Executive Board
Second Regular Session

Rome, 27–30 October 2008

EVALUATION REPORTS

Agenda item 6

For consideration

Distribution: GENERAL
WFP/EB.2/2008/6-A/Rev.1
30 October 2008
ORIGINAL: ENGLISH

SUMMARY REPORT OF THE THEMATIC EVALUATION OF WFP'S HIV AND AIDS INTERVENTIONS IN SUB-SAHARAN AFRICA

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NOTE TO THE EXECUTIVE BOARD

This document is submitted to the Executive Board for consideration.

The Secretariat invites members of the Board who may have questions of a technical nature with regard to this document to contact the WFP staff focal points indicated below, preferably well in advance of the Board's meeting.

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EXECUTIVE SUMMARY

The thematic evaluation highlighted numerous factors that constrain the staff in operationalizing WFP's policy on the human immuno-deficiency virus (HIV) and acquired immune-deficiency syndrome (AIDS) and fulfilling its responsibilities as a lead agency in the Joint United Nations Programme on AIDS division of labour. It found that in spite of resourcing challenges in the years following the adoption of an HIV and AIDS policy, WFP has raised the profile of food and nutritional responses to HIV and AIDS among food-insecure people.

The pioneering policy document *Programming in the Era of AIDS: WFP's Response to HIV/AIDS*, which was based on evidence available in 2003, now requires revision in line with emerging knowledge, technical advances, best practices and national responses. It also needs a results framework, even though the Strategic Objective results matrix in the previous Strategic Plan (2006–2009) shows expected outputs and outcomes for supporting households with people living with HIV and households affected by AIDS under Strategic Objectives 2, 3 and 4.

HIV and AIDS activities are implemented in approximately half of the countries assisted by WFP, accounting for 4 percent of WFP food deliveries and 2 percent of beneficiaries. Most of WFP's HIV and AIDS activities are implemented in Africa under protracted relief and recovery operations; a major proportion of WFP's HIV and AIDS resources are invested in mitigating the impacts of the epidemic.

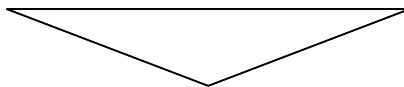
WFP recognizes its weaknesses in providing robust and systematic evidence of results,[1] but monitoring and evaluation has not been developed sufficiently to enable WFP to assess the effectiveness of its HIV and AIDS interventions.

The thematic evaluation made recommendations to WFP management about updating the policy, enhancing human resources and adapting staffing mechanisms to maintain adequate in-house HIV and AIDS expertise.

WFP has been undergoing organizational change since completion of this evaluation. The thematic evaluation did not cover these changes, among which was the dissolution of the HIV and AIDS Service after the evaluation had been completed. A number of staff were absorbed into the Policy, Planning and Strategy Division, but there was a reduction in the number of dedicated HIV and AIDS officers. It is important that issues raised by this evaluation are not lost in the new structures and that further evaluation is planned to determine how WFP will continue its role in the response to the AIDS epidemic.

[1] WFP Strategic Plan (2006–2009), p. 8.

DRAFT DECISION*



The Board takes note of "Summary Report of the Thematic Evaluation of WFP's HIV and AIDS interventions in Sub-Saharan Africa" (WFP/EB.2/2008/6-A/Rev.1) and "Management Response to the Summary Report of the Thematic Evaluation of WFP's HIV and AIDS interventions in Sub-Saharan Africa" (WFP/EB.2/2008/6-A/Add.1), and encourages further action on the recommendations, taking into account considerations raised by the Board during its discussion.

* This is a draft decision. For the final decision adopted by the Board, please refer to the Decisions and Recommendations document (WFP/EB.2/2008/15) issued at the end of the session.

BACKGROUND

Context

1. There are 33.2 million people worldwide infected with HIV. The latest *AIDS Epidemic Update* estimates that 76 percent of AIDS-related deaths have occurred in sub-Saharan Africa and that AIDS is the primary cause of death in the region. Apart from serious public health concerns, the impact of the epidemic on productive members of society, and increasingly on women, has major long-term consequences for human, social and economic development. The food and nutritional needs of people infected with HIV and tuberculosis (TB) and the social protection of people affected by AIDS, particularly orphans and other vulnerable children (OVC), have only recently been incorporated into responses to the epidemic. These have tended to focus on prevention and the management of viral load with the roll-out of anti-retroviral therapy (ART) and the treatment of opportunistic infections such as TB.

WFP's HIV and AIDS Policy and Operations

2. WFP has been engaged in the HIV and AIDS response since 2000. In 2003 it established an institutional framework with the launch of the policy document *Programming in the Era of AIDS: WFP's Response to HIV/AIDS*. WFP has engaged in HIV and AIDS responses and advocacy in 40 countries;[2] internally it has mainstreamed prevention and awareness through its HIV/AIDS in the Workplace programme.

3. The goal of WFP's HIV and AIDS initiatives is to provide food and nutritional support for food-insecure individuals and families who are infected with HIV and affected by AIDS. The main activities are providing food and nutritional support for treatment and care programmes, support for orphans and children affected by AIDS, school feeding, food-for-work (FFW) and food-for-assets (FFA) programmes and linking prevention education with relief operations. The establishment of partnerships and gender mainstreaming are important elements in WFP's HIV and AIDS activities.

4. In 2003, WFP established an HIV and AIDS Service (PDPH) in the Policy, Strategy and Programme Support Division (PDP). The specialist team was responsible for HIV and AIDS policy, developing programmatic guidance and providing technical support for field operations. PDPH was required to develop global policy papers and detailed guidance and to provide on-call advice on implementation in different contexts.

5. During the reference period of the thematic evaluation survey, HIV and AIDS activities were implemented in 54 percent of the countries assisted regularly by WFP, accounting for 4 percent of food deliveries and 2 percent beneficiaries in that period. Most HIV and AIDS activities were implemented in Africa under protracted relief and recovery operations (PRROs); a major proportion of HIV and AIDS resources were invested in mitigating the impacts of HIV and AIDS.[3]

[2] "Report on HIV/AIDS Thematic Evaluation Survey Results". Office of Evaluation (OEDE), April 2007.

[3] Full details are presented in "Thematic Evaluation Survey: Report on HIV/AIDS Thematic Evaluation Survey Results". OEDE, April 2007.

Evaluation

6. The objective of this evaluation was to assess the extent to which the 2003 HIV and AIDS policy had been implemented, particularly in terms of internal and external coherence, relevance, appropriateness, effectiveness and efficiency. In addition to providing accountability for Board and other stakeholders, the evaluation aimed to serve learning functions and make recommendations for WFP's evolving programming in response to food insecurity among people living with HIV (PLHIV) and people affected by AIDS.

7. The evaluation was conducted in collaboration with relevant departments, particularly PDPH and the Evaluation Reference Group: evolving documents and surveys were shared, and feedback was incorporated. The evaluation involved document reviews and interviews with governments, bi-lateral and multi-lateral stakeholders, non-governmental organizations (NGOs), community-based organizations (CBOs), food aid recipients and staff at Headquarters, regional bureaux, country offices and sub-offices. Budgetary constraints limited fieldwork to four case studies in Burkina Faso, Côte d'Ivoire, Tanzania and Uganda. Recent information about HIV and AIDS work in Lesotho, Malawi, Mozambique, South Africa and Zimbabwe, collected during the 2007 mid-term evaluation (MTE) of the southern Africa PRRO, was also used.

8. Scarcity of monitoring and evaluation (M&E) data made it difficult to draw conclusions as to the effectiveness and impact of WFP's HIV and AIDS interventions, so local consultants were recruited with assistance from country offices to comment on WFP's approaches and extract data from the databases of implementing partners (IPs) for analysis in Rome.

PERFORMANCE HIGHLIGHTS

WFP Policy on HIV and AIDS

9. *Programming in the Era of AIDS: WFP's Response to HIV/AIDS* was a pioneering policy document when it was adopted by the Board in 2003 in that it prepared the ground for WFP to incorporate HIV and AIDS issues in all programme categories and stated that when the epidemic placed food security at risk, WFP would consider HIV and AIDS as a basis for a PRRO. The policy stated that food insecurity driven by the epidemic could be addressed directly through WFP programmes and that activities could be used as platforms for other HIV and AIDS activities such as prevention education. It committed WFP to adjusting programming tools to reflect the realities of HIV and AIDS and defined WFP's role in advocating for the inclusion of food in national responses in partnership with local and international partners, NGOs, governments and United Nations agencies. The policy is not guided by a logical framework: the results matrix in the Strategic Plan (2006–2009) sets out expected outputs and outcomes for support for PLHIV and households affected by AIDS under Strategic Objectives 2, 3 and 4.[4]

10. Updates have been presented to the Board annually, but the policy itself has not been revised to reflect evolving national and international approaches, emerging knowledge and technological advances since 2003. Given advances in treatment since it was written, the

[4] All references in this document to the Strategic Objectives of WFP refer to the previous Strategic Plan (2006–2009).

policy requires revision to incorporate the duration of food assistance and graduation from food assistance, on which the sustainability of results depends.

11. In line with the United Nations HIV and AIDS in the Workplace policy, WFP launched its own *HIV/AIDS in the Workplace Programme* (HAWP) in 2004. This was aligned with United Nations policy and approaches, but there was an apparent lack of internal coherence among internal documents[5] and among the HAWP work plans.[6] The evaluation team encountered a lack of institutional memory of HAWP since 2006, after which there was evidence of a gradual reduction of engagement and activity across WFP. This was reflected in some of the country offices visited during the evaluation, where it was apparent that a number of minimum standards were not being met.

External and Internal Coherence

12. WFP's advocacy has contributed to the integration of food assistance and nutrition support into national AIDS planning documents in 32 of the 41 countries where it carried out HIV and AIDS activities and advocacy during the 2004–2005 reference period. This was also apparent in three of the case study countries, where WFP participated in planning meetings of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and was reflected in the inclusion of food assistance and nutrition support in some 2007 work plans of the United Nations Development Assistance Programme (UNDAF). But "nutrition support" was not defined in any of the national documents seen, and it was not clear whether they included nutrition activities such as assessment, education and counselling.

13. WFP's 2003 HIV and AIDS policy is in line with central elements of the Memorandum of Understanding (MOU) with UNAIDS. But section 13 of the MOU prescribes expanded collaboration in supporting research that is not reflected in policy or to any great extent in practice, or embraced by many of the staff interviewed.

14. In the UNAIDS division of labour (DOL)[7],WFP is the lead organization for dietary and nutritional support. This lead role applies to discussions on the delivery of food assistance and nutrition support, identification of gaps at the country level, advice to national stakeholders and stimulation of demand for such services. The definition of the lead role in UNAIDS DOL documentation remains vague, however. Fieldwork showed that some senior WFP managers did not appear to support WFP's HIV and AIDS policy fully nor its role in the DOL; some United Nations organizations endorsed WFP's lead role in food support, but questioned its capacities in dietary and nutritional support.

15. Interviews with staff of United Nations organizations in the case study countries and at Headquarters revealed an appreciation of the importance of food and nutritional support in response to HIV and AIDS, particularly in enabling adherence to and optimizing the effectiveness of drug treatment among food-insecure people infected with HIV and TB.

16. WFP collaborated with Office of the United Nations High Commissioner for Refugees (UNHCR) and United Nations Children's Fund (UNICEF) in integrating food and nutrition support for HIV-positive and AIDS-affected refugees. It also worked with UNHCR and

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[5] The Executive Director's 2004 memorandum launching HAWP and the "Agents of Change Conceptual Framework", which set out different goals and objectives.

[6] The 2004 work plan refers to the objectives in the "Agents of Change Conceptual Framework"; the 2005, 2006 and 2007 work plans refer to the objectives stated in the Board memorandum.

[7] See *UNAIDS Technical Support Division of Labour: Summary and Rationale*, available at data.unaids.org/una-docs/JC1146-Division_of_labour.pdf.

UNAIDS on the 2006 publication *Development of Programme Strategies for Integration of HIV, Food and Nutrition Activities in Refugee Settings*.

17. The 2003 policy requires that HIV and AIDS concerns be incorporated into all WFP programming categories. In the case study countries, little mainstreaming of HIV prevention activities was observed beyond the integration of HIV prevention and awareness in primary schools. The policy also calls for the adjustment of all programming tools to reflect the reality of HIV and AIDS, but Uganda was the only country office in the four case study countries observed to have made progress in this regard.

Relevance and Appropriateness

18. The lack of reference to the duration of food assistance and beneficiary graduation in the 2003 policy document was reflected in variations in strategies and practices in the case study countries. Only the Uganda country office had formulated the period of food assistance in guidelines.

19. Linkages with partners and projects specializing in livelihoods, income-generating activities and vocational training was found to be limited, but crucial to the sustainability of WFP's approaches in support of HIV-infected and AIDS-affected beneficiaries. A Livelihood and Social Protection Unit was set up at Headquarters in mid-2007, but it was dismantled the same year during the restructuring process.

20. In the case study countries there was variability in the food basket and its nutritional composition. Follow-up at Headquarters established that PDPH did not recommend standardized HIV rations, which field staff often requested; instead it supported country offices in developing HIV rations based on the objectives of food assistance and the vulnerability of the target population. This approach was informed by WFP's experience in attempting to standardize rations in the Great Lakes Region in 1999 and from recent work in southern Africa in which common *logic* in developing HIV rations was emphasized over a common HIV ration; this approach has recently been reflected in the draft ration guidelines.[8] The evaluation agreed that WFP should continue to develop rations based on the objectives of food assistance and the vulnerabilities of the target population; country offices that do not have the nutrition expertise to implement this alone should receive extra support. The draft ration design guidance and recent work to enhance the HIV and AIDS component of vulnerability analysis and mapping (VAM) are expected to support this approach.

21. Food distribution modalities are not mentioned in WFP's policy document nor in previous PDPH guidance, although it is briefly covered in the recent handbook by WFP and the Food and Nutrition Technical Assistance (FANTA), *Food Assistance Programming in the Context of HIV*. Observations in the case study countries highlighted variations in food distribution mechanisms and their consequences for the well-being of recipients infected with HIV and TB and those affected by AIDS. The main report indicated that in the case study countries food transport issues related to the distance between final distribution points and beneficiaries' homes, and noted that the cost and effort involved in milling whole grains reduced programme effectiveness and efficiency.

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[8] "WFP Food Assistance in the Context of HIV Ration Design Guide" (draft), September 2007.

Efficiency and Effectiveness

22. The targeting of assistance was identified as a weakness in WFP's HIV and AIDS interventions in sub-Saharan Africa. Geographical targeting is difficult in HIV and AIDS interventions because areas with high levels of food insecurity do not necessarily overlap with areas of high HIV prevalence. At the time of the evaluation mission, however, the Headquarters VAM unit was preparing guidance on integrating HIV and AIDS issues into food security and vulnerability analyses.[9]

23. Although WFP has some highly qualified and motivated staff, observations during the case studies showed that low priority was given to in-house HIV and AIDS expertise, and that staff rotations made the situation worse. Most country offices concentrated their HIV and AIDS knowledge and expertise in a single member of staff; some assigned the role of HIV and AIDS focal point to junior or temporary staff member who had no relevant knowledge or experience. Staff rotation procedures were inefficient in terms of placing officers experienced in food and nutritional approaches to HIV and AIDS in positions where they might use their skills. These factors severely limit the implementation of HIV and AIDS policy, advocacy and representation of WFP's approaches in fora at the national level.

24. The M&E systems in the four case study countries were only partly developed and implemented, so there was little evidence of analysis and reporting of results to provide information on effectiveness of interventions and guide the development of approaches.

25. Other challenges included funding constraints and the limited capacity of implementing partners (IPs), which was partly the result of a limited choice of local IPs and issues regarding their capacity. The evaluation survey of country offices implementing HIV and AIDS activities revealed that resourcing was the primary constraint to the implementation of policy: only about 4 percent of country office resources were directed to HIV and AIDS activities during the 2004–2005 reference period.

Impact

26. The *WFP Indicator Compendium* provides guidance for monitoring interventions and determining the effectiveness of outputs. But the collection of data on the impact of HIV and AIDS interventions such as weight gain and adherence to treatment was not mandatory. As a consequence of the lack of M&E reporting, the extent to which planned outcomes relating to HIV and AIDS — set out in the results matrix of the Strategic Plan (2006–2009) — had been achieved was largely unquantified. It was therefore difficult for the evaluation to assess the impact of WFP approaches in terms of goals and objectives. During the evaluation, however, PDPH was working on an M&E document to rectify this.

27. In terms of quantitative evidence of the impact of food assistance, an unpublished study from Zambia[10] reports a significantly greater increase in weight and adherence to treatment among food-insecure HIV patients on ART after 12 months of receiving WFP food assistance compared with a similar control group. Quantitative data also indicate that WFP take-home rations contribute to increased school enrolment and attendance among OVC.

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[9] "Integrating HIV/AIDS into Food Security and Vulnerability Analysis" (draft), October 2007.

[10] Megazzini, K. 2006. "Nutritional Supplementation for Food-Insecure Patients on Antiretroviral Therapy: Impact of a Pilot Program in Zambia". Centre for Infectious Disease Research in Zambia (CIDRZ) and University of Alabama at Birmingham, AL, USA. PowerPoint presentation.

28. At the time of the thematic evaluation, other WFP-assisted studies were under way in sub-Saharan Africa: WFP's collaboration with the Makerere University and Johns Hopkins University Project, for example, aimed to address critical gaps in the evidence base such as the impact of food assistance on ART treatment outcomes.

29. The evaluation team also found very little viable raw data as to the impact on beneficiaries' quality of life of WFP's HIV and AIDS interventions.[11] At the request of OEDE, the evaluation team identified at two clinics run by IPs in Uganda some relevant data that were extracted and processed in Rome. Analysis of data from 126 HIV-positive women patients indicated modest weight gains averaging 1 kg and increases in body mass index averaging 0.28 over six months from the start of food assistance and ART.

CONCLUSIONS AND RECOMMENDATIONS

Overall Assessment

30. WFP has a distinctive role in providing food and nutritional support for food-insecure PLHIV and households affected by AIDS. It requires appropriate human and financial resources to fulfil its responsibilities in the UNAIDS DOL and to achieve Strategic Objectives 2, 3 and 4.

31. WFP has some well qualified senior HIV and AIDS and nutrition specialists, but at the country and sub-office levels capacities are often inadequate to fulfil its corporate responsibilities and its responsibilities as a UNAIDS co-sponsor. Restructuring at Headquarters in the weeks following the evaluation led to a reduction in dedicated HIV and nutrition staff, so it is crucial that WFP examine its commitments and the resources allocated to the HIV and AIDS response.

32. During the evaluation, there were indications that with improved human resources – in particular enough dedicated HIV and AIDS staff and frequent investment in their professional development – country offices might achieve better results in mainstreaming WFP's HIV and AIDS policy. The Uganda country office, for example, had substantially more staff dedicated to HIV and AIDS than the other three case study countries, which enabled it to develop a portfolio of approaches to mainstreaming WFP HIV and AIDS policy and to collaborate in international research on the impact of food assistance on PLHIV and to develop and disseminate HIV and nutrition materials. Other case-study country offices had dedicated staff, but they were fewer in number; this was also the case in the other country offices visited in southern Africa, where the HIV prevalence rate is much higher. In two of the four case study country offices, the HIV and AIDS focal points were temporary consultants, which gave the impression that this aspect of policy was not regarded as a priority. The evaluation team also saw how a lack of priority for HIV and AIDS expertise could undermine representation in national HIV and AIDS working groups and faith in WFP's ability to fulfil its role in the UNAIDS DOL.

33. The HIV and AIDS policy was innovative when introduced in 2003, but it needs urgent revision in the light of current best practices and approaches that have evolved in the context of the global response. WFP subscribes to the United Nations Policy on HIV/AIDS in the Workplace, but there has been a notable lack of visible, sustained commitment to the

[11] Weight gain and adherence to treatment are two indicators of Outcome 3.4 – Improved quality of life of beneficiaries targeted in HIV/AIDS supported programmes. See the *WFP Indicator Compendium* relative to the 2006–2007 biennium.

policy and principles since the end of 2006. This must be addressed in line with United Nations policy on informing and protecting staff, and to enhance capacities to fulfil responsibilities in responding to HIV and AIDS.

34. WFP needs to address several issues raised by the evaluation relating to targeting of beneficiaries, food distribution management, and modalities to improve effectiveness and efficiency. Improved M&E of HIV and AIDS initiatives and approaches will inform this process and enhance knowledge about operational food and nutritional support in response to the epidemic. This will provide the basis on which donors can make informed decisions regarding investment in innovative approaches and address the resource mobilization issues that WFP has identified.[12]

Issues for the Future

35. The progression of the HIV epidemic in sub-Saharan Africa continues to exert a profound negative effect on the productivity, livelihoods and food security of some of the poorest and most vulnerable people and communities. Poverty and food insecurity have emerged as major drivers of the epidemic in the region; the prevalence rate of the virus in some countries has reversed development and poses a threat to economic stability and to security. The protracted nature of the food insecurity and nutritional impacts of HIV and AIDS in sub-Saharan Africa requires multilateral responses to ensure the survival of AIDS-affected households and the increasing number of OVC. Support for households rendered food-insecure by HIV and AIDS has a clear role in the region, but to ensure the sustained recovery of household economies and the future of vulnerable children, short-term food and nutritional assistance must be linked to government and partners' social-protection programmes and livelihoods initiatives to support future food security and self-sufficiency.

36. Infected people in sub-Saharan Africa are increasingly able to recover their health and economic capacities as a result of improvements in therapeutic management of the viral load and the enabling effect on the roll-out of ART of funding mechanisms such as the Global Fund to Fight AIDS, TB and Malaria and the President's Emergency Plan for AIDS Relief, along with treatment for opportunistic infections and the directly observed treatment, short-course (DOTS) for TB. Clinical and field experience indicates that adequate food and nutrition are fundamental to the outcome of TB and AIDS drug therapies. It is therefore essential that the United Nations respond adequately to the special nutritional needs of households made food-insecure by the epidemic to ensure sustained recovery.

RECOMMENDATIONS

37. These recommendations respond to critical findings and issues in the case study countries.

Recommendation 1. The thematic evaluation recommends that WFP's HIV and AIDS policy be revised to reflect the realities, experience and knowledge that have evolved since 2003. Policy objectives and a results framework should be clarified. The strategy should be refined to make optimal use of limited resources and adapted to enable

[12] The Strategic Plan (2006–2009) notes that "... resource mobilization has been hindered because WFP is not well known to the public or in donor countries".

country offices to respond to local needs within their budgets and to be supported with a view to achieving a higher quality of measured outputs, albeit with reduced scope.

Recommendation 2. Indicators relating to HIV and AIDS activities should be rapidly developed, made mandatory and as far as possible standardized to enable WFP to gauge the effectiveness of its inputs and make informed programming adjustments. Adequate resources should be allocated to train staff of IPs, country offices and sub-offices in the collection of monitoring data on adherence to ART and DOTS and attendance at prevention of mother-to-child transmission appointments. Baseline and subsequent body weight measurements should be taken from beneficiaries participating in WFP programmes supporting treatment and care such as ART, DOTS and home-based care as an indicator of the effectiveness of approaches to Strategic Objective 3.[13]

Recommendation 3. Given the lack of clarity regarding UNAIDS DOL lead roles, the new WFP structures that have assumed the roles of PDPH should formulate a clear and realistic definition of WFP's role as the lead organization in dietary/nutrition support at the global and country office levels. A list of measurable activities to be implemented by HIV and AIDS officers at Headquarters and in country offices should be developed, along with implementation and monitoring guidance.

Recommendation 4. In line with the MOU[14] with UNAIDS, which prescribes WFP's collaborative role in supporting research on food and nutritional support in response to HIV and AIDS, WFP should lobby to ensure that adequate funds are budgeted for studies to investigate links between HIV and AIDS and household food security; these could include coping mechanisms and mitigation strategies during times of crop failure. WFP should also ensure an adequate financial allocation for sharing the information generated by research it supports.

Recommendation 5. WFP should reassess its commitment to the wider United Nations HIV and AIDS in the Workplace policy and principles, and ensure the maintenance of training for temporary and fixed-term employees. WFP should take responsibility for ensuring employees' access to accurate information in line with United Nations directives. The WFP intranet page on HIV and AIDS in the workplace should be updated. The inconsistencies in implementation activities and staff training must be addressed immediately, regardless of when "UN Cares" becomes effective in WFP.

Recommendation 6. HIV prevention and awareness education should be mainstreamed in all WFP development and relief programmes and operations such as FFW and food for training (FFT), and mother-and-child health and nutrition, therapeutic feeding and school feeding programmes through the development of partnerships with local organizations.

Recommendation 7. Before finalizing guidance on ration design in HIV and AIDS programming, WFP should consider incorporating more specific information about appropriate macronutrient and micronutrient composition. Additional information should be given to IPs about determining the composition and size of household rations.

Recommendation 8. To enhance the efficiency and effectiveness of food and nutritional support:

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[13] Strategic Objective 3: Support the improved nutrition and health status of children, mothers and other vulnerable people.

[14] Section 13.

- The structures that have taken over the responsibilities of the Nutrition Service and PDPH should determine the feasibility and effectiveness of providing beneficiaries with new specialized foods such as fortified home-based care products, ready-to-use-supplementary foods and improved blended foods to address the nutritional needs of different groups, especially PLHIV, when cereals cannot be fortified before distribution.
- Country offices should investigate ways of providing IPs with more consistent food and nutrition training to optimize the use of rations by beneficiaries.

Recommendation 9. To enhance programming, WFP guidance on therapeutic and supplementary feeding should be updated to include information about HIV and acute malnutrition and about the integration and/or referral of patients with acute malnutrition for voluntary counselling and testing.

Recommendation 10. To support greater integration of nutrition and HIV and AIDS programmes, closer working relationships need to be developed between specialist Headquarters staff (previously PDPH and PDPN) and HIV and AIDS focal points and nutritionists in country offices. At the country level, nutritionists with expertise in HIV should be engaged to supervise the nutrition components of HIV programming.

Recommendation 11. Measures should be put in place to ensure that sustained investment is made in short-term assistance, that gradually evolves from food support to livelihood activities, either through WFP activities such as FFT or through delegation to partners.

- Each WFP country office should improve linkages with ministries, national institutions, multilateral and bilateral donors, NGOs, CBOs and other partners specializing in livelihoods to develop mechanisms by which beneficiaries graduate from food assistance to sustainable livelihoods.
- In collaboration with IPs, country offices should prepare guidelines based on local conditions, with clear criteria to facilitate beneficiary graduation from food assistance to livelihoods support.

Recommendation 12. To respond to the constraints on specialist HIV and AIDS human resources, the evaluation recommends the following:

- WFP should develop a "starter pack" of basic training and information for focal points to enable those with no HIV and AIDS expertise to fulfil their role more confidently and effectively. The pack could contain an e-learning training course like that used in United Nations security training: this would provide cost-effective training for focal points as soon as they take up their duties. To complement this, focal points should be offered continuous in-service training to ensure that skills are developed and maintained in the case of staff changes and as new guidance documents are introduced.
- Human resources mechanisms should be adapted to enable country directors to fill vacant positions with specialist HIV and AIDS staff rather than with generalists.
- To make more efficient use of in-house expertise, WFP should ensure that job descriptions for rotating staff are specific when HIV focal point posts are advertised. WFP should consider creating a pool of expert staff for HIV focal points and nutrition specialists.

ACRONYMS USED IN THE DOCUMENT

ART	anti-retroviral therapy
CBO	community-based organization
DOL	UNAIDS technical support division of labour
DOTS	directly observed treatment, short-course (for TB)
FANTA	food and nutrition technical assistance
FFA	food for assets
FFT	food for training
FFW	food for work
HAWP	HIV/AIDS in the Workplace Programme
IP	implementing partner
M&E	monitoring and evaluation
MOU	Memorandum of Understanding
MTE	mid-term evaluation
NGO	non-governmental organization
OEDE	Office of Evaluation
OVC	orphans and other vulnerable children
PDP	Policy, Strategy and Programme Support Division
PDPH	HIV and AIDS Service (formerly a unit within WFP)
PLHIV	people living with HIV
PRRO	protracted relief and recovery operation
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VAM	vulnerability analysis and mapping