FAQ on CARE's Impact Data and Contributions to Impact from Advocacy
March 2021

What do you mean by *impact*?

- CARE defines our impact as improvements in people's lives resulting from changes in policies or program outcomes. This can include changes in people's economic situation, access to health or other services, and/or a greater sense of power and ability to negotiate.
- Impact is different from the *reach* of CARE's programming, which is a count of women and men who participated in one or more program activities. Impact is a longer-term measure of change that includes people whom CARE did not reach directly but who benefit from changes that CARE contributed to.
- All INGOs report on how many people they have reached around the world, but this isn't enough to demonstrate positive changes in their lives. CARE is one of the only organizations that systematically reports the collective impact of its work around the world.

How large is CARE's impact?

- Between fiscal year 2015 and 2020, CARE has compiled evidence of impact for **157 million people, 63% of whom are women or girls**. This represents the cumulative impacts of 1,304 projects/ initiatives in 85 countries since the start of the CARE 2020 program strategy. Over 40% of this, 66 million, comes from advocacy and influencing work, with a similar proportion coming from long-term development programming (42%), with the remainder coming from CARE and partners' humanitarian assistance programs (16%).
- The largest portion of advocacy impact, 44 million people consists results from the success of a CARE USA-led advocacy coalition in increasing US Government humanitarian funding in 2017 and 2018.
- CARE has now **exceeded by 5% its impact target of 150 million people** by the end of 2020.

Where do these global impact numbers come from?

- CARE's global impact numbers come from external evaluations, showing changes primarily against 21 global indicators, mostly taken from or aligned with the indicators of the Sustainable Development Goals (SDGs). For some indicators (such as access to informal financial inclusion, or crisis or disaster-affected people obtaining quality humanitarian assistance, or being satisfied with quality of that assistance) we also include data from project Monitoring, Evaluation, Accountability and Learning (MEAL) systems. Nearly all of CARE's external evaluations are available online.
- Data has been compiled for all projects reporting impacts between July 2014 and June 2020, the period of CARE's 2020 Program Strategy.
- Impact data is reported in the annual PIIRS process, which has been carried out globally by all CARE country offices and members since 2016. Numbers are supported by evidence from CARE's MEL systems and/or external sources to demonstrate changes in people's lives. They are not estimates or projections.
- Figures are checked for reasonableness by global MEAL advisors working in CARE's Outcome and Approach teams (such as Gender Justice, Sexual & Reproductive Health Rights, or Humanitarian Assistance). Numbers reported are also frequently double-checked against evaluation reports or other sources to prove the data is valid.

How do you know that it was CARE's work that led to these changes?

- Our approach to MEAL is based on the understanding that in addition to CARE and the partners we work with, there are always many other stakeholders (communities, governments, NGOs, private sector, etc.) contributing to change in the dynamic and complex contexts in which we work. In that sense, we prefer to talk about our ***contribution*** to change, not *attribution*.
- While some projects can prove ***attribution***, through evaluations using a Randomized Control Trial (RCT) or quasi-experimental design (such as these examples in Rwanda, Burundi or India), in most cases CARE's programs work across many areas of change, in partnership with many other actors, and in situations where RCTs would not be appropriate.
- As nearly all of CARE's projects are implemented in partnership with others - local civil society organizations, social movements, governments, other international NGOs, UN agencies or the private sector - we aim to talk about the impacts of **CARE and partners**, rather than just of CARE on our own.

- In compiling our impact data, we only include cases where CARE and partners' contribution to change could be considered **significant**, where we can demonstrate a leadership, coordinating or significant role such that the changes would not have happened regardless of CARE's efforts.

Are you just cherry-picking large numbers, to show you have met your targets?

- We have actually been very conservative in the numbers we include in our global impact compilation:
  - If a project reports to change against multiple indicators, we usually only take **the highest number as the total impact of that project**, assuming that those experiencing change in one area (economic empowerment) are the same people as those experiencing change in another area (sexual and reproductive health). In reality, these may not be the same people, so we are undercounting the total numbers of people experiencing change. Only in a few cases where it is absolutely clear that impacts are for different populations (women of reproductive age experiencing fulfilment of their sexual and reproductive health rights, and children under five experiencing improvements in nutritional status) do we make any adjustments to the total numbers to take this into account.
  - For our humanitarian assistance work, where we have measured the levels of satisfaction with assistance (indicator 5) on average 89% of those receiving assistance were satisfied with the relevance, timeliness and accountability of humanitarian interventions. For that reason, we **only count those who are satisfied with assistance** towards our global humanitarian assistance numbers, reducing the numbers in those cases that haven't reported on indicator 5 by 11% to reflect this assumed level of satisfaction. This reduces the total impact we are counting from the humanitarian influencing work from 50.5m to 44.9m, and our direct humanitarian assistance numbers from 28.5 to 25.5m, a total reduction of 8.5m.
  - Where projects report negative outcomes - increased food insecurity, for example (so long as this was measured at the same time of year and is comparable) - we **subtract such negative numbers** from other indicators where positive change has been achieved.
  - Where we have a more rigorous indicator to use, we apply that: for example, we adjusted one of the indicators used to report the impact of the Bihar health program in India, changing from "% of pregnant women who underwent 3 or more Antenatal Check-ups" to the more standard "% of live births for which the mother received at least 4 ante-natal care visits", which reduced the impact numbers by 1.4m.
  - In our donor advocacy cases, we take care to reduce the total numbers reported on that case by the numbers from any CARE projects that could have been **funded by the same source** (thus reducing the humanitarian supplemental funding impacts from 50.8m to 49.5m.
  - We are only including impact numbers from projects that have reported from evaluations, AIIR tools or solid project information systems, but we know that many projects have not been able to report their impact numbers. In fact, only about a third of projects that ended in the last year of the program strategy (2020) have reported their impact numbers so far. While we have followed up with the larger programs to get their numbers where available, we can assume that there is still a **significant amount of unreported impact** from CARE and our partners' work that we have not been able to capture. We aim to close this gap further in future years.
  - In some cases, we are only reporting change amongst half of the population: our health program in Bihar will have contributed to better health services for everyone, not just amongst the women for whom we can demonstrate impact. As we move from the CARE 2020 Strategy to Vision 2030, we will need to broaden our measurement of the right to health to cover all populations.
  - Double-counting: where possible, teams at country level have identified cases where multiple projects have worked with the same communities, and so impact numbers need to be adjusted to avoid double-counting the same people under different projects. While we recognize that this may not have been carried out in all cases, our other more conservative assumptions above can be reasonably assumed to more than cancel out any remaining non-adjusted double-counting.

How do you measure the impact of your advocacy work?

- CARE's guide to MEL for advocacy outlines a set of different tools that can be used to determine the changes that CARE and partners' influencing work has contributed to. One tool in particular that has been helpful over the last few years is the AIIR tool (Advocacy and Influencing Impact Reporting Tool). This tool

requires teams to outline the advocacy win they have contributed to, the nature and level of CARE's contribution, its potential and actual impact, and lessons learned about the most effective influencing tactics.

- For programs using advocacy strategies, the PIIRS forms collect data on CARE indicator 20 (influencing policy, budgets and programs of others), which is similar to the questions in the AIIR Tool.

What does *potential impact* mean and how is that different from *actual impact*?

- Potential impact is a calculation of how many people's lives could be positively impacted by a policy or practice change, if that change is fully resourced and implemented in the future.
- Often when an advocacy win occurs, such as a policy being agreed or the signing of an international agreement (like ILO convention 190 on sexual harassment in the world of work), it can take many years before the policy is resourced and implemented or an agreement is ratified, domesticated and applied - and even further until there is measurable data showing positive change. That's why CARE starts by estimating potential impacts of advocacy work, then quantifying actual impact later on.
- Documenting actual impact often depends on having the resources to measure change some years after a project ends or a win is achieved. New funding for post-project sustainability research grants that CARE is starting to implement offers one way to do that.

Can you give some examples of advocacy impacts?

- Some of the advocacy and influencing successes of CARE and our partners whose impacts we have been able to capture include:
  - Supporting legal change to penalize denying women their inheritance rights in Egypt
  - Influencing government and others to include VSLAs in policies and programs in Niger
  - Launching a coalition that helped government make addressing child malnutrition a priority in Peru
  - Helping Congress approve increased funding for US Government humanitarian famine relief
  - Getting proven Disaster Risk Reduction models and approaches adopted in Madagascar

Is all impact equal? It seems like the impact achieved through advocacy is different to a situation where we have long term engagement with a community?

- The CARE indicators measure different types of change: receiving quality humanitarian assistance (indicator 4) or joining a VSLA (16) is a different level of impact to increasing women's decision-making on reproductive health (9) or household finances (17), or to reducing intimate partner violence (11) or stunting (14). Whether those different changes are achieved through long-term engagement with communities or through advocacy is less relevant. A child no longer stunted in Peru from our work with allies to influence Government, or a woman no longer disinherited in Egypt from advocacy to change policy, experiences the same impact if this comes as a result of advocacy and influencing as if we had contributed to these changes directly through long-term development projects.
- Similarly, famine-affected people receiving food or other humanitarian assistance **experience the same change** if supported directly by CARE or partners through a CARE project as if supported by other NGOs or agencies funded by the additional $1bn in annual humanitarian funding that the CARE US-led advocacy campaign influenced.

What is the relationship between Advocacy and the rest of our programming? If we can get so much impact through advocacy, should we stop doing our other work and focus on influencing?

- Our advocacy work builds off and is always deeply connected to our humanitarian and development programming. Without **programmatic experience** showing how to contribute to Disaster Risk Reduction in Madagascar, or financial inclusion in Malawi, or women's empowerment in Vietnam, and the deep relations built with Government, partners and donors, CARE and partners would never have been successful in the advocacy work that was able to contribute to even greater change, through advocacy and influencing. Without seeing at first hand in our programs the devastating impacts of increased famine in South Sudan, Somalia, Nigeria and Yemen in 2016, CARE and allies would not have had the evidence to advocate for increased humanitarian funding in 2017.

- This is exactly the approach to Multiplying Impact that the CARE 2020 Program Strategy envisioned: "*Together with our partners we use the evidence, learning and innovation from our humanitarian action and long-term development programs to influence broader social change, at significant scale*".
- We should clearly continue to invest in advocacy, systems-strengthening, supporting social movements and **other pathways to impact at scale** - given their huge potential for scale and systems-level change - but have to ensure that it has the programmatic evidence base to draw on to be legitimate and effective; and that comes from the impactful, transformative humanitarian and development programming that is complementary to the advocacy work, and equally important.

What's the relationship between direct/indirect participants and impact/reach? Surely work with direct participants is more impactful than indirect?

- CARE and partners can contribute to impact both by working directly with impact populations, or doing so indirectly: strengthening local partners or social movements, for example, so they in turn increase the voice or power or agency of marginalized women and girls.
- While perhaps in the past CARE thought that direct reach had greater importance than indirect reach, our adopting of a rights-based approach (RBA) and programming principles that highlight partnership, and responsibility of power holders, along with our increasing role of Multiplying Impact, mean that it is often the indirect participants, rather than direct participants, in whose lives we seek to see change. We know that focusing solely on the "agency" of direct participants is not enough to making lasting gender-transformative impact at scale, and our work needs to focus on "relations" and "structures" too (where women and girls are often "indirect participants").
- As mentioned above, what matters is the impact that our programs **contribute to**, not whether we did so directly or indirectly, or through advocacy and influencing or direct engagement in communities.

Why are you sharing just numbers? Does this not privilege what can be counted or what generates the biggest numbers?

- While we collect and aggregate quantitative information on change, we also make sure we capture the story of why and how CARE and partners contributed to that change, to be able to draw learning from our most successful work, and promote greater application of these lessons and strategies into the rest of CARE work. We have such ***learning behind the numbers*** for our work on preventing & responding to gender based violence, increasing women's financial decision-making, meeting crisis/disaster-affected people's needs for shelter, improving nutrition, promoting inclusive governance or advocacy for greater impact.
- We look at impacts in terms of breadth (how many people's lives are changed) and depth (the quality and sustainability of those changes). This requires a combination of numbers and descriptive evidence.

Will CARE's impact go up in the future?

- Yes. In fiscal year 2020, CARE reported **potential impact of 597 million** people from advocacy wins around the world – far higher than the actual impact of advocacy measured to date. We do not anticipate all of this potential impact to be actualized, since implementation and resourcing of policies is likely to be incomplete in many countries. Nonetheless, even if only a portion of potential impact can be measured in the future, CARE and partners could more than double its current impact numbers from documenting actual impacts of advocacy wins already achieved.
- With CARE's increasing emphasis on advocacy as an approach to impact at scale, the **annual number of recorded or updated advocacy wins** around the world is steadily increasing from 32 in 2016 to 86 in 2020. Not all of these wins have quantifiable impacts, but as our advocacy successes continue to grow, we expect to be able to document a corresponding rise in the number of people whose lives are impacted.

Why does CARE report its contributions towards the Sustainable Development Goals (SDGs)?

- Aligning our dataset to the SDGs is a critical component of CARE's measurement system, and increases our ability to tell a coherent story of impact. Using the SDGs to guide our data collection gives us a common global frame and set of commitments to shape our evidence base, and a shared platform to discuss results with others, especially governments and UN bodies. Because so many actors have made

commitments to the SDGs, being able to show that a specific intervention contributes to achieving those common goals helps make the case for adopting those tools more broadly.

- We first produced a report on our contributions to the SDGs in 2019, and will be producing a new report later this year.