today. The implicit formula for development, contained in this MDG, is to increase growth, consumption and to open up markets, while it does not include indicators regarding the redistribution of wealth. It talks about the “sustainability” of debt, which has been criticized widely by social movements who seek debt forgiveness.

With regard to CARE’s contributions to this MDG, we will focus in this section on achieving good administration of public affairs (included in target 8A), especially for social services, within the framework of decentralization processes. This is the issue under this MDG where we have focused the most effort.

We believe that good management of public resources is closely related to broad participation and citizen oversight. So, in order to contribute to this MDG, our approach – promoted worldwide in our programs by CARE UK in its governance work – has been the following:

- **Strengthening citizen participation.** We work with population groups at various levels, especially with the most marginalized and excluded, to promote their participation in decision-making regarding public resources. Actions taken within this line of work include providing training in the area of human rights, supporting social oversight and control, as well as strengthening civil society organizations to take part in participatory budgeting efforts.

- **Promoting accountability and the effectiveness of public services.** We primarily support municipal governments, in order to build their capacities in management and the transparent administration of public goods, as well as their abilities in dialoguing with citizens.

- **Establishing spaces for negotiation.** We support fora in which governments and citizens can make joint decisions about issues affecting the common good, especially social services. We develop the capacities of stakeholders to be able to negotiate in more equal conditions, for example in processes around participatory budgets.

It is important to take into account that although in this chapter we have included specific actions to promote citizen participation and the effectiveness of public services, our work in all of the issues included in this report – health, education, water and sanitation, etc. – involved a strong component of providing training to civil society groups and local governments. For example, in Honduras, we worked extensively with six municipalities in order to promote public education services.
We are listing here the main achievements in this regard, first the numeric achievements and then descriptions of a few concrete cases. Our contributions to public resource management benefitted a total of **448,287 people in Bolivia, Ecuador, El Salvador, Guatemala, Haiti, Nicaragua and Peru.**

### Strengthening citizen participation

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaders trained in human rights, participation and citizen oversight</td>
<td>4,075</td>
</tr>
<tr>
<td>Number of community members with enhanced capacities to participate in budgeting and social monitoring processes.</td>
<td>83,877</td>
</tr>
</tbody>
</table>

### Promoting the accountability and effectiveness of public services

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public officials trained in the management and control over public goods, as well as in participatory processes</td>
<td>2,204</td>
</tr>
<tr>
<td>Municipal governments strengthened</td>
<td>284</td>
</tr>
<tr>
<td>Population living in supported municipalities (decentralization and participatory budgeting)</td>
<td>448,287</td>
</tr>
</tbody>
</table>
All of the actions mentioned in the table contributed to establishing spaces for negotiation in more equitable conditions between citizens and local governments. We cite here some examples of our extensive work on this issue:

• In Bolivia, we supported 151 activities to promote public dialogue and a democratic culture between State actors and civil society. A total of 35,632 people participated in these activities to build bridges between citizen and public sector initiatives.

• In Ecuador, we supported more than 20 cantons in the southern and northern border regions of the country in processes and mechanisms for social auditing and oversight, in order to more fully engage the population and increase the accountability of municipal, school, and provincial authorities and the private sector. Overall, 79% of residents of the municipalities felt, at the end of the program, that the management of their municipalities was more transparent. We also supported a social responsibility platform with a national scope, to promote the transparency and social auditing of public and private sectors. The 19 members of the coalition share the goal of contributing to the exercise of social responsibility in Ecuador.

• In Guatemala, we contributed to the development of 13 municipal plans to reduce poverty, with broad participation from the population.

• In Haiti, we promoted an innovative experience called “the children’s parliament”, where they presented their demands in defense of their rights. A total of 5,441 girls and 4,515 boys participated in this experience and chose their representatives to the children’s parliament in Gonaives. Their demands focused above all on fostering the treatment of children with dignity in schools.

• In Nicaragua, we raised the awareness of 2,360 people about the exercise of their civic rights; 40% of them used what they learned in these trainings and took concrete actions in citizen participation fora.

• In Peru, we contributed to the approval of the modification of law 27813, which expands the composition of the national and regional health councils, incorporating more representatives of the population in these entities. We strengthened citizen participation in health by supporting social auditing bodies for health care services, which have become a nationally recognized model for encouraging respect and transparency in treating the people who avail themselves of those services, especially in the most marginalized areas.

In addition to fostering citizen participation and transparent management of public services, we supported some other issues that are included in MDG 8, such as foreign debt, access to markets and development aid effectiveness. Here we site some examples:

• Long before the January 2010 earthquake, we participated actively in the initiative to forgive Haiti’s foreign debt as part of the Jubilee Network. It was finally forgiven after the earthquake, in recognition that a country that is in the midst of a massive recovery effort cannot carry the burden of debt obligations.

“I had always heard about human rights, without knowing what they were about. What are my rights; who is violating them? Now I am a municipal leader and I know what actions to take to defend them.”

Octavio Mamani, Potosí, Bolivia
• We supported **fair trade** and corporate social responsibility for initiatives in Brazil (cacao), El Salvador (tourism), Honduras (bananas) and Peru (artichokes).

• We participated in global alliances and networks on the **accountability of NGOs**, in which we supported agreements and dialogues about the effectiveness of development aid in the framework of the Paris Declaration and the Accra meeting⁸.

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⁸ For example, see CARE UK’s related Policy Paper at http://www.reliefweb.int/rw/lib.nsf/db900sid/ASAZ-7RZBWZ/$file/CARE_Aug2008.pdf?openelement
Emergency response and disaster risk reduction
CARE has worked in Latin America and the Caribbean since 1953. In the first decades, we concentrated our efforts on emergency response. Today, our programs primarily contribute to development processes, but emergency response and disaster risk reduction continue to be fundamental lines of our work, given the fact that emergencies are both a cause and a consequence of poverty and social injustice. In this chapter, we present the results of our emergency response and disaster risk reduction work.

During this period, we have responded to the needs of people affected by earthquakes (Haiti and Peru), droughts and flooding (Bolivia), hurricanes and tropical storms (Cuba, Haiti, Honduras and Nicaragua) and volcanic activity (Ecuador and Nicaragua). The conditions prior to these disasters were what determined the degree to which sectors of the population were vulnerable to them; the poorest and most marginalized people were the most affected by these events.

CARE’s emergency response efforts have come in different forms, depending on the needs identified. It is important to keep in mind that we have responded to different phases of the emergencies: immediate response after a disaster stroke, rehabilitation afterwards, and the reconstruction of infrastructure, production, livelihoods and social services, as well as capacity building and alliance strengthening in preparing for emergencies. We present here our most significant contributions, both of our direct actions as well as our influence on public policies.

In the past five years, we have reached a total of 502,983 people in Latin America and the Caribbean through our emergency response and risk reduction efforts. More than 300,000 of these were women, men, girls and boys in Haiti, victims of the January 2010 earthquake. Therefore, we are presenting our actions in Haiti separately later in this chapter.

In the table below, we have included some examples of CARE’s contributions in responding to emergencies or reducing the risk of disasters in the region, which provide an indication of some of the activities carried out.

<table>
<thead>
<tr>
<th>Shelter</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who received temporary housing after an emergency (Bolivia and Peru)</td>
<td>14.795</td>
</tr>
<tr>
<td>People whose houses were rehabilitated and upgraded (Honduras)</td>
<td>2.130</td>
</tr>
</tbody>
</table>

“My house was damaged by the earthquake of 2007, the walls cracked and we were afraid to keep living there. We were assigned a place to relocate our house in a new area. The municipality helped by providing machinery and we contributed with our will and effort. Now I have a safe home. I am proud to lead a committee in my new neighborhood. We have a number of needs like electricity, health care and the maintenance of the water network.”

Aurora Palomino Matamoros, Perú
<table>
<thead>
<tr>
<th>Category</th>
<th>Action</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food security</strong></td>
<td>Family food rations distributed (Bolivia and Ecuador)</td>
<td>99,653</td>
</tr>
<tr>
<td><strong>Water and sanitation</strong></td>
<td>People who had a sanitation alternative in place immediately after an emergency (Peru)</td>
<td>51,245</td>
</tr>
<tr>
<td></td>
<td>Potable water systems reestablished and functioning properly post-emergency (Bolivia, Ecuador, El Salvador and Peru)</td>
<td>135</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>Professionals trained to perform play-centered psycho-pedagogical interventions during moments of crisis (El Salvador)</td>
<td>1,253</td>
</tr>
<tr>
<td></td>
<td>People trained in risk management, using a protected schools approach (Guatemala and Honduras)</td>
<td>4,211</td>
</tr>
<tr>
<td><strong>Livelihoods</strong></td>
<td>Families receiving inputs to recover productive land (Bolivia, Cuba and El Salvador)</td>
<td>18,242</td>
</tr>
<tr>
<td></td>
<td>Family plots with complete production ensured for the following agricultural cycle (Bolivia)</td>
<td>2,454</td>
</tr>
<tr>
<td><strong>Organizational strengthening</strong></td>
<td>Local technicians trained in supporting the housing construction process (Peru)</td>
<td>722</td>
</tr>
<tr>
<td></td>
<td>Community representatives and local authorities trained in emergencies and risk management (Bolivia, Ecuador, Honduras and Peru)</td>
<td>8,225</td>
</tr>
<tr>
<td><strong>Infrastructure</strong></td>
<td>Number of protective infrastructure projects developed as risk prevention measures: bridges, roads, drains (Bolivia, Ecuador, El Salvador, Honduras and Nicaragua)</td>
<td>66</td>
</tr>
</tbody>
</table>

We have emphasized **accountability** in our humanitarian work. In **Bolivia**, we are a part of a consortium of humanitarian agencies and other stakeholders to build emergency response capabilities, coordination, adopting Sphere standards and the use of the *Good Enough Guide*. In **Peru**, we set up a free telephone line so that people affected by the 2007 earthquake could give us their opinion on CARE’s activities.
As with our long-term development work, based on our emergency response activities we have contributed to public policies that benefit the most vulnerable populations. These are some examples for each of the areas where we have worked in emergency response and disaster risk reduction:

**Housing and shelter:** We contributed in Peru to the creation of a national rural housing program, based on the anti-seismic and healthy housing developed by CARE, the Bank of Materials of the government and other partners. In September 2010, the program was approved by Congress and elevated to the level of law, after advocacy efforts by the Safe and Healthy Housing alliance, of which CARE is part. The alliance has built 3,800 houses in rural areas - close to 40% of all of the rural housing destroyed by the 2007 earthquake.

**Food security.** In Bolivia, we supported a number of municipalities in ensuring the provision of 6,000 complementary food rations to children less than two years of age in families that were victims of disasters, as well as in improving the administration of nutritional units in emergency situations.

**Education.** In El Salvador, we contributed to national policy through a methodology to address the psychosocial issues of children in emergency situations. This policy was incorporated into the national emergency intervention plan.

**Organizational strengthening.** Various CARE programs have contributed to public policies in the area of strengthening organizations:

- In Bolivia we supported the development and approval of the “Guide for preparedness and response to disaster situations and/or emergencies at the municipal level.” We also helped to incorporate a risk management approach in municipal development plans in El Alto, Monteagudo and Villa Vaca Guzmán, as well as the watershed management plan of Sauce el Zapallar.
- In Ecuador and Peru, we strengthened border integration and disaster prevention on a bi-national basis. We contributed to the border consensus-building committee of the Ecuador and Peru, to integrate emergency operation centers, volunteers and citizens.
- In Nicaragua, we supported the design of the risk management strategy within the departmental development plan of Estelí, which establishes coordination between municipalities and communities for risk management.
CARE’s response to the earthquake in Haiti

The destruction caused by the earthquake in Haiti on January 12, 2010 was of immense proportions. More than 220,000 people lost their lives, and 1.5 million people were left homeless. Just hours after the earthquake, CARE began to respond to the needs of the survivors. Between January and June, we assisted more than 300,000 people in Port-au-Prince and Léogâne with tarps, mattresses, blankets, cooking utensils, containers, hygiene and childbirth kits, food, sanitation, and safe water and hygiene.

In our efforts to support the people most affected by the earthquake, we coordinated our work with the government of Haiti as well as with other organizations providing humanitarian assistance. In response to the emergency, we used the humanitarian standards and rules agreed upon globally to ensure that the beneficiaries receive quality assistance. Here we describe our most important contributions:

### CARE’s support to earthquake survivors (January to June 2010)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who received tarps to build emergency shelters</td>
<td>76,757</td>
</tr>
<tr>
<td>People who received safe drinking water each day</td>
<td>44,550</td>
</tr>
<tr>
<td>Latrines built in spontaneous settlements</td>
<td>800</td>
</tr>
<tr>
<td>Hygiene kits distributed (soap, sanitary pads, toothbrushes)</td>
<td>37,378</td>
</tr>
<tr>
<td>People living in settlements who benefited from CARE’s work in solid waste management</td>
<td>165,305</td>
</tr>
<tr>
<td>People who received food rations</td>
<td>120,000</td>
</tr>
<tr>
<td>Kits for childbirth without risk distributed</td>
<td>838</td>
</tr>
<tr>
<td>Women helped to prevent gender-based violence</td>
<td>3,314</td>
</tr>
<tr>
<td>People assisted with cash-for-work schemes to clear irrigation ditches and roads.</td>
<td>2,410</td>
</tr>
</tbody>
</table>
Even though in this report we present the impacts of the actions carried out in response to the Haiti earthquake, we want to mention the activities that we will focus on until March 2011. This will keep us accountable to the commitments made.

- **Housing.** Support more than 3,000 families to leave the spontaneous settlements, providing materials to build temporary housing.
- **Water, sanitation and hygiene.** Continue to support families in spontaneous settlements in the municipalities of Carrefour and Léogâne with potable water services. Build 700 latrines and continue hygiene activities.
- **Food security.** Continue the cash-for-work program for cleaning out ditches. Provide seeds to 7,500 farmers in Léogâne.
- **Reproductive health and gender violence.** Continue outreach activities in spontaneous settlements for reproductive health and preventing gender-based violence. Guarantee access to family planning.
- **Education and psychosocial support.** Encourage the reopening of schools and school attendance by distributing school materials, facilitating participatory planning in 10 schools and equipping 70 schools.

As an organization that has worked in Haiti for 56 years, and with an unbreakable commitment to support the development of the Haitian people, we have prepared a longer-term strategy for our work over the next five years. In this strategy, for which we consulted extensively with government representatives, social organizations and earthquake victims, we have put priority on working with vulnerable children, young people and women living on less than $1 per day, as well as with people with special needs.

The inequalities in the country have increased following the devastation caused by the earthquake. Social exclusion, the lack of access to education and other social services, limited economic opportunities and environmental degradation are some of the determining factors of poverty in Haiti that have to be addressed. We want to contribute to building the capacities of the Haitian society and to its reconstruction efforts.
CARE as seen by partners and allies: opinions about our programs
In this chapter, we will present the results of the external survey conducted in 2010 to assess how our partners and allies perceive our contributions in the region. Even though many of the evaluations of our programs were external, it was important to know how our work is viewed.

The survey was conducted on-line in order to ensure the confidentiality of the responses, and was responded to by a total of 200 representatives of community and multilateral organizations, international and national NGOs, officials of national and municipal governments, participants in social movements, donors, academics from universities and other research centers, as well as representatives from private companies of all of the countries of the region where we work. It was sent to 320 people, which means that 63% of those that received the survey responded to it. Overall, 39% of responses were from women and 61% from men; 60% of partners and allies who responded belonged to governments or NGOs. Half of respondents had known CARE for more than five years.

We included two types of questions in the survey: in the first part, we asked our partners and allies about their opinion of the quality and impact of CARE programs; and in the second section we asked for their views about their relationship with CARE.

The results of the survey show that 28% of respondents felt that CARE programs are of excellent quality and another 64% said that their quality is good. The vast majority of partners and allies said that CARE programs were relevant or very relevant to the context in which they took place. In response to the question about CARE’s impact on poverty and inequality, 39% said that we had a significant impact, while 46% felt that our impact was moderate. In an open question included in the questionnaire, the reasons given for the response of ‘moderate’ were that progress towards poverty reduction in Latin America and the Caribbean is slow, and therefore impacts are necessarily moderate. In terms of the extent to which CARE works with others to have impact, 85% responded that we worked well or very well with others.
Partners and allies who participated in this survey also gave us their opinions about their interactions with CARE. The questionnaire included a list of statements and respondents were asked to indicate whether they agreed or disagreed with those statements. The answers are listed in the graph. In general, our partners and allies felt that their relationship with CARE is important and they gave high marks to the communication that they have with us. The aspects that require our attention are ensuring a greater participation of partners and allies in decision-making, and improving the agility of the processes.

**Opinions of partners and allies about their relationship with CARE**

Note: Please note that the last five statements of this graph were formulated negatively, and therefore the “disagree” response denotes a positive evaluation of CARE. The questionnaire was designed to guarantee the consistency of the data; “negative” statements were mixed in with those that were formulated positively.
The survey also included some open-ended questions intended to elicit suggestions and recommendations from our partners and allies. Below we are including some of these responses.

We want to sincerely thank all those who took the time to share their perspectives about our work with us. We will use the information received to improve our actions and to be a better partner to those with whom we work.

“Keep developing relationships with partners based on the principles of equality and complementarity. You have made a lot of progress but could improve even more your work with others.”

“Take more risks; take better advantage of the spaces that are available to you.”

“You have to influence more the inequitable power relations at the global level and their impacts on poverty in countries in the South.”

“It is fundamental to improve the systematization of the work you do in order to be able to use this learning more broadly.”

“There are big differences among CARE program teams; sometimes they are so big that they seem like different organizations.”

“The only ‘but’ that I see in CARE is that the administrative processes are slow. It is important to improve them.”

“This kind of honest self-evaluation that you are doing is essential.”
What we have learned in these five years
This is the first time that we have done an exercise of this scope on CARE’s contributions to combating poverty and inequality in Latin America and the Caribbean. Previously, we have published reports on our activities with regard to specific projects, but not about the impacts obtained at the aggregate level for the entire region. Many NGOs report the results and conclusions of their projects, but few of them analyze their contributions beyond that.

The lessons that we have learned from doing this report have been immense, both in terms of our contributions as well as in relation to the ways to measure the impact of initiatives that we have participated in. Here we present some of these lessons.

Lessons learned about CARE’s contributions in the region

With respect to our contributions over the past five years in promoting development and social justice, we would like to offer the following reflections:

In all of the work presented in this report, we have contributed to impact but in no way were we the only ones responsible for these achievements. No organization can, nor should, claim credit for the changes generated as if they were attributable only to their efforts, especially when dealing with processes that seek impacts that go beyond the local level. Many stakeholders participate and contribute to processes of social transformation, and it is the very diversity of their experiences that enriches them.

We think that in this report we have shown that CARE’s contributions to fighting poverty in Latin America and Caribbean over the last five years have been significant, especially in areas like economic poverty, chronic child malnutrition, education and child labor, maternal and child health, HIV/AIDS and tuberculosis, the environment, water and sanitation, citizen participation, and emergency response. The data presented in this report demonstrate our contributions to MDGs, among which we want to highlight:

- In Bolivia, Haiti, Honduras and Peru, we contributed to an average increase of 112% in the annual incomes from agriculture of 94,283 households, which is the equivalent of an average increase from US$1,130 to US$2,394 per household per year.
- We supported the reduction of chronic child malnutrition from 25% to 19%, for 2,226,371 children under five years of age in Bolivia, Honduras and Peru. This means that 132,885 girls and boys under 5 overcame chronic malnutrition.
- We worked with 44,491 children and adolescents in Ecuador, Haiti, Honduras, Nicaragua and Peru in developing innovative models to improve the quality of education.
- We worked to reduce the mortality of children under five in Bolivia, Ecuador, Haiti, Honduras, Nicaragua and Peru; the models employed in direct work with 113,492 children were used to improve public policies.
- In Bolivia, Ecuador, Guatemala, Haiti, Honduras, Nicaragua and Peru we helped to improve obstetric and reproductive health services for 779,223 people.
- In Ecuador and Peru, we had a national level impact on the prevention and treatment of HIV/AIDS and tuberculosis. We helped get 1,068,485 people access to voluntary HIV counseling and/or testing.
- We supported access to safe water for 595,110 people in Bolivia, Ecuador, El Salvador, Guatemala, Haiti, Nicaragua and Peru.
• We reached more than 500,000 people with emergency response efforts, of which over 300,000 were men, women and children victims of the January 2010 earthquake in Haiti.

The results show that we have had greater success when we worked with partners and allies to develop and promote innovative strategies focused on reducing poverty, and were able to demonstrate their impact. When we used the evidence we gathered to propose or support public policies, the impacts were the most significant. In these processes, we worked in close collaboration with governments, other NGOs, members of grassroots organizations, as well as other sectors of society.

In many cases, the models that we have developed together with our partners have supported the social policies and programs of governments and contributed to national objectives. We have aligned our work with goals that go beyond the more narrow scope of projects traditionally managed by NGOs.

The opinions about our work from the point of view of partners and allies, obtained through the external survey, confirmed that our contributions were valued. We will use the recommendations made to better our performance in the areas that need improvement.

Lessons learned about measuring our impact

Although in this report we have organized the information on our impacts according to MDGs, we have also noted in each chapter the limitations of these goals. It is important to expand our view to issues not included in MDGs, especially those related to equity and discrimination.

As we mentioned in the chapter on the methodology for preparing this report, we have solid information available on impacts and results about 72% of the projects and programs that we have implemented in the past five years. We have to improve the way we measure impact in order to be able to inform others about our work. Also, and even in the actions that were evaluated, not all of the analyses provided sufficient evidence about our contributions.

In some cases, we were not able to add up data regarding impacts, since different indicators and definitions were used that made it impossible to compare one project’s outcomes with another. As a result, in this report we are presenting a partial and not complete picture of our work. From now on, we will be more disciplined in documenting and systematizing our contributions.

For the future, we are going to define a limited number of indicators for our programs, which fall within the MDG framework but which are not limited to it – especially in areas where we have noted the limitations of MDGs. We will place special emphasis on more solidly documenting our contributions to gender equity and citizen participation.

The system that we will construct will combine, as does this report, quantitative data and qualitative information, using methodologies like the Most Significant Change and surveys with partners and allies regarding their perceptions of our efforts.

In conclusion, and although we feel that we have taken an important step forward in generating this report, we commit ourselves to significantly improve how we measure the impact of our actions. We want to encourage a wider dialogue about the most appropriate methodologies
that can lead to a better evaluation of the contributions of NGOs and to thus make their efforts more transparent.

We will remain firmly committed to contributing to MDGs with equity, in order to insure that they are reached for the most excluded groups in the region. We know that there are many of us – in all areas and sectors of society – who identify ourselves with the struggle for development and social justice. Measuring impacts is a fundamental ingredient in moving towards this goal and in being accountable to the societies in which we work.
Our donors

Our work in Latin America and the Caribbean is made possible by the contributions of the donors who fund it. We are grateful for their support and trust in CARE. The main donors to CARE in the past five years were:

- **Bilateral donors:** Governments of Australia, Germany, Canada, Denmark, Finland, France, Japan, Luxemburg, the Netherlands, Spain, United Kingdom, United States, as well as the European Union and its agencies.

- **Multilateral cooperation:** the Inter-American Development Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the United Nations and its agencies, and the World Bank.


We have worked extensively with national and local governments in Latin America and the Caribbean, who have significantly supported the processes of which we have been part of.

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