19-21 August 2019
Kuala Lumpur, Malaysia

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A Note

Greetings and welcome to FH's CFCT Global Learning Workshop. We are really excited to be able to gather together in beautiful and exciting Kuala Lumpur this week to share and learn from your experience.

Birthed out of our Latin American region, CFCT was developed as a way to organize and strengthen FH's global work around the world. As an organization FH has invested thousands of hours to research, coordinate, develop, train, pilot and adapt tools and methodologies to serve vulnerable people around the world. We call this initial phase of work CFCT 1.0. In this we have seen great success and faced several challenges. We are committed to learning from both of these, and making the necessary adjustments so that a future CFCT 2.0 can be even more effective as we live out the Heartbeat in a changing world.

The lessons learned from our time together will directly impact FH's Corporate Strategy and position FH for even greater Kingdom impact as we live out our Heartbeat's Values, Vision and Purpose. The scripture we have selected for the workshop aligns us to Jesus' purpose and hope for us all:

"I have come that they may have life, and have it to the full."
John 10:10b

Thank you for your participation and contribution to making this workshop a success.

On behalf of FH's Executive Leadership Team,

Peter Howard
Chief International Operations Officer

Luis Noda
Vice President, Transformational Engagement

Values

1. We follow Jesus

We are ambassadors of Jesus in our thoughts, words and deeds.

2. Our work is relational

We pursue reconciled relationships of grace with those with whom we work, partner and serve.

3. We invest wisely and focus on results

We are stewards in God's Kingdom and strive to invest all resources to maximize missional impact.

4. We serve with humility

We recognize the dignity of others and put their interests above our own.

5. We pursue beauty, goodness and truth

In a broken world, we are witnesses through our relationships and work of God's beauty, goodness and truth.

Vision

All forms of human poverty ended worldwide

Purpose

Together we follow God's call responding to human suffering and graduating communities from extreme poverty.

The People

We have the privilege of sharing this workshop with a global representation of experienced staff from around the globe. Representatives were nominated by their supervisors based on their expertise and involvement with CFCT's design and implementation. We are fortunate to be able to spend this week with such an experienced group. See the table below for a list of representatives and their contact information.

FH's Senior Director for Learning and Evaluation, Ryan Smedes, has coordinated the development of this workshop with the great support of a Steering Committee, a Facilitation Team, and an external consultant.

This workshop will be led by a Facilitation Team (team members marked with a ^ in the table below). This team will help ensure that workshop activities are clear and flow smoothly. They are familiar with the agenda and should be able to help answer any questions.

A Steering Committee (marked with a *) was established early on in the planning process. This committee helped develop the overall direction and plans for this workshop, and governed the progress as it went along.

Finally, we are grateful for the strategic direction and facilitation by Paula Rowland, a friend and consultant from ORS Impact. Paula's expertise in organizational learning, strategy and evaluation have enriched this process immensely. Find Paula's bio in Appendix A.

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The Situation

The Steering Committee first met together at the end of 2018 to plan how to improve CFCT for the future. Many things had happened in the previous years. FH had invested significantly to define CFCT as a model and framework for overarching program integration, and to develop several tools for field office use. There were multiple rounds of research, design, rollout, and implementation. It seemed that now was a good time for a deep dive to learn from this past experience.

We understand that many of the CFCT tools are helpful and working well, but some projects are implemented in contexts that prove challenging for their use. Around the world, understanding of what CFCT is varies. Some projects deeply emphasize elements of our Christian faith. Some projects are multi-sectoral while others focus on highly relevant singular issue.

The committee thought about ways to best gather lessons learned from around the globe from this big organizational push. We contemplated several layers of interviews, several learning events, and reviews of evaluations and previous CFCT Summit decisions. We ultimately decided to hold a global learning workshop so that we could all learn from the lessons of one another.

We have also been witnessing some profound global demographic trends, which were brought into sharp focus through the regional conferences conducted throughout the past year. Issues like urbanization, migration and climate change are dramatically changing how poverty and vulnerability are felt and who experiences them. As we face this changing future, FH is developing its corporate strategy to re-define our program identity to address these issues.

Our lessons learned from the design and implementation of CFCT will directly contribute to these adaptations and will position FH to contribute to even greater future impact. We have put much thought and planning into the development of this workshop, including contracting a professional organization, ORS Impact, to help us. We defined the purpose of this workshop

to be to understand the lessons learned and challenges from CFCT design and implementation to date. We will ensure that these results will inform future refinements of FH's program approaches and tools.

The Desired Outcomes

Together we have determined that the success of the workshop will be evident if all representatives:

- Engage in a participatory process to arrive at a shared common understanding of the concepts, essential components, and spirit underlying the CFCT program model
- Increase understanding of successes and challenges of the CFCT design and implementation in different contexts, including organizational enablers and barriers.
- Provide recommendations for improved design and implementation and organizational supports for CFCT 2.0
- Renew a commitment to a unified vision for transformational development

A survey sent to all the representatives prior to the workshop captured some additional hoped-for outcomes:

- Define roles of the GSC, ROs, FOs in the CFCT design, contextualization, and implementation
- Greater integration of God's Story and Heartbeat into CFCT 2.0
- Further clarity on graduation (and post-graduation) process, and distinction between graduating communities (development) and responding to human suffering (relief)
- Cross-learning between countries to increase understanding of diverse contexts
- Application of CFCT across different funding types (i.e. sponsorship, grants) and contexts (rural, peri-urban, urban, etc.)
- Understanding and revitalization of the 'lesser domains' (previously cross-cutting sectors), including environment, gender, etc.
- A common and unified understanding of the training methodology of CFCT

We will do our best to meet all of these outcomes together in our workshop.

The Content and Achievement-Based Objectives

By the end of this workshop, you will have done the following to ensure the success of our outcomes (named above):

1. Met and learned about your colleagues
2. Built and increased sense of community across the FH globe
3. Increased your understanding of how others see and understand CFCT
4. Better understood how CFCT is being implemented in each region
5. Discerned the degree of alignment between regions and what learnings are adaptable across regions
6. Increased understanding of successes and challenges of the CFCT design and implementation in different contexts, including organizational enablers and barriers
7. Improved skills to meaningfully analyze data
8. Increased capacity to use data for program improvement and learning

9. Increased skills on using both data and stories to strengthen communication
10. Increased shared ownership of solutions
11. Increased reliance on God's help to overcome barriers
12. Provided recommendations for improved design and implementation and organizational supports for CFCT 2.0
13. Increased energy and enthusiasm for the work ahead
14. Increased clarity of next steps for regional teams

The Place and the Space

The Hotel

ParkRoyal Hotel
Jalan Sultan Ismail
50250 Kuala Lumpur
Malaysia
Telephone +60 3 2147 0088

Check-in time is 14:00 and check-out time is 12:00 unless you have already made arrangements with Sarah D for a late checkout of 18:00 (additional 50% cost). You have complimentary use of the hotel gymnasium, sauna, and Jacuzzi at the Fitness Centre. Complimentary WiFi and breakfast is available for each guest. The CFCT Workshop sessions will be held in the Lower Lobby in Meeting Rooms **Plaza 1 - 4**.

The Meals

Breakfast is provided **each day** of your stay in the Chatz Brasserie restaurant in the Lower Lobby of ParkRoyal Hotel. Breakfast hours are 6:30-10:30 AM.

Lunch is provided on **Monday, Tuesday,** and **Wednesday** (19-21 August) in the Chatz Brasserie restaurant in the Lower Lobby of ParkRoyal Hotel. This is paid by FH in advance. Lunch time will be according to conference schedule.

Evening dinner is provided only Wednesday evening at the hotel in the Bougainvillea restaurant at 18:00 in the hotel Lower Lobby. This is paid by FH in advance. For all other evening meals, we encourage you to explore the various restaurants nearby the hotel. Make sure you have Malaysia currency (Ringgits).

Local Restaurant Recommendations
BB is Bukit Bintang, the area immediately around the hotel as shown in the map.

Malaysian

- Food Courts / Food Areas - $
  - Sungei Wang Plaza (Lower Basement One) - www.sungeiwang.com
  - Berjaya Times Square (Lower Ground) – berjayatimessquarekl.com/
  - Pavilion Mall (Level 1) - https://www.pavilion-kl.com
  - Suria KLCC Mall (Level 4) - www.suriaklcc.com.my

- Bijan Bar & Restaurant, BB (just past Changkat area) - www.bijanrestaurant.com
- Serai at Pavillion, Pavilion Mall, Level 7 - http://www.seraigroup.com.my/ $$
- Opium KL, BB, Changkat Street - opiumkl.com $$
- Open House, KLCC Mall - www.openhouse.my $$$

Indian

- Passage thru India, BB (will need to take taxi there, as there is no train stop nearby) www.passagethruindia.com - $$

Chinese

- Hutong Food Court,Lot 10 Mall, Lower Level http://www.lot10hutong.com/- $
- Jalan Alor Street, BB (Changkat Area)- $
- Din Tai Fung (Dim Sum), "Pavilion Mall, Level 6 or KLCC Mall, 4th Floor, Note: The Suria KLCC location does not have pork.), http://www.dintaifung.com.my/ - $$
- Spring Garden Suria KLCC Mall, Level 4, www.taithong.com.my/sgklcc - $$

Vietnamese

- Pho Vietz, Pavilion Mall, Level 4, www.pavilion-kl.com/viewstore/Pho-Vietz - $
- Sao Nam, BB (behind Jalan Alor Street), http://www.saonam.com.my/ - $$

Japanese

- J's Gate Food Court, Lot 10 Mall, 4th Floor, http://js-gate.com/ - $
- 4F The Table Restaurants, Lot 10 Mall, Isetan Department Store, 4th Floor - $$
- Kampachi, Pavilion Mall, Level 6, http://www.kampachi.com.my/- $$$

American

- Wild Honey, Pavilion Mall, Level 6, wildhoney.com.sg/our-restaurants/kl/kl-menu/ -$
- Friday's Pavilion Mall, Level 6, - $$
- Hard Rock Café, BB (Beside the Concorde hotel) -$$
- Chili's, Suria KLCC Mall, Level 3 - $$

Italian

- The Italian Market (TIM), BB, Changkat Street, http://www.theitalianmarket.com.my/ - $$
- Sassorosso (reservations recommended), KLCC/Ampang Park (will need to take taxi there as there is no train stop nearby), http://www.sassorosso.com.my/ - $$$

Spanish

- El Iberico, Pavilion Mall, Level 4 - $$
- Mr. Chew's Chino Latino Bar & Restaurant (reservations highly recommended), BB (at the top of the Wolo Hotel), mr-chew.com - $$$
- Fuego (advanced reservations needed), KLCC/Ampang Park, Trokia Sky Dining, http://www.troikaskydining.com/fuego/ - $$$

Cafés / Coffee

- Feeka, BB, https://www.facebook.com/feekacoffeeroasters/ - $
- Q-Cup, around the corner from Park Royal, http://www.qcup.com.my/ - $
- Union Artisan Coffee, outside Lot 10 Mall, near H & M - $

Salads / Vegetarian Options

- The Salad Atelier, Avenue K (across from Suria KLCC Mall), www.saladatelier.com - $
- La Juiceria, Avenue K (across from Suria KLCC Mall), http://lajuiceria.com.my/wp/ - $
- The Simple Life, simplelife.com.my - $
    - Pavilion Mall, Level 1 (in the underpass to Fahrenheit 88 Mall); Lot 10, Level 3
    - Suria KLCC Mall, 3rd Floor Signature Food Court
- Salad Stop, Pavilion Mall, Level 1, www.saladstop.com.sg/en/ - $
- The Fish Bowl, Pavilion Mall, Level 1, thefishbowl.my - $

For the View (Drinks/Non-alcoholic drinks)

- The Sky Bar (on top of Trader's Hotel), KL City Centre, http://www.shangri-la.com/kualalumpur/traders/dining/bars-lounges/sky-bar/ - $$
- The Wetdeck Pool Bar at the W Hotel, KL City Centre, thecitylist.my/venue/wet-deck-at-w-hotel-kuala-lumpur - $$
- Marini's on 57, KL City Centre, marinis57.com - $$$
- Troika Sky Dining (Coppersmith, Claret Wine Bar, & Canteloupe. KL City Centre, / Ampang Park, http://www.troikaskydining.com - $$$

Tourism

Place	Cost	Website
Skybridge & Observation Deck at Petronas Twin Towers	Adult: RM80 --> $19 USD	www.petronastwintowers.com.my/en
Hop-on / Hop-off Bus	See site for details	www.myhoponhopoff.com/kl/
Menara Kuala Lumpur (aka KL Tower)	See site for details	https://www.menarakl.com.my/
Aquaria KLCC	Adult: RM69 --> $16.50 USD	http://aquariaklcc.com/
Go KL City Bus	Free	http://www.kuala-lumpur.ws/magazine/go-kl-city-bus.htm
KLCC Park - Light Show w/ Music	Free	www.suriaklcc.com.my/attractions-2/esplanade-lake-symphony/
Central Market	Free	http://www.kuala-lumpur.ws/attractions/central-market.htm
Chinatown - Petaling Street	Free	http://www.kuala-lumpur.ws/klareas/chinatown_petaling.htm
Batu Caves	Free	http://www.kuala-lumpur.ws/attractions/batu-caves.htm
Sultan Abdul Samad Building	Free	http://www.kuala-lumpur.ws/attractions/sultan-abdul-samad-building.htm
Perdana Botanical Gardens (aka Lake Gardens)	Free	http://www.klbotanicalgarden.gov.my/

The Time and Timing

The workshop is August 19 - 21 from 8:30am to 5pm each day. We will have a few breaks as well as a one-hour lunch break each day.

Breakfast and lunch will be served in the hotel. Breakfast begins at 6:30 AM (see section MEALS for more details).

Note: Full participation all three days is expected so that the group can build on each other's learning and support. Please let *Ryan or Sarah know if you anticipate any conflicts.*

The Agenda

Day 1 | Sharing a Common Understanding of CFCT

Monday, August 19 | 8:30 AM – 5:00 PM

Time	Topic
8:30	Welcome, Introductions, Orientation
	Laying the Groundwork
	Building a Shared Understanding of CFCT
12:30	Lunch: Meeting New Friends – Chatz Brasserie – Lower Lobby
14:00 - 17:00	Building a Shared Understanding of CFCT (continued) • Regional sharing of CFCT experience
	Consolidating Learning • Reflection and response

Building a Shared Understanding of CFCT

Current understanding of CFCT

Concept Mapping

- On your own, take a few minutes to think about what do you consider the essential components of CFCT as implemented in your region? Write these components in the box below:

- As a team, jot down on post-it notes:
    - What are the essential components of CFCT?
- Arrange the post-it notes on a flip chart paper in the sequence that makes the most sense to you
- Clearly label your worksheet with your region and the names of those in your small group- we will refer back to this on day 3. Copy it down in the box below for future reference:

Gallery Walk

- Take a "gallery walk" around the 3 rooms, taking notes in your workbook of at least 2 displays in each room.
- What do you notice about the different displays?

Debrief Concept Maps

- Go back to your regional group
- Discuss what you noticed: common elements, any patterns, differences, or surprises
- Jot these down below to use these notes on Day 3:

Regional Sharing of CFCT Experience: Presentations

In your workbooks, jot down one thing you want to remember from each presentation

Africa

Asia

Latin America & Caribbean

In a Word

▪Think of one word that summarizes today for you. This word can describe a reaction, highlight, priority, feeling, or idea. Write it in the box below:

Day 2 | Identifying Successes, Challenges, and Gaps in CFCT

Tuesday, August 20 | 8:30 AM – 5:00 PM

Time	Topic
8:30	Setting the Tone for the Day
	Learning from Mid-term Evaluations • Celebrating Success
12:30	A Meal with Friends – Chatz Brasserie – Lower Lobby
14:00 - 17:00	Learning from Mid-term Evaluations • Identifying challenges and gaps in implementation
	Consolidating Learning • Insights and observations

Learning from Mid-Term Evaluations

Celebrating Success as an Organization

- In your booklet, write down 1-2 things you heard from the presentation that we can praise God for together:

Making Meaning from the Data - Round 1

Case Study Round 1 - Country: _____

- What indicators showed positive changes?

- What indicators did not show positive changes?

- What are the implementation, technical, and contextual challenges?

- What does this tell us about the essential components of CFCT?

- What else would you need to know to answer any of the above questions?

Case Study Round 2 - Country: _____

- What indicators showed positive changes?

- What indicators did not show positive changes?

- What are the implementation, technical, and contextual challenges?

- What does this tell us about the essential components of CFCT?

- What else would you need to know to answer any of the above questions?

Reflection time

- Take 5 minutes to reflect on the two case studies your group reviewed
- Answer the questions in the box below:

What did you learn from the process of reviewing the data? Is there anything you learned that applies to your work/context?

Gallery Walk

- Take a "gallery walk" around the posted flip charts
- Note patterns, differences, or surprises between case studies in the box below:

Day 3 | Prioritizing Core Principles of CFCT

Wednesday, August 21 | 8:30 AM – 9:00 PM

Time	Topic
8:30	Setting the Tone for the Day
	Data Informed Story Telling • Regional sharing
12:30	A Meal with Friends
14:00 - 17:00	Data Informed Decision-making • Prioritizing essential elements of CFCT • Sharpened understanding of CFCT
	Consolidating Learning • Bringing learnings home
18:00	Celebration Dinner

Data Informed Storytelling

Regional Storytelling

What 1-2 things you heard this morning do you want to remember from the regional presentation?

What will you apply to improve your work?

Data Informed Decision-making

New Understanding of CFCT

Individual Reflection

Based on your notes and everything you have seen and heard this week, reflect on your understanding of CFCT:

What changed? Why? How will you communicate with your colleagues back home about how your understanding of CFCT has changed?

Consolidate Learnings

Setting our Intention

Take 20 minutes to flip through your workbook. Reflect on everything you have learned over the last 3 days. List 1-3 action steps you intend to take:

Supporting Documents

The following are supporting documents for your use during this workshop:

Appendix A: Paula Rowland Bio
Appendix B: Shared Terms and Definitions
Appendix C: CFCT List of Tools
Appendix D: CFCT Mid-Term Evaluation Summaries

Appendix A: Paula Rowland Bio

Paula Rowland, PhD

DIRECTOR

Paula finds joy in using her knowledge of evaluation to support small and large organizations whose work makes the world a better place for all of us. Professionally, she is happiest when leveraging the collective wisdom of a team. Paula brings her experiences with nonprofit management, evaluation consulting with nonprofits and foundations, and cultural competence from living and working cross-culturally. She is known as a careful listener who finds ways to translate data and findings to all stakeholders, from the board of directors to beneficiaries in a wide range of projects focused on improving education, health and social wellbeing at individual, community, state, national and international levels.

Paula joined ORS in 2011 after working as an independent consultant supporting nonprofits in strategic planning and evaluation and collaborating on several international projects with the United Nations and family foundations in sub-Saharan Africa. Paula has a PhD in Comparative International Education and a Master's in Public Health from UCLA. She is fluent in Spanish and has lived and volunteered in Africa, Asia, and Latin America.

When not working or traveling, Paula is often cooking or baking for family and friends.

Appendix B: Shared Terms and Definitions

When we use the term _____ within FH, what do we mean?
Shared understanding and consistency in our terminology is important to ensure we are working together well. The following are key terms with explanations and background on why these words were chosen.

Developed by CFCT Global Learning Workshop Steering Committee Members:
Victor Cortez, Sarah Dalrymple, Mitzi Hanold, Leena Hill, Peter Howard, Subodh Kumar, Luis Noda, Shep Owen, Ryan Smedes

Child Focused Community Transformation (CFCT)

Child Focused Community Transformation (CFCT) is how FH achieves its purpose to respond to human suffering and graduate communities from extreme poverty. CFCT frames the overall goals of all FH programs and projects, and provides guidelines on how to achieve FH's Purpose while permitting adaptation to local realities. Children are the most prominent and vulnerable persons and disproportionately suffer from diseases and death. The level to which children in a community are thriving is an excellent measure of the spiritual, social, and economic status of a community in general. While CFCT promotes child well-being outcomes, not every activity or program must directly involve children.

CFCT as a Framework versus Model versus Approach:

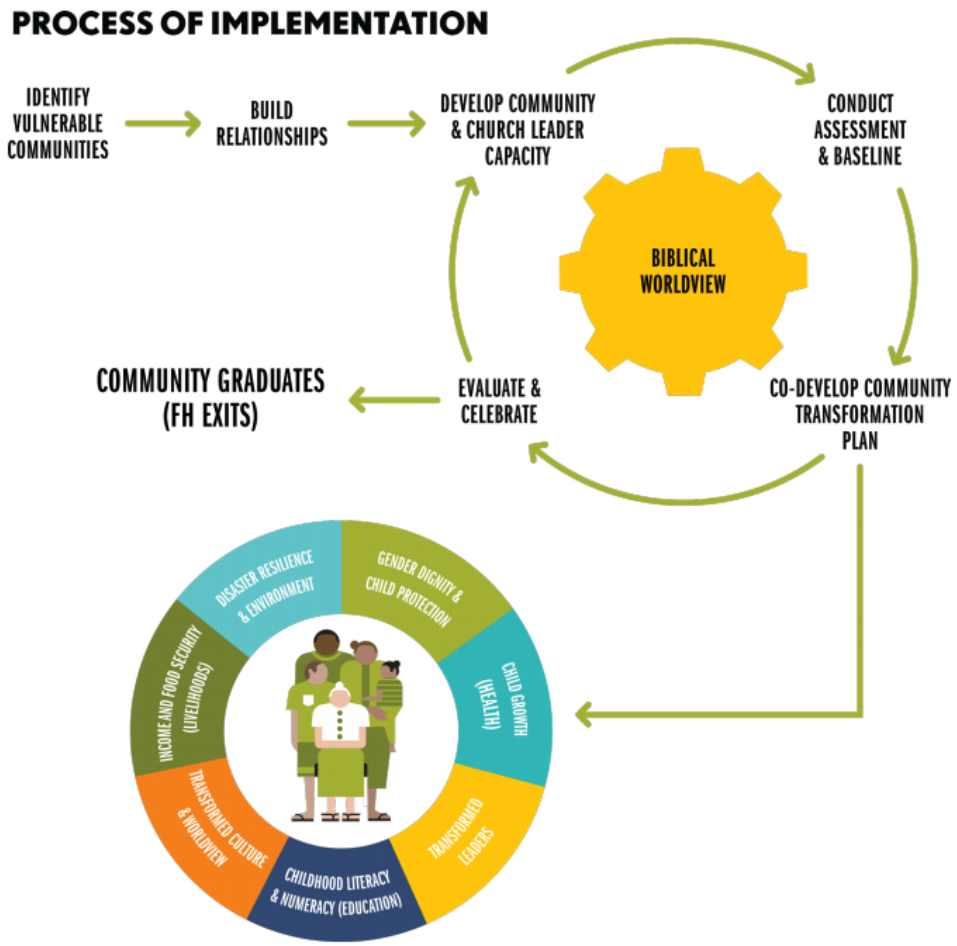
In the past these three terms have been used interchangeably to describe CFCT. While this has led to some confusion, it is quite understandable since the development of CFCT has included elements of a framework, model and an approach. While we would like to move toward a more unified definition, this conference provides us with a useful data point of what is our current understanding. ***For this workshop we will be using Framework and Model to define CFCT*** based on the following definitions of the three terms:

Framework:
A framework is a conceptual structure that organizes a set of ideas, rules, or beliefs for the realization of a defined result/goal (i.e. FH's purpose), and on which decisions (organizational or programmatic) are based.

Model:
A model is a presentation that clarifies how central concepts are used and integrates them and their meanings into a coherent ***framework*** that guides all aspects of our work. A model characterizes an organization's view of the main development concepts involved in its work and provides guidelines for using these concepts to design, implement, measure and generate evidence for learning and adaptation.

Community Partnership Process:

Historically, the below diagram has been used to describe the CFCT Model/Process of Implementation. This diagram depicts FH's relationship with communities - how we enter, engage and graduate a community. For purposes of this workshop, this diagram will be referred to as FH's Community Partnership Process.



CFCT is not....a program, project, set of activities, set of tools or funding source. CFCT should not be considered a parallel goal, rather, should represent the integrated results of every FH country program and project.

Community Exit

Community Exit refers to the conclusion of FH's partnership with a given community under circumstances other than community graduation based on results achieved. This may include lack of ongoing funding, conflict, and other strategic and administrative reasons which may be sudden or gradual, which cause FH to end the partnership and leave the community.

Community Graduation

FH's purpose includes *"graduating communities from extreme poverty."* Community Graduation refers to ending FH's work in a community because the community has shown evidence of transformation and that it is capable of continuing the pursuit of transformational

development on its own. The timing of FH's withdrawal and handover is based on the assessed performance and capacity of the community as measured against the ***Community Graduation Criteria*** (*see definition*).

Community Graduation Criteria and Community Graduation Readiness Index

A community's readiness to graduate is based on its assessed performance and capacity in the following criteria areas:

1. Improvement in child and family well-being (measured by *CFCT* ***Domains of Change Key Performance Indicators -*** *see definitions*)
2. Increased ability of community members to care for others
3. Communities' emergence of hope in their future
4. Community participation in transformational development
5. Reduced risk of disasters and increased community resilience
6. Community and churches' capacity to sustain the long term viability and impact of its transformational development processes

A community's performance and capacity towards the Graduation Criteria is evaluated through baseline studies and mid-term evaluations (MTEs). The scores from the MTEs are brought together to form a Community Graduation Readiness Index. This index, developed by FH, is based on the global Multidimensional Poverty Index, with additional metrics on the moral, social, emotional and spiritual dimensions of poverty.

Domains of Change

A Domain of Change refers to an area in which change must occur in order to reach the desired, long-term outcome. The CFCT Domains of Change are integrated parts of a whole expressing that community transformation doesn't occur through focus on a singular aspect, but rather through addressing the whole in an integrated way. CFCT's seven Domains of Change represent 'common denominator' areas believed to be globally relevant and transformational among the most vulnerable. They are measured through global ***Key Performance Indicators (KPIs)*** *(see definition)*. The seven Domains of Change include:

1. Childhood Literacy & Numeracy (Education)
2. Income & Food Security (Food Security)
3. Child Growth (Health)
4. Transformed Leaders
5. Gender Dignity & Child Protection
6. Risk & Resilience
7. Transformed Culture & Worldview (God's Story)

Why not Sector? Sector relates to units in the office, pieces of a puzzle, or sections of a pie, where pieces are separate and distinct from one another, but fit together to make a whole. "Domain" demonstrates an area or integrated part of a whole. For example, the nervous system is a part of the body that is integrated into each part (arm, leg, eye). Likewise the immune system is part of the whole body sustaining health in each part. These systems aren't separate pieces which can be added or subtracted, but an integrated part of the body.

Key Performance Indicators

FH's Key Performance Indicators (KPIs) are the quantitative measurements of progress towards transformation across the Domains of Change. Measuring these indicators across FH's programs enables us to know how well, or not, key results are being achieved across the global family. The following table lists FH's Domains of Change, the Goal of each Domain, and related Global KPIs.

Domain of Change	Goal	Global Key Performance Indicators
Childhood Literacy & Numeracy (Education)	Children reach grade level standards	- Percentage of children in grade 3 who have attained the reading, comprehension and numeracy standards according to the national standards. - Percentage of children in the year prior to entry into preschool that have attained the national standards of early childhood development
Income & Food Security (Food Security)	Improve food security and livelihoods	- Months of adequate household food provisioning - Household Hunger Scale
Child Growth (Health)	Children grow at proper height per age	Percentage of children 0-23 months below height for age < –2 SD of the WHO Child Growth Standards median
Transformed Leaders	Leaders drive sustainable change in the community	Leadership Effectiveness Index
Gender Dignity & Child Protection	Promote gender equality and dignity	Gender Empowerment Index
Risk & Resilience	Communities are protected from, prepared for, and resilient to disasters, shocks, and stresses	Risk and Resilience Score
Transformed Culture & Worldview (God's Story)	Behaviors align to God's truth	Worldview Score

Location Terms

Community:
A locality inhabited by a group of households geographically demarcated and administratively (politically) recognized, having a common culture, historical heritage, and a common elected or traditional leader.

Cluster:
One or more communities defined and organized in a geographical area for FH's program management purposes.

Household:
People living under the same roof and sharing the same kitchen with one or more self-identified and defined family units with one or more members.

Family:
People who identify themselves as a separate family unit who may, in whole or in part, live in the same household.

Program

A Program is defined at a Country level with clearly defined strategic and operational goals and objectives to be accomplished through implementation of ***Projects*** *(see definition)*.

Project

A project is a time-bound intervention that is carefully planned and designed to achieve a particular aim, organized by specific elements of objectives (goal, purposes, outputs and activities), with specified funding and geographical implementation location

- Some projects include multiple issues, while other projects focus on a single issue.
- Projects can be implemented in one or more geographical locations.

Program Quality Standards

Program Quality Standards provide guidance for implementing projects along the Domains of Change of CFCT, serving as a basis for a common understanding of the critical elements necessary for a given program to be effective regardless of its location.

Program Quality Standards are not....focused on results, but rather on implementation; execution versus achievement. It is assumed that high quality execution will lead to achieving the desired results.

Toolkit

A toolkit is a set of "tools" including manuals, guidance documents, and assessments all related to one topic. These tools are kept together in one "kit" or package. CFCT Toolkits were

developed based on best practices to help program staff in implementing CFCT. During the global release of CFCT materials, FH introduced various toolkits including the Health Toolkit, the Staffing and Volunteer Toolkit, the Vulnerability Assessment and Community Clusters Selection Toolkit, and the Community & Church Leaders Relationship Building Toolkit.

Transformation and Transformational Relief & Development

FH uses the term ***"transformation"*** to refer to "*the Spirit driven process of radical change in the behaviors, attitudes, beliefs, and worldviews of individuals, communities or cultures towards living in healthy relationships with God, others, themselves, and God's creation"* (God's Story publication). This inner transformation sustainably motivates the community and its members towards development and flourishing. FH uses the term ***"transformational development"*** to refer to the work that staff and community members do in Relief and Development in order to promote, facilitate and achieve mutual transformation to advance and accelerate measurable wellbeing improvements of the most vulnerable.

Appendix C: CFCT List of Tools

All CFCT tools may be reviewed and downloaded on FH Connect at:
https://fhconnect.org/content/Intranet_Main/Business/GSC/RPD.php

1. CFCT staff and Cascade Group Volunteer Calculator
2. Vulnerability Assessment and Community Clusters Selection Toolkit
3. Focus Group Discussion Guides
4. Community and Church Leaders Relationship Building Toolkit
5. Community Leaders Training Manual
6. M&E Manuals (A, B, C, D)
7. (2011) Model Implementation Manual (MIM)
8. (2016) Model Implementation Overview
9. Program Quality Standards
10. Holistic Community Assessments
11. Church Leaders Training Manual
12. Health Toolkit
13. Health Questionnaire
14. Health Flipchart Modules 1-6
15. Education Sector Guide
16. Education CG Modules and flipcharts
17. Education Assessment Tools (Enumerator Guide, Questionnaires, Training Materials)
18. Savings Group Manual
19. Rapid Food Security and Livelihoods Assessment (RFSLA) Training Manual
20. Business Skills Training Manual
21. CMDRR Manual (for stand-alone DRR projects outside of CFCT)
22. DRR/M Manual for Managers
23. Belief and Behavior Change Manual

Appendix D:
CFCT Mid-Term Evaluation Summaries

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Nicaragua

Nicaragua**,** country of Central America, is the largest of the Central American Republics. It is a beautiful tropical country with amazing landscapes and friendly people. Its warm climate and biodiversity are enough to lure visits from all over the world. Nicaragua can be characterized by its agricultural economy, its history of autocratic government, and its imbalance of regional development—almost all settlement and economic activity are concentrated in the western half of the country. Almost three quarters of the Nicaraguan **people live on only $2** per day and nearly half live in **poverty.** The Nicaraguan **economy is based** mostly on agriculture, tourism, mining and manufacturing.

Food for the Hungry (FH) commenced its operations in Nicaragua in 1972, as a response to a humanitarian emergency to a major earthquake. It was not until the year 2009, that FH Nicaragua (FHN) started working towards a long-term community development. Child sponsorship was introduced in three communities in the municipality of Chinandega. Later seven new communities were added. With the roll out of CFCT in 2013, the program expanded to 59 communities, and the baselines were conducted in these communities. Between the year 2013 and 2016, FH Nicaragua rolled out CFCT following the different CFCT phases as rolled out globally. FH Nicaragua formed cascade groups, savings groups, trained community leaders and church leaders and enabled them to develop their community transformation plan.

Mid Term Evaluation was conducted in Nicaragua from November 14-22, 2016. Both Inductive and Deductive methodology was employed for the midterm evaluation. Household survey was conducted during last week of October and early November 2016 and qualitative data was collected during the MTE. 285 households were interviewed to measure quantitative indicators in three different clusters using Lot Quality Assurance Sampling (LQAS) methodology. Data for qualitative indicators introduced as part of MTE methodology was collected through 42 FGDs conducted during the evaluation. Quantitative data was analyzed using Epi-Info, while ORID methodology was used for qualitative data analysis.

One of the key purposes of the mid-term evaluation was to help FH Nicaragua understand the community's readiness to graduate. Though none of communities was yet ready to graduate, however 50% of the communities were almost reaching the graduation level and only need few more years before they are ready to graduate. The other major objective of the MTE was also to calculate the movement out of poverty. This calculation is based on people who meet FH's success criteria. FH's success criteria are defined as people showing significant change in both visible and invisible elements of transformation. During the baseline only 23%, people met the FH's success criteria. It has dramatically improved to 45%. This resulted in 7,522 people moving out of poverty. This is remarkable achievement for the Nicaragua team. This indicators that showed significant change were exclusive breastfeeding, gender-based violence and worldview. Exclusive breastfeeding rate increased from a baseline value of 37% to 59.3 %. Gender-based violence i.e. proportion of women who said that it is ok for a husband to beat his wife reduced dramatically from 48.8% to only 7%. Worldview score improved from 77.7 to 84.

However, there were also indicators that need more attention. There was not much change seen amongst children 6-23 months who are receiving four or more food groups. The baseline

value was 85%, whereas it has only changed by 2 percentage points to 87.5%. The deworming coverage actually declined to 69.5% from a baseline value of 82.1%. There was also no significant change in the stunting level when compared to baselines. The stunting prevalence is only 6.7%, well below the global target. The evaluation team concluded that stunting is not an issue in Nicaragua and they can actually work with the government health facilities to sustain this results while utilize FH Nicaragua's resources in other pressing issues.

During the MTE, two new indicators: Emergence of Hope and Caring for Others were introduced. These two indicators use qualitative methodology for measurement. The results for these indicators can actually be considered as baselines. Overall emergence of hope was found to be low for men and children while it was rated as medium for women. Rating for community caring for others was medium for men and women but low for children. Both men and women clearly articulated their vision and plans for their community, which included infrastructure for education and agriculture. Their dependency on external sources is still quite high. Both men and women related that God is the center of their life who gives them strength and guidance to deal with their day-to-day life. With God's help, they can make the difference. Community taking care of the vulnerable was a constant theme both in men and women's discussions. Women have increased their involvement in family as well as community decision-making processes, which was endorsed by men as well. Both men and women felt that leadership in the community needs to be strengthened in terms of planning and execution.

The impact of savings groups was highly visible. Women now have money available to meet their needs during the time of emergencies and to celebrate birthday and year-end celebrations. Women in the savings group believed that they were valued and respected both in their families and in the community and that, they provided leadership. Trainings on health issues were being well received by cascade group volunteers, because topics are of interests to the women and applies to their daily lives. Increasing engagement of the neighborhood circle was something they were finding it challenging. Church leaders mentioned good synergy between the churches, especially between the denominations, however only limited number of participants were trained. They understand that one of the significant roles of the church is to serve the neediest *"getting out of the temple."* Great examples of practical applications of the training especially act of love, which continues even after the training.

The methodological approach to CFCT Mid Tern Evaluation is based on the idea of a "learning process approach" to CFCT implementation. This approach differs significantly from a "blueprint approach" to program implementation that is the traditional and still most widely used approach. FH's adaption to Results Based Monitoring and Evaluation to program implementation makes this MTE approach fundamentally different. In this approach to MTE, monitoring and evaluation activities are concerned not only with the extent to which the planned activities are carried out but also with how they are carried out. In this approach to MTE, mechanisms were developed to help program staff learn from both the successes and problems encountered in implementing the activities in order to improve the program in the future. For example, in this evaluation approach it would be important to know not only how many savings group have been formed but also to identify both the successful and problematic aspects of forming and training the savings group. This would allow program staff to identify ways to improve future trainings and saving groups meetings. In this approach, monitoring and evaluation activities involve the collection of important quantitative information but priority is given to the collection of qualitative information, which describes the

process involved in carrying out each type of activity. For example, information might be collected on the "number of cascade group volunteers trained" but also on the "quality of the training," on the "feedback from trainees on the usefulness of the training content" and on "how trainees are using what they were taught" in their work with communities.

Based upon the information collected during the evaluation, "lessons learned" were formulated which will be fed back into the program plan. Modifications in program activities and strategies will continuously be made based upon the lessons, which were formulated during the evaluation. From beginning to end the orientation of the evaluation methodology exercise addresses the question "What can we learn from what we have already accomplished in order to improve the program in the future?" Perhaps the two most important facets of the methodology are the involvement of program stakeholders in all steps in the evaluation process and the focus of the evaluation on the development of lessons learned which are translated into an action plan.

Following were the key challenges that were identified during the evaluation:

Community used to hand outs: Community members were so used to handouts during the CDP. Dealing with this mentality during the transition to CFCT approach posed quite a challenge to field staff. Funding was also limited.

CFCT Phases and Materials: The sequence of work with the leaders after Phase I was not clear. Staff suggested looking for greater synergy between phases and materials. The manuals are not always translated and are not available in time to implement them.

Meeting the community needs versus CFCT focus: Sometime addressing community needs due to limited resources while also implementing the CFCT activities posed challenge specially related with adolescents. There is no defined strategy for working with adolescents in CFCT. It would be good in such case to help the community identify all vulnerable people and develop a plan to support them.

Staff Selection: FH Nicaragua has to be careful with the selection of personnel as by law you cannot discriminate in recruitment. Going through the political and religious lines also posed a challenge in the application.

Community Leadership: Lack of organization and leadership to manage development actions, which creates high dependence on the government and NGOs. Being a woman in the leadership of the church can generate a situation in which she does not feel respected. The man feels threatened because the barriers for women are being removed.

Savings Group Meetings: The meeting timing of the groups did not work for many women who also work. This led to several women dropping out of the savings group.

Lessons learnt: Following lessons learnt were drawn during the evaluation:

Facilitation, relationship and conflict resolution skills are indispensable for FH facilitators.
Devotional times and spiritual formation with staff serve to motivate and contribute to conflict resolution. It is necessary to strengthen the processes of spiritual formation beyond institutional devotional ones.

The system of assigning CFCT mentors and staff sponsorship is good practice.

The organizational structure has to be adapted to the conditions and community context.

The FH staff has documented the process of developing CFCT in each community to preserve the institutional memory of the work.

It is necessary to relate, respect and work together with the political institutions of the country.

It is important to adapt the images, vocabulary and technical level of the CFCT manuals to the context.

Facilitators need to be creative and add more dynamics and visual aids to facilitate workshops with manuals.

Improve the connection of the manuals with the compliance of the indicators being evaluated.

There were some issues around the baseline values. Evaluation team recommended that baseline results be reviewed and then compared with the final evaluation. Further, evaluation team recommended sustaining health activities by collaborating with Government and use FH resources in other CFCT sectors such as Education and Livelihood. The MTE team also recommended strengthening the capacity development process of Community Leaders by repeating the trainings, reinforcing key messages, providing access to technical resources, follow-up and providing constructive feedback and developing community transformational plan. Another recommendation was to develop a comprehensive livelihood strategy such as agriculture production, value chain etc. for providing livelihood opportunities to the families. The MTE also suggested exploring issues around abuse, protection and violence especially with children and appropriately addressing them through the newly developed project designs and exploring issues and challenges with the adolescents and teens and develop programmatic interventions to address them. The MTE also suggested that FH Nicaragua team work towards strategies to encourage ways and means to engage men in the programs. Finally, the MTE team applauded the efforts of the FH Nicaragua leadership in training staff and suggested to continue and strengthening staff mentoring and discipling through a structured coaching process.

NICARAGUA

Program Key Performance Indicator	CHINANDEGA LB	CHINANDEGA 2016	Stat. Sig	NUEVA SEGOVIA LB	NUEVA SEGOVIA 2016	Stat. Sig	SOMOTILLO LB	SOMOTILLO 2016	Stat. Sig	NICARAGUA BL2013	NICARAGUA MTE2016	Stat. Sig
(UNDER WEIGTH) % of children 0-23m who are underweight (WAZ< -2.0)	9.6%	6.7%	NO	3.0%	4.6%	NO	7.4%	8.4%	NO	**6.7%**	**6.5%**	NO
(EXCLUSIVE BREASTFEEDING) % of children 0-6m who are exclusively breastfed	19.0%	58.8%	NO	56.0%	40.0%	NO	33.3%	72.7%	YES	**37.0%**	**59.3%**	NO
(INFANT DIETARY DIVERSITY) Infant/Child Dietary Adequacy Score		6.7			5.1			6.7			**6.2**	
(FOUR OR MORE FOOD GROUPS) % of children 6-23m with a dietary diversity score of four or moreusively breastfed	71.0%	87.2%	NO	95.0%	77.5%	NO	84.6%	93.2%	NO	**83.0%**	**85.7%**	NO
(HOUSEHOLD DIETARY DIVERSITY) Average number of food groups consumed by households	7.6	8.3	YES	9.3	7.6	NO	8.6	8.3	NO	**8.5**	**8.0**	NO
(DEWORMING) % of children 5-19 years who received deworming medication within the last 6 months	84.2%	78.9%	NO	84.2%	70.5%	NO	77.9%	58.9%	NO	**82.1%**	**69.5%**	NO
(WORLDVIEW) Average worldview index score	79.6	85.2	YES	75.5	82.0	YES	78.1	84.9	YES	**77.7**	**84.0**	YES
(OK TO BEAT WIFE) % of mothers (of children 0-18y) who say that it's okay for a man to hit his wife	38.9%	3.2%	YES	45.3%	8.4%	YES	62.1%	9.5%	YES	**48.8%**	**7.0%**	YES
(LEADERSHIP EFFECTIVENESS) % of mothers/CC who rate the effectiveness of their community leaders a 'high' or 'very high.	31.6%	71.6%	YES	42.1%	71.4%	YES	52.6%	88.4%	YES	**42.1%**	**76.5%**	YES
(CHURCH LEADERSHIP EFFECTIVENESS) % of mothers/CC who state that church leaders in their community do activities outside of their place of worship that are open to involve the entire community 'some of the time' or 'a	66.3%	86.3%	YES	67.4%	51.1%	NO	87.4%	60.0%	NO	**73.7%**	**64.1%**	NO
(HOUSEHOLD PRAYS) Average of households with children 0-18 that prayed together 4 or more times during the past week	2.4	2.8	YES	2.7	2.5	NO	2.7	2.4	NO	**2.6**	**2.6**	NO
(ABSENTISM) % of children 3-18 years missed two or more school days last 10 days	45.6%	30.4%	NO	23.7%	18.6%	NO	27.4%	32.1%	NO	**31.2%**	**25.9%**	NO
(ENROLLMENT) % of children 3-18 years in the household who are registered in school.	71.3%	90.2%	YES	94.4%	92.6%	NO	76.8%	83.0%	NO	**80.9%**	**89.1%**	YES
(SOCIAL SUPPORT) Average of households with children 0-18 that prayed together 4 or more times during the past week	16.6	16.5	NO	15.7	16.0	YES	15.8	16.9	YES	**16.0**	**16.4**	YES
(DRR WORLDVIEW) Average DRR worldwide score of respondents	10.6	12.6	YES	10.9	12.2	YES	11.7	12.3	YES	**11.1**	**12.4**	YES

Program Key Performance Indicator	CHINANDEGA LB	CHINANDEGA 2016	Stat. Sig	NUEVA SEGOVIA LB	NUEVA SEGOVIA 2016	Stat. Sig	SOMOTILLO LB	SOMOTILLO 2016	Stat. Sig	NICARAGUA BL2013	NICARAGUA MTE2016	Stat. Sig
(PERSONAL RESILIENCE) Average Personal Resilience Score	19.2	19.8	YES	19.6	21.2	YES	19.6	20.7	YES	**19.5**	**20.6**	YES
(SELF EFFICACY) Average generalized self-efficacy score.	16.2	16.3	YES	15.5	16.2	YES	14.9	16.3	YES	**15.5**	**16.2**	YES
(SAFE WATER) % of families that have a safe water source % de familias que cuentan con una fuente de	67.4%	86.3%	YES	40.0%	76.7%	YES	27.4%	61.1%	YES	**44.9%**	**74.9%**	YES
(TREATMENT) % of households that have treated water during the last 48 hours		0.0%			0.0%			0.0%			**0.0%**	
(HAND WASHING) Proportion of households where the caregiver of young children 0-23 months reported adequate hand washing behavior	50.5%	66.3%	NO	84.2%	75.2%	NO	77.9%	75.8%	NO	**70.9%**	**72.8%**	NO
(SANITARY INSTALATION) % of homes of children 5-17 years old who have latrines / toilets with basic facilities.	91.6%	94.7%	NO	92.6%	95.5%	NO	81.1%	92.6%	NO	**88.4%**	**94.4%**	NO
(PERCEPTION QUALITY EDUCATION) % of mothers / CP of children between 5-17 years who rate the quality of their children's education as high or very high.	69.5%	87.4%	YES	84.2%	91.0%	NO	85.3%	92.6%	NO	**79.6%**	**90.4%**	YES
(EDUCATION LEVEL-SUCCESS) % of mothers / CP who say that secondary education or higher education is necessary to be successful today	91.6%	100.0%	YES	90.5%	100.0%	YES	97.9%	100.0%	NO	**93.3%**	**100.0%**	YES
(ADEQUATE PLACE FOR TASKS) % of caregivers of children (1-3 grade) who have separated a particular place for your child to study at home (or near her).		88.4%			82.0%			67.4%			**79.6%**	
(CP CHECK THE TASKS) % of child caregivers (1-3 grade) who have reviewed their child's homework at least twice in the last school week.		81.1%			80.5%			74.7%			**78.9%**	
(MEETING WITH THE TEACHER) % of child caregivers (1-3 grade) who have met with your child's teacher in the last two months at least once to discuss your child's progress.		94.7%			89.5%			78.9%			**87.9%**	
(TREATMENT FOR DIARRHEA) % of children 0-23 months of age with diarrhea in the last two weeks who received oral rehydration solution (ORS) and / or homemade fluids		35.3%			45.7%			50.0%			**44.1%**	
(ACUTE RESPIRATORY INFECTION TREATMENT) % of children 0-23 months of age who have had cough and rapid and difficult breathing in the last two weeks and were taken to a health facility (who received antibiotics from an appropriate person in the health sector)		68.8%			26.7%			52.9%			**50.0%**	

Program Key Performance Indicator	CHINANDEGA LB	CHINANDEGA 2016	Stat. Sig	NUEVA SEGOVIA LB	NUEVA SEGOVIA 2016	Stat. Sig	SOMOTILLO LB	SOMOTILLO 2016	Stat. Sig	NICARAGUA BL2013	NICARAGUA MTE2016	Stat. Sig
(SYMPTOMS ATTENDED IN MEDICAL CENTERS) % of mothers of children 0-23 months who know about three or more warning signs that indicate their child needs medical attention. (You can also report the known average number)		90.5%			92.5%			96.8%			93.2%	
% of children aged 0-3 who have three or more books for children.		2.1%			0.8%			0.0%			0.9%	
% of children 0-3 years with two or more toys.		70.5%			71.4%			75.8%			72.4%	
Number of community actors trained to lead educational activities that reinforce learning goals by grades, from preschool to third grade		83.2%			72.2%			94.7%			82.0%	
VACCINES		60.0%			59.4%			40.0%			53.9%	

FOOD FOR THE HUNGRY

Guatemala

Guatemala is located in the Central American isthmus with a territorial extension of 108,889 sq. km, integrated by 22 departments, which are divided into 331 municipalities. Given the political, social, economic and health conditions that the Guatemalan population is going through, it is apparent that Guatemala is going through a complex period of political transition towards the consolidation of democracy. This process dates back to 1985, when it was promulgated by the Political Constitution of the republic currently in force and then qualified by the Peace Accords in 1996. This globalization resulted in an economic, social and cultural transition. An epidemiological transition has taken place due to the increasing prevalence of chronic and degenerative diseases and a lagged demographic transition. Additionally, Guatemala is seated on three tectonic plates that cause frequent seismic movements of varying intensity. The economy of this developing country constitutes the largest economy in Central America, and the eleventh in Latin America. Its GDP represents one third of the regional GDP. The country maintains solid macroeconomic fundamentals in recent years, with a high level of reserves, a controlled level of the public deficit (2.8% in 2011), the external deficit and a low public debt of 24.3% of GDP in 2011. The economic level of the population is medium low with 50% of its inhabitants below the poverty line and 15% in extreme poverty[1] . The largest sector in the Guatemalan economy was traditionally agriculture, with Guatemala being the world's largest exporter of cardamom, the fifth largest exporter of sugar and the seventh largest coffee producer. The tourism sector is the second largest generator of foreign exchange for the country after remittances from emigrants; the industry is an important branch of the Guatemalan economy and the service sector is increasing in importance as a result. In 2016, Guatemala is the fourth country with the highest inequality in Latin America (after Honduras, Colombia and Brazil)[2].

FHG uses an innovative and Biblical approach to decrease the chronic malnutrition in children between 0-5 years old and transforming the lives of the children, youth, families, and leaders in the areas of operations. The CFCT model enables the integration and harmonization of all FHG programming to achieve our vision and mission as laid out in the five VMV Core Components. While there may be great diversity in projects and donors, there are some things that FH seeks to accomplish everywhere – in particular, walking with churches, leaders and families by training them in the essentials of what they need to know to lead godly and healthy lives. CFCT focuses on the transformation of people. FH uses the term “transformation” to refer to the Spirit-driven process of radical change in the behaviors, attitudes, beliefs, and worldviews of individuals, communities or cultures towards living in healthy relationship with God, others, and God’s creation. The focus of the CFCT model is on children and the most vulnerable. The purpose is to strengthen and equip the community to nurture and provide for them as God designed.

During the theory of change analysis the team identified that chronic malnutrition is a complex problem, but all the Pathways of Change could be considered in the four categories or sectors of the CFCT: Disaster Risk Reduction (DRR); Health (includes Nutrition); Livelihoods, and Education. The crosscutting areas (gender, environment and Biblical Worldview), would be integrated into the programmatic design of all four sectors. In addition, it was necessary to analyze the support areas (Financial, Human Resources and Resource Development) to

[1] http://www.gt.undp.org/content/guatemala/es/home/countryinfo.html
[2] http://www.bbc.com/mundo/noticias/2016/03/160308_america_latina_economia_desigualdad_ab

identify the key interventions needed to contribute to the FHG defined strategic goals. According to the geographical area, FHG will be growing to other municipalities where it will be applying Strategic Criteria on poverty. FHG will follow its strategic direction and goals to fulfill its call: "FHG is an innovative and biblical leader in the eradication of chronic child malnutrition, achieving a comprehensive transformational impact in children, youth, families, communities, organizations and government in Guatemala". With this approach, FHG will focus on the achievements of the different strategic objectives both in operational work in the field and the administrative efforts to encourage and motivate the staff at the different levels of the structure.

With the necessity of a more rigorous evaluation design that would provide the most irrefutable conclusions regarding the implementation of CFCT and that would best help measure the impact of program interventions, the mid-term evaluation (MTE) of CFCT model implemented, as part of the global implementation, a two component quantitative data collection in Guatemala from November to December 2016 using parallel sampling. Lot Quality Assurance Sampling methodology (LQAS) was used for the quantitative method for collecting information using household surveys in three different clusters. In the second component, the qualitative indicators were collected using 39 Focus Groups Discussion (FGDs) in July 2017, in the evaluation. For quantitative data analysis, we used Microsoft Access and Epi Info for indicators in Education, while we used Objective, Reflective, Interpretive, Decisional (ORID) methodology for qualitative data analysis. FH Guatemala after this MTE learned many things in this process, and understands the communities' readiness to graduate. 51% of the communities in 23 supervision areas were approaching the graduation level.

Women mentioned that it was easier for them to take out loans from the savings group compared to the bank, as it takes lot of time and paperwork to get loans from the bank. Significant inter-loaning has taken place in the saving groups, predominantly for productive purposes such as starting small businesses. Participation in the savings groups resulted in changed values and attitudes among women towards each other. There was growing trust, peace, and harmony, improving interpersonal relationships. There were also evidences of growing self-esteem and confidence amongst women, leading to their improvement in public speaking.

Volunteer mothers expressed that they have the capacity to develop their role through the knowledge they have acquired and the tools that have been provided for them. At the same time, they recognize that if they practice what they have learned, it is easier for others to follow their example in their community. They feel accepted by their community because of the role they play and at the same time feel very encouraged because of the changes, they see in the families of their community.

The results for the worldview in the MTE compared to the base line show a little increase. This change could be due to the interventions that have been carried out. For example, in many communities, there is a change that is occurring in mothers who are participating more in the cascade groups and the GAG groups, beginning to express their opinions and participate, while they used to be very shy to express their opinions.

The methodological approach to CFCT Mid Tern Evaluation is based on the idea of a "learning process approach" to CFCT implementation. This approach differs significantly from a "blueprint approach" to program implementation that is the traditional and still most widely used approach. FH's adaption to Results Based Monitoring and Evaluation to program

implementation makes this MTE approach fundamentally different. In this approach to MTE, monitoring and evaluation activities are concerned not only with the extent to which the planned activities are carried out but also with how they are carried out. In this approach to MTE, mechanisms were developed to help program staff learn from both the successes and problems encountered in implementing the activities in order to improve the program in the future. For example, in this evaluation approach it would be important to know not only how many savings group have been formed but also to identify both the successful and problematic aspects of forming and training the savings group. This would allow program staff to identify ways to improve future trainings and savings groups meetings. In this approach, monitoring and evaluation activities involve the collection of important quantitative information, but priority is given to the collection of qualitative information, which describes the process involved in carrying out each type of activity. For example, information might be collected on the "number of cascade group volunteers trained" but also on the "quality of the training," on the "feedback from trainees on the usefulness of the training content" and on "how trainees are using what they were taught" in their work with communities.

Based upon the information collected during the evaluation, "lessons learned" are formulated which will be fed back into the program plan. Modifications in program activities and strategies will continuously be made based upon the lessons, which were formulated during the evaluation. From beginning to end the orientation of the evaluation methodology exercise addresses the question "What can we learn from what we have already accomplished in order to improve the program in the future?" Perhaps the two most important facets of the methodology are the involvement of program stakeholders in all steps in the evaluation process, and the focus of the evaluation on the development of lessons learned which are translated into an action plan.

Success Factors

- People at all levels played a crucial role in success of CFCT implementation.
- Listening to community and prioritizing the activities
- CFCT is an adaptive model; it is designed by the guidance of the Holy Spirit.
- Materials were adapted to suit the Guatemala context.
- The focus of the CFCT is on behavior change.
- Programmatic intervention of sectors and systemic training guide for implementation of various sectors.
- Focus on community empowerment model
- Strategic partnership with other organizations such as FEMSA, Health ministry etc.
- Effective monitoring and evaluation mechanism that provided regular feedback through process monitoring.
- Reorganize the staff structure in order to address the programmatic need.

Key Challenges

- Guatemala's program has grown, but the number of staff has remained the same. This has led to an increase in workload.
- Balancing staff training and capacity building with the implementation of activities.
- Conflict in time regarding staff availability and availability of the community leaders
- Frequent rotation of community leadership and migration of families
- Absence of tools for MSF promoters to make their work more efficient and effective
- No understanding on when community is ready to graduate

These were several lessons that were drawn during the evaluation. Firstly, the CFCT model allows for identification of specific issues, leveraging resources, and partnership with other organizations. Secondly, implementing more activities does not necessarily create more impact. The focused activity is more effective. Thirdly, rather than focusing on a specific group of children, it is more effective to work with the entire community to impact lives of children. Fourthly, mutual transformation is key for community transformation and discerning God's will and his guidance plays an important role in growth and management of the organization. Fifthly, it is important to do cost/benefit and effective analysis rather than make decisions purely based on cost. Empowerment approach and building community capacity is more effective and requires fewer resources compared to direct implementation and service delivery model. Finally, new Savings Group methodology that focused on entrepreneurial skills and loans proved to be more effective than VSLA model where payouts were primarily used for consumption.

Some of the recommendations that were jointly agreed on by the FH Guatemala Team and the Mid Term Evaluation Team are that Global Monitoring and Evaluation Team support the comprehensive review of the monitoring and evaluation system including sampling and streamlining of the analysis. While strengthening the existing health interventions, FH Guatemala should focus on designing a comprehensive Livelihood project strategy to address the economic needs of the community. FH Guatemala should also conduct a workflow analysis of the staff and identify the business processes that are unnecessary and consuming more time in order to address the workload issue. They should speed up the recruitment of staff in order to address the workload. They need to review training materials and develop materials with graphics for facilitators. They should also develop professional development plans for staff for the sake of their retention and motivation. Update the country strategic plan and project design based on the evaluation findings. They need to understand that capacity building of the community leaders should be a continuous process as leaders change over time. Finally, they need to design education interventions and strategies to address the educational needs of the adolescents, especially girls.

After this MTE, FH Guatemala has learnt that for future projects take this report as a base and a guide for planning the graduation of supervision areas in the next few years. FH Guatemala will prepare a plan of requirements for each sector of CFCT to cover the necessities as it works in each community to prepare the supervision area to graduate. FH Guatemala is also planning to make a base line measurement in new areas, applying all the lessons learned and will coordinate the support of the global office. It will include the education sector and use stronger strategies as it trains the new staff and maintains the quality of the interventions for all the communities.

GUATEMALA

Performance Indicator	Alta Verapaz (BL)	Alta Verapaz (MTE)	Stat. Sig	Huehuetenango (BL)	Huehuetenango (MTE)	Stat. Sig	Ixil (BL)	Ixil (MTE)	Stat. Sig	GUATEMALA (BL)	GUATEMALA (MTE)	Stat. Sig
(STUNTING) % of children 0-23m who are stunted (HAZ< -2.0)	50.5%	42.6%	NO	66.1%	68.1%	NO	59.8%	61.0%	NO	58.9%	58.4%	NO
(WASTING) % of children 0-59m who are wasted (WHZ< -2.0)	62.6%	52.2%	YES	74.9%	74.2%	NO	70.6%	69.9%	NO	69.3%	66.9%	NO
(UNDER WEIGTH) % of children 0-23m who are underweight (WAZ< -2.0)	16.3%	7.6%	YES	23.9%	20.7%	NO	21.4%	16.5%	NO	20.6%	15.4%	YES
(UNDER WEIGTH) % of children 0-59m who are underweight (WAZ< -2.0)	17.1%	8.1%	YES	26.6%	19.3%	YES	25.6%	17.1%	YES	23.3%	15.5%	YES
% of mothers of children 6-23 months who used at least 2 perceptual complementary feeding behaviors, last 24 hours.		64.9%			51.1%			76.8%			65.9%	
% of mothers of children 0-5 months who recognize at least 2 signs of hunger in their baby.		64.9%			41.4%			77.9%			63.4%	
% of mothers of children 0-5 months who used at least 2 perceptual breastfeeding behaviors, last 24 hours		68.4%			51.1%			76.3%			66.6%	
(HOUSEHOLD DIETARY DIVERSITY) Average number of food groups consumed by households	5.5	4.6	NO	5.616541353	6.0	YES	6.884210526	5.9	NO	6.137299771	5.6	NO
% of mothers of children 0-23 months of age who took iron supplements for at least 3 months, in the last pregnancy.	82.5%	78.1%	NO	54.1%	48.9%	NO	83.2%	81.6%	NO	74.1%	70.7%	NO
% of mothers of children 0-5 months who recognize at least 2 signs indicating that their baby wants interaction		5.3%			1.5%			14.7%			8.2%	
% of mothers of children 0-5 months who recognize at least 2 signs indicating that their baby does NOT want interaction.		0.34			0.22			0.28			0.28	
Proportion of homes of children 0-23 months who properly disposed of the stool of the youngest child the last time they defecated.		57.9%			16.5%			20.3%			28.9%	
(FOUR OR MORE FOOD GROUPS) % of children 6-23m with a dietary diversity score of four or more	0.52	46.2%	NO	0.35	60.3%	YES	0.70	73.7%	NO	0.54	62.6%	NO
(EXCLUSIVE BREASTFEEDING) % of children 0-6m who are exclusively breastfed	89.8%	76.2%	NO	85.7%	78.9%	NO	89.8%	68.9%	NO	88.6%	74.1%	NO
Proportion of households where the caregiver of young children aged 0-23 months reported adequate hand washing behavior.	17.5%	39.5%	YES	0.0%	62.4%	YES	16.3%	57.9%	YES	11.7%	54.5%	YES
(WORLDVIEW) Average worldview index score	20.9	21.3	YES	20.9	22.4	YES	20.0	20.6	YES	20.5	21.3	YES
% of children, at the nationally recommended age to finish third grade, who have reached reading, comprehension and math standards to finish 3rd grade												

Performance Indicator	Alta Verapaz (BL)	Alta Verapaz (MTE)	Stat. Sig	Huehuetenango (BL)	Huehuetenango (MTE)	Stat. Sig	Ixil (BL)	Ixil (MTE)	Stat. Sig	GUATEMALA (BL)	GUATEMALA (MTE)	Stat. Sig
Average planted area for non-traditional crops	2.8	2.8	NO	0.0	2.1	YES	1.9	1.9	NO	1.6	2.2	YES
Average of different types of non-traditional crops	3.6	3.6	NO	2.1	5.6	YES	2.7	2.7	NO	2.7	3.8	YES
% of respondents who say they are able to provide better for their families since they have been participating in the savings / GAG groups.	0.10	27.2%	YES	0.00	4.5%	YES	0.02	3.7%	NO	0.03	10.1%	YES

Bangladesh

FH has been operating in Bangladesh since 1972. Over the past 45 years, FH Bangladesh's (FH/B's) work has progressed from relief, to micro-lending, to directly running schools, to today's focus of supporting communities to build upon their own resources to rise out of poverty. Throughout these years, FH has collaborated with Bangladeshi leaders and impoverished communities to create better living conditions. FH Bangladesh started the implementation of Child Focused Community Transformation (CFCT), in 2013. Currently it is implementing CFCT in seven regions: Bogra, Dhamrai, Mid-West, Mymensingh, PB Coastal, Godagari and Tanore.

As part of a global pilot testing of CFCT Mid Term Evaluation Methodology, a Mid Term Evaluation (MTE) was conducted in Bangladesh from March 27- April 03, 2017. Both Inductive and deductive methodology was employed for the midterm evaluation. Quantitative data was collected using a household survey in March 2017 and qualitative data was collected during the MTE. 480 households were interviewed to measure quantitative indicators in five different clusters using Lot Quality Assurance Sampling (LQAS) methodology. Data for qualitative indicators was collected using Focus Group Discussion (FGDs). 62 FGDs were conducted during the evaluation. Quantitative data was analyzed using Epi-Info, while ORID methodology was used as a framework for qualitative data analysis.

One of the key purposes of the mid-term evaluation was to help FH Bangladesh understand the community's readiness to graduate. Only 39% of the communities in 7 supervision areas were almost reaching the graduation level and only need few more years before they are ready to graduate, most of the evaluated communities were not yet ready to graduate.

The other major objective of the MTE was to calculate the progression out of poverty. This calculation is based on people who meet FH's success criteria. FH's success criteria are defined as people showing significant change in both visible and invisible elements of transformation. During the baseline only 10.1%, people met the FH's success criteria. At MTE, the criteria have dramatically improved to 24.4%. This resulted movement of 38,412 people out of poverty. This is considered a remarkable achievement for the Bangladesh team. In addition, on average it only costed FH Bangladesh $43 to move a person out of poverty.

There were some great achievements in implementation. There were 300 cascade groups formed with 2411 trained cascade group volunteers reaching out to 17, 2013 pregnant and lactating mothers. The average attendance rate in the trainings was 98%. This resulted in reduction of children who are underweight from 37.5% to 34.1%. The prevalence of stunting is around 24%. Though this indicator was not measured in the baseline, given the food security situation in Bangladesh, the prevalence rate is not very high. Global acceptable standard is 15%.

FH Bangladesh has also formed 635 savings groups reaching out to 12,175 households in 166 communities. They have been cascaded into 14 CBOs. FH Bangladesh's sustainability strategy is to form the savings group in CBOs and then graduate them. The current total asset of these savings groups is $669, 346. Forming savings groups and encouraging people to save and do inter-loaning is one of FH's strategies in CFCT to increase income and make difference in the quality of life of children. Household dietary diversity score is one of the proxy indicators to measure the change in income. The household dietary diversity score has increased from 6.3

to 7.5. This means that children and family have access to eight different types of food groups from recommended 12 groups. This is a remarkable achievement.

FH Bangladesh have formed 117 Community Development Committees (CDC) and trained approximately 1107 community leaders using CFCT community leaders training manual. After being trained, leaders are expected to develop DRR plans and Community Transformational (CT) Plans. Now 28% (N= 166) of the communities have their DRR plan and almost all of them have their CT plans. Given that Bangladesh is a Muslim country; working with Church Leaders is a challenge. Only 21 church leaders were trained in one of the clusters that had a Church.

One of the most impressive findings of this MTE was change in worldview. The worldview score has improved from 73 to 79. This was evident through intimate partner's violence indicator. Bangladesh is known globally for intimate partner's violence. The percentage of women who said it is ok for a man to beat his wife has dramatically reduced from 73.5% to 43.3%. Even though, most of the staff of Bangladesh are Muslim, the biblical worldview concepts have been integrated in all trainings and everything that FHB does. During the staff, FGD staff mentioned that their work was effective due to the integration of biblical worldview into their work.

During the MTE, two new indicators: Emergence of Hope and Caring for Others were introduced. These two indicators use qualitative methodology for measurement. The results for these indicators can actually be considered as baselines. Overall emergence of hope was found to be medium for men, women and children. Rating for community caring for others was low for men but medium for women and children. Both men and women clearly articulated their vision and plans for their community, which included infrastructure for education and agriculture. Their dependency on external sources is still quite high. Both men and women related that God is the center of their life who gives them strength and guidance to deal with their day-to-day life. With God's help, they can make the difference. Community taking care of the vulnerable was a constant theme both in men and women's discussions. Women have increased their involvement in family as well as community decision-making processes, which was endorsed by men as well. Both men and women felt that leadership in the community needs to be strengthened in terms of planning and execution.

The methodological approach to CFCT Mid Tern Evaluation is based on the idea of a "learning process approach" to CFCT implementation. This approach differs significantly from a "blueprint approach" to program implementation that is the traditional and still most widely used approach. FH's adaption to Results Based Monitoring and Evaluation to program implementation makes this MTE approach fundamentally different. In this approach to MTE, monitoring and evaluation activities are concerned not only with the extent to which the planned activities are carried out but also with how they are carried out. In this approach to MTE, mechanisms were developed to help program staff learn from both the successes and problems encountered in implementing the activities in order to improve the program in the future. For example, in this evaluation approach it would be important to know not only how many savings group have been formed but also to identify both the successful and problematic aspects of forming and training the savings group. This would allow program staff to identify ways to improve future trainings and saving groups meetings. In this approach, monitoring and evaluation activities involve the collection of important quantitative information but priority is given to the collection of qualitative information, which describes the process involved in carrying out each type of activity. For example, information might be collected on the "number of cascade group volunteers trained" but also on the "quality of

the training," on the "feedback from trainees on the usefulness of the training content" and on "how trainees are using what they were taught" in their work with communities.

Based upon the information collected during the evaluation, "lessons learned" were formulated which will be fed back into the program plan. Modifications in program activities and strategies will continuously be made based upon the lessons, which were formulated during the evaluation. From beginning to end the orientation of the evaluation methodology exercise addresses the question "What can we learn from what we have already accomplished in order to improve the program in the future?" Perhaps the two most important facets of the methodology are the involvement of program stakeholders in all steps in the evaluation process and the focus of the evaluation on the development of lessons learned which are translated into an action plan.

Following were the key challenges that were identified during the evaluation:

- Volunteerism is a new concept for the community and not all NGOs promote volunteerism. This affects the community participation.
- There is workload of the promoters due to multi-task nature of their work. This restricted them to complete some of the task such as observing neighborhood circle meetings by Cascade group volunteers.
- CFCT focused on increasing knowledge and changing practices. As a result there was increase demand for health services, but health facilities were not strengthened to meet that demand.
- Health trainings were focused on mothers, whereas mother in laws and husbands are still dominates in the family and much of the behaviors are influenced by them

There were some great lessons that we drew out of this evaluation:

- It is easy to implement CFCT in a new community, as there are no pre-set perceptions and practices.
- Empowering community members and enabling them to know their issues in their communities helps them increasing their participation in their own development.
- Training staff at all levels helps in the early adoption of new tools or concepts.
- Having a baseline at early stage of implementation helps determine clear goals. The regular monitoring of progress helps the team know if any corrective action needs to be taken.
- Effective use of technology can save time and resources.
- Training on values and character formation is not enough. Leaders have to model these behaviors to encourage people to adopt them.
- Regular follow up with staff, not simply conducting training helps in developing spirit, values and commitment.

Integration is helpful in initial stages of implementation, however when program grows, more focused approach is required including adjustment in the staffing structure.
Finally, these are the recommendations that were jointly agreed by the FH Bangladesh Team and the Mid Term Evaluation Team. It was recommended that FH Bangladesh should start focusing on community graduation. They should strengthen the capacity development process of Community Leaders by repeating the trainings, reinforcing key messages, providing access to technical resources, follow-up and providing constructive feedback and review and implementation of community transformational plan. In terms of growth, FHB should focus on depth rather breadth. They should review the coverage and reach in each cluster. Change in

population-based indicators requires good program reach. FHB should also strengthen partnership with Government especially in the area of health and engage with other NGOs to address other community needs. FHB should encourage ways and means to engage men especially in the health activities.

FHB should capitalize on Savings Groups, identify the economic engine and develop a comprehensive livelihood strategy including enterprise development or other livelihood opportunities for the saving group members. Conduct the impact evaluation studying both the economic and non-economic effects of the Savings Group, document and share the findings with the larger organization. FHB should explore issues and challenges with the adolescents and teens and develop programmatic interventions to address them. FHB should make use of their M&E data, refine the theory of change, log frame for each of the projects, and adjust tools and systems for tracking change over time. Adjust the staffing structure to align to country strategy enabling the implementation of new project designs while also addressing the staff workload issues as identified during this evaluation.

BANGLADESH

Performance Indicator	BOGRA (BL)	BOGRA (MTE)	Stat. Sig	DHAKA (BL)	DHAKA (MTE)	Stat. Sig	MID-WEST (BL)	MID-WEST (MTE)	Stat. Sig	MYMENSINGH (BL)	MYMENSINGH (MTE)	Stat. Sig	PB COASTAL (BL)	PB COASTAL (MTE)	Stat. Sig	**BANGLADESH (BL)**	**BANGLADESH (MTE)**	Stat. Sig
{STUNTING} % of children 0-23m who are stunted {HAZ< -2.0}		18.1%			18.1%			32.6%			32.3%			21.9%			**24.6%**	
{UNDER WEIGTH} % of children 0-23m who are underweight {WAZ< -2.0}	38.5%	32.3%	NO	34.4%	24.3%	NO	45.9%	32.6%	NO	31.1%	44.4%	NO	36.2%	37.2%	NO	**37.5%**	**34.2%**	NO
{MUAC} % of children 6-59m who have a low MUAC																		
{EXCLUSIVE BREASTFEEDING} % of children 0-6m who are exclusively breastfed	64.7%	87.0%	NO	50.0%	51.7%	NO	68.2%	55.6%	NO	62.5%	52.8%	NO	54.5%	66.7%	NO	**62.2%**	**61.5%**	NO
{INFANT DIETARY DIVERSITY} Infant/Child Dietary Adequacy Score																		
{FOUR OR MORE FOOD GROUPS} % of children 6-23m with a dietary diversity score of four or moreusively breastfed	90.2%			75.0%			71.4%			75.9%			74.3%			**78.4%**		
{HOUSEHOLD DIETARY DIVERSITY} Average number of food groups consumed by households	6.5	7.7	YES	6.4	7.6	YES	5.4	6.9	YES	6.7	8.2	YES	6.4	7.3	YES	**6.3**	**7.5**	YES
{DEWORMING} % of children 5-19 years who received deworming medication within the last 6 months	73.6%	90.6%	YES	73.5%	93.8%	YES	88.0%	93.8%	NO	86.4%	97.9%	YES	84.6%	76.0%	NO	**81.0%**	**90.4%**	YES
{WORLDVIEW} Average worldview index score	69.5	86.3	YES	74.6	78.5	YES	71.5	80.2	YES	74.7	79.7	YES	77.8	74.3	NO	**73.6**	**79.8**	YES
{OK TO BEAT WIFE} % of mothers {of children 0-18y} who say that it's okay for a man to hit his wife	97.9%	97.9%	NO	100.0%	77.1%	YES	99.0%	94.8%	NO	93.8%	97.9%	NO	98.9%	96.9%	NO	**97.9%**	**92.9%**	YES
{AVERAGE THREATS} Average number of threats the mother has experienced from her intimate partner in the last 12 months	1.2	1.1	YES	0.6	0.6	NO	0.9	0.6	YES	1.3	1.4	NO	1.2	1.1	YES	**1.0**	**1.0**	YES
% of mother experienced 2 or more threats from her intimate partner in the last 12 months	31.3%	30.2%	NO	9.4%	14.6%	NO	24.0%	17.7%	NO	36.5%	39.6%	NO	29.5%	33.3%	NO	**26.1%**	**27.1%**	NO
% of mother says that 4 or more reasons is okay for a husband to hit his wife	69.8%	31.3%	YES	70.8%	22.9%	YES	69.8%	44.8%	YES	76.0%	57.3%	YES	81.1%	60.4%	YES	**73.5%**	**43.3%**	YES

Bolivia

Food for the Hungry has been in Bolivia since 1978. To date they have worked with more than two million people, transferring basic health, hygiene, nutrition, livelihoods and education knowledge to overcome poverty. Currently FH Bolivia is implementing the global programmatic model Child Focus Community Transformation in clusters in various areas of the country.

As part of the global implementation of CFCT, a Mid Term Evaluation (MTE) was conducted in Bolivia from August 21 – 29, 2017. Both quantitative and qualitative methods were employed for the midterm evaluation. Quantitative data was collected using a household survey in June 2017 and qualitative data was collected during the MTE. 399 households were interviewed to measure quantitative indicators in six different clusters using Lot Quality Assurance Sampling (LQAS) methodology. Data for qualitative indicators was collected using Focus Group Discussion (FGDs). A total of 41 FGDs were conducted during the evaluation. Quantitative data was analyzed using Epi-Info, while ORID methodology was used as a framework for qualitative data analysis.

One of the key purposes of the mid-term evaluation was to help FH Bolivia understand the community's readiness to graduate. MTE concluded that only 17% of the communities in 9 supervision areas were almost reaching the graduation level and only need few more years before they are ready to graduate; most of the evaluated communities were not yet ready to graduate.

The other major objective of the MTE was to calculate the progression out of poverty. This calculation is based on people who meet FH's success criteria. FH's success criteria are defined as people showing significant change in both visible and invisible elements of transformation. During the baseline only 42.13%, people met the FH's success criteria. At MTE the criteria has dramatically improved to 53.51. Overall FH Bolivia has reduced multi-dimensional poverty by 11.38%. In El Alto, multi-dimensional poverty is reduced by 12%, in rural areas by 8.89% and in peri-urban it is reduced by 12.89%. This has resulted in approximately 5000 people progressing out of poverty between fiscal year 2013 to 2017.

Overall FH Bolivia has reduced multi-dimensional poverty by 11.38%. This has resulted in approximately 5000 people progressing out of poverty between fiscal year 2013 to 2017.

There were some other commendable achievements in implementation. There were 98 cascade groups formed with 304 trained cascade group volunteers reaching out to 2,733 pregnant and lactating mothers. The average attendance rate in the trainings was 86%. This resulted in reduction of children who are underweight from 26.8% to 22.2%.

FH Bolivia has also formed 44 savings groups reaching out to 783 households in 38 communities. The current total asset of these savings groups is $42,404. Forming savings groups and encouraging people to save and do inter-loaning is one of FH's strategies in CFCT to increase income and make a difference in the quality of life of children. Household dietary diversity score is one of the proxy indicators to measure the change in income. The household dietary diversity score has increased from 5.5 to 6.4. This means that children and family have access

to almost seven different types of food groups from recommended 12 groups. This is a remarkable achievement.

FH Bolivia has trained 414 community leaders and 101 church leaders in strategic planning, implementation and monitoring. Community leaders as well as church leaders are able to articulate their plans for their particular institutions. They were also trained in basic monitoring tools that allow them to see the progress they made in accomplishing their plans. To date all community based organizations have a strategic plan, called Community Transformational Plan, and are implementing activities to reach their vision. In the case of churches, most churches have clear plans to serve their community.

During the MTE, two new qualitative indicators related to Emergence of Hope and Caring for Others were introduced. These two qualitative indicators measure overall holistic impact at the community level. Overall emergence of hope was found to be low for men, medium for women and low for children. Men and women mentioned that without the aid of an external institution it would be very hard to achieve their dreams, showing a high dependency on external sources. Both and men and women mentioned multiple times that they have organized at various times to demand things from the local government. This clearly shows the strength of the community organization to reach objectives in the future. At the same time, men and women said that one of their biggest desires is for their children to go to college and break the cycle of poverty. Men, women and children mentioned God a source of strength and hope for the future.

Concerning ability to care for others men, women and children were rated low. Men and women mentioned that they care for others. However, the motivation to care for others is limited to members of their extended family and in a quid pro quo basis, meaning that they support someone else in the community with the expectation to receive help when needed. When talking about gender balance, men and women reported that women are empowered in the community to make decisions at home but not at the community level. They also mentioned that there is no difference in opportunities among boys and girls.

The methodological approach to CFCT Mid Tern Evaluation is based on the idea of a "learning process approach" to CFCT implementation. This approach differs significantly from a "blueprint approach" to program implementation that is the traditional and still most widely used approach. FH's adaption to Results Based Monitoring and Evaluation to program implementation makes this MTE approach fundamentally different. In this approach to MTE, monitoring and evaluation activities are concerned not only with the extent to which the planned activities are carried out but also with how they are carried out. In this approach to MTE, mechanisms were developed to help program staff learn from both the successes and problems encountered in implementing the activities in order to improve the program in the future. For example, in this evaluation approach it would be important to know not only how many savings group have been formed but also to identify both the successful and problematic aspects of forming and training the savings group. This would allow program staff to identify ways to improve future trainings and saving groups meetings. In this approach, monitoring and evaluation activities involve the collection of important quantitative information but priority is given to the collection of qualitative information, which describes the process involved in carrying out each type of activity. For example, information might be collected on the "number of cascade group volunteers trained" but also on the "quality of the training," on the "feedback from trainees on the usefulness of the training content" and on "how trainees are using what they were taught" in their work with communities.

Based upon the information collected during the evaluation, "lessons learned" were formulated which will be fed back into the program plan. Modifications in program activities and strategies will continuously be made based upon the lessons, which were formulated during the evaluation. From beginning to end the orientation of the evaluation methodology exercise addresses the question "What can we learn from what we have already accomplished in order to improve the program in the future?" Perhaps the two most important facets of the methodology are the involvement of program stakeholders in all steps in the evaluation process and the focus of the evaluation on the development of lessons learned which are translated into an action plan.

Following were the key challenges that were identified during the evaluation:

Challenges extracted from guided workshop participants

- The Saving Group members identified that they lack entrepreneurship skills and ideas on how to use their savings
- Cascade group members identified lack of time as they have household chores to address and that their husbands do not trust them when they go for training.
- Both Church leaders and Community leaders identified the lack of resources and the continuity in implementation of their CT plans.
- The Church leaders also identified their dilemma of focusing on community development and loosing focus on Christian formation.

Challenges extracted from Focus Group with Staff

- Members of FH Bolivia staff feel that the implementation of the CFCT model increases their workload.
- The staff felt that changes at the global level such as change in mission, vision and values, envision 2020 strategy, etc. affect their work.
- Sometimes materials are not available and staff has to create their own materials such as integrating biblical worldview in the different domains of change.
- Sponsorship and CFCT are not integrated. Staff recommended integrating both systems to ensure a good start of operations in a given community.
- Churches still struggle to understand the holistic nature of CFCT.
- Maintaining the motivation of leaders is a challenge. Community leadership changes every year. Just using the leadership manual for training is not helpful.
- There is a high turnover of facilitators and given the nature of CFCT it takes a long time to onboard new hires into their roles.
- There is no formal transition process for change in local leadership and as a result the CT plans some times are discontinued.
- Lack of resources to develop or buy high quality training materials and supplemental audio and visual resources
- Lack of documentation about the CFCT implementation learned experiences in the community.

Lessons Learned

- It is not only important to have a theoretical knowledge of Biblical Worldview. Staff should also know the practical application of the Biblical Worldview in all areas of their work.
- Staffs need to exemplify and be a role model for transformation to leaders, families and peers.

- Well identified projects at the community level increases the likelihood of leveraging counterpart (co-financing) resources.
- Having a managerial score card is not enough. The SLT should use the data for evidence based decision making.
- M&E data if used on a regular basis can help improve the field performance and help in making program adjustments.
- Training of Trainers in Biblical worldview brings in personal transformation positively affecting the relationships in families and at work place.

Finally, the MTE team made some recommendations that were jointly agreed with the FH Bolivia team. The MTE recommended reviewing the organizational culture of FH Bolivia and aligning it to FH's heartbeat. FH Bolivia is encouraged to implement a continuous discipleship model to develop the potential of the staff and ensure new staff has access to documented experience and learning during their onboarding process. It was further recommended that FH Bolivia reviews and adjust its Country Strategy and revive the fund raising strategy to diversify funding and align with organizational identity.

FH Bolivia is also encouraged to establish a mechanism for constructive feedback to the leaders, community members and municipalities and ensure the continuation of the implementation of community transformational plan. While the MTE Team appreciates and commends FH Bolivia's efforts towards engagement of women at the community level, however, the women empowerment process needs to be further deepened.

Finally, MTE Team recommends that FH Bolivia integrate sponsorship in the CFCT implementation processes both at FH Bolivia level as well as FH Global level. Lastly, FH Bolivia is encouraged to develop a comprehensive knowledge management strategy and document promising practices, CFCT implementation experience and leveraging resources from municipality so that others can learn from rich experience that FH Bolivia possess.

BOLIVIA

Program Key Performance Indicator	COCHABAMBA D2 (BL)	COCHABAMBA D2 (MTE)	Stat Sig	TORO TORO (BL)	TORO TORO (MTE)	Stat Sig	ACASIO (BL)	ACASIO (MTE)	Stat Sig	EL ALTO D8 (BL)	EL ALTO D8 (MTE)	Stat Sig	SUCRE D2 (BL)	SUCRE D2 (MTE)	Stat Sig	SUCRE D3 (BL)	SUCRE D3 (MTE)	Stat Sig	POROMA (BL)	POROMA (MTE)	Stat Sig	**BOLIVIA (BL)**	**BOLIVIA (MTE)**	Stat Sig
(STUNTING) % of children 0-23m who are stunted (HAZ< -2.0	18.9%	10.1%	NO	24.6%	33.1%	NO		38.0%		25.0%	29.6%	NO	34.8%	13.6%	YES	34.8%	22.5%	NO	31.6%	25.3%	NO	**28.1%**	**24.2%**	NO
(UNDER WEIGTH) % of children 0-23m who are underweight (WAZ< -2.0)																								
(MUAC) % of children 6-59m who have a low MUAC																								
(EXCLUSIVE BREASTFEEDING) % of children 0-6m who are exclusively breastfec	69.2%	68.2%	NO	46.7%	90.5%	YES		73.1%		66.7%	82.1%	NO	81.8%	63.2%	NO	81.8%	59.6%	NO	68.4%	67.9%	NO	**67.7%**	**71.9%**	NO
(INFANT DIETARY DIVERSITY) Infant/Child Dietary Adequacy Score																								
(FOUR OR MORE FOOD GROUPS) % of children 6-23m with a dietary diversity score of four or moreusively breastfed	96.3%	92.6%	NO	77.4%	83.8%	NO		81.1%		82.9%	93.3%	NO	97.2%	85.1%	NO	97.2%	84.3%	NO	64.5%	74.6%	NO	**85.7%**	**86.0%**	NO
(HOUSEHOLD DIETARY DIVERSITY) Average number of food groups consumed by households	5.8	7.0	YES	5.8	5.6	NO		5.0		6.1	8.1	YES	5.3	6.2	YES	5.3	6.5	YES	4.1	4.4	YES	**5.4**	**6.3**	YES
(DEWORMING) % of children 5-19 years who received deworming medication within the last 6 months																								
(WORLDVIEW) Average worldview index score	67.6	69.4	YES	66.0	66.8	YES		68.2		67.7	75.0	YES	71.4	65.0	NO	71.4	64.0	NO	58.4	61.8	YES	**67.0**	**67.5**	YES
(OKTO BEAT WIFE) % of mothers (of children 0-18y) who say that it's okay for a man to hit his wife																								
Average number of threats/ abuse episodes the mother has experienced from her partner in the last 12 months.	1.6	1.3	YES	1.5	1.0	YES		1.0		0.6	0.9	NO	1.0	1.9	NO	1.0	1.9	NO	1.2	0.8	YES	**1.1**	**1.3**	NO
Personal resilience Index based on: 1) the Generalized Self-Efficacy Scale, 2) the Depression Score, and 3) the Social Support Seeking score. Add together the Depression Score, the Generalized Selfefficacy Score, and the Social Support Seeking Score.	47.6	48.7	YES	46.2	47.4	YES		49.2		47.5	48.6	YES	43.0	45.1	YES	43.0	44.9	YES	40.4	45.8	YES	**44.6**	**47.1**	YES
% of children - of the nationally recommended age for completion of grade three - who have attained the reading - comprehension and numeracy standards according to the national standards for completion of grade 3.		3.0%			0.8%			0.0%			1.1%			2.2%			1.3%			2.1%			**1.5%**	
% of caregivers of children 0-3 years of age who have engaged in four or more activities to promote learning in the last three days.		2.5%			3.1%			2.9%			9.9%			6.9%			3.7%			5.7%			**5.2%**	
% households storing drinking water that store water safely		78.3%			94.2%			95.3%			99.4%			95.0%			95.6%			86.5%			**92.7%**	
% households that have applied effective water treatment within the last 24 hours. (See Behavior / Message for "effective" methods)	76.8%	58.3%	NO	34.5%	19.9%	NO		13.2%			63.2%		46.9%	24.8%	NO	46.9%	20.3%	NO	24.0%	16.3%	NO	**45.0%**	**32.3%**	NO
% of households where the caretaker of the youngest child 0-59 months reported appropriate hand-washing behavior.		38.3%			41.0%			17.9%			33.3%			27.3%			17.1%			3.8%			**26.7%**	
% of children under age five who had diarrhea in the prior two weeks	46.3%	27.5%	YES	64.9%	25.6%	YES		21.7%		64.0%	18.1%	YES	58.3%	26.4%	YES	58.3%	48.1%	NO	69.8%	23.1%	YES	**60.5%**	**27.7%**	YES
% of caregivers (of children in grades 1-3) who have reviewed their child's homework at least 2 times in the last school week.		84.9%			57.0%			72.8%			92.2%			79.7%			78.9%			77.6%			**78.3%**	
% of households with moderate or severe hunger		81.5%			79.3%			80.2%			100.0%			99.2%			100.0%			96.1%			**91.1%**	
Annual per capita income		777.8			345.0			342.8			714.0			656.7			591.6			258.9			**526.5**	
Prevalence of women of reproductive age consuming a minimum acceptable diet		64.7%			29.6%			17.4%			82.1%			19.8%			28.7%			8.8%			**38.6%**	
Prevalence of children 6-23 months receiving a minimum acceptable diet		31.0%			18.8%			17.9%			41.8%			11.8%			11.8%			5.6%			**21.0%**	

Burundi

FH has been operating in Burundi since 2006 with humanitarian support for the returnees. Over the past 12 years, FH Burundi's (FH/B's) work has been progressed from relief, to micro-lending, to directly running schools, to today's focus of supporting communities to build upon their own resources to get out of poverty. Throughout these years, FH has partnered with Burundi's government leaders and community leaders at various levels, church leaders and families to create better living conditions. FH Burundi started the implementation of Child Focused Community Transformation (CFCT) in 2013. Currently it is implementing community development programs in three clusters: Bugabira, Gisuru and Kabarore.

As part of CFCT Methodology, a Mid Term Evaluation (MTE) was conducted in Burundi from November 12-23, 2017. Both inductive and deductive methodologies were employed for the midterm evaluation. Quantitative data was collected using a household survey in October 2017 and qualitative data was collected during the MTE. A total of 768 households were interviewed to measure quantitative indicators in three different clusters using cluster-sampling methodology. Data for qualitative indicators was collected using Focus Group Discussions (FGDs). A total of 42 FGDs were conducted during the evaluation. Quantitative data was analyzed using Epi-Info, while ORID (Observation, Reflection, Insights and Decision) methodology was used as a framework for qualitative data analysis.

One of the key purposes of the mid-term evaluation was to help FH Burundi understand the community's readiness to graduate. Overall FH Burundi has reduced multi-dimensional poverty by 14.1%. In Bugabira, poverty is reduced by 14%, in Gisuru by 15.4% and in Kabarore MDP is reduced by 12. 9%. This has resulted in approximately 16,405 (+-10percentage) people progressing out of poverty between 2013-2017. Net impact in terms of both progress out of poverty (quantitative) and community impact (qualitative) at the household and community level was higher in Gisuru. This cluster would be ready to graduate in next 3-5 years. Other two clusters require more work.

There were some great achievements in implementation of the program. There were 108 cascade groups formed with 1570 trained cascade group volunteers reaching out to 16,211 pregnant and lactating mothers. The average attendance rate in the trainings was 90.33%. This resulted in children who are underweight to be 30%. The prevalence of stunting is around 36.1%. Though this indicator was not measured in the baseline, given the food security situation in Burundi, the prevalence rate is not very high. Global acceptable standard is 15%.

FH Burundi has also formed 335 savings groups reaching out to 8,850 households in 50 communities. FH Burundi's sustainability strategy is not yet worked out that would help to form the savings groups in CBOs and then graduate them. The current total asset of these savings groups is $214,391 (@2000 Burundi Francs). Forming savings groups and encouraging people to save and do inter-loaning is one of FH's strategies in CFCT to increase income and make a difference in the quality of life for children. Household dietary diversity score is one of the proxy indicators to measure the change in income. The household dietary diversity score has not shown difference at country level, remaining at 3.1. In Gisuru, it increased from 3.1 to 4.3. This means that children and families have access to four different types of food groups from the recommended 12 groups. This is a remarkable achievement.
FH Burundi has formed 49 Community Development Committees (CDC) and trained approximately 151 community leaders using CFCT community leaders training manual. After

being trained, leaders are expected to develop DRR plans and Community Transformational (CT) Plans. Now 59% (N= 29) of the communities have their DRR plan and almost all of them have their CT plans. Given that Burundi is a Christian dominated country, working with church leaders is an advantage. A total of 146 church leaders were trained in the three clusters. During the evaluation, FGD staff mentioned that their work was effective due to the integration of biblical worldview into their work.

One of the most impressive findings of this MTE was change in worldview. The worldview score has improved from 58.6 to 71.4. This was evident through their explanation of dependence in God for their future and for what they are doing. Burundi is known globally for intimate partner's violence. The percentage of women who said it is ok for a man to beat his wife has dramatically increased from 65.2 % to 70.5%. This might be attributed with the recent nationwide violence that has happened in Burundi.

During the MTE, two new indicators were introduced: Emergence of Hope and Caring for Others. These two indicators use qualitative methodology for measurement. The results for these indicators can actually be considered as baselines. Overall emergence of hope was found to be medium for men, women and children. Rating for community caring for others was low for men but medium for women and children. Both men and women clearly articulated their vision and plans for their community, including infrastructure for education and agriculture. Their dependency on external sources is still quite high. Both men and women related that God is the center of their life who gives them strength and guidance to deal with their day-to-day life. With God's help, they can make the difference. Community taking care of the vulnerable was a constant theme both in men and women's discussions. Women have increased their involvement in family as well as community decision-making processes, which was endorsed by men as well. Both men and women felt that leadership in the community needs to be strengthened in terms of planning and execution.

The methodological approach to CFCT Mid Tern Evaluation is based on the idea of a "learning process approach" to CFCT implementation. This approach differs significantly from a "blueprint approach" to program implementation that is the traditional and still most widely used approach. For example, in this evaluation approach it would be important to know not only how many savings group have been formed but also to identify both the successful and problematic aspects of forming and training the savings group. This would allow program staff to identify ways to improve future trainings and savings groups meetings. In this approach, monitoring and evaluation activities involve the collection of important quantitative information, but priority is given to the collection of qualitative information, which describes the process involved in carrying out each type of activity. For example, information might be collected on the "number of cascade group volunteers trained" but also on the "quality of the training," on the "feedback from trainees on the usefulness of the training content" and on "how trainees are using what they were taught" in their work with communities.

Based upon the information collected during the evaluation, "lessons learned" are formulated which will be fed back into the program plan. Modifications in program activities and strategies will continuously be made based upon the lessons, which were formulated during the evaluation. From beginning to end the orientation of the evaluation methodology exercise addresses the question "What can we learn from what we have already accomplished in order to improve the program in the future?" Perhaps the two most important facets of the methodology are the involvement of program stakeholders in all steps in the evaluation

process, and the focus of the evaluation on the development of lessons learned which are translated into an action plan.

Success Factors: Following were some of the CFCT implementation success as identified by the staff:

- Quality programming due to increase in staff and ability to hire specialists for programming support. Increased in staffing also reduced staff workload.
- Assurance of sustained funding due to increase in child sponsorship.
- CFCT encouraged integrated programming so that beneficiaries needs can be addressed holistically.
- CFCT brought in a focus in terms of implementation and a culture of doing things systematically.
- Due to prioritization of beneficiaries, resources were well utilized.
- CFCT encouraged partnering that helped in avoiding any duplication and encouraged complementarity in programming with others

Implementation Challenges

In Bugabira, the cascade group volunteers have to walk long distances within the community, thus reducing the expected coverage of lessons delivered to households. As a result the quality of training is compromised. It was mentioned that the volunteers have to spend extra time to reach their circles. This hindrance has many implications in their livelihoods, which eventually could discourage them to continue. Furthermore, the mothers require many lessons to be repeated to understand the concepts, thus reducing the overall coverage of the lessons. In Gisuru, the cascade group volunteers mentioned that the training content and the messages are difficult to comprehend among the low literate neighborhood circle members. The time commitment required by cascade group volunteers is too demanding and affects their livelihood. Furthermore there is a reluctant behavior amongst the church members to accept some of the positive changes due to various cultural issues. There are delays in paying loans borrowed by some members of the savings groups. There is a restrictive legislation for savings groups in which members are limited to borrow an amount that is no more than 3 times their savings. Finally, there is a low attendance of community leaders in meetings.

As far as the CFCT implementation challenges are concerned, the mid-term evaluation revealed the following issues:

- There were significant delays in program implementation due to fuel shortage in the country. This was attributed to the political unrest during 2015.
- Some of the programs could not be implemented due to policy regulation on currency and all types of imports.
- Due to dollar value being affected because of fluctuations in the global market, there was a loss in overall cash flow and the budget had to be re- adjusted.
- There was no implementation for several months due to the political crisis in 2015. Several children dropped out of the program due to migration at the Tanzania and Rwanda borders.
- Due to community reluctance in acceptance of artificial insemination, breeding activities had to be stopped. The staff had to carry cash that posed security concerns for them due to absence of financial institutions in the community.
- High turnover of staff in 2016 affected the communication with sponsors and delayed program implementation, reporting and follow up with the community.

- Bad internet connection in the country posed challenges to all types of communications internally and externally.

There were some lessons that were drawn out during the evaluation. These lessons are grouped as programming and systems related. At the programming level, one of the lessons learnt was that partnering with other like-minded groups reduces duplication of efforts and increases opportunities for complementarity to each other's work. Second lesson learnt was that engaging community in planning, implementation, monitoring and evaluation empowers them and increases the possibility of community ownership. Third lesson learnt was that piloting and demonstrating the new technology prior to scaling up will go long way in addressing community's reluctance to adopt new technology. Further, it was also learnt that using and depending on local products rather than importing products can help in reducing delays in program implementation. Finally, it was learnt that focused programing increases visibility of the organization at all levels. Having a risk management plan right from the beginning ensures continuation of the program even during crises.

At the systems level, it was learnt that having efficient systems and streamlined business helps in effective program management. Secondly, the investment in spiritual formation of staff increases staff commitment and helps staff view their work as vocation and calling from God. Investment in spiritual formation also helps in building staff understanding that they are ambassadors of hope in their community. It was also learnt that staff turnover affects the quality of program implementation. Policies and practices for staff recognitions will motivate the staff and help to increase staff retention. Finally, it was learnt that better internet connectivity could be helpful in addressing all types of communication challenges with all stakeholders.

The evaluation team commended the excellent work of FH Burundi. Evaluation team recommended continuing building on this great work, especially in Gisuru. Burundi team should document the success factors and share with the other two clusters for learning. The team should reduce implementation efforts in Gisuru; focus on transition by strengthening community leaders' capacity; plan to graduate communities in Gisuru Cluster in the next 3-5 years. The MTE team recommended disseminating the evaluation findings to all the three clusters and in particular discussing the findings with the Bugabira community leaders to develop an integrated plan addressing programming gaps as identified during the evaluation. The team should also explore supplementary funding to support programming especially in Bugabira to scale up impact. Keeping in mind the recent crisis in Burundi, develop comprehensive strategy in building resilience at both the community and household level. MTE team recommended that FH Burundi should move beyond VSLA groups and develop comprehensive livelihood and food security strategy to address high levels of malnutrition. Children have great dreams and vision. Strengthen education programming to focus on improvement in quality of learning so that they can realize their dreams. Intentionally integrate strategies in all projects to address gender empowerment issues, especially the violence against women as evident in the HH survey findings and sexual abuse of girls. Review and adapt all CFCT Manuals for relevance to FH Burundi programming. Finally review the baseline values, compare the results with the secondary data and design programmatic interventions specifically to improve the indicators that have dropped down.

BURUNDI

Performance Indicator	Bugabira (BL)	Bugabira (MTE)	Stat. Sig	Gisuru (BL)	Gisuru (MTE)	Stat. Sig	Kabarore (BL)	Kabarore (MTE)	Stat. Sig	Gatsinda (BL)	Gatsinda (MTE)	Stat. Sig	BURUNDI (BL)	BURUNDI (MTE)	Stat. Sig
(STUNTING) % of children 0-23m who are stunted (HAZ< -2.0)		31.3%			37.8%			39.3%			26.1%			**33.8%**	
(UNDER WEIGTH) % of children 0-23m who are underweight (WAZ< -2.0)		34.8%			31.6%			24.8%			17.4%			**27.1%**	
(WASTING) % of children 0-23m who are wasted (WHZ< -2.0)		19.6%			8.3%			4.7%			9.1%			**10.5%**	
(EXCLUSIVE BREASTFEEDING) % of children 0-6m who are exclusively breastfed	97.6%	72.2%	NO	76.0%	58.3%	NO	85.7%	72.7%	NO		59.7%		**85.7%**	**66.8%**	NO
(INFANT DIETARY DIVERSITY) Infant/Child Dietary Adequacy Score	2.35	1.41	NO	3.55	3.41	NO	2.94	2.80	NO		2.93		**2.94**	**2.52**	NO
(FOUR OR MORE FOOD GROUPS) % of children 6-23m with a dietary diversity score of four or more	8.6%	8.9%	NO	45.0%	44.0%	NO	30.3%	38.0%	NO		33.9%		**30.3%**	**29.6%**	NO
(HOUSEHOLD DIETARY DIVERSITY) Average number of food groups consumed by households	2.65	2.19	NO	3.11	4.31	YES	3.02	3.64	YES		3.05		**3.02**	**3.24**	YES
(INDIVIDUAL HOUSEHOLD HUNGER SCORE)											162.7%			**162.7%**	
% of households of children 0-18 years old that have a household hunger score of 0-1	30.6%	23.4%	NO	70.8%	77.7%	NO	50.6%	50.5%	NO		52.9%		**50.6%**	**49.5%**	NO
(DEWORMING) % of children 5-19 years who received deworming medication within the last 6 months	74.3%	85.7%	YES	90.0%	90.0%	NO	82.1%	88.9%	NO		82.2%		**82.1%**	**86.5%**	YES
(WORLDVIEW) Average worldview index score	36.90	71.45	YES	39.83	71.32	YES	38.36	70.80	YES		69.77		**38.36**	**70.79**	YES
(OK TO BEAT WIFE) % of mothers (of children 0-18y) who say that it's okay for a man to hit his wife	64.2%	73.1%	NO	66.2%	72.1%	NO	65.2%	67.0%	NO		87.3%		**65.2%**	**75.1%**	NO
(AVERAGE THREATS) Average number of threats the mother has experienced from her intimate partner in the last 12 months		2.98			2.97			2.80			0.53			**2.26**	
% of mothers/CG who say that someone in their household needs to cut down on alcohol use	43.4%	25.0%	YES	47.1%	16.3%	YES	45.2%	36.0%	NO		33.0%		**45.2%**	**28.8%**	YES
% of mothers/CG of children 0-18 years who are "mostly happy" or "completely happy" with their husband/partner	69.4%	69.3%	NO	74.2%	78.9%	NO	71.8%	72.8%	NO		53.1%		**71.8%**	**67.7%**	NO
% of mothers/CC of children 0-18 years who quarrel with their husband/partner "one or two days a week" or "almost every day."	31.3%	24.9%	NO	29.6%	16.7%	YES	30.4%	16.0%	YES		24.2%		**30.4%**	**20.6%**	YES

Performance Indicator	Bugabira (BL)	Bugabira (MTE)	Stat. Sig	Gisuru (BL)	Gisuru (MTE)	Stat. Sig	Kabarore (BL)	Kabarore (MTE)	Stat. Sig	Gatsinda (BL)	Gatsinda (MTE)	Stat. Sig	BURUNDI (BL)	BURUNDI (MTE)	Stat. Sig
% of mothers/CG of children 5-18 who rate the quality of children's education as "high" or "very high."	60.9%	83.0%	YES	73.3%	83.4%	NO	66.8%	86.6%	YES		75.9%		**66.8%**	**82.2%**	YES
% of mothers/ CG who say that an educational level of secondary school or higher is required to be successful today.	97.5%	87.0%	NO	94.6%	92.2%	NO	96.1%	90.9%	NO		86.4%		**96.1%**	**89.0%**	NO
% of children 5-18 years in the HH who are registered in school	69.7%			79.0%			74.2%	87.1%	YES		60.4%		**74.2%**	**76.4%**	NO
Average number of days (last 7 days) families with children 0-18 years prayed together	0.31	2.16	YES	2.59	3.43	YES	1.53	3.81	YES		1.83		**1.53**	**2.78**	YES
% of households of children 0-18 years possessing a Bible [or Qu'oran]	31.4%	23.3%	NO	41.7%	49.5%	NO	36.5%	46.5%	YES		34.0%		**36.5%**	**37.7%**	NO
Average number of days (last 30 days) one or more of respondent's children attended a religious worship service or other religious activity	3.50	1.43	NO	4.21	2.17	NO	3.85	2.17	NO		1.12		**3.85**	**1.66**	NO
(GENDER WV) Average Score on Gender Attitudes	8.22	12.13	YES	10.85	12.42	YES	9.53	12.22	YES		12.17		**9.53**	**12.22**	YES
(DRR WV) Average DRR worldview Score	5.74	10.48	YES	6.59	10.40	YES	6.17	9.95	YES		9.81		**6.17**	**10.14**	YES
Average Depression Score	16.77	18.91	NO	18.91	20.46	NO	17.84	20.32	NO		20.07		**17.84**	**19.92**	NO
Average Generalized Self-Efficacy Score	12.34	14.50	YES	12.90	15.48	YES	12.62	14.48	YES		14.76		**12.62**	**14.75**	YES
Average Social Support-Seeking Score	16.45	16.06	NO	16.73	16.46	NO	16.59	16.05	NO		15.85		**16.59**	**16.08**	NO
% of mothers/CG who believe their community leaders' level of honesty & integrity is "high" or "very high."		66.5%		73.3%	77.7%	NO	73.3%	82.5%	NO		77.7%		**73.3%**	**76.1%**	NO
% of mothers/CG who rate the integrity of church leaders in the community as "high" or "very high."	78.1%	69.4%	NO	86.3%	86.9%	NO	82.2%	83.8%	NO		83.6%		**82.2%**	**80.7%**	NO
% of mothers/CG who state that church leaders in their community do activities outside of their place of worship that are open to or involve the entire community "some of the time" or "a lot of the time."	50.4%	33.6%	NO	58.8%	76.5%	YES	54.6%	66.4%	YES		58.7%		**54.6%**	**57.9%**	NO

Dominican Republic

A Midterm Evaluation (MTE) was conducted in the Dominican Republic (DR) in May 2018 using quantitative as well as qualitative methods. One of the key purposes of the midterm evaluation was to help FH Dominican Republic assess the impact of the Child Focused Community Transformation (CFCT) programmatic model and understand the community's readiness to graduate.

FH DR began operations in response to Hurricane David in 1979. Soon after, a field office was established in the capital city of Santo Domingo reaching vulnerable communities in the western and central regions of the country with humanitarian aid and child development programs.

Dominican society has experienced many socio-economic changes in the past 35 years. FH DR has also gone through a series of changes and developments during this period that includes the implementation of the CFCT model starting in 2010. CFCT is a programmatic model of social transformation with the objective of combating a series of values, attitudes, and beliefs that impede the economic, social, and spiritual development of the most vulnerable communities in the world. To combat these values, attitudes, and beliefs, FH implements four programmatic sectors. These sectors are health, education, livelihoods, and leadership. Each of the country offices establishes the scope of each sector autonomously. FH DR sectoral objectives are described below.

Education: To improve the school performance of Dominican children by transforming their minds and hearts. To accomplish this, FH DR implements the Apacienta Mis Ovejas (AMO) program to promote children's spiritual formation, and the implementation of reading and writing rooms to promote their academic formation. FH DR focuses on children with low academic performance.

Health: To reduce the rate of infant mortality and morbidity of children and adolescents. To accomplish this, FH DR promotes maternal and child health behaviors like hand washing, exclusive breastfeeding, and water treatment, among others.

Livelihoods: To guarantee household food security and income generation capacity. To accomplish this, FH DR implements activities that allow parents to obtain the economic resources necessary to satisfy the basic needs of their children. In rural communities, the objective is to improve household food quantity and quality in addition to the economic resources necessary to satisfy basic needs (food, clothing, housing, education, transport, and telecommunications). In urban areas, the goal is to help parents get and/or create quality jobs with social and legal security that guarantee a minimum level of welfare for their families.

Leadership: To increase the capacity of church leaders and community leaders to promote the integrated development of their communities. To accomplish this, FH DR promotes communities caring for each other.

Currently FH DR implements its projects in rural and urban areas made up of 55 communities distributed in three clusters: 25 at the border of Haiti, 21 at the central area of the country, and 9 in the urban area close to the capital.

CFCT Mid Term Evaluation findings revealed 10% increase in the exclusive breastfeeding. Even though the EBF prevalence in the areas where FH DR operates are still low, it is also worth mentioning that they exceed the national rate by at least 10%. The MTE shows that the overall dietary diversity score has declined by 1.9 points. Children in the DR at baseline consumed 8.8 food groups, which declined at midterm evaluation to 6.9 food groups. The biggest decline happened in the cluster close to the border with Haiti, which experienced a decline of 2.7 points.

The MTE shows that overall there has been a 0.5-point decline in average number of food groups consumed in the household. The biggest change could be seen in the area close to the border with Haiti, where the household dietary diversity score declined 1.5 points. Even though the household dietary diversity score in the Dominican Republic is acceptable, there is room for improvement given that the highest possible score for the indicator is twelve food groups. The MTE shows that overall there has been a14.6percentage increase in the percentage of children that have been dewormed in the past six months. FH DR made improvements in increasing the access to safe water for project participants. At a national level, there has been a slight increase of 7.8%. The greatest difference between baseline and midterm evaluation can be observed in the central area, which saw a 32% increase in access to safe water among project participants.

For the indicator "percentage of women who say that it is okay for a man to hit his wife", there has been a decrease of 24.5% at the national level. The greatest difference can be seen in the area close to the Haiti border, which had a decrease of 30.7%. The MTE shows an overall increase in worldview score by 9.3 points at the national level. Most of the areas have similar increase in worldview index, showing a steady increase in the results for this indicator.

Emergence of hope means that men, women, girls, and boys perceive and demonstrate hope in the future. Development begins as an attitude in the hearts and minds of people. When the attitude is missing, programs, funds, and development interventions can do more harm than good. This qualitative indicator on *emergence of hope* seeks to find out if hope for a brighter future is emerging and growing among the people. Only hope for a better future will provide necessary motivation for people to overcome critical limiting factors in their living situations. Hope for the future relates to people's perceptions of themselves as well as perceptions of the past and present and whether past and present are seen only in negative terms or as learning experiences or celebrations on the road to the future. The summary of the focus group scores is presented in table 12below. Overall, the emergence of hope indicator is considered "low."

The *Ability to care for others* indicator seeks to measure attitudes, actions, and values of community members, which are fundamental to their relationships. *Care for each other* means that men, women, boys, and girls perceive that they care for others and others in their community care for them. The summary of the scores from the FGD on community's ability to care for each other is presented in Table 13 below. The overall score is rated to be low.

The MTE shows that all three areas in FH DR had significant progress in reducing Community Multidimensional Poverty. Overall, FH DR has reduced Community Multidimensional Poverty Index (CDMPI) by 16.90%. In the Central Area, CDMPI reduced by 17.69%. In the area bordering Haiti, CDMPI reduced by 16.32%. Finally, in the Urban Area, CDMPI reduced by 16.67%. This has resulted in approximately 8,689 (+ -10%) people who left extreme poverty between 2014 - 2018.

The methodological approach to CFCT Mid Tern Evaluation is based on the idea of a "learning process approach" to CFCT implementation. This approach differs significantly from a "blueprint approach" to program implementation that is the traditional and still most widely used approach. FH's adaption to Results Based Monitoring and Evaluation to program implementation makes this MTE approach fundamentally different. In this approach to MTE, monitoring and evaluation activities are concerned not only with the extent to which the planned activities are carried out but also with how they are carried out. In this approach to MTE, mechanisms were developed to help program staff learn from both the successes and problems encountered in implementing the activities in order to improve the program in the future. For example, in this evaluation approach it would be important to know not only how many savings group have been formed but also to identify both the successful and problematic aspects of forming and training the savings group. This would allow program staff to identify ways to improve future trainings and savings groups meetings. In this approach, monitoring and evaluation activities involve the collection of important quantitative information, but priority is given to the collection of qualitative information, which describes the process involved in carrying out each type of activity. For example, information might be collected on the "number of cascade group volunteers trained" but also on the "quality of the training," on the "feedback from trainees on the usefulness of the training content" and on "how trainees are using what they were taught" in their work with communities.

Based upon the information collected during the evaluation, "lessons learned" are formulated which will be fed back into the program plan. Modifications in program activities and strategies will continuously be made based upon the lessons, which were formulated during the evaluation. From beginning to end the orientation of the evaluation methodology exercise addresses the question "What can we learn from what we have already accomplished in order to improve the program in the future?" Perhaps the two most important facets of the methodology are the involvement of program stakeholders in all steps in the evaluation process, and the focus of the evaluation on the development of lessons learned which are translated into an action plan.

Key Challenges

- Increased time demand to establish a relationship with community leaders because they were accustomed to receive tangible benefits.
- Due to the technical requirements of the CFCT model, the staff had to adapt in order to develop these capacities.
- Difficulty learning and implementing new material and manuals.
- Rejection of church leaders because of the difference in worldview.

Lessons Learned

- Having a defined programmatic structure and clear roles allow the staff to be more efficient in the use of their resources.
- Community capacity building and empowering approach to development is more sustainable compared to welfare and charity approach to development..
- Having a good monitoring and evaluation system right from the commencement of the projects enables to see the progress made and also learning and adapting for better programming.
- Shifting the focus of program planning from activity oriented to results oriented enhances the program quality as well achieving desired results.

- Increased in resources not only enhances program quality but also helps in scaling up and expanding program reach.
- Investment in spiritual formation of staff increases staff commitment and considering their work as vocation and calling from God.
- Investment in spiritual formation also helps in building staff understanding that they are ambassadors of hope in their community
- Transiting from CDP to CFCT provided opportunity for holistically impacting the community.
- It is more meaningful from the programmatic point of view to have programmatic approach to graduation rather than system based or time bound approach to community exit.

Following were the recommendations jointly agreed with the MTE:

- Identifying and clarifying their role in the communities
- Encourage technical training for employees:
- Based on the results of this evaluation review country strategies to determine which domains to implement and which ones to stop implementing.
- Evaluate the possibility of including men in the implementation of projects.
- Establish indicator review system for reflection to adjust the Country Strategy.

D. REPUBLIC

Performance Indicator	ZONA CENTRAL (BL)	ZONA CENTRAL (MTE)	Stat Sig	ZONA FRONTERIZA (BL)	ZONA FRONTERIZA (MTE)	Stat Sig	ZONA URBANA (BL)	ZONA URBANA (MTE)	Stat Sig	DOMINICAN REPUBLIC (BL)	DOMINICAN REPUBLIC (MTE)	Stat Sig
{STUNTING} % of children 0-23m who are stunted {HAZ< -2.0}	10.2%			7.7%			10.2%			9.4%		
{UNDER WEIGTH} % of children 0-23m who are underweight {WAZ< -2.0}	4.6%			3.9%			4.6%			4.3%		
{MUAC} % of children 6-59m who have a low MUAC												
{EXCLUSIVE BREASTFEEDING} % of children 0-6m who are exclusively breastfed	22.5%	45.7%	YES	19.0%	27.9%	NO	22.5%	19.7%	NO	21.3%	31.3%	NO
{INFANT DIETARY DIVERSITY} Infant/Child Dietary Adequacy Score	7.9	7.3	NO	8.9	6.2	NO	9.0	7.5	NO	8.8	6.9	NO
{FOUR OR MORE FOOD GROUPS} % of children 6-23m with a dietary diversity score of four or more food groups	100.0%	89.5%	NO	100.0%	87.5%	NO	93.8%	97.4%	NO	98.0%	91.2%	NO
{HOUSEHOLD DIETARY DIVERSITY} Average number of food groups consumed by households	8.8	9.5	YES	9.9	8.4	NO	9.9	9.4	NO	9.6	9.1	NO
{DEWORMING} % of children 5-19 years who received deworming medication within the last 6 months	55.4%	78.4%	YES	56.5%	66.5%	NO	64.3%	73.3%	NO	57.5%	72.1%	YES
{WORLDVIEW} Average worldview index score	67.6	75.7	YES	68.0	78.3	YES	72.9	80.1	YES	68.8	78.1	YES
{OK TO BEAT WIFE} % of mothers {of children 0-18y} who say that it's okay for a man to hit his wife	35.1%	6.3%	YES	45.3%	14.6%	YES	18.4%	16.0%	NO	36.8%	12.3%	YES
{AVERAGE THREATS} Average number of threats the mother has experienced from her intimate partner in the last 12 months	0.2	2.9	NO	0.3	10.9	NO	0.2	5.0	NO	0.3	5.9	NO
{AVERAGE REASON} Average number of reasons mother gives for when it's okay for a husband to hit his wife	0.7	0.1	YES	1.0	0.3	YES	0.6	0.3	YES	0.8	0.2	YES
{LEADERSHIP INTEGRITY} % of mothers/CG who believe their community leaders' level of honesty & integrity is "high" or "very high."	38.6%	66.7%	YES	38.9%	60.4%	YES	36.8%	53.0%	NO	38.4%	59.9%	YES
{CHURCH LEADERSHIP INTEGRITY} % of mothers/CG who rate the integrity of church leaders in the community as "high" or "very high."	56.1%	85.4%	YES	37.9%	76.0%	YES	65.8%	63.0%	NO	48.9%	74.7%	YES

Performance Indicator	ZONA CENTRAL (RI.)	ZONA CENTRAL (MTF)	Stat. Sig.	ZONA FRONTERIZA (RI.)	ZONA FRONTERIZA (MTF)	Stat. Sig.	ZONA URBANA (RI.)	ZONA URBANA (MTF)	Stat. Sig.	DOMINICAN REPUBLIC (RI.)	DOMINICAN REPUBLIC (MTF)	Stat. Sig.
(CHURCH REACH) % of mothers who state that church leaders do activities outside of their place to involve the entire community "some of the time" or "a lot of the time."	68.4%	71.9%	NO	34.7%	64.6%	YES	65.8%	48.0%	NO	51.1%	61.3%	NO
(SCHOOL REGISTRATION) % of children 5-18 years who are at school age and are registered	98.9%	75.3%	NO	96.8%	96.9%	NO	99.0%	70.5%	NO	98.6%	82.0%	NO
(WATER SOURCE) % of households using save source of water to drink or cook	26.3%	58.3%	YES	65.3%	68.8%	NO	70.5%	78.0%	NO	60.7%	68.5%	NO
(HAND WASHING BEHAVIOR) % of households where the caretaker reported appropriate hand-washing behavior.	1.8%	10.4%	NO	4.2%	0.0%	NO	26.3%	16.0%	NO	7.9%	8.9%	NO
% of children 0-23 months who had diarrhea in the prior two weeks		16.1%			28.1%			34.0%			26.3%	
% of children 0-23 months with diarrhea in the last two weeks who received Oral Rehydration Solution and/or Recommended Home Fluids.		46.7%			59.3%			70.6%			61.8%	
% of children 0-23 months who had cough and fast/difficult breathing in the last two weeks		48.4%			75.0%			52.0%			58.5%	
% of children 0-23 months with cough and fast/difficult breathing in the last two weeks who were taken to a health facility		66.7%			63.9%			69.2%			66.3%	
Average of properties of households		7.8			14.5			2.6			8.2	

Peru

Perú se encuentra localizado en la parte occidental de América del Sur. Tiene una extensión de 1'285,215 km2 y limita territorialmente con los países de Ecuador, Colombia, Brasil, Bolivia y Chile. En su territorio se pueden identificar tres grandes regiones naturales según sus altitudes tradicionalmente conocidas como: costa, sierra y selva. La población del país alcanza los 31'237,385 habitantes[3]. La actual división política administrativa del país comprende 24 departamentos, 195 provincias, 1845 distritos y una provincia constitucional. El territorio peruano se encuentra determinado por la interacción de dos placas tectónicas: la Sudamericana al este, donde se halla todo su territorio continental y la de Nazca, debajo del océano Pacífico que causan frecuentes movimientos sísmicos de variable intensidad; el ultimo evento sísmico importante registrado fue el terremoto de Pisco en el año 2007, que tuvo una magnitud de 8,0 grados y fue uno de más violentos ocurridos en el Perú en los últimos años. Por otro lado, su ubicación geográfica hace que su territorio sea afectado por el calentamiento de las aguas del pacifico, produciendo el fenómeno climático conocido como "El Niño," lo que ocasiona fuertes y dramáticos cambios en el clima de toda la región intertropical, especialmente en el Perú, produciendo fuertes lluvias, precipitaciones y el incremento en el caudal en los ríos, el ultimo Niño Costero en el 2017 provocó uno de los mayores desastres naturales en el Perú, con más de 100 000 damnificados, 75 fallecidos, 10 000 viviendas colapsadas y medio millón de afectados.

La económica del Perú mantuvo un importante crecimiento en la región entre los años 2002 al 2013, con una tasa de crecimiento promedio del PBI de 6,1% anual. Sin embargo, entre los años 2014 y 2017 la expansión de la economía se desaceleró a un promedio de 3,1% anual. En este contexto, el déficit por cuenta corriente disminuyó rápidamente de 4,8% del PBI en 2015 a 1,1% en 2017. Ello dado a que la economía peruana es pequeña y muy dependiente de las condiciones económicas internacionales, en ese sentido los choques externos tienen una particular importancia en el desarrollo económico del país. Actualmente las condiciones económicas internacionales se encuentran deterioradas, economías como la de Estados Unidos de América y China presentan un crecimiento por debajo de lo esperado en los últimos cinco años, estos factores implican una reducción de la demanda global, lo cual a su vez ha implicado una reducción de los precios internacionales de las materias primas, y esto afecta directamente a la balanza comercial del Perú, cuya principal actividad económica es la extractiva, entre la agraria y de servicio. Por otro lado, el gobierno peruano ha hecho poco por contrarrestar el embate económico; la inversión privada ha pasado de crecer 11% el 2011 a -2% el 2014, por último, los gobiernos nacionales han tenido una mala capacidad de gasto público, sin mencionar la calidad de este gasto, por lo que el estado enfrenta un reto económico grande. Frente a los esfuerzos conseguidos por reducir la pobreza y pobreza extrema el Perú presenta aun un grave problema de desigualdad en su población, la cual es una de las principales amenazas para su desarrollo. Según cifras del Banco Mundial (BM) a través del coeficiente de Gini –donde el número cero indica que todos tienen el mismo ingreso y el 1 significa que una persona concentra todo el ingreso y el resto no tiene nada –la desigualdad en el Perú registra un 0,44 en el 2015[4] y es importante mencionar que el Perú no ha reducido su desigualdad en los últimos cuatro años de acuerdo al BM. De esta manera existen otros aspectos, no necesariamente económicos que afectan a los peruanos, como son la inseguridad, el acceso a la salud, acceso a los servicios básicos, endeudamiento, bajos

[3] Censo Nacional 2017 - INEI
[4] América Latina (18 países): índice de desigualdad de Gini, 2002-2016

niveles de educación y violencia contra las mujeres y los niños. Este último con altos índices dentro de los hogares.

Actualmente en el Perú el 65,4% de las mujeres alguna vez sufrieron algún tipo de violencia por parte del esposo o compañero. Entre las formas de violencia, la psicológica y/o verbal fue mayor (61,5%), la violencia física alcanzó 30,6% y la violencia sexual 6,5%. Entre las formas para corregir a las hijas/hijos, de 1 a 5 años de edad, el padre tiene mayor propensión que la madre en reprenderlos verbalmente cuando se portan mal, no hacen caso o muestran falta de respeto (60,1% y 59,6% respectivamente). También alcanzó altos porcentajes en cuanto a corregir a hijas o hijos, hablar con él o ella y explicar su conducta (42,3% en la madre y 41,1% en el padre)[5]. La violencia familiar en el Perú es un problema social que se ha vuelto cotidiano y que exige una solución integral.

En esta coyuntura FH Perú comienza la implementación del modelo programático CFCT en el 2013, tanto para su zona de intervención en Lima como en Huancavelica, iniciando el relacionamiento con el liderazgo en sus nuevas comunidades, para posteriormente empezar un proceso de evaluación comunitaria holística con la población, que incluyó una línea de base realizada en junio de 2014 y la posterior construcción de Planes de Transformación Comunitaria en cada una de sus comunidades. La intervención de FH Perú para la línea base fue de 53 comunidades y para esta evaluación de medio término con un alcance en 139 comunidades a nivel nacional. La finalidad de esta evaluación corresponde a la necesidad de proporcionar información rigurosa acerca del impacto de las intervenciones del programa, así como de conocer los logros y desafíos que van gestando dentro de la comunidad como parte de su desarrollo, pero también como parte de las desigualdades e iniquidades en las que se encuentran y que incrementan su vulnerabilidad, especialmente la de las mujeres, las niñas y los niños.

Los hallazgos de la evaluación nos dicen que los líderes han aprendido que el cambio empieza en ellos, la importancia de la unidad en la comunidad y la planificación para lograr sus metas plasmadas en sus planes de transformación comunitaria, sin embargo, reconocen que tienen la necesidad de profundizar aún más en los recursos relacionados al conocimiento para su gestión, que la transformación es progresiva y que requieren de un continuo acompañamiento en practicar un liderazgo de servicio. Los líderes reconocen que es necesario la formación de nuevos cuadros dirigenciales en la juventud de la comunidad para contrarrestar los nuevos problemas que les aquejan: la inseguridad, la violencia y la falta de acceso a servicios para una mejor calidad de vida. Las madres voluntarias de grupos cascada (VGC) identifican su rol como voluntarias de su comunidad como los beneficios de enseñar a otras madres, pero al mismo tiempo de cambiar ellas mismas en este proceso. Las madres voluntarias han logrado tener un mayor optimismo frente a la vida, a su familia y su comunidad expresado en un mayor compromiso en su rol como VGC, son claras en manifestar que Dios las ama y han sido creadas únicas y valiosas. Mencionan la necesidad de mejorar su capacidad de resiliencia, autoestima y enfrentar sus miedos especialmente al hablar de la violencia dentro de sus hogares. Un reto esencial que mencionan es la incorporación del varón en este proceso de transformación.

Actualmente los miembros de los grupos de ahorro practican una adecuada distribución del dinero familiar, lo cual les ha permitido la generación de ahorro que está siendo utilizado en gastos planificados/no planificados y/o emprendimientos. La existencia de los grupos de

[5] Encuesta Demográfica y de Salud Familiar – ENDES 2017

ahorro les ha ayudado a mejorar las relaciones interpersonales dentro del grupo, la familia y la comunidad y mencionan la necesidad de iniciar una multiplicación de estos grupos internos y/o aperturar nuevos grupos de ahorro con vecinos y comunidades en donde no los hay, manteniendo un constante acompañamiento por parte del staff de FH que mantengan los principios y fundamentos sobre los cuales el ahorro es iniciado.

Los indicadores de violencia que fueron consultados manifiestan que el 42.3% de mujeres dicen que está bien que los hombres golpeen a sus esposas bajo ciertas circunstancias como la infidelidad o el descuido de los hijos. El 16% de mujeres en Lima pelea con su pareja, mientras que el 37% lo hace en Huancavelica. En relación a los adolescentes la evaluación encontró que el 54% dice que está bien que los hombres golpeen a sus esposas bajo ciertas circunstancias entre la principal encontramos la infidelidad.

Respecto a la salud se evidenció que el 46,6% de niños de 0 a 6 meses de edad a nivel nacional no se encuentra lactando exclusivamente utilizando otras formas alternativas para su alimentación. Mientras que, a nivel nacional, los niños entre 6 a 35 meses de edad evaluados consumen en promedio solo 2.3 grupos de alimentos diariamente. Estos resultados refuerzan la existencia de anemia y desnutrición crónica en la población infantil, según ENDES 2017 a nivel nacional, la Anemia afectó al 43,6% de las niñas y niños de 6 a 35 meses.

El resultado de cosmovisión en la evaluación de medio término muestra un incremento en relación con la línea de base realizada en 2014, de 72.4 a 74.9 de puntaje promedio alcanzado, sin embargo, este incremento aún no es significativo. La población consultada da cuenta de un discurso que aún está en proceso de ser llevado a la práctica y/o la acción, ya que aún sus paradigmas y cosmovisiones están influenciados por mensajes aprendidos previamente desde la infancia y reforzados por su entorno. Es en este nivel en el que FH Perú trabaja directamente, en lo que conocemos como transformación. Actualmente en porcentaje las comunidades de FH Perú, están aún en un proceso de transformación y de afianzamiento de su sostenibilidad autónoma para poder iniciar un proceso hacia su graduación, por lo que en conclusión requieren de más tiempo para este proceso. Sin embargo, se logran identificar logros importantes y nuevos desafíos para el programa. Tras la evaluación las lecciones aprendidas están en relación a iniciar permanentes espacios de análisis de la implementación del programa. Innovar en nuevas herramientas de apoyo para una mejorar implementación del modelo CFCT, involucrar la apertura y experiencia del staff para el planteamiento de las nuevas estrategias contextualizando la implementación a las realidades locales en cada zona de intervención. Promover un sistema constante de M&E que promueva reflexión para el aprendizaje y elaborar nuevo plan de crecimiento que considere las implicaciones en cuanto a la implementación y monitoreo y evaluación del CFCT. Iniciar proceso de capacitación constante al personal para el entendimiento continuo de la implementación de los dominios de cambios requeridos por el CFCT.

El enfoque metodológico para la evaluación de medio término del período de CFCT se basa en la idea de un "enfoque de proceso de aprendizaje" para la implementación de CFCT. Este enfoque difiere significativamente de un "enfoque modelo" a la implementación del programa, que es el enfoque tradicional y aún más ampliamente utilizado. La adaptación de FH al monitoreo y evaluación basados en resultados a la implementación del programa hace que este enfoque de MTE sea fundamentalmente diferente. En este enfoque de MTE, las actividades de monitoreo y evaluación se refieren no solo a la medida en que se llevan a cabo las actividades planificadas, sino también a la forma en que se llevan a cabo. En este

enfoque de MTE, se desarrollaron mecanismos para ayudar al personal del programa a aprender de los éxitos y problemas encontrados en la implementación de las actividades para mejorar el programa en el futuro. Por ejemplo, en este enfoque de evaluación sería importante saber no solo cuántos grupos de ahorro se han formado, sino también identificar los aspectos exitosos y problemáticos de la formación y capacitación del grupo de ahorro. Esto permitiría al personal del programa identificar formas de mejorar las futuras reuniones de capacitación y grupos de ahorro. En este enfoque, las actividades de monitoreo y evaluación implican la recopilación de información cuantitativa importante, pero se da prioridad a la recopilación de información cualitativa, que describe el proceso involucrado en la realización de cada tipo de actividad. Por ejemplo, se puede recopilar información sobre el "número de voluntarios capacitados en grupos en cascada", pero también sobre la "calidad de la capacitación", sobre la "retroalimentación de los participantes sobre la utilidad del contenido de la capacitación" y sobre "cómo los participantes utilizan lo que fueron enseñados" en su trabajo con las comunidades.

Sobre la base de la información recopilada durante la evaluación, se formulan "lecciones aprendidas" que se incorporarán al plan del programa. Las modificaciones en las actividades y estrategias del programa se realizarán continuamente en función de las lecciones que se formularon durante la evaluación. De principio a fin, el ejercicio de orientación de la metodología de evaluación aborda la pregunta "¿Qué podemos aprender de lo que ya hemos logrado para mejorar el programa en el futuro?" Quizás las dos facetas más importantes de la metodología son la participación del programa. Partes interesadas en todos los pasos del proceso de evaluación, y el enfoque de la evaluación en el desarrollo de las lecciones aprendidas que se traducen en un plan de acción.

Success Factors

- En los últimos 3 años FHP experimentó un crecimiento económico y geográfico a través del aumento de Patrocinio, lo cual generó un incremento del personal y ajuste de la estructura organizacional para cubrir las demandas de reportes de Patrocinio y los sectores de CFCT.
- La transición hacia el CFCT ha contribuido positivamente a la planificación y organización de los programas. FHP cuenta con un Plan Estratégico, teoría de cambio, diseño de 6 proyectos diferentes con un sistema de monitoreo actualizado, y los planes de transformación comunitarios son ahora más sistemáticos.
- Se ha trabajado de manera intencional para contextualizar los sistemas de CFCT a las condiciones de las áreas de intervención, desarrollar el llamado de país para incluir las realidades rurales y peri urbanas, y hacer una sistematización de la experiencia de grupos cascada en zonas peri urbanas.
- Se está formando alianzas estratégicas con entidades públicas y privadas.
- Los devocionales ayudan al personal en diversas áreas del trabajo y las relaciones interpersonales.

Key Challenges

- Llamado de país a ser implementado en 2 contextos diferentes (rural / urbano) con la necesidad de adaptar el modelo CFCT a la zona peri urbana tanto en diseño como tiempos de implementación que varían del contexto rural y peri urbano.
- Poder identificar e implementar la estructura ideal de personal en las diferentes unidades y Clusters considerando la rotación de personal especialmente en Lima.

- Lograr la diversificación de recursos de manera saludable en los diferentes fondos y diversas fuentes de donación a fin de crear resiliencia durante recortes de presupuestos.
- No contar con un plan y recursos para respuestas a emergencias fuera de las comunidades que servimos durante un evento.

Lessons Learnt

- Apertura del personal para recibir diferentes herramientas de apoyo para mejorar su implementación del modelo CFCT, y el monitoreo y evaluación.
- Es vital adecuar las herramientas y guía del CFCT al contexto y llamado de País.
- Elaborar un plan de crecimiento que considere las implicaciones en cuanto a la implementación y monitoreo y evaluación del CFCT.
- Identificar comunidades con buen potencial para la implementación del CFCT.
- Importancia del entendimiento del personal operativo relacionado a la implementación de los dominios de cambios requeridos por el CFCT.

Las recomendaciones dadas a FH Perú se encuentran en relación con la incorporación de los varones en intervenciones dirigidas para abordar los temas de las relaciones entre varones y mujeres, respeto y violencia dentro de hogar. Generar estrategias para el tratamiento del trabajo con adolescentes, así como desarrollar elementos de emprendimientos a partir de los grupos de ahorros con las madres. Identificar las áreas que requieran estudios formativos adicionales específicos para analizar las barreras que tiene la población para adoptar nuevos comportamientos. Y modificar, de ser necesario, la planificación de los proyectos para un mayor impacto. FH Perú tomara este informe como base y guía para planificar la graduación de sus áreas de supervisión en los próximos años. FH Perú está trabajando en realizar la actualización de su programa según los resultados obtenidos en la MTE.

PERU

Performance Indicator	HUANCAVELICA (BL)	HUANCAVELICA (MTE)	Stat. Sig	LIMA (BL)	LIMA (MTE)	Stat. Sig	PERU (BL)	PERU (MTE)	Stat. Sig
(STUNTING) % of children 0-23m who are stunted (HAZ< -2.0)	25.3%	13.7%	YES	16.7%	12.4%	NO	**21.0%**	**13.1%**	YES
(MINIMUM ACCEPTABLE DIET) % of children 0-23m who have an Acceptable Minimum Diet		49.0%			29.0%			**39.3%**	
(EXCLUSIVE BREASTFEEDING) % of children 0-6m who are exclusively breastfed		51.9%			54.8%			**53.4%**	
(INFANT DIETARY DIVERSITY) Infant/Child Dietary Adequacy Score		2.6			2.1			**2.3**	
(FOUR OR MORE FOOD GROUPS) % of children 6-23m with a dietary diversity score of four or more		29.6%			24.8%			**27.2%**	
(HOUSEHOLD DIETARY DIVERSITY) Average number of food groups consumed by households	5.8	8.3	YES	6.3	9.1	YES	**6.1**	**8.7**	YES
(DEWORMING) % of children 5-19 years who received deworming medication within the last 6 months		53.1%			42.0%			**48.1%**	
(WORLDVIEW) Average worldview index score	69.4	73.3	YES	75.5	76.5	YES	**72.4**	**74.9**	YES
(OK TO BEAT WIFE) % of mothers (of children 0-18y) who say that it's okay for a man to hit his wife	54.2%	59.9%	NO	32.3%	24.6%	NO	**43.2%**	**42.3%**	NO
(AVERAGE THREATS) Average number of threats the mother has experienced from her intimate partner in the last 12 months		0.4			0.6			**0.5**	
(AVERAGE REASON) Average number of reasons mother gives for when it's okay for a husband to hit his wife	0.7	1.3	NO	0.4	0.4	NO	**0.6**	**0.9**	NO
(LEADERSHIP INTEGRITY) % of mothers who believe that the level of honesty and integrity of their community leaders is "high" or very "high"		31.5%			44.1%			**37.8%**	
(INTEGRITY OF LEADERSHIP IN THE CHURCHES) % of mothers who believe that the level of honesty and integrity of church leaders is "high" or very "high"		27.5%			50.7%			**39.1%**	
(SCOPE OF THE CHURCHES) % of mothers who say church leaders do activities outside the church to involve the entire community "sometimes" or "many times"		45.8%			42.5%			**44.1%**	

Performance Indicator	HUANCAVELICA (BL)	HUANCAVELICA (MTE)	Stat. Sig	LIMA (BL)	LIMA (MTE)	Stat. Sig	PERU (BL)	PERU (MTE)	Stat. Sig
(ACCESS TO WATER SOURCES) % of households that use a safe source of water for drinking or cooking	85.4%	97.7%	YES	91.7%	57.0%	NO	**88.5%**	**77.3%**	NO
(HANDWASH BEHAVIOR) % of households where the mother reports appropriate handwashing behavior	0.0%	0.0%	NO	26.0%	0.0%	NO	**13.0%**		
(WATER TREATMENT) % Households that have applied an effective water treatment in the last 24 hours	71.9%	63.1%	NO	75.0%	89.7%	YES	**73.4%**	**76.4%**	NO
(DEWORMING) % of children 5-19 years who received deworming medication within the last 6 months		50.9%			49.3%			**50.1%**	
(BODY PUNISHMENT) % of children aged 5 to 18 who have received punishment / have been beaten in the last 7 days	36.5%	26.5%	NO	32.3%	46.4%	NO	**34.4%**	**36.3%**	NO
(AVERAGE INCOME) Average household income		1297.2			1428.0			**1366.6**	

Mozambique

Food for the Hungry (FH) began its operations in Mozambique in 1987 as an emergency response program to assist the people impacted by the civil war. Rehabilitation and development interventions continued in order to improve the education and economic condition of program participants. Child Focused Community Transformation (CFCT) model was introduced in 2013. The primary objective of this Mid-term Evaluation (MTE) is to assess the quality of implementation of CFCT model and determine the readiness of the FH assisted communities to graduate out of extreme poverty. The evaluation methodology used mixed method approach. The household survey was conducted from interviewing 1575 households. 526 people participated in the qualitative survey.

Combining all efforts of the quantitative and qualitative data it becomes informative to see the two clusters Caia and Gorongosa their level of readiness for graduation. The evaluation result finally contributes for the improvements of the remaining project period through learning process. There will be adjustments of targets during the remaining project phase depending on the lessons learned and subsequent recommendations. Ultimately, the midterm evaluation inform us weather the community is ready to graduate out of poverty or not.

There are positive changes shown in some of the key indicators in general as indicated in the report. The country level-stunting rate of children is decreased from 53.2% in the baseline dropped to 38.1% during the midterm evaluation. Stunting was significantly dropped in Gorongosa from 64.5% to 38.2% while in Caia from 50.4% to 38.1%. This is amazing result to have stunting rate went down like this. We have to take lesson and learn from this achievement what the country office has exerted to see such drastic change in the community.

As the desired change of underweight was to reduce, an improvement has been recorded on the underweighted children in Gorongosa that was dropped from 38.7% in the baseline then comes to 19.5% children are underweight. Surprisingly the data shows the underweighted children in Caia has worsen from the baseline that increased from 23.6% to 30.5%, this will be further examined the reason for this deteriorating results. The cumulative effect at country level, underweighted children does not show any difference, remain with 26.3% from that was 26.6%.

Infant dietary adequacy score in both clusters have shown reduction from 8.6 to 6.5. When breast milk is no longer enough to meet the nutritional needs of the infant, complementary foods should be added to the diet of the child. The transition from exclusive breastfeeding to family foods, referred to as complementary feeding, typically covers the period from six to 18-24 months of age, and is a very vulnerable period. It is the time when malnutrition starts in many infants, contributing significantly to the high prevalence of malnutrition in children under five years of age worldwide. WHO estimates that 2 out of 5 children are stunted in low-income countries? In this regard, the trend is an informative for the reduction of the rate. Therefore, FH Mozambique with the support of the health department from the GSC would have to observe the reason why this rate is reduced from the baseline data.

Household food access is defined as the ability to acquire a sufficient quality and quantity of food to meet all household members' nutritional requirements for productive lives. Household dietary diversity, defined as the number of unique foods consumed by household members over a given period, has been validated to be a useful approach for measuring household food access.

In this regard FH Mozambique has various interventions to meet the diversity of food intakes at household level. Because of this, the diversity score in figure 12 shows it is 7.2 for both clusters. In addition, no baseline data has been recorded to compare the changes.

Intimate partners' violence is one of the indicator that FH is measuring during the MTE. The required direction of change is reduction. Though baseline data is missed, the status of violence is indicating very high in both clusters. In Gorongosa it is 94% of respondents confirm there is intimate partners' violence and in Caia 87.8% resulted to country level results 90.7%. Ultimately, the FHM team would have to revise the program and strategy to reduce this alarming rate.

Both Caia (six communities) and Gorongossa (seven communities) have demonstrated declining trend in the multi-dimensional poverty. Works towards graduation by setting a threshold to 20%. Overall FH Mozambique has decreased multi-dimensional poverty by 17.36%. In Gorongoosa, poverty is decreased by 15.40% and in Caia by 18.07%. This has resulted in approximately 31,015 people moving out of poverty between 2014-2018.

FH Mozambique has identified that moving away from parallel management structure and bringing in uniformity and decentralization of decision making at the field level enabled effective management of budget and field activities. It is also noted that bringing in technical specialists in staffing increased the creativity and innovation in program design and implementation. While recruiting staff, keeping in mind the long term integration enables staff to be more effective rather than being segmented and being focused on one specific grant alone. Monitoring and Evaluation should not only focus on donor accountability, but also in providing data for evidence based decision making both for strategic and operational management. It is also noted that the importance of having sustainable and long term strategic plan than being dependent on grants after grants. Having a dedicated resource development staff enables the country office to respond to the opportunities timely and effectively. Further, diversifying funding at the country level helps FH Mozambique become more visible. The evaluation team pointed out that awareness on child sponsorship should not only be limited to the families but influential people in the community should also be included so that they can support the FH's programmatic approach.

- Key Challenges: Existence of multiple child sponsorship agencies in the same area of operation with different approach to sponsorship posed the challenge for CFCT implementation. It was difficult for community to understand the CFCT approach of moving away from handouts to capacity building and empowerment approach. Historical baggage and legal challenge also affected the program implementation. Insecurity, crime and armed conflict both in Gorongoosa, Caia and Cabo Delgado interrupted program implementation. Frequent drought and need for emergency programming affected the implementation of long term development strategies. Staff knowledge and capacity in understanding of CFCT as well as implementation was a limiting factor as trainings were limited to only few staff. Community Leaders were not fully engaged or were not clear about their role and participation due to inadequate planning and phasing of Community Leaders training. M&E data was not adequately utilized for program review and planning. The M&E staff is not engaged in providing evidences for strategic and operational management of the country program

Lessons Learnt

- Moving away from parallel management structure and bringing in uniformity and decentralization of decision making at the field enabled effective management of budget and field activities.
- Bringing in technical specialists increased the creativity and innovation in program design and implementation.
- While recruiting staff, keeping in mind the long term integration enables staff to be more effective rather than being segmented and being focused on one specific grant alone.
- Monitoring and Evaluation should not only focus on donor accountability, but also in providing data for evidence based decision making both for strategic and operational management.
- It is important to have sustainable and long term strategic plan than being dependent on grants after grants
- Having a dedicated resource development staff enables the country office to respond to the opportunities timely and effectively. Further, diversifying funding at the country level helps FH become more visible.
- Awareness on child sponsorship should not only be limited to the families but influential people in the community should also be included so that they can support the FH's programmatic approach.

The Evaluation Team and FH Mozambique agreed on the following recommendations:

- Address the issue of high level of malnutrition as reflected in the anthropometric data
- Conduct formative research to identify the barriers and review the pathways of change in the theory of change.
- Intentionally include the Design for Behavior Change (believes and behavior) in project designs for all sectors
- Review M&E system and use domains of change through indicators (Global KPIs as well as Project Specific) in your M&E system
- Identify drivers of change for risk
- Identify opportunity and comprehensiveness in livelihood strategy and implement interventions beyond savings groups
- Review theory of change for education interventions (cost on infrastructure)
- Strengthen Community Leadership as an institution towards sustainability

MOZAMBIQUE

Performance Indicator	GORONGOSA (BL)	GORONOGOSA (MTE)	Stat. Sig	CAIA (BL)	CAIA (MTE)	Stat. Sig	MOZAMBIQUE (BL)	MOZAMBIQUE (MTE)	Stat. Sig
(STUNTING) % of children 0-23m who are stunted (HAZ< -2.0)	50.4%	58.0%	NO	64.5%	45.7%	NO	**53.2%**	**54.6%**	NO
(UNDERWEIGTH) % of children 0-23m who are underweight (WAZ< -2.0)	23.6%	28.3%	NO	38.7%	32.1%	NO	**26.6%**	**29.4%**	NO
(EXCLUSIVE BREASTFEEDING) % of children 0-6m who are exclusively breastfed		90.2%			76.2%			**85.5%**	
(INFANT DIETARY DIVERSITY) Infant/Child Dietary Adequacy Score	8.6	6.5	NO	8.8	6.5	NO	**8.6**	**6.5**	NO
(FOUR OR MORE FOOD GROUPS) % of children 6-23m with a dietary diversity score of four or more	99.2%	79.2%	NO	100.0%	83.9%	NO	**99.4%**	**80.8%**	NO
(HOUSEHOLD DIETARY DIVERSITY) Average number of food groups consumed by households	7.2			7.2			**7.2**		
(SCHOOL REGISTRATION) % of children 5-18 years in the HH who are registered in school	95.2%	91.5%	NO	97.5%	87.8%	NO	**95.6%**	**89.7%**	NO
(WORLDVIEW) Average worldview index score	73.3	69.8	NO	75.9	70.7	NO	**73.9**	**70.2**	NO
(OK TO BEAT WIFE) % of mothers (of children 0-18y) who say that it's okay for a man to hit his wife	25.0%			26.3%			**25.3%**		
(AVERAGE THREATS) Average number of threats the mother has experienced from her intimate partner in the last 12 months	0.6			0.5			**0.6**		
(AVERAGE REASON) Average number of reasons mother gives for when it's okay for a husband to hit his wife	0.6			0.5			**0.6**		
(COMMUNITY LEADERS INTEGRITY) % of mothers/CG who believe their community leaders' level of honesty & integrity is "high" or "very high."	17.9%	85.8%	YES	23.7%	79.8%	YES	**19.2%**	**82.9%**	YES

Performance Indicator	GORONGOSA (BL)	GORONOGOSA (MTE)	Stat. Sig	CAIA (BL)	CAIA (MTE)	Stat. Sig	MOZAMBIQUE (BL)	MOZAMBIQUE (MTE)	Stat. Sig
(CHURCH LEADERS INTEGRITY) % of mothers/CG who rate the integrity of church leaders in the community as "high" or "very high."	10.4%	90.0%	YES	13.2%	79.8%	YES	**11.0%**	**85.0%**	YES
(CHURCH SCOPE) % of mothers/CG who state that church leaders in their community do activities outside of their place of worship that are open to or involve the entire community "some of the time" or "a lot of the time."	3.8%			2.6%			**3.5%**		
(ACCESS TO WATER) % households with an improved source for drinking water within acceptable reach - and available daily.		52.9%			61.2%			**57.0%**	
(HOUSEHOLD WATER TREATMENT) % households that have applied effective water treatment within the last 24 hours. (See Behavior / Message for effective methods)		27.5%			40.1%			**33.7%**	
(WATER STORAGE) % households storing drinking water that store water safely		97.3%			99.4%			**98.5%**	
(SANITATION FACILITY) % of households using an basic sanitation facility		52.5%			66.7%			**60.8%**	
(DIARREHA MANAGEMENT) % of children aged 0-59 months with diarrhea in the last two weeks who received Oral Rehydration Solution [ORS] and/or Recommended Home Fluids [RHF]		100.0%			99.9%			**99.9%**	
(PREVALENCE OF DIARRHEA) % of children under age five who had diarrhea in the prior two weeks		6.0%			7.3%			**6.6%**	
(DIARREHA MANAGEMENT) % of children aged 0-59 months with diarrhea in the last two weeks who received Oral Rehydration Solution [ORS] and/or Recommended Home Fluids [RHF]		100.0%			99.9%			**99.9%**	

Uganda

Food for the Hungry (FH) started operations in Uganda in 1989 with the ultimate goal to eliminate poverty among the most vulnerable communities in Uganda. Child Focused Community Transformation (CFCT) is FH's "essentials" model for transformational development and is a unified model across all operational countries. At the heart of the CFCT model is the welfare of the most vulnerable members of the community, especially children. CFCT grew out of FH's Child Development Program (CDP) model; building on FH's love and care for children, their expertise in multi-sectoral development programs, and a desire to see children grow physically, socially and spiritually.

In 2013, FH Uganda (FHU) transitioned from the CDP model, rolling out CFCT in all five clusters: Kitgum, Kole, Kween, Namutumba and Mbale. The primary intervention strategy of CFCT is the use of Cascade Groups to reach entire communities. In response to health related problems, FHU implemented the health and nutrition program through cascade groups. Village Savings and Loan Associations were established enabling participants to save and use credit and invest in various income generating activities that help them to improve their livelihood. The Disaster Risk Reduction (DRR) program approach facilitated the formation of community level disaster risk management committees in each village, establishing early warning teams and supporting the development of community managed disaster management plans.

This midterm evaluation (MTE) was conducted in Uganda between August 27, 2018 and September 5, 2018 using both inductive and deductive methods. Quantitative data was collected through a household survey in June 2018 while qualitative data was collected during the MTE workshop in August 2018. For deductive sampling, 573 households from five different clusters were interviewed to measure quantitative indicators while 998 people participated in the 75 focus group discussions including community members and FHU staff.

The main purpose of the MTE was to evaluate the impact of the program and measure community readiness to graduate. Overall, FHU has reduced multi-dimensional poverty (MDP) by 13.4%. In Kole MDP is reduced by12.87percentage, in Namutumba by 11.9%, in Mbale by 15.3%, in Kween by 15.5% and in Kitgum by 14.3%. This has resulted in approximately 15,072 people progressing out of poverty between 2013 and 2018. Eight communities in Mbale and Kitgum Clusters will be ready to graduate in two to three years.

Stunting of children under two years of age declined from the baseline in Kole, Kween and Kitgum clusters. Infant/Child Dietary Diversity increased in all clusters except Kitgum, which remained virtually unchanged from the baseline. The indicator on exclusive breast-feeding was not measured at the baseline and was reported at the midterm to be 54.5% across all clusters. Rates varied by cluster with Kitgum participants reporting the highest rate of exclusive breastfeeding (77.4%) and Kween participants reporting the lowest (30.8%). Household dietary diversity increased in Kole and Namutumba but remained the same or slightly lower in the other three clusters. Intimate partner violence remains high at the midterm with some variance by cluster. Perhaps the most encouraging finding from the quantitative data is the increase in Worldview Index Scores in all five clusters. Overall, the average score increased from 73.6% to 88% from the baseline to the midterm.

Scores of indicator on emergence of hope from guided workshops with men, women and children were low to medium. Levels also varied by cluster and by type of participant. Scores

from all three types of groups (men, women and children) in Mbale cluster were scored as medium, the highest level for any cluster in the evaluation. The lowest scores were found in Kole and Kween clusters where all the three types of groups were scored at the low level. Scores of children tended to reflect a lower level of hope than the other two groups, scoring low in every cluster except Mbale Cluster were scores of children were scored at a medium level. Scores of indicator on caring for others from guided workshops with men, women and children were scored at the low level for all groups in all clusters except the men and women in Mbale cluster, which were score was medium.

The methodological approach to the CFCT Midterm Evaluation is based on the idea of a "learning process approach" to CFCT implementation. This approach differs significantly from a "blueprint approach" to program implementation that is the traditional and still most widely used approach. FH's adaption to Results Based Monitoring and Evaluation to program implementation makes this MTE approach fundamentally different. In this approach to MTE, monitoring and evaluation activities are concerned not only with the extent to which the planned activities are carried out but also with how they are carried out. In this approach to MTE, mechanisms were developed to help program staff learn from both the successes and problems encountered in implementing the activities in order to improve the program in the future. For example, in this evaluation approach it would be important to know not only how many savings groups have been formed but also to identify both the successful and problematic aspects of forming and training the savings groups. This would allow program staff to identify ways to improve future trainings and saving group meetings. In this approach, M&E activities involve the collection of important quantitative information but priority is given to the collection of qualitative information, which describes the process involved in carrying out each type of activity. For example, information might be collected on the "number of cascade group volunteers trained" but also on the quality of the training, on the feedback from trainees on the usefulness of the training content and on how trainees are using what they were taught in their work with communities.

Based upon the information collected during the evaluation, "lessons learned" were formulated which will be fed back into the program plan. Modifications in program activities and strategies will continuously be made based upon the lessons which were formulated during the evaluation. From beginning to end the orientation of the evaluation methodology exercise addresses the question, "What can we learn from what we have already accomplished in order to improve the program in the future?" Perhaps the two most important facets of the methodology are the involvement of program stakeholders in all steps in the evaluation process and the focus of the evaluation on the development of lessons learned which are translated into an action plan.

The following are the key challenges identified during the evaluation.

- Community resistance to the CFCT capacity building approach due to different development approaches by other NGOs, many of which are still giving handouts
- Reduced level of community participation due to construction activities now contracted
- Low level of implementation due to flat structure of FH at the community level and limited sectoral staff
- Over dependency of government on FH due to their limited resources
- Competing tasks affecting the implementation of activities as country level staff do not take the current plan into consideration

- Limited volunteerism as other NGOs provide incentives to their community volunteers
- Some materials are not culturally sensitive and there are language barriers for translation since multiple dialects are spoken at the community level
- Low participation of community leaders in the program due to their multiple roles and inadequate early planning and failure to mobilize them
- Delays in procurement due to centralized procurement and limited approval authorities to the cluster managers
- Inconsistency of volunteers in attending program activities due to male dominance in decision making
- Poor time management by the community due to multiple home chores

Lessons Learnt: The following are the key lessons learnt from the evaluation.

- Building leadership capacity at the community and church levels requires moving beyond one time use of CFCT manuals to a commitment to long term strategic engagement.
- Alternative sources of funding in addition to sponsorship enable the acceleration of progress towards community graduation.
- In addition to providing more resources, grants bring enhanced technical capacity that can be leveraged to build staff capacity and improve program quality in non-grant programs.
- Being creative, innovative and open to learning through research projects, like the Eleanor Crook Foundation (ECF) grant, enables transfer of learning to privately funded projects which otherwise would not have the same opportunity and thereby enhances their quality.
- Structures, budgets and organizational decisional process are not stand alone activities rather driven by organizational approach to results orientation.
- Having long term program strategy and quality design does not necessarily mean effective and efficient program implementation. It requires having an adequate staffing structure with a professional capacity for execution.
- Investing intentionally to improved workplace culture enhances staff engagement, satisfaction and retention.
- Intentional investment in staff professional capacity enables staff to address the work related challenges and thereby reduces the number of issues that would otherwise require the time and attention of a supervisor.
- Changes in ideological thinking, organizational strategies and program model, and supporting resources should be updated on a regular basis and effectively communicated at all the levels in the organization to assure common understanding and avoid confusion.
- Effective use of technology and automating the business processes leads to reliable and high quality results which are essential traits of good program management.

Success factors: Following were identified as success factors during the evaluation.

- The CFCT model creates greater impact. It is concentrated in a small manageable geographical area which gives staff enough time to engage the community. The tools and methodology contribute to significant impact.
- The model has been highly accepted and embraced by the community to bring about transformational change because it brings on board several stakeholders; church leaders, community leaders and families which are essential for community transformation.
- There is easy measurement of change, since the model is implemented across all five clusters with similar harmonized tools and indicators.
- Staff capacity has been built by training in the CFCT approach in all the sectors.

The evaluation team recommended that FHU should consolidate operations in Mbale, Kitgum and Kole clusters, and focus on strengthening community leadership capacity for sustainability and gradually phase out from these clusters over the next two to three years. FH Uganda should also start working on identify replacement communities.

The evaluation team also recommended to make best use of M&E data by being responsive and adapting the learning and refining the project design for each of the clusters. FHU should capitalize on savings groups, identify the economic engines in the different clusters and develop a comprehensive livelihood strategy including entrepreneurship development or other livelihood opportunities for community members. Now that results are available from CLA and IDELA, FHU should intentionally focus education strategy and design on improving learning outcomes (i.e. attaining the reading, comprehension and numeracy standards according to the national standards). As the project designs are adapted and modified, FHU should also review the flip charts and improve all the flip charts. The project designs should also include addressing gender inequalities in each of the clusters. FHU should also focus on building leaders' capacity to reduce dependency on external actors.

Finally, FHU should ensure staff are aligned with FH's understanding of transformational development and the CFCT approach inculcating biblical worldview. FHU should help staff review and adapt program approaches that addresses cultural lies in order to change the mindset of community members, increase community participation and encourage volunteerism in the community.

UGANDA

Performance Indicator	KOLE (BASELINE)	KOLE (MTE)	Stat Sig	NAMUTUMBA (BASELINE)	NAMUTUMBA (MTE)	Stat Sig	MBALE (BASELINE)	MBALE (MTE)	Stat Sig
{STUNTING} % of children 0-23m who are stunted (HAZ< -2.0)	45.2%	39.3%	NO	27.8%	41.6%	NO	32.2%	41.6%	NO
{UNDERWEIGTH} % of children 0-23m who are underweight (WAZ< -2.0)	15.2%	22.9%	NO	8.9%	13.4%	NO	6.3%	10.5%	NO
{EXCLUSIVE BREASTFEEDING} % of children 0-6m who are exclusively breastfed		62.6%			57.4%			47.8%	
{FOUR OR MORE FOOD GROUPS} % of children 6-23m with a dietary diversity score of four or more	51.0%	68.5%	NO	82.5%	90.6%	NO	70.8%	80.0%	NO
{HOUSEHOLD DIETARY DIVERSITY} Average number of food groups consumed by households	4.7	5.9	YES	6.7	7.4	YES	6.5	6.5	NO
{SCHOOL REGISTRATION} % of children 5-18 years in the HH who are registered in school	89.7%	85.4%	NO	92.2%	77.7%	NO	92.6%	92.9%	NO
{WORLDVIEW} Average worldview index score	72.8	95.4	YES	71.6	89.4	YES	76.8	86.3	YES
{OK TO BEAT WIFE} % of mothers (of children 0-18y) who say that it's okay for a man to hit his wife	91.7%	94.3%	NO	86.0%	88.1%	NO	83.3%	84.4%	NO
{AVERAGE THREATS} Average number of threats the mother has experienced from her intimate partner in the last 12 months	1.3	1.1	YES	0.8	1.3	NO	0.9	1.3	NO
{COMMUNITY LEADERS INTEGRITY} % of mothers/CG who believe their community leaders' level of honesty & integrity is "high" or "very high."	68.8%	62.3%	NO	58.8%	54.2%	NO	69.8%	78.1%	NO
{CHURCH LEADERS INTEGRITY} % of mothers/CG who rate the integrity of church leaders in the community as "high" or "very high."	93.8%	91.5%	NO	86.8%	82.2%	NO	89.6%	87.5%	NO
{CHURCH SCOPE} % of mothers/CG who state that church leaders in their community do activities outside of their place of worship that are open to or involve the entire community "some of the time" or "a lot of the time."	64.6%	67.9%	NO	78.9%	68.6%	NO	61.5%	69.8%	NO
{ACCESS TO WATER} % of HHs with daily access to an improved source of drinking water	87.5%	93.4%	NO	96.5%	98.3%	NO	91.6%	99.0%	NO
{WATER STORAGE} % of households that store their drinking water safely in clean containers	59.4%	72.6%	NO	71.9%	76.3%	NO	62.1%	66.7%	NO
{SANITATION FACILITY} % of households that have a latine with basic installations	39.6%	37.7%	NO	57.9%	46.6%	NO	72.6%	50.0%	NO
{PREVALENCE OF DIARRHEA} % of children under age five who had diarrhea in the prior two weeks	35.4%	34.9%	NO	31.6%	40.7%	NO	44.2%	42.7%	NO
{FAMILY PLANNING} % of mothers who report at least a place where they can obtain a Child spacing method	89.6%	90.6%	NO	67.5%	73.7%	NO	82.1%	83.3%	NO
{HYGIENE PRACTICES} Proportion of households where the caretaker of the youngest child 0-23 months reported appropriate hand-washing behavior	93.8%	88.7%	NO	89.5%	91.5%	NO	95.8%	93.8%	NO
{DEWORMING} % of children 5-18 years who received deworming medication within the last 6 months.	50.0%			42.1%			57.9%		
{LITERACY} % of students who by the end of grade two can read and explain the meaning of a simple sentence	4.0%	1.3%	NO				15.0%	11.5%	NO

FOOD FOR THE HUNGRY

UGANDA

Perfomance Indicator	KWEEN(BASELINE)	KWEEN(MTE)	Stat. Sig	KITGUM(BASELINE)	KITGUM(MTE)	Stat. Sig	UGANDA (BL)	UGANDA (MTE)	Stat. Sig
(STUNTING) % of children 0-23m who are stunted (HAZ<-2.0)	43.4%	28.7%	NO	25.8%	14.3%	NO	34.6%	32.4%	NO
(UNDERWEIGTH) % of children 0-23m who are underweight (WAZ<-2.0)	14.7%	13.7%	NO	8.7%	8.8%	NO	10.8%	13.6%	NO
(EXCLUSIVE BREASTFEEDING) % of children 0-6m who are exclusively breastfed		30.8%			77.4%			54.5%	
(FOUR OR MORE FOOD GROUPS) % of children 6-23m with a dietary diversity score of four or more	73.5%	76.7%	NO	56.0%	54.5%	NO	67.0%	73.9%	NO
(HOUSEHOLD DIETARY DIVERSITY) Average number of food groups consumed by households	6.8	6.8	YES	4.0	3.8	NO	574.7%	608.4%	YES
(SCHOOL REGISTRATION) % of children 5-18 years in the HH who are registered in school	89.0%	84.4%	NO	79.7%	87.4%	NO	88.7%	84.4%	NO
(WORLDVIEW) Average worldview index score	75.4	86.6	YES	71.9	85.9	YES	7355.1%	8863.9%	YES
(OK TO BEAT WIFE) % of mothers (of children 0-18y) who say that it's okay for a man to hit his wife	92.0%	94.7%	NO	99.1%	90.0%	NO	90.6%	90.6%	NO
(AVERAGE THREATS) Average number of threats the mother has experienced from her intimate partner in the last 12 months	1.5	1.2	YES	1.5	1.3	YES	118.6%	123.7%	NO
(COMMUNITY LEADERS INTEGRITY) % of mothers/CG who believe their community leaders' level of honesty & integrity is "high" or "very high."	54.0%	56.4%	NO	40.0%	48.3%	NO	57.6%	59.0%	NO
(CHURCH LEADERS INTEGRITY) % of mothers/CG who rate the integrity of church leaders in the community as "high" or "very high."	80.0%	84.2%	NO	89.6%	75.0%	NO	87.9%	83.8%	NO
(CHURCH SCOPE) % of mothers/CG who state that church leaders in their community do activities outside of their place of worship that are open to or involve the entire community "some of the time" or "a lot of the time."	59.0%	69.2%	NO	43.5%	43.3%	NO	61.4%	63.5%	NO
(ACCESS TO WATER) % of HH s with daily access to an improved source of drinking water	46.5%	69.9%	NO	93.0%	91.7%	NO	83.6%	89.5%	NO
(WATER STORAGE) % of households that store their drinking water safely in clean containers	36.4%	32.3%	NO	37.7%	27.5%	NO	53.5%	53.6%	NO
(SANITATION FACILITY) % of households that have a latine with basic installations	70.7%	42.1%	NO	33.3%	45.0%	NO	54.2%	44.2%	NO
(PREVALENCE OF DIARRHEA) % of children under age five who had diarrhea in the prior two weeks	30.3%	25.6%	NO	46.5%	32.5%	NO	37.6%	34.7%	NO
(FAMILY PLANNING) % of mothers who report at least a place where they can obtain a Child spacing method	85.9%	88.0%	NO	86.8%	81.7%	NO	82.0%	83.4%	NO
(HYGIENE PRACTICES) Proportion of households where the caretaker of the youngest child 0-23 months reported appropriate hand-washing behavior	80.8%	91.7%	NO	82.5%	70.8%	NO	88.2%	87.1%	NO
(DEWORMING) % of children 5-18 years who received deworming medication within the last 6 months.				49.1%			49.4%		
(LITERACY) % of students who by the end of grade two can read and explain the meaning of a simple sentence	0.7%	0.8%	NO	0.0%	7.1%	YES	3.0%	3.6%	NO
Pupil latrine stance ratio	104.2	74.4	NO	44.5	54.2	YES	7158.5%	7007.0%	NO
Pupil classroom ratio	81.0	88.5	YES	66.0	73.9	YES	8577.0%	9027.0%	YES

Cambodia

Food for the Hungry (FH), Cambodia, operates as a field office Food for the Hungry Association, founded 1971 by Dr. Larry Ward. It has been operating in Cambodia since 1992. FH Cambodia is based in Svay Leu district of Siem Reap province. While Siem Reap province is the location of the world-famous Angkor Wat temple and is thus known for heavy tourist traffic, that glamorous reputation conceals pockets of significant poverty within the province. Among 194 municipalities and districts throughout Cambodia, Svay Leu district ranked 184th in the overall Cambodian Millennium Development Goals (CMDG) score according to a recent report issued by the Ministry of Planning. Svay Leu had the lowest overall CMDG score among all districts in Siem Reap province.

FH Cambodia's work has progressed over the past 25 years. Over time, operations were transitioned from Kampot Province on the border of Vietnam, to the northern part of Cambodia on the border of Thailand in Otdar Meanchey Province, followed by the neighboring Siem Reap province and into Svay Leu District. Starting with six villages in 2014, the program in Svay Leu has grown into 24 villages. FH Cambodia's ministry focuses on Education, Health, Savings and Livelihood, and Leadership Development. In 2013, the FH Cambodia program began the process of adapting the Child Focused Community Transformation (CFCT) program model to the clusters in Svay Leu Region; Ta Siem in 2013 followed the succeeding year by Boeng Mealea Cluster. Two other clusters, Svay Leu and Kantuot Clusters began implementing the CFCT model in 2015.

This Midterm Evaluation (MTE) was conducted in Cambodia in three parts: (1) Quantitative data collection was conducted December 6-15, 2017; (2) qualitative data collection was January 8-15, 2018; and lastly, the Reflection, Learning, and Adapting (RLA) event was November 28 to December 3, 2018. The key purpose of the MTE was to help FH Cambodia assess the progress, efficiency, relevance and effectiveness of the different project interventions under the CFCT model in the communities. This will serve as basis for organizational learning and improvement. Another major objective of the MTE was to assess the progression of people moving out of poverty. To achieve these objectives, both inductive and deductive methodologies were employed. Quantitative data was collected using a household survey with a sample of 1,067 households. The survey measured quantitative indicators in five different clusters using Lot Quality Assurance Sampling (LQAS) methodology. Data for qualitative indicators was collected using Focus Group Discussion (FGDs). A total of 84 FGDs were conducted during the evaluation.

There were some great achievements in implementation of the CFCT model observed during this midterm evaluation. There was an increase in the prevalence of mothers practicing exclusive breastfeeding from 73% to 76% over the baseline. The prevalence of children 0-23 months who received food from four or more food groups also increased from 74% to 88%. Another major achievement was the increase in access to a toilet facility from 12% at the baseline to 41% at the midterm. The Household Dietary Diversity (HDD) score, a proxy indicator for change in household income, increased from 5.6 to 6.6. Further, the average World-View Index score also improved over the baseline from 50.9 to 60.1.

In spite of great achievements mentioned above, there were also some indicators that did not show much progress. Amongst them was the prevalence of stunting which is actually a reversal indictor. Prevalence of stunting increased from 19% to 25%; however, this is still 7% lower

than the country's average of 32%. Intimate partner's violence was another indicator of concern. The percentage of women who said it is ok for a man to beat his wife was as high as 85% at the midterm.

All FGDs with CGVs in Health (CGVs-H) reported that the lessons and training that they received are very relevant to the issues in their community. The impact of these lessons included the reduction of serious illnesses such as Dengue and Malaria, improved relations with husbands due to improved practices in the home and greater confidence to raise and educate their children. Participants in FGDs with SGs reported that the method of training was very relevant to them, making the information easy to learn. Impacts of the training include: they are better able to provide for the educational needs of their children, the can purchase equipment for farming and other purposes, there is greater trust in the group, and women feel respected by their husbands. Participants in FGDs with CGVs in Agriculture (CGVs-A) mentioned that the trainings were fun and engaging making it easy to understand and remember the learning that they gained.

The program resulted in the formation of 77 savings groups (SGs) reaching out to 1,031 households in 24 communities. The current total assets of these savings groups is $77,770. The program also formed 24 Community Development Committees (CDC) and trained approximately 236 community leaders using CFCT community leaders training manual. After being trained, leaders are expected to develop Disaster Risk Reduction (DRR) plans and Community Transformation (CT) Plans.

The MTE introduced two new indicators, Emergence of Hope and Caring for Others. These two indicators use a qualitative methodology for measurement. The results for these indicators can be considered as baselines since they were not measured during the previous baseline. Overall, Emergence of Hope was found to be medium for men, women and children. The same was found for Community Caring for Others. Men, women, and children, showed positivity about the future. They articulated their dreams for the future; however, they recognized that they need the support of external sources. They believe that there is a supreme being that is helping them in times of difficulty and will help them achieve the goals they set for themselves, for their family and their community.

It was very evident that the men, women and children shared their resources with others, especially to the most vulnerable. There is active participation in the development of their community. They help one another in addressing the conflicts and challenges that they face. Children felt protected; however, gender issues are still present.

During the baseline only 21%, people met FH's criteria for success for moving out of poverty. At the MTE the percentage of people, meeting the criteria dramatically improved to 40%. This resulted in the movement of 4,629 people out of poverty. This is a remarkable achievement for the Cambodia team.

The methodological approach to CFCT Mid Tern Evaluation is based on the idea of a "learning process approach" to CFCT implementation. This approach differs significantly from a "blueprint approach" to program implementation that is the traditional and still most widely used approach. FH's adaption to Results Based Monitoring and Evaluation to program implementation makes this MTE approach fundamentally different. In this approach to MTE, monitoring and evaluation activities are concerned not only with the extent to which the planned activities are carried out but also with how they are carried out. In this approach to

MTE, mechanisms were developed to help program staff learn from both the successes and problems encountered in implementing the activities in order to improve the program in the future. For example, in this evaluation approach it would be important to know not only how many savings group have been formed but also to identify both the successful and problematic aspects of forming and training the savings group. This would allow program staff to identify ways to improve future trainings and saving groups meetings. In this approach, monitoring and evaluation activities involve the collection of important quantitative information but priority is given to the collection of qualitative information, which describes the process involved in carrying out each type of activity. For example, information might be collected on the "number of Cascade Group Volunteers trained" but also on the "quality of the training," on the "feedback from trainees on the usefulness of the training content" and on "how trainees are using what they were taught" in their work with communities.

Based upon the information collected during the evaluation, "lessons learned" were formulated which will be fed back into the program plan. Modifications in program activities and strategies will continuously be made based upon the lessons, which were formulated during the evaluation. From beginning to end the orientation of the evaluation methodology exercise addresses the question "What can we learn from what we have already accomplished in order to improve the program in the future?" Perhaps the two most important facets of the methodology are the involvement of program stakeholders in all steps in the evaluation process and the focus of the evaluation on the development of lessons learned which are translated into an action plan.

The following are the key successes identified during the evaluation:

- Increased the organizational capacity within FH Cambodia and its impact on programming delivery
- Community leaders are implementing projects that have lifelong impact for their communities.
- Objectives of the program correspond to the needs of the population
- Inclusion of the most vulnerable is well documented and celebrated
- Mechanisms for collaboration are strengthened resulting in cohesion among other like-minded organizations and government agencies
- FH Cambodia starting to attract attention as a learning hub
- Quality operational delivery; excellent contextualization, facilitation skills and living out the Heartbeat in the communities resulting from
- Organizational expertise is recognized by government resulting in collaboration supporting long term buy-in of FH programs

The following are the key challenges identified during the evaluation:

- The political situation makes it difficult to secure permits and MOUs, especially regarding health and customs issues
- Initial shortage in technical competency for sectoral projects
- Lack of English language competency for reporting and hosting visitors
- Contextualizing CFCT manuals and flipcharts, and timing for lessons (FH timing vs. community)
- Volunteers drop out of the project because of migration

Lessons learnt: The following are lessons learnt from the CFCT Midterm Evaluation

- Whenever an organization changes its programmatic approach, philosophy or ideology on an issue, it is critical that the rationale be well explained to the staff and that they are trained on the new approach to avoid any unnecessary conflicts in their understanding of the issue.
- Continuous backstopping and technical support to the countries enhances the quality of programs
- High quality programs attracts donors
- Diversification of resources leads to growth in programs and enables countries to hire highly competent staff
- For effective implementation of programs, it is critical that organizations dedicate resources towards staff capacity building
- Intentional adaptation of cultural/contextual realities into the program design is beneficial in the implementation of quality programming

The evaluation team and FH Cambodia jointly agreed to the recommendations of consistently building the capacity of CGVs and to support them during the cascading of the behaviors being promoted to decrease stunting. Intentionally partnering with like-minded organizations who work with the same target communities to overcome issues related to securing permits and MOUs, particularly health issues. Strengthening the integration of the livelihood initiatives, i.e. savings and loans used for productive investments, which will augment the family's income resulting in the ability to better meet the needs of their family. Integrating lessons of worldview in every training conducted with leaders, volunteers and other members of the community. As part of an integrated development approach, continue engaging and strengthening the most vulnerable group in the target communities such as people with disabilities, widows, orphans, and those belonging to the poor 1 and 2 categories and seeking continuous backstopping and technical support from the global program team to enhance the quality of programs.

CAMBODIA

Performance Indicator	BOENG MEALEA (BL)	BOENG MEALEA (MTE)	Stat. Sig	TA SIEM (BL)	TA SIEM (MTE)	Stat. Sig	KANTUOT (BL)	KANTUOT (MTE)	Stat. Sig	SVAY LEU (BL)	SVAY LEU (MTE)	Stat. Sig	CAMBODIA (BL)	CAMBODIA (MTE)	Stat. Sig
(STUNTING) % of children 0-23m who are stunted (HAZ< -2.0)	10.8%	30.1%	NO	13.6%	22.9%	NO	25.1%	20.8%	NO	25.7%	26.7%	NO	**19.2%**	**24.7%**	NO
(UNDERWEIGTH) % of children 0-23m who are underweight (WAZ< -2.0)	19.5%	26.3%	NO	24.7%	27.7%	NO	30.5%	22.1%	NO	17.4%	21.5%	NO	**22.8%**	**24.2%**	NO
(EXCLUSIVE BREASTFEEDING) % of children 0-6m who are exclusively breastfed	87.5%	82.8%	NO	56.4%	71.1%	NO	78.6%	74.2%	NO	70.4%	76.5%	NO	**73.1%**	**75.8%**	NO
(INFANT DIETARY DIVERSITY) Infant/Child Dietary Adequacy Score	6.6	6.7	YES	7.3	6.8	NO	3.7	8.1	YES	5.0	5.4	YES	**5.6**	**6.8**	YES
(FOUR OR MORE FOOD GROUPS) % of children 6-23m with a dietary diversity score of four or more	90.5%	95.1%	NO	89.3%	86.1%	NO	50.0%	92.7%	YES	71.3%	75.6%	NO	**74.2%**	**87.6%**	YES
(HOUSEHOLD DIETARY DIVERSITY) Average number of food groups consumed by households	6.5	6.8	YES	6.6	6.6	YES	5.2	7.0	YES	4.9	5.7	YES	**5.8**	**6.6**	YES
(WORLDVIEW) Average worldview index score	36.6	65.2	YES	37.2	59.7	YES	48.6	66.0	YES	53.1	49.4	NO	**43.9**	**60.1**	YES
(OK TO BEAT WIFE) % of mothers (of children 0-18y) who say that it's okay for a man to hit his wife		86.8%			77.2%		93.0%	91.2%	NO	97.4%	85.1%	NO	**95.2%**	**85.1%**	YES
(AVERAGE THREATS) Average number of threats the mother has experienced from her intimate partner in the last 12 months		1.6			1.7		0.7	1.9	NO	0.9	2.3	NO	**0.8**	**1.9**	NO
(AVERAGE REASON) Average number of reasons mother gives for when it's okay for a husband to hit his wife	3.2	2.5	YES	3.0	1.9	YES	3.2	3.2	NO	4.0			**3.4**	**2.5**	YES

Philippines

Since beginning its formal operation in 1992, Food for the Hungry Philippines (FHP) has worked to improve the living conditions of the most vulnerable, especially households with children 0-18 years old. Despite its growing economy, 22 million, or one-fifth, of the population of the Philippines still live below the national poverty line. At the national level, the proportion of undernourished people is 13.5%. In the 2017 World Risk Report, the Philippines ranked third of 171 countries around the world for being at risk of natural disaster. Country statistics show that only 67% of primary school age children are age-appropriate for their grade level and that 11% of these children will drop out of school before completing grade five.

FHP has expanded its geographical presence from Luzon, covering the National Capital Region and Bulacan province, to Bicol and Eastern Visayas (Samar and Leyte) with a total of 72 barangays or communities. In 2013, Food for the Hungry (FH) global introduced Child Focused Community Transformation (CFCT) to all its field offices. CFCT is an integrated program model of intervention comprised of four (4) components, namely: Livelihoods, Health, Disaster Risk Reduction (DRR) and Education. The model also provides FHP a platform, which allows cross-cutting themes of gender, protection, environment, and biblical worldview which permeate interventions.

This midterm evaluation (MTE) was conducted in the Philippines between October, 2017 and February, 2018 using both inductive and deductive methods. For deductive sampling, 965 households from five different clusters were interviewed to measure quantitative indicators. For inductive sampling, 444 community members and 28 field staff participated in the 53 guided workshops and focus group discussions. The objectives of this MTE were to: measure changes in the program indicators, including the global key performance indicators; celebrate FH Philippine's achievements and learn from their constraints; assess the communities' readiness to graduate and recommend graduation decisions; and draw lessons learned and make recommendations for future programming.

A reduction in the prevalence of underweight children of 10.28% was observed across all clusters from the baseline (36.24%) to the midterm (25.96%). The prevalence of underweight children declined in all but Bulacan Cluster. The prevalence of exclusive breastfeeding increased overall by 29.34% from the baseline (14.82%) to the midterm (44.16%). All clusters except Bulacan Cluster reported an increase in exclusive breastfeeding. The Infant/Child Dietary Adequacy Score and the Household Dietary Diversity both dropped from the baseline to the midterm. The Worldview Index Score dropped somewhat in Bulacan, Malabon and Navotas clusters but increase slightly in Bicol 1 and Bicol 2.

Findings from the Focus Group Discussions suggest that the training with Cascade Group Volunteers (CGVs), Savings Group (SG) members, Community Leaders and Church Leaders was relevant and effective. Participants reported they learned the material and were applying what they learned. In addition to increased knowledge and capacity, the social standing of those trained was reported to have increased. Problems with attendance, scheduling and time management were among the challenges most often mentioned by participants.
Scores on the indicator, Emergence of Hope, from guided workshops with men, women and children were low to medium. Levels varied somewhat by cluster and by type of participant. Bulacan and Bicol 1 clusters had the highest average score (2.3) while Bicol 2 had the lowest average score (2.1) On average, men scored the lowest (1.98), women scored 2.32 and

children scored the highest (2.38). Scores on the indicator, Caring for Others, from the same guided workshops were also low to medium. Biocol 2 had the greatest average score (2.3) on Caring for Others. Navotas, Bulacan and Bicol 1 all scored, on average, the lowest (2.1). Malabon had an average score of 2.2. Women scored the highest on Caring for Others (2.28) followed by children (2.14) and men (2.08)

The methodological approach to CFCT Mid Term Evaluation is based on the idea of a "learning process approach" to CFCT implementation. This approach differs significantly from a "blueprint approach" to program implementation that is the traditional and still most widely used approach. FH's adaptation of Results Based Monitoring and Evaluation to program implementation makes this MTE approach fundamentally different. In this approach to MTE, monitoring and evaluation activities are concerned not only with the extent to which the planned activities are carried out but also with how they are carried out. In this approach to MTE, mechanisms were developed to help program staff learn from both the successes and problems encountered in implementing the activities in order to improve the program in the future. For example, in this evaluation approach it would be important to know not only how many savings group have been formed but also to identify both the successful and problematic aspects of forming and training the savings group. This would allow program staff to identify ways to improve future trainings and saving groups meetings. In this approach, monitoring and evaluation activities involve the collection of important quantitative information, but priority is given to the collection of qualitative information that describes the process involved in carrying out each type of activity. For example, information might be collected on the "number of cascade group volunteers trained" but also on the "quality of the training," on the "feedback from trainees on the usefulness of the training content" and on "how trainees are using what they were taught" in their work with communities.

Based upon the information collected during this evaluation, "lessons learned" were formulated which will be fed back into the program plan. Modifications in program activities and strategies will continuously be made based upon the lessons that were formulated during the evaluation. From beginning to end, the orientation of the evaluation methodology exercise addresses the question, "What can we learn from what we have already accomplished in order to improve the program in the future?" Perhaps the two most important facets of the methodology are the involvement of program stakeholders in all steps in the evaluation process and the focus of the evaluation on the development of lessons learned which are translated into an action plan.

Key Challenges

- The workload of staff is considered overwhelming. For example, staff are aware of their project deliverables but Child Sponsorship requirements are equally important and takes most of their time, so their project tasks are put aside.
- A large proportion of staff are new (Tag. 70.5%, Bicol 83%). These staff feel they have little to no knowledge/background about CFCT.
- Because there are many newly hired staff, it takes time for them to understand the project goals.
- Staff perceive there is big gap/delay in implementation (set targets, timeframe).
- In Bicol, partnering with churches has become challenging as churches are sensing they are expected to deliver tasks they are not trained to do and have little resources.
- Corporate and LGU partnership were not sustained
- Men are minimally engaged in program interventions.

- Funds are not utilized. (Ex. Staff say there are inadequate funds when reports shows FHP is significantly underspending)

Lessons Learned

- It is easier to implement CFCT in newly opened communities and/or communities with no experience with other NGOs' or other development programs. There are no expectations based on these other approaches.
- Empowering community members and enabling them to know their issues increases their participation in their own development.
- Training staff at all levels helps in the early adoption of new tools or concepts.
- Staff job descriptions are clear to guide them of the project deliverables.
- Having a baseline and logframe (with targets) at an early stage of implementation helps determine clear deliverables. The regular monitoring of progress helps the team know if any corrective action needs to be taken.
- Integration is helpful in initial stages of implementation, however when program grows, more focused approach is required including adjustment in the staffing structure.
- More structured and thematic activities were conducted, and staff are guided with appropriate curriculum or manuals to be used.
- Empowering community leaders and volunteers are a big help in accomplishing tasks.

As a result of this MTE, the evaluation team recommends that FHP decide on the numerical targets (output-level indicators) and how the targets can be reached within the project's lifespan. FHP should identify a domain (sector) to focus on. If the current framework identifies a bigger gap in Livelihoods, then, FHP should develop a comprehensive livelihood strategy. FHP should explore opportunities to engage men to enhance the influence cycle within households. FHP should strengthen partnership both with local government and private institutions to gain support, complement the work of others, and avoid service duplication. FHP should implement a staff on-boarding plan to guide new staff on what the organization values and is aiming to achieve. This would foster clarity on expectation and decrease project implementation gaps. FHP should also identify and implement opportunities for program quality enhancement to increase organizational effectiveness and attract donors for fund diversification.

PHILIPPINES

Performance Indicator	BULACAN (BL)	BULACAN (MTE)	Stat. Sig	MALABON (BL)	MALABON (MTE)	Stat. Sig	NAVOTAS (BL)	NAVOTAS (MTE)	Stat. Sig
(STUNTING) % of children 0-23m who are stunted (HAZ< -2.0)	40.7%	4.8%	YES	22.9%	3.1%	YES	41.0%	3.8%	YES
(UNDER WEIGTH) % of children 0-23m who are underweight (WAZ< -2.0)	18.9%	22.7%	NO	27.1%	5.6%	YES	33.3%	25.3%	NO
(EXCLUSIVE BREASTFEEDING) % of children 0-6m who are exclusively breastfed	39.4%	31.6%	NO	30.7%	56.3%	NO	0.0%	31.6%	YES
(INFANT DIETARY DIVERSITY) Infant/Child Dietary Adequacy Score	6.48	0.8	NO	10.1	0.72	NO	6.39	0.52	NO
(HOUSEHOLD DIETARY DIVERSITY) Average number of food groups consumed by households	8.21	7.5	NO	9.8	7.31	NO	8.43	7.44	NO
(DEWORMING) % of children 5-19 years who received deworming medication within the last 6 months	58.3%			53.1%			55.8%		
(WORLDVIEW) Average worldview index score	74.16	72.31	NO	76.61	72.79	NO	75.82	72.16	NO
(OK TO BEAT WIFE) % of mothers (of children 0-18y) who say that it's okay for a man to hit his wife	77.1%	40.4%	YES	74.0%	70.7%	NO	84.4%	69.7%	YES
(AVERAGE THREATS) Average number of threats the mother has experienced from her intimate partner in the last 12 months	0.36	0.57	NO	0.61	0.64	NO	0.54	0.55	NO
(AVERAGE REASON) Average number of reasons mother gives for when it's okay for a husband to hit his wife	3.63	2.39	YES	1.66	5.62	NO	1.96	4.76	NO
Proportion of children enrolled in school	92.9%	64.9%	NO	97.3%	71.4%	NO	95.8%	69.2%	NO
Proportion of mothers who rated quality of teaching as high or very high	91.5%	88.5%	NO	91.5%	87.2%	NO	75.3%	93.7%	YES
Proportion of mothers who said secondary school and above education would be sufficient for one to be successful today	100.0%	96.7%	NO	92.7%	97.9%	NO	99.0%	98.6%	NO
Individual household hunger score	87.5%	61.1%	NO	84.4%	72.8%	NO	96.9%	72.1%	NO
Proportion of mothers who spoke to their friends or extended family at least on a daily or weekly basis	46.9%			76.0%			60.4%		
(COMMUNITY LEADERS INTEGRITY) % of mothers/CG who believe their community leaders' level of honesty & integrity is "high" or "very high."	57.3%	65.4%	NO	55.2%	51.3%	NO	45.8%	69.4%	YES
Proportion of mothers who rated the effectiveness of leaders as high or very high	59.4%	66.3%	NO	58.3%	52.9%	NO	58.3%	64.4%	NO
(CHURCH LEADERS INTEGRITY) % of mothers/CG who rate the integrity of church leaders in the community as "high" or "very high."	94.8%	82.2%	NO	83.3%	85.9%	NO	79.2%	88.8%	NO
Proportion of mothers who said the involvement of religious leaders in this community a lot of times	39.6%	27.4%	NO	33.3%	31.9%	NO	20.8%	32.2%	NO
Proportion of mothers who said they are mostly happy or completely happy with their husband	82.1%			80.6%			71.9%		
Proportion of mothers who said they quarrel with their husband almost everyday	28.6%			9.7%					
Proportion of households who feel that they should cut down drinking of alcohol	52.1%			54.2%			54.8%		
Proportion of household who receive support in cutting down alcohol consumption	21.9%			26.0%			26.3%		
Average number of days during the last week family prayed other than meal time	2.27			3.06			1.73		
Proportion of household who owns a Bible	74.0%			74.0%			78.1%		
Average number of days that the family read the bible together/ listened to religious program in TV or radio in the last week	1.25			1.94			1.71		
Average number of days one or more of the children participated in religious activity in the last month	2.4			2.44			2.22		
Depression score	16.99			17.22			16.22		
Generalized self-efficacy score	14.78			15.06			15.33		
Social support seeking score	14.27			14.09			14.3		
Personal Resiliency Score	46.04								
DRR Worldview score	10.64	10.54	NO	11.31	10.4	NO	10.86	10.48	NO
Gender Score	14.9	14.48	NO	15.54	14.86	NO	15.8	14.64	NO
(FOUR OR MORE FOOD GROUPS) % of children 6-23m with a dietary diversity score of four or more		10.6%		100.0%	9.1%	NO	78.6%	6.4%	NO
(HOUSEHOLD WATER TREATMENT) % households that have applied effective water treatment within the last 24 hours. (See Behavior / Message for effective methods)									
(PREVALENCE OF DIARRHEA) % of children under age five who had diarrhea in the prior two weeks									
(DIARREHA MANAGEMENT) % of children aged 0-59 months with diarrhea in the last two weeks who received Oral Rehydration Solution [ORS] and/or Recommended Home Fluids [RHF].									

FOOD FOR THE HUNGRY

PHILIPPINES

Performance Indicator	BICOL 1 (BL)	BICOL 1 (MTE)	Stat. Sig	BICOL 2 (BL)	BICOL 2 (MTE)	Stat. Sig	PHILIPPINES (BL)	PHILIPPINES (MTE)	Stat. Sig
(STUNTING) % of children 0-23m who are stunted (HAZ< -2.0)	50.0%	43.4%	NO	56.8%	30.4%	YES	41.9%	12.9%	YES
(UNDER WEIGTH) % of children 0-23m who are underweight (WAZ< -2.0)	47.7%	37.3%	NO	54.2%	38.9%	YES	35.8%	25.0%	YES
(EXCLUSIVE BREASTFEEDING) % of children 0-6m who are exclusively breastfed	4.0%	45.0%	YES	0.0%	56.3%	YES	15.6%	43.3%	YES
(INFANT DIETARY DIVERSITY) Infant/Child Dietary Adequacy Score	6.22	4.75	NO	8.58	4.91	NO	7.23	1.38	NO
(HOUSEHOLD DIETARY DIVERSITY) Average number of food groups consumed by households	8.32	7.72	NO	9.13	7.52	NO	8.78	7.46	NO
(DEWORMING) % of children 5-19 years who received deworming medication within the last 6 months		85.3%		87.4%			63.6%	85.3%	YES
(WORLDVIEW) Average worldview index score	75.19	76.15	YES	73.11	75.43	YES	74.98	73.03	NO
(OK TO BEAT WIFE) % of mothers (of children 0-18y) who say that it's okay for a man to hit his wife		71.6%			68.4%		78.5%	63.6%	YES
(AVERAGE THREATS) Average number of threats the mother has experienced from her intimate partner in the last 12 months							0.51	0.58	NO
(AVERAGE REASON) Average number of reasons mother gives for when it's okay for a husband to hit his wife	1.74	1.52	YES	1.8	1.25	YES	2.16	2.66	NO
Proportion of children enrolled in school		97.6%		97.3%			95.7%	73.9%	NO
Proportion of mothers who rated quality of teaching as high or very high		91.6%		88.4%			86.6%	90.8%	NO
Proportion of mothers who said secondary school and above education would be sufficient for one to be successful today		100.0%		98.9%			97.7%	98.2%	NO
Individual household hunger score	25.3%	42.1%	NO				73.6%	66.3%	NO
Proportion of mothers who spoke to their friends or extended family at least on a daily or weekly basis							61.1%		
(COMMUNITY LEADERS INTEGRITY) % of mothers/CG who believe their community leaders' level of honesty & integrity is "high" or "very high."	60.4%	68.4%	NO	65.6%	70.5%	NO	56.9%	65.0%	NO
Proportion of mothers who rated the effectiveness of leaders as high or very high							58.7%	62.1%	NO
(CHURCH LEADERS INTEGRITY) % of mothers/CG who rate the integrity of church leaders in the community as "high" or "very high."	78.1%	81.1%	NO	83.3%	80.0%	NO	83.8%	85.2%	NO
Proportion of mothers who said the involvement of religious leaders in this community a lot of times		22.1%			23.2%		31.3%	29.2%	NO
Proportion of mothers who said they are mostly happy or completely happy with their husband							77.6%		
Proportion of mothers who said they quarrel with their husband almost everyday							16.8%		
Proportion of households who feel that they should cut down drinking of alcohol							53.7%		
Proportion of household who receive support in cutting down alcohol consumption							24.5%		
Average number of days during the last week family prayed other than meal time							2.35		
Proportion of household who owns a Bible							75.3%		
Average number of days that the family read the bible together/ listened to religious program in TV or radio in the last week							1.63		
Average number of days one or more of the children participated in religious activity in the last month							2.35		
Depression score							16.81		
Generalized self-efficacy score							15.06		
Social support seeking score							14.22		
Personal Resiliency Score							46.04		
DRR Worldview score							10.94	10.48	NO
Gender Score							15.41	14.65	NO
(FOUR OR MORE FOOD GROUPS) % of children 6-23m with a dietary diversity score of four or more		68.0%			72.2%		87.8%	19.1%	NO
(HOUSEHOLD WATER TREATMENT) % households that have applied effective water treatment within the last 24 hours. (See Behavior / Message for effective methods)		49.5%			60.0%			54.7%	
(PREVALENCE OF DIARRHEA) % of children under age five who had diarrhea in the prior two weeks		15.8%			18.9%			17.4%	
(DIARREHA MANAGEMENT) % of children aged 0-59 months with diarrhea in the last two weeks who received Oral Rehydration Solution [ORS] and/or Recommended Home Fluids [RHF].		33.3%			16.7%			24.2%	

Rwanda

Food for the Hungry (FH) began its work in Rwanda as a relief response to the poverty and human suffering caused by the 1994 genocide. Over the years, FH Rwanda's work evolved from an emergency response to a reconstruction and development program. Child Focused Community Transformation (CFCT) is FH's "essentials" model for transformational development and is a unified model across all operational countries. At the heart of the CFCT model is the welfare of the most vulnerable members of the community, especially children.

In 2011, FH Rwanda opened Nyarubaka and Cyeza Clusters. Kabacuzi and Mwendo Clusters were opened in 2012, and Gatunda and Nyagiganga Clusters were opened in 2014. In 2013, FH's CFCT program approach was rolled out in Nyarubaka, Kabacuzi and Mwendo Clusters. By 2016, all clusters were fully aligned to CFCT. The primary intervention strategy of CFCT is the use of Cascade Groups to reach entire communities. In response to health related problems, FH Rwanda implemented the health and nutrition program through cascade groups. Village Savings and Loan Associations were established enabling participants to save and use credit and invest in various income generating activities that help them to improve their livelihood. FH Rwanda has been walking alongside community and church leaders, providing trainings designed to build capacity in leadership, planning and implementation of Community Transformation Plan and Disaster Risk Reduction.

This midterm evaluation (MTE) was conducted in Rwanda between May 27, 2019 and June 3, 2019 using both inductive and deductive methods. Quantitative data was collected through a household survey in January 2019 while qualitative data was collected during the MTE workshop in May and June 2019. For deductive sampling, 2,253 households in six different clusters were interviewed to measure quantitative indicators while 1,018 community members and FH Rwanda staff participated in the 75 focus group discussions and guided workshops.

The main purpose of this MTE was to evaluate the impact of the program and measure community readiness to graduate. Overall, FH Rwanda has reduced multi-dimensional poverty (MDP) by 11.5%. In Nyagihanga MDP was reduced by 14.7%%, in Kabacuzi by 13.8%, in Gatunda by 13.0%, in Cyeza by 11.4% and in Nyarubaka by 9.1%. This has resulted in approximately 15,287 people progressing out of poverty between 2013 and 2019. While significant progress has been made, none of the communities were deemed ready to graduate. Communities in Cyeza, Kabacuzi and Nyagihanga clusters need more work but may be ready to graduate in a couple of more years.

Infant/Child Dietary Diversity increased in all clusters except Gatunda, which decreased from 6.0 to 4.4. Exclusive breast-feeding (EBF) increased from the baseline in Kabacuzi, Nyagihanga and Gatunda Clusters and decreased significantly in Mwendo and Nyarubaka Clusters. Prevalence of EBF varied by cluster at the midterm with mothers in Gatunda reporting the highest rate (66.7%) and mothers in Kabacuzi reporting the lowest (15.6%). Household dietary diversity increased in Mwendo, Nyarubaka and Kabacuzi but declined somewhat in Nyagihanga and Gatunda. Results from the three Intimate Partner Violence indicators present a picture of mixed results. The number of threats or abuse episodes experienced by mothers remained virtually unchanged at an average of just under one per year. The average number of reasons mothers gave for when it is okay for a husband to hit his wife declined in Nyagihanga from 4.2 to 2.8. In Gatunda it declined from 4.0 to 3.8. Baseline measures for the other clusters were not available. The proportion of mothers who say that it is okay for a man to hit his wife

under certain circumstances increased significantly in the three clusters where baseline data was available. Further inquiry into this important issue is warranted in order to better understand the factors that have contributed to these findings and to plan effective interventions. Worldview Index scores remained virtually unchanged at a relatively high level (72.0-74.1) in Mwendo, Nyarubaka and Kabacuzi clusters. Scores increased from low levels (30.5 and 30.2) in Nyagihanga and Gatunda to relatively high levels (73.2 and 71.5) at the midterm.

Average scores for the indicator on Emergence of Hope from guided workshops with men, women and children were low, overall. Scores were slightly higher for men than for women and children. Scores for men in Kabacuzi were the highest (2.7) and scores for children in Gatunda were the lowest (1,7). Average scores for children were lower than both men and women, due primarily to the low score given in Gatunda Cluster. Overall, average scores for the Caring for Others indicator were medium for all three groups with men and women receiving an equal score (2.7), a somewhat higher score than children (2.5). Kabacuzi received the highest scores for all three groups. Mwendo received the lowest scores for men (2.4), Gatunda and Mwendo were equally low for women (2.4) and Gatunda was scored lowest for children (2.0).

The methodological approach to CFCT Mid Term Evaluation is based on the idea of a "learning process approach" to CFCT implementation. This approach differs significantly from a "blueprint approach" to program implementation that is the traditional and still most widely used approach. FH's adaption to Results Based Monitoring and Evaluation to program implementation makes this MTE approach fundamentally different. In this approach to MTE, monitoring and evaluation activities are concerned not only with the extent to which the planned activities are carried out but also with how they are carried out. In this approach to MTE, mechanisms were developed to help program staff learn from both the successes and problems encountered in implementing the activities in order to improve the program in the future. For example, in this evaluation approach it would be important to know not only how many savings group have been formed but also to identify both the successful and problematic aspects of forming and training the savings group. This would allow program staff to identify ways to improve future trainings and saving groups meetings. In this approach, monitoring and evaluation activities involve the collection of important quantitative information but priority is given to the collection of qualitative information, which describes the process involved in carrying out each type of activity. For example, information might be collected on the "number of cascade group volunteers trained" but also on the "quality of the training," on the "feedback from trainees on the usefulness of the training content" and on "how trainees are using what they were taught" in their work with communities.

Based upon the information collected during the evaluation, "lessons learned" were formulated which will be fed back into the program plan. Modifications in program activities and strategies will continuously be made based upon the lessons, which were formulated during the evaluation. From beginning to end the orientation of the evaluation methodology exercise addresses the question "What can we learn from what we have already accomplished in order to improve the program in the future?" Perhaps the two most important facets of the methodology are the involvement of program stakeholders in all steps in the evaluation process and the focus of the evaluation on the development of lessons learned which are translated into an action plan.

Success Factors: The following are key factors contributing to the success of the program that were identified during the evaluation:

- There is an improvement in overall program quality. There is easy measurement of change, since the model is implemented across all the 5 clusters with similar harmonized tools and indicators. This makes measurement easy.
- Staff capacity has been built. Because staff have been trained in the CFCT approach in all sectors, they are motivated and their engagement has increased.
- Although many staff are new, they have been well oriented to the model, which makes implementation effective. This is because the CFCT model comes with standardized tools.
- The CFCT model results in greater impact. It is concentrated in a small manageable geographical area, which gives staff enough time to engage the community. There is programmatic integration; tools and methodology contribute to significant impact.
- There is sustainability of the CFCT interventions even after graduation. This is because churches, leaders, and families are heavily involved from the beginning and empowered to solve their own problems.
- Partnerships with government and communities have improved resulting in greater trust between FH and government and FH and communities.
- There is also increased visibility of FH. The quality of our program and the results achieved have enhanced FH's reputation.

Key Challenges: The following are the key challenges identified during the evaluation:

- It was difficult for the community to understand the CFCT approach of moving away from handouts to capacity building and empowerment.
- Addressing the hand out mindset in the community and the transition from sponsorship programming to CFCT.
- Community resistance to the capacity building approach and their expectation to receive compensation or some other handout for participating in the trainings.
- Targeting the wrong people and not sequencing the interventions properly.
- Staff knowledge and capacity in understanding of CFCT. Some staff have a mindset that development is about distribution of tangible resources.
- Staff's inability explain CFCT clearly to government and other key stakeholders.
- Saving groups creation with neighbors from various economic strata.
- Lack of regular communication between multi-sectoral staff and child sponsorship facilitators regarding community level activities.

Lessons Learned

- The following are key lessons learned from the CFCT Evaluation.
- Managing adaptively is more likely to improve outcomes when decision making is placed close to the frontline staff.
- Having a clear organizational focus and robust strategy leads to enhanced impact.
- The right organizational structure and hiring of committed staff are key to achieving organizational goals.
- Incarnational living (staff living in the communities they serve) is a critical factor for Transformational Development.
- Continuous learning is linked with job satisfaction, empowerment, employee engagement and ultimately improving the performance of our programs i.e. *focus on results (value#3).*

- M&E is positively associated with achieving our results when incorporated into project management for learning and decision making.
- Community capacity building and empowerment rather than simply distributing resources at the household and community levels, results in more sustained changes.
- Participatory planning with front line staff, community and other stakeholders facilitates ownership and transparent management of resources.
- Focusing on adjacent communities and grouping them into clusters enables greater depth of intervention rather than breadth and create more impact.

Based on MTE findings, and in alignment with our understanding of poverty in reference to God's story, The MTE team recommends that FH Rwanda refine their Program Theory for each of the clusters in order to focus on priorities, clarify strategies for intervention and reinforce the CFCT program approach among staffs. The team also recommends that FH Rwanda explore issues around abuse, protection and violence and address them appropriately through newly developed project designs. The team further recommends that FH Rwanda pursue greater integration of Sponsorship and Multi-sector programmatic processes to facilitate the coordination of joint actions and consistent messaging with stakeholders. Finally, FH Rwanda should ensure staff are aligned with FH's understanding of transformational development and the CFCT approach inculcating biblical worldview.

RWANDA

Performance Indicator	mwendo	mwendo	Stat. Sig	nyarubaka	nyarubaka	Stat. Sig	cyeza	cyeza	Stat. Sig	kabacuzi	kabacuzi	Stat. Sig	nyagihanga	nyagihanga	Stat. Sig	gatunda	gatunda	Stat. Sig	RWANDA (BL)	RWANDA (MTE)	Stat. Sig
(STUNTING) % of children 0-23m who are stunted (HAZ< -2.0)	51.0%			56.5%						57.5%									54.9%		
(UNDER WEIGTH) % of children 0-23m who are underweight (WAZ< -2.0)	20.6%			27.0%						21.4%									22.4%		
(EXCLUSIVE BREASTFEEDING) % of children 0-6m who are exclusively breastfed	80.6%	43.2%	NO	81.8%	25.0%	NO		42.4%			15.6%		15.4%	21.4%	NO	25.9%	66.7%	NO	57.1%	36.1%	NO
(INFANT DIETARY DIVERSITY) Infant/Child Dietary Adequacy Score	3.8	4.5	YES	4.1	4.4	YES		3.5		4.4	4.6	YES	5.0	6.5	YES	6.0	4.4	NO	4.5	4.7	YES
(FOUR OR MORE FOOD GROUPS) % of children 6-23m with a dietary diversity score of four or more	53.5%	60.3%	NO	64.4%	64.0%	NO		46.6%		66.1%	64.7%	NO		81.5%			64.1%		61.0%	63.8%	NO
(HOUSEHOLD DIETARY DIVERSITY) Average number of food groups consumed by households	3.9	4.5	YES	4.1	5.0	YES		4.2		4.2	4.6	YES	5.0	4.5	NO	6.0	4.6	NO	4.8	4.6	NO
(WORLDVIEW) Average worldview index score	73.2	72.0	NO	74.0	73.8	NO		74.1		73.8	71.8	NO	30.5	73.2	YES	30.2	71.5	YES	51.9	72.7	YES
(OK TO BEAT WIFE) % of mothers (of children 0-18y) who say that it's okay for a man to hit his wife	59.3%	87.4%	NO	69.5%	86.2%	NO		80.4%		62.6%	85.2%	NO		77.3%			85.7%		63.0%	83.7%	NO
(AVERAGE THREATS) Average number of threats the mother has experienced from her intimate partner in the last 12 months	0.6	0.7	NO	0.8	0.8	NO		0.6		0.8	0.8	YES		0.6			1.1		0.8	0.8	NO
(AVERAGE REASON) Average number of reasons mother gives for when it's okay for a husband to hit his wife		3.4			3.5			3.0			3.0		4.2	2.8	YES	4.0	3.8	YES		3.3	