World Food Programme

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by the Office of Evaluation

Thematic Evaluation of WFP's HIV and AIDS Interventions in Sub-Saharan Africa

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Responsibility for the opinions expressed in this report rests solely with the authors. Publication of this document does not imply endorsement by WFP of the opinions expressed.

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Acronyms

ADHC	Human Resources Staff Development Branch
AG	Advisory Group
AIDS	Acquired Immuno-Deficiency Syndrome
AGENTS	Agents of Change (WFP HAWP)
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BCM	Beneficiary Contact
BMI	Body mass index
CAP	Consolidated Appeals Process
CBO	Community Based Organization
CCA	Common Country Assessment
CCA	Common Country Assessment
CCM	Country Co-ordinating Mechanism (of the GFATM)
CCP	Country Cooperation Partner
CD	Country Director
CERF	Central Emergency Response Fund
CFSAM	(FAO/WFP) Crop and Food Supply Assessment Mission
CFSVA	Comprehensive Food Security Vulnerability Analyses
CFW	Cash-for-Work
CHS	Community and Household Surveillance
CIDA	Canadian International Development Agency
CMEA	Common Monitoring and Evaluation Approach
CO	Country Office
COMPAS	Commodity Tracking System
COR	Consolidated Outputs Reports
CP	Cooperating Partner (formerly Implementing Partner)
CSB	Corn-Soya Blend
CSI	Coping Strategies Index
CTD	Commodity Tracking Data
CVA	Comprehensive Vulnerability Assessment
DAC	Development Assistance Committee
DA/IO	Data Analyst/Information Officer
DFID	Department for International Development
DOL	UNAIDS Technical Support Division of Labour
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment, Short-course (for TB)
EB	WFP Executive Board
DP	Distribution Point
DSP	Direct Support Costs
EB	Executive Board
ECHO	European Community Humanitarian Office
EC	European Community
ECW	Enhanced Commitments to Women
EDP	Extended Delivery Point
EMOP	Emergency Operations Programme
ENA	Emergency Needs Assessment
FAM	Food Aid Monitor

FANTA	Food and Nutrition Technical Assistance
FAO	Food and Agriculture Organization
FDC	Food Distribution Committee
FDD	Funding Division
FDP	Final Distribution Point
FEWSNET	Famine Early Warning System Network
FFA	Food-for-Assets
FFE	Food-for-Education
FFI	Food-for-Infrastructure
FFS	Food-for-Skills
FFT	Food-for-Training
FFW	Food-for-Work
FGD	Focus Group Discussions
FSM	Food Security Monitoring
GFATM0	Global Fund to Fight AIDS, TB and Malaria
GOBF	Government of Burkina Faso
GOCDI	Government of Côte d'Ivoire
GOT	Government of Tanzania
GOU	Government of Uganda
HQ	Head Quarters
HBC	Home-Based Care
HDR	Human Development Report (UNDP)
HFE	Household Food Economy
HIV	Human Immunodeficiency Virus
IAC	International AIDS Conference
IASC	Inter-agency Standing Committee
IDP	Internally-Displaced Person
IOM	International Organisation for Migration
IP	Implementing Partner
IRA	Immediate Response Account
ISC	Indirect Support Costs
ITSH	Internal Transport, Storage and Handling
LoA	Letter of Agreement
JUNTA	Joint UN Team on AIDS
MAP	Multi-Country AIDS Programme of the World Bank
MDR	Monthly Distribution Report
MCHN	Mother-Child Health and Nutrition
M&E	Monitoring and Evaluation
MOA	Ministry of Agriculture
MOF	Ministry of Finance
MOH	Ministry of Health
MoHSW	Ministry of Health and Social Welfare
MOU	Memorandum of Understanding
MT	Metric Tons
MTE	Mid-Term Evaluation
MTE SA PRRO	Mid-Term Evaluation of the Southern Africa Protracted Relief and Recovery Operation
MUJHU	Makerere University Johns Hopkins University Project
NAC	National AIDS Council
NACWOLA	National Community of Women Living with AIDS (UG)

NGO	Non-Governmental Organization
NFI	Non Food Item
NRU	Nutritional Rehabilitation Unit
OCHA	Office for the Coordination of Humanitarian Affairs
ODD/Y	Regional Bureau Dakar
ODJ	Regional Bureau Johannesburg
ODK	Regional Bureau Kampala
ODO	Operations Department
ODOC	Other Direct Operational Costs (a WFP budget category)
OEDE	Office of Evaluation
OVC	Orphans and other Vulnerable Children
PDM	Post-Distribution Monitoring
PDE	External Relations Division
PDP	Policy, Strategy and Programme Support Division
PDPF	School Feeding Service
PDPG	Gender and MCH Service
PDPH	HIV and AIDS Service
PDPN	Nutrition Service
PDPT	Emergency and Transitions
PEPFAR	United States President's Emergency Plan for AIDS Relief
PET	Programme for Enhanced Targeting
PLHIV	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PR	Principal Recipient (of GFATM awards)
PRRO	Protracted Relief and Recovery Operation
PRSP	Poverty Reduction Strategy Paper
PSA	Programme Support and Administration
RB	Regional Bureau
RBM	Results Based Management
RVAC	Regional Vulnerability Assessment Committee
SA PRRO	Southern Africa PRRO
SCIH	Swiss Centre for International Health
SDC	Swiss Agency for Development and Co-operation
SDC/HA	Swiss Agency for Development and Co-operation Humanitarian Aid Division
SF	School Feeding
SFP	Supplementary Feeding Programme
SGR	Strategic Grain Reserve
SO	Sub-office
SPR	Standardised Project Report
SPP	Social Protection Programme
STIs	Sexually Transmitted Infections
TA	Targeted Assistance
TB	Tuberculosis
THR	Take-Home Rations
TFD	Targeted Food Distribution
TFP	Therapeutic Feeding Programme
TF/SFP	Therapeutic Feeding/Supplementary Feeding Programme
TOR	Terms of Reference
UBW	UNAIDS Unified Budget and Workplan

UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	UN Country Team
UNDAF	United Nations Development Assistance Framework
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nation General Assembly Special Session
UNHCR	UN High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNV	United Nations Volunteers (Programme)
USAID	United States Agency for International Development
USD	United States Dollar
VA	Vulnerability Assessment
VAC	Vulnerability Assessment Committee
VAM	Vulnerability Analysis and Mapping
VCT	Voluntary Counselling and Testing
VGF	Vulnerable Group Feeding
WB	World Bank
WCF	Working Capital Fund
WFP	World Food Programme
WHO	World Health Organisation
WINGS	WFP Information Network and Global System
WVI	World Vision International

Executive Summary

The most recent estimates suggest that some 33.2 million people are infected with the Human Immunodeficiency Virus (HIV) worldwide and East and Southern Africa continue to represent the epicentre of the global pandemic. Apart from the grave public health concerns, the impact upon productive members of society and increasingly women and children has major and long-term effects on human, social and economic development, as well as direct and indirect consequences upon agricultural and production capacity and ultimately food security.

WFP has been actively engaged in the HIV and AIDS response since 2000, and in 2003 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 activities in over 40 countries and in advocacy and internal mainstreaming through its *HIV/AIDS in the Workplace Programme.*

The 2007 Mid-Term Evaluation of the Southern Africa PRRO underlined the important role of food in regional and national responses to food insecurity associated with the AIDS epidemic. The situation is particularly complex as funding has been channelled towards public health interventions, HIV-prevention and the roll-out of anti-retroviral therapy (ART) and the evidence base concerning food and nutritional support is not yet fully developed.

Recently the Executive Board (EB) requested that WFP move from programme to thematic evaluations. In order to take stock of WFP's pioneering food and nutritional responses to the AIDS epidemic in Sub-Saharan Africa, a thematic evaluation was considered to be timely and well-justified The objective was to assess the extent to which the 2003 Policy has been implemented, particularly in terms of internal and external coherence, relevance, appropriateness, effectiveness and efficiency. In addition to providing accountability to the Executive Board and other stakeholders, the evaluation had the stated purpose of serving learning functions and offering recommendations to contribute to WFP's evolving programming in response to food insecurity among HIV-infected and AIDS-affected people.

Evaluation approach and methods

To inform and guide the Thematic Evaluation a survey was conducted to determine the volume and scope of all WFP country offices' HIV and AIDS activities during the selected reference period of 2004-2005. In May 2007 the findings of the survey and report were presented in Rome to the Thematic Evaluation Reference Group. This consisted of a meeting at HQ and teleconference attended by members of OEDE, the Team Leader, RBs (ODK, ODD/Y), PDPH, PDPF, and ODO. The criteria for selection of case study countries from the Sub-Saharan Region were discussed and finalised. Uganda, Tanzania, Côte d'Ivoire and Burkina Faso were selected: To provide recent complementary information on WFP activities in the region, it was agreed that data collected by two of the Evaluation Team members in the course of the 2007 Mid-Term Evaluation of the Southern Africa PRRO would also be used. This provided information on WFP HIV and AIDS activities in Zimbabwe, Malawi, Mozambique, Lesotho and South Africa.

Emphasis was placed upon the evaluation taking a collaborative approach and the TOR were presented to the Reference Group and circulated within WFP. Feedback was incorporated into the draft Inception Report which was shared with WFP departments and external reviewers to clarify post-TOR developments regarding the evaluation team profile, evaluation approaches and to obtain wider inputs.

The evaluation team consisted of three specialists in the fields of HIV and AIDS, Nutrition and Food Security. These were supported by an Information Officer and Data Analyst. A desk review of relevant documents was undertaken and an evaluation matrix developed to standardise the evaluation approach. The draft was also shared with WFP and external reviewers and their comments incorporated in the final document. Fieldwork was conducted in two stages. Between 2 and15 September 2007, the team worked in Uganda and Tanzania; and between 22 September and 6 October 2007 in Côte d'Ivoire and Burkina Faso. Given the scarcity of monitoring and evaluation data, in order to comment on the effectiveness of WFP approaches, the team with assistance from COs recruited local consultants to extract existing data from implementing partners' data bases for analysis in Rome. Post-field semi-structured telephone interviews were conducted with senior HQ HIV and AIDS officers of sister UN agencies in Geneva and New York.

Results

WFP policy on HIV and AIDS

The pre-field survey results showed that 74 countries were assisted regularly by WFP during for the year 2004-2005 and that HIV and AIDS activities were implemented in 54% of these countries. This represents 4% of WFP's overall food deliveries and 2% of the total assisted beneficiaries in that time period. As expected, the majority of WFP HIV and AIDS activities were implemented in Africa within the frame of PRROs. The major share of WFP HIV and AIDS resources were invested in the mitigation of the impacts of HIV and AIDS.

At the strategic level, although HIV and AIDS Updates were presented annually to the Executive Board on evolving approaches to the epidemic, the 2003 WFP HIV and AIDS policy was not updated to reflect emerging knowledge and technical advances, best practice and evolving national responses. The policy is not guided by an overall logical framework, however, the WFP Strategic Objective Results Matrix of the 2006-9 Strategic Plan sets out expected outputs and outcomes for support to HIV-infected people and AIDS-affected households under strategic objectives (SO) 2- 4.

A number of relatively consistent themes emerged from the interviews undertaken with specialist counterparts from sister UN agencies: there was good awareness of WFP's policy relating to its response to food insecurity in relation to HIV and AIDS. Some commented that the head of PDPH had been proactive in advocating the importance of food and nutritional responses to HIV and AIDS as well as WFP's role. A number of officers also cited WFP's dedicated public website was as an important resource by sister agencies.

External and internal coherence

WFP's advocacy efforts have contributed to the integration of food assistance and nutrition support into the national AIDS planning documents in 32 countries where WFP is operational. This was evident in three of the case study countries where WFP actively participated in UNAIDS planning meetings and was reflected in the inclusion of food

assistance and nutrition support in some countries' 2007 UNDAF Work Plans. However, the exact meaning of "nutrition support" was not specified in these national documents and it was not clear whether the Work Plans assumed inclusion of activities beyond food assistance, such as, nutrition assessment, education and counselling.

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

Within the UNAIDS Division of Labour, WFP has the lead role in "dietary and nutritional support" with WHO, UNICEF and UNESCO as its main partners. This leadership role applies to global discussions related to the delivery of food assistance and nutrition support along with identifying gaps at the country level, advising national stakeholders and stimulating demand for such services. PDPH staff acknowledged however, that the definition of the lead role in UNAIDS DOL documentation remains vague and that WFP has little experience in this capacity, having relatively recently adopted this function. Field work highlighted that some senior officers appear not to fully support WFP's HIV and AIDS policy or role within the UNIADS Division of Labour. The multi-sectoral ramifications of dietary and nutritional responses to the AIDS epidemic present a complex working field. Indeed, not all of WFP's staff interviewed by the evaluation team reported endorsement of the selection of WFP in the lead role in *dietary and nutritional* support. In Nairobi, for example WFP requested a co-organiser role along with UNICEF and WHO in the 2007 Eastern/Southern Africa Regional Meeting on Nutrition and HIV and AIDS which was denied. However, within the limits of the fieldwork the evaluation team also observed dedicated staff commitment to WFP's role within the UN Division of Labour. For example in Uganda WFP supported a key study on the role of nutrition and the effectiveness of food assistance in supporting HIV-infected patients' treatment and care.

Interviews conducted with staff working for sister UN agencies in case study countries and at HQ illustrated a strong appreciation of the importance of food and nutritional support in response to the epidemic and particularly in enabling and optimising adherence and efficacy of drug regimens among food insecure people infected with HIV and TB. However, whilst WFP's mandate was generally well understood at the country-level, some sister agencies did not appear to fully appreciate WFP's presence in their own geographical areas. This was more so the case when WFP worked predominantly with non-governmental partners, implying that this approach can reduce the visibility surrounding WFP's role.

The 2003 policy requires that HIV and AIDS concerns be incorporated into all WFP programming categories. In the case study countries, beyond the integration of HIV prevention and awareness in primary schools, little mainstreaming of HIV prevention activities was observed. It was notably absent from rural development programming, such as Food-for-Work or Food-for-Training. It was also absent from some Mother and Child Health programmes; and it was not included in programming for refugees and internally displaced persons in countries visited by the evaluation team. The 2003 policy furthermore calls for the adjustment of all WFP programming tools (for example needs assessments and vulnerability analysis) to reflect the reality presented by HIV and AIDS. Among the four case study countries Uganda was the only CO observed to have made progress in this regard.

Regarding its *HIV and AIDS in the Workplace Policy* (HAWP), WFP is well-aligned with broader UN policy and approaches. It subscribes to the 1991 *United Nations HIV and AIDS Personnel Policy* that is further elaborated in the 2003 document *UN Policy on HIV/AIDS in the Workplace*. WFP also subscribes to the *ILO Code of Practice on HIV and AIDS in the World of Work*. Published in 2001, the ILO Code of Practice was adopted by the UN to support its Personnel Policy on HIV and AIDS. In support of these commitments, in October 2004, WFP released its HIV and AIDS in the Workplace strategy document *Agents of Change - Conceptual Framework for Programme Design and Implementation*. Indeed in planning its workplace approaches, such as the two-day staff training curriculum, WFP consulted with a number of sister agencies including ILO, UNAIDS, UNICEF, UNFPA, UNDP, WB and adapted their training materials for internal purposes.

There is, however, an apparent lack of internal coherence between the WFP Executive Director's 2004 Memorandum launching HAWP and the Agents of Change Conceptual Framework which set out different goals and objectives. The ED memo defines objectives that are more comparable to outcomes (i.e. meeting the UN minimum standards; supporting the programme in all regions, etc.). Conversely, the Agents of Change Conceptual Framework is more goal-oriented in terms of the final impact of the programme (i.e. reduction of HIV transmission, and mitigation of the impact of HIV and AIDS on WFP staff and their families). This is likely to have generated confusion that is reflected in a further lack of coherence between the various WFP work plans over the years. For example, the 2004 work plan refers to the objectives provided by the Agents of Change Conceptual Framework, whereas subsequent work plans (2005, 2006 and 2007) refer to the objectives stated in the ED memo.

The evaluation team encountered a lack of institutional memory of HAWP since 2006 and there was evidence that since then there has been an organisation-wide tail-off in HAWP activities and engagement. The HAWP website on the WFP intranet appeared not to have been kept updated and the field component of the Thematic Evaluation highlighted that in some COs a number of minimum standards were not being met

Relevance and Appropriateness:

Linkage with partners and projects specialising 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. Although a Livelihood, Social Protection Unit was set up in WFP headquarters in mid-2007, it was, however, dismantled in the restructuring process the same year. Targeting of assistance was identified by the evaluation team to be an area of weakness, where the WFP response could be further enhanced in the future.

Due to variation in policy development in the countries visited it was difficult to assess the overall alignment of WFP's objectives with countries' nutrition and HIV policies and resource issues. However, in Uganda where HIV programming had a higher profile, WFP's objectives were well-aligned with the Ministry of Health HIV and nutrition policy. Food security and nutrition feature prominently in the 2007 HIV Programme Guidelines that were jointly produced by WFP and the Ugandan government. In other countries such as Tanzania, the WFP CO had to work with an outdated national policy document.

Duration of food assistance and graduation (or exit) from food assistance are not referred to in the 2003 Policy document. Country Offices in the four case study countries had different strategies and practices with regard to the duration of food aid, exit from food assistance and potential graduation from food to livelihood assistance. Only in the case of Uganda, was the duration of food assistance formulated in guidelines. In Tanzania and Côte d'Ivoire there was no evident plan for follow-up assessment to determine beneficiaries were ready to be phased out of food support. Furthermore, no linkage with partners livelihood activities were planned to support the phase out from food assistance. In Burkina Faso some IPs did not seem to be aware of a finite duration for food assistance and some beneficiaries received food for several years.

Variability was noted in the food basket and its nutritional composition in the different case study countries. The HIV and AIDS Service did not recommend standardised HIV rations, which field staff often requested; rather it supported COs in developing HIV rations based on the objectives of food assistance and the identified vulnerability of the target population. This approach was informed by WFP's experience in attempting to standardize rations in the 1999 Great Lakes Region programming and from more recent work in the Southern Africa region where "common logic" in developing HIV rations was emphasized over "a common HIV ration". Recently this approach has been reflected in the draft ration design guidelines.

Food distribution modalities are not mentioned in the WFP HIV and AIDS policy document or PDPH guidance, although it is briefly covered in the recently published WFP/FANTA handbook: *Food Assistance Programming in the Context of HIV*. Observations in the case study countries highlighted variation in food distribution mechanisms and their consequences upon the energy expenditure and well being of HIV and TB infected and AIDS affected recipients' of food aid.

Efficiency and Effectiveness

With regard to geographical targeting in the case study countries, the mission noted a lack of overlap of high level of food insecurity and high HIV prevalence, which according to the 2003 Policy should be the priority areas for HIV and AIDS interventions. In some countries such as Burkina Faso, the most food insecure areas are in the North and East, whereas the highest prevalence of HIV and AIDS is in the West and more generally in urban and peri-urban areas. HIV and AIDS assessment and targeting therefore pose a challenge of operating in relatively food secure areas such as urban and peri-urban areas, also in terms of VAM tools, which are primarily developed for use in rural areas. However, WFP has developed some guidance regarding assessments in urban areas.

Observations during fieldwork in Southern, Eastern and Western Africa highlighted that low priority was given to in-house HIV and AIDS expertise, which was further diluted by staff rotation mechanisms. In some Country Offices the role of HIV and AIDS Focal Point is allocated to junior and temporary staff with no prior knowledge or experience of this theme. This severely limits HIV and AIDS policy implementation, advocacy and representation of WFP's approaches in response to the epidemic at the national level. In spite of the challenges organisational human resourcing issues place on HIV and AIDS policy implementation, in the course of the evaluation many well-motivated staff informed themselves as best they could and were highly committed to operationalising the HIV and AIDS policy. Some staff at the CO and RB levels expressed the opinion that the ongoing technical assistance provided by PDPH staff also helped them in this respect.

Other challenges to the implementation of WFP HIV and AIDS policy were identified to include funding constraints and the limited capacity of implementing partners (IPs). This was due in part to an inadequate choice of IPs at the local level, and also to broader IP capacity issues. The pre-field survey of all COs implementing HIV and AIDS activities revealed resourcing to be the primary constraint to the implementation of policy, as only 3-4 % of COs' resources were directed towards HIV and AIDS activities during the reference period 2004-5.

Impact of WFP Food Assistance

The WFP Indicator Compendium provides guidance for monitoring interventions and determining the effectiveness of outputs. However, the collection of data that might inform on impact, for example weight gain and treatment adherence data, were not mandatory. There was therefore an overall lack of data available for the Evaluation to assess the impact of WFP approaches in regard to stated goals and objectives. However, during the course of the evaluation PDPH was already working on an M&E document to rectify this.

In terms of quantitative evidence of the impact of food assistance, an unpublished study from Zambia reports a significantly higher increase in weight among food insecure HIV patients on ART after 12 months of receiving WFP food assistance compared to a similar control group. Quantitative data also indicate that WFP's "take home rations" contribute to increased School Enrolment and Continuation for orphans and vulnerable children.

At the time of the thematic evaluation a number of WFP-assisted studies were underway in sub-Saharan Africa. Those such as WFP's collaboration with the Makerere University Johns Hopkins University Project aimed to address critical gaps in the evidence base, such as the impact of food assistance on ART treatment outcomes.

Given the scarcity of analysed and reported M&E data by which to evaluate the impact of WFP's HIV and AIDS policy, the evaluation team identified and extracted relevant IP data that were processed in Rome. Analysis of viable data from two WFP IP clinics in Uganda with 126 female HIV-positive patients indicated modest weight gains (average 1 kg.) over a six month period starting with their initiation of food assistance and ART. Additionally analysis revealed an average increase in body mass index of 0.28 in these patients during the 6 month period of food assistance.

Conclusions

The World Food Programme has a distinctive role in providing food and nutritional support to food insecure HIV-infected people and AIDS-affected households. As such it requires appropriate human and financial resources to enable staff to fulfil these responsibilities and objectives. While the WFP HIV and AIDS policy was innovative when first introduced in 2003, it is in need of urgent revision in light of current best practice and approaches that have evolved in the context of the subsequent global response. Although WFP subscribes to the UN Policy on HIV/AIDS in the Workplace there was a notable lack of visible, sustained corporate commitment to the policy and principles since the end of 2006. This must be addressed in line with wider UN policy on informing and protecting staff and to enhancing capacities to fulfil obligations and responsibilities in responding to HIV and AIDS. Issues raised relating to targeting of beneficiaries, food distribution management and modalities, and M&E need to be addressed to improve effectiveness and efficiency. Although WFP has some well-qualified senior HIV and AIDS and nutrition specialists, at the country and sub-office

levels capacities are often inadequate to fully meet WFP's corporate responsibilities and those as a UNAIDS cosponsor. This situation may have deteriorated given the restructuring and reductions in specialist staff that occurred after completion of the evaluation.

Key Issues for the future

The progression of the HIV epidemic in Sub-Saharan Africa continues to exert a profoundly negative effect on productivity and food security of some of the poorest and most vulnerable people and communities. The unique and 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 growing number of children made vulnerable and orphaned by the epidemic. Emergency food support to households rendered food-insecure by the impact of the virus forms a linchpin in achieving an effective response in the region. Clinical and field experiences already indicate that sufficient food and adequate nutrition are fundamental to the tolerance and outcome of TB and AIDS drug therapies. With progress in the therapeutic management of the viral load and the enabling effect of funding mechanisms such as the GFATM on the roll-out of anti-retroviral therapy, treatment for opportunistic infections and DOTS for TB, infected people in the region are increasingly able to recover their health and economic capacities. It is crucial that the UN family adequately and appropriately responds to the special nutritional needs of households made food insecure by the epidemic. However, to ensure the recovery of household economies and the future security of children made vulnerable by AIDS, it is essential that food and nutritional responses have a sustained impact and that assistance is designed to link with support for future food security and self-sufficiency.

Recommendations

Given the fast moving pace of developments in the field of HIV and AIDS, WFP is called upon to update its policy on HIV and AIDS to integrate recent trends and current best practices. The evaluation team were of the opinion that the overall scope the policy could be made more adaptable to enable country officers to better respond to local needs and budget realities. It is suggested that WFP, in addition to mainstreaming HIV into existing programmes, focus on establishing effective programming models in response to HIV, AIDS and TB that enable short-term yet sustained investment though graduation from food support to appropriate livelihoods activities. To better gauge the effectiveness of its inputs and make informed programming adjustments WFP should ensure that indicators relating to HIV and AIDS activities are rapidly developed, made mandatory and to the extent possible, standardized.

To strengthen monitoring and evaluation and inform and guide HIV and AIDS programming, the evaluation team recommends that Regional Bureaux assist COs to revise and enhance their M&E systems to incorporate relevant and durable indicators. This should be carried out as a global revision to ensure that data collection and presentation are harmonised to facilitate organisation-wide data compilation and analyses. COs should be encouraged to use logical frameworks as planning tools to ensure that operations are conducted to enable results-based thinking and management.

Given that HIV and AIDS Focal Points are often junior and new to WFP, they should be prepared to represent WFP's HIV and AIDS approaches in the countries of work with "Starter Packs" comprising a concise overview of WFP HIV and AIDS policy together with key relevant points from EB Updates. In light of recent restructuring and staff cuts, WFP must ensure that draft documents being developed by PDPH are completed, rolled out and accompanied by adequate and appropriate training.

Furthermore, to remain in line with UN practice and organizational policy, WFP should renew efforts to follow the Regional Workplace Co-ordinators' recommendation for continued mainstreaming of HIV and AIDS and ensure continuity of activities. WFP should take responsibility for ensuring employees' access to current, accurate and local information in line with UN directives. The dedicated HIV and AIDS in the Work Place website on the WFP intranet should be immediately and consistently updated. The inconsistencies in implementation activities and staff training must be addressed immediately, regardless of when the common UN Programme "UN Cares" becomes effective within WFP

As well as preparing national graduation guidelines with clear graduation criteria, COs are encouraged adapt the eligibility assessment form used for selection of beneficiaries to local conditions and ensure that it is used as a tool to determine beneficiary suitability for phase-out and graduation from food assistance. In this way beneficiaries might move from food assistance to IGA/livelihoods support offered by IPs and other local organisations in an informed manner.

Prior to finalizing the draft guidance on HIV ration design, WFP should consider incorporating more specific information on the appropriate macro and micronutrient composition of HIV rations along with examples of ART or OVC take-home rations and how to develop them. Additional information should be provided to IPs on determining the composition of household rations and their size. Furthermore guidance on the shelf life of CSB is needed to clarify confusion in the field that should be accompanied by enhanced training and closer of supervision of IPs, particularly as this relates to the specific needs of storage of CSB in warm and humid climates.

WFP is encouraged to continue its HIV advocacy of food and nutritional responses to the HIV epidemic in Sub-Saharan Africa. Given on-going UN reform and common funding mechanisms, WFP needs to maintain skilled representation at all levels of the organisation to ensure the visibility of food and nutrition within the global HIV and AIDS response and that the agency receives adequate budget allocations to enable it to rise to the challenging role ascribed to it in the UNAIDS Division of Labour.

I. Introduction

I.I Context

1. The December 2007 UNAIDS/WHO AIDS Epidemic Update[1] estimates some 33.2 million people to be infected with the Human Immunodeficiency Virus (HIV) worldwide. Last year alone 2.5 million people became infected with the virus and 2.1 million people died as a result of Acquired Immuno-Deficiency Syndrome (AIDS) resulting from HIV infection. Apart from the grave public health concerns of the epidemic, its impact upon productive members of society and increasingly women has major and long-term consequences for human, social and economic development. According to the latest AIDS Epidemic Update, 76% of AIDS-related deaths are estimated to have occurred in the Sub-Saharan region in 2007 and AIDS is the primary cause of death in sub-Saharan Africa.

2. In 2007 WFP commissioned a Mid-Term Evaluation of the Southern Africa Protracted Relief and Recovery Operation (MTE SA PRRO). Outcomes of the MTE of the SA PRRO highlighted the important role of food in the regional and national responses to the HIV epidemic in southern Africa. In southern Africa the generalised epidemic is driven by, and in turn exacerbates a complex of dynamics that perpetuate food insecurity and social inequalities that in turn threaten the future recovery of nations most heavily affected. The highest prevalence of the virus is among the most productive members of society. As a consequence, households are faced with increasing food insecurity as household income is compromised in urban areas and subsistence production is affected in rural areas. The resulting food insecurity increases negative short-term coping strategies that include the sale of production assets (cattle, seed, land, etc) and high-risk transactional sex to meet basic food needs.

3. The death of adults from AIDS-related illness has led to large population of orphaned children who are unable to attend school as they have to work or devise other means to cope with the loss of their parents, carers and providers. This rapidly renders vulnerable children food insecure, at increased risk of malnutrition and exposed to exploitation and at direct risk of becoming infected with the virus themselves through sexual coercion and abuse. The lack of adult guidance in learning food production techniques and other livelihood skills impedes the productivity and food security of orphans and vulnerable children as future adults. This further exacerbates the cycle of food insecurity and vulnerability to HIV infection and AIDS. As many of the active adult population have died from AIDS human resources have been compromised in basic services such as health and education.

1 http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf

4. Over the past few years, increasing evidence has emerged on the links between nutrition and HIV and AIDS. It is now understood that HIV infection contributes to malnutrition and that appropriate nutrition for PLWHA helps to maintain body weight and fight opportunistic infection. Further evidence demonstrates that nutrient intake can improve antiretroviral absorption and tolerance; and that individuals taking ART who receive appropriate nutrition are more likely to regain weight and adhere to their medication.[2] It has also been shown that appropriate nutrition can improve the health and quality of life for PLWHA.[3] This has supported the integration of nutrition interventions into HIV and AIDS programmes and the broader role of nutrition and food assistance in prevention, treatment, mitigation and care. WHO recognizes nutritional support as an integral component of a comprehensive response to HIV and AIDS and has provided guidance and recommendations to this end.

5. The role of adequate nutrition and longer-term food security as basic foundations for a successful response to the epidemic were highlighted in the course of the PRRO evaluation. There is a growing evidence-base on the specific nutritional needs of HIV patients relating to the effect of the virus on increasing metabolic rate. In addition to which, nutritionally adequate, sufficient and secure food supplies are a prerequisite to optimising the uptake, tolerance and efficacy of anti-retroviral therapy in AIDS patients recovering their strength and productive capacity. Food and nutritional support has also been shown to improve uptake and adherence in PMTCT and TB DOTS programs, which in turn, improves TB treatment outcomes and decreases mother-to-child transmission of the virus. However, funding focuses on public health, prevention and drug therapy responses to the epidemic and is not channelled to fully enable more holistic food and nutritional support of HIV-infected and AIDS-affected people.

I.2 WFP HIV and AIDS Policy and Operations

6. WFP was active in over 80 countries throughout the world. In response to the AIDS epidemic WFP engaged in specific HIV and AIDS activities in 41 countries[4] during the period of 2004-5[5] and undertook advocacy including internal mainstreaming through its *HIV/AIDS in the Workplace Programme*. The stated goal of WFP's HIV and AIDS initiatives is to provide food and nutritional support to food insecure individuals and families who are infected with the virus and affected by AIDS. Main activities are the provision of food and nutritional support to treatment and care programmes, support to orphans and children affected by AIDS, school feeding programmes, food for work and assets, and linking prevention education with relief operations activities. The establishment of effective partnerships and gender mainstreaming are important elements in all WFP's HIV and AIDS activities.

2PEPFAR, Report on Food and Nutrition for People Living with HIV/AIDS, May 2006, Report to Congress Mandated by House Report 109-265.

3 Ibid.

4 According to the OEDE survey conducted over the period 2004-2005

5 This time period was used as the reference for the initial Thematic Evaluation survey to inform the selection of country case studies. See methods in annex D for details.

7. WFP has actively engaged in the HIV and AIDS response since 2000 and within the framework of the policy paper Programming in the Era of AIDS: WFP's Response to HIV/AIDS, approved by the Executive Board in February 2003. Figure 1 maps the timeline of developments in WFP's responses to the epidemic, alongside global developments.

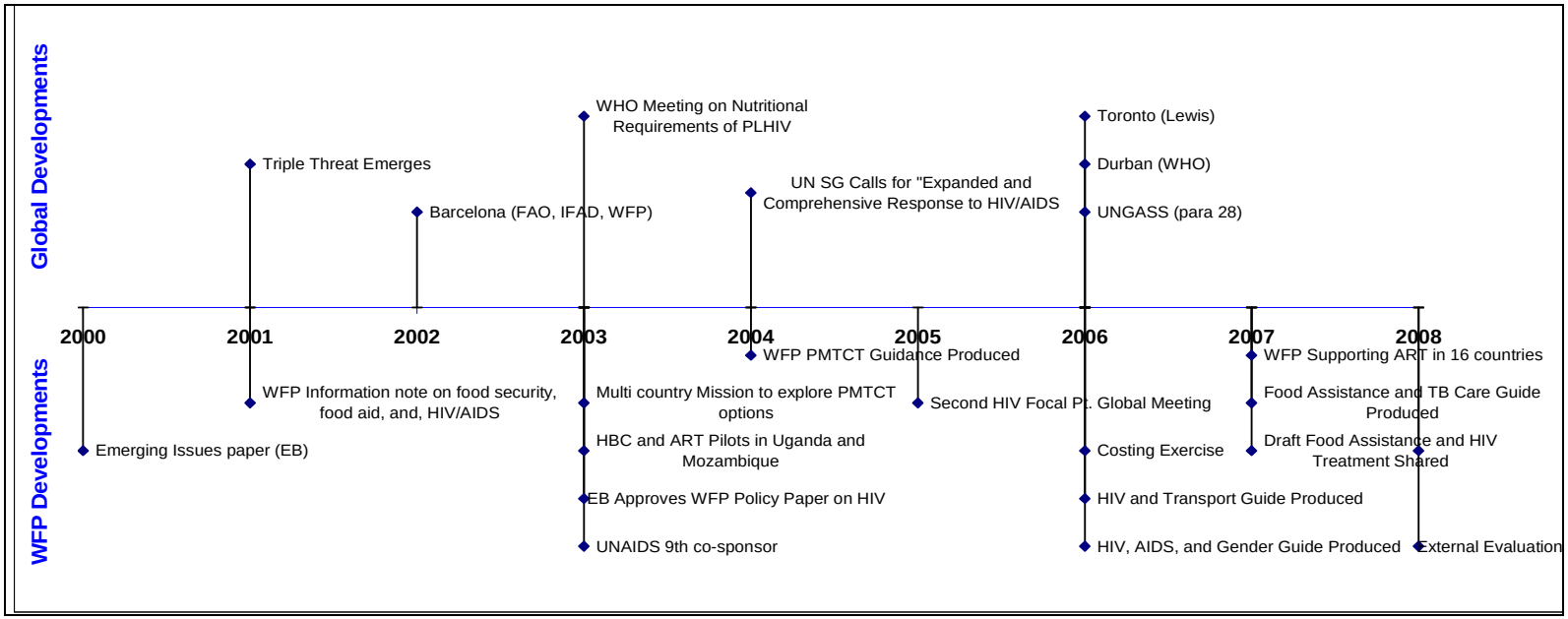

Figure 1: WFP HIV and AIDS Developments in response to the epidemic

8. In view of the key role of the epidemic in the "Triple Threat"[6] to human development and security in southern Africa, the high profile of the pandemic on the international agenda and within WFP, as well as the resources spent on HIV and AIDS activities within WFP, an independent evaluation was intended to strengthen the international response to the epidemic by gathering and highlighting the lessons learned from WFP's nutritional support to the most vulnerable food insecure who are infected and affected by the virus.

9. To inform and guide the evaluation survey was conducted[7] to determine the volume and scope of all WFP COs' HIV and AIDS. This was carried out in collaboration with PDPH and with the support of RBs, COs and HIV and AIDS Focal Points. The survey quantified that within the entire WFP portfolio, 74 countries were assisted by WFP on a regular basis during the reference period of 2004-5. It revealed that HIV and AIDS activities were implemented in 54% of the surveyed countries; representing 4% of the WFP food deliveries and 2% of the assisted beneficiaries in that year.

10. Given that WFP HIV and AIDS Policy is not led by a logical framework, the survey exercise also mapped out WFP HIV and AIDS objectives, activities and roles of food aid. These are illustrated below:

6 UN concept of the "Triple Threat" of food insecurity, weakened governance capacity and AIDS in southern Africa.

7 Report on HIV/AIDS Thematic Evaluation Survey Results, Laura LoCicero for OEDE April 2007.

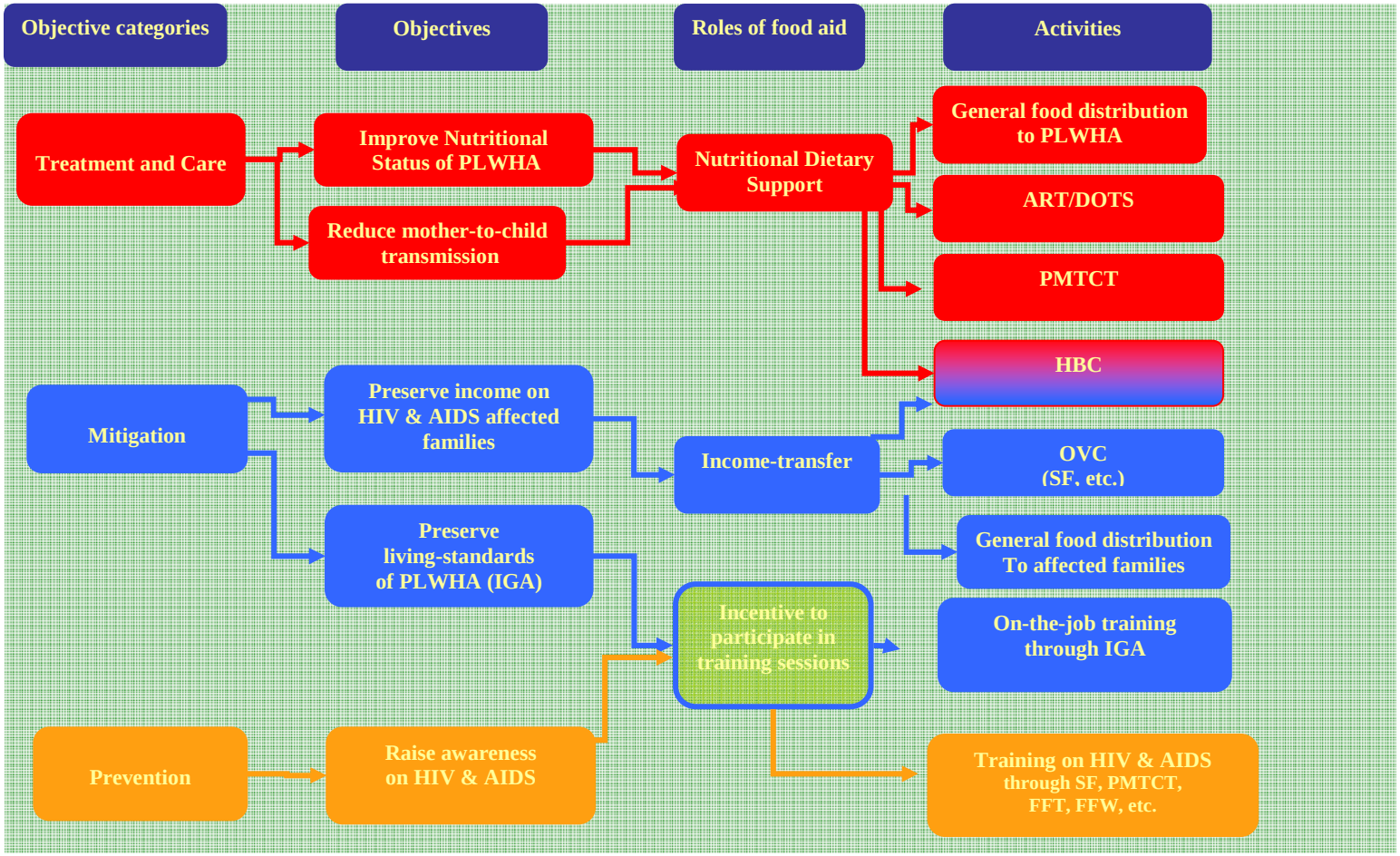

Figure 2: WFP HIV and AIDS objectives, activities and roles of food aid identified by the pre-evaluation survey.

(Report on HIV/AIDS Thematic Evaluation Survey Results, Laura LoCicero for OEDE April 2007.)

11. The survey revealed that the major share of WFP HIV and AIDS resources were invested in the mitigation of the impacts of HIV and AIDS. This represented 77% of all HIV and AIDS-targeted food assistance and 74% of assistance to HIV-infected and AIDS-affected beneficiaries.

12. WFP's HIV and AIDS activities were also identified to be mostly implemented in Africa and through Protracted Relief and Recovery operations (PRROs). In Africa, where the HIV and AIDS prevalence rates are some of the highest in the world, the distribution of WFP HIV and AIDS activities were not found to always match the UNAIDS mapping of prevalence. For example, in Cameroon the HIV prevalence rate was above 5% but WFP did not implement any HIV and AIDS activities there between 2004 and 2005. The top ten countries receiving WFP food delivered for HIV and AIDS activities were Zambia, Malawi, Mozambique, Lesotho, Zimbabwe, Burundi, Uganda, Tanzania, Eritrea and Ethiopia and the main implementing partners were international and local NGOs.

13. The survey identified that the main obstacles to implementing WFP HIV and AIDS policy reported by Focal Points were lack of funding and the inadequate choice of appropriate and capable implementing partners.

Note on donor support to the Thematic Evaluation

14. As set out in the SDC AIDS Policy 2002–2007, HIV and AIDS were to receive increased attention within the work of the Swiss Agency for Development and Cooperation. SDC is committed to integrative and cross-sectoral responses to the global epidemic in collaboration with its partner countries and international organisations. In order to learn more about approaches of food security and nutritional support in response to the epidemic in food-insecure countries, SDC supported WFP in its 2007 Mid-Term Evaluation of the Southern Africa Protracted Relief and Recovery Operation (MTE SA PRRO). The SDC Humanitarian Africa Division fully funded an HIV and AIDS specialist to ensure that aspects of food security and nutrition relating to HIV and AIDS were addressed in the evaluation and recommendations, along with those of the four WFP-funded specialists.

15. SDC made the decision to support WFP in its broader and in-depth Thematic Evaluation of WFP's HIV and AIDS responses to further inform on approaches to food and nutritional support in WFP working contexts beyond the Southern Africa PRRO by fully funding the HIV and AIDS specialist/team leader.

I.2. Evaluation Purpose and Objectives

According to section two of the TOR,[8] the over arching purpose of the Thematic Evaluation was to serve both accountability and learning purposes, the objectives were to:

- assess the extent to which the objectives outlined in the Policy Paper "Programming in the Era of AIDS: WFP's Response to HIV/AIDS" (WFP 2003) as well as those outlined in the EB Information Notes circulated to the WFP EB (2004, 2005 & 2006) have been achieved;
- assess the relevance, coherence, appropriateness, effectiveness, efficiency, outcomes/impact and connectedness of objectives laid out in the strategy;

8 See annex A.

- produce recommendations which will support and shape WFP's future HIV and AIDS programming; and
- provide accountability to the Executive Board and other stakeholders.

16. The evaluation team members also interpreted the purpose of the evaluation to be the gathering, processing and sharing of knowledge gained from WFP's experience (the TOR set out the objective and purpose to be to "serve both accountability and learning purpose.") Consequently the evaluation was designed with the intention to draw together information on the experience of WFP's pioneering approaches in response to the AIDS epidemic, with a special focus on four case study countries. In countries where potential outcome data had not been analysed and reported in terms of impact, the team made efforts to work with CO and implementing partners (IPs) to extract relevant data from their records for subsequent analysis in Rome.
17. As the TOR were not fully revised to incorporate the various stakeholder and evaluation team inputs and decisions, the Inception Report provides the detailed interpretation of the TOR that were applied to the evaluation process. *It is therefore important that the Inception Report is used as the definitive reference document as the team profile differed markedly from that set out in the TOR.* [9]
18. Given the specialist profile of the evaluation team it was deemed inappropriate for the evaluation to attempt to assess cost-effectiveness of activities, as set out in the TOR.

1.3 Evaluation Scope and Key Issues to be Addressed

19. The TOR state that: "The overall scope of the evaluation will be the consideration of HIV and AIDS policies, policy mainstreaming, activities, partnership mechanisms and project operations undertaken by WFP at corporate as well as country/local level in the period of 2003 – 2006, starting from the time when the strategy was approved".
20. The interpretation of the Thematic Evaluation scope and key issues from the TOR were developed through discussion with OEDE and the Evaluation Reference Group, most recently at the meeting of 7 May in Rome to which OEDE invited all relevant service divisions to attend, and regional bureaux participated via teleconference. The refined scope and key issues were elaborated in the Evaluation Inception Report and are summarised in the Evaluation Matrix in Annex C.

9 Given the specialist profile of the evaluation team it was deemed inappropriate for the evaluation to attempt to assess cost-effectiveness of activities, as set out in the TOR.

1.4 Stakeholders

21. While the main users of this Thematic Evaluation were considered to be WFP's EB, management, the Policy and Programme Support Division (PDP), and the HIV and AIDS Service (PDPH) at HQ, on a practical level it is intended to support the work of WFP COs and RBs through its approach to drawing out themes and innovative approaches and providing a tool for sharing experiences on approaches that are effective (and less effective) in particular contexts. It was also envisaged that the outcomes and lessons highlighted by the evaluation would be pertinent to regional, national and local government institutions engaged in responding to the epidemic as well as sister UN organisations, NGOs, civil society, multi and bilateral organisations. WFP's donors are also stakeholders in this evaluation, which is designed to enhance knowledge of the role of food security and nutritional support in the global response to HIV and AIDS.

1.5 Methods

22. The Terms of Reference (TOR) for the Thematic Evaluation are set out in Annex A. Due to a number of factors including staff rotation at WFP's Office of Evaluation (OEDE) the TOR underwent substantial change between the 2006 zero draft and those produced from March 2007. On May 7 2007 the TOR were presented in Rome to the Thematic Evaluation Reference Group meeting and teleconference attended by members of OEDE, the Team Leader, RBs (ODK, ODD/Y), PDPH, PDPF, and ODO. This discussed and finalised the criteria for selection of case study countries.

23. Rather than updating the TOR, OEDE requested that the evaluation team present the decision-making regarding outstanding issues relating to the TOR, evaluation team composition and the team's interpretation of the TOR in an Inception Report. A draft was circulated to the evaluation Reference Group and the final Inception Report dated August 2007 represents the team's interpretation of the TOR on which this report is based.

24. The evaluation was conducted according to the criteria set out in the ToR that specify the application the evaluation norms and standards established by the United Nations Evaluation Group (UNEG).[10] The team interpreted this to mean adhering to the 2005 UNEG Norms for Evaluation in the UN System[11] and UNEG Standards for Evaluation in the UN System.[12]

25. The team consisted of three specialists in the fields of HIV and AIDS, Nutrition and Food Security. These were supported by an Information Officer and Data Analyst.

26. The evaluation team took a collaborative approach, working in close partnership with service departments at WFP HQ, particularly PDPH, as well as COs and RBs to ensure that the evaluation serves the needs of policy and implementing staff, divisions and offices. Team members worked towards fulfilling the Thematic Evaluation TOR by taking the lead within their own areas of specialisation as appropriate. These are set out in the evaluation matrix in annex C.

27. The evaluation matrix was developed by the team with the intention of ensuring that all aspects of the TOR were addressed as agreed in the Inception Report. This also

10 UNEG website: http://www.uneval.org/

11 UNEG Norms for Evaluation in the UN System 29 April 2005.

12 UNEG Standards for Evaluation in the UN System 29 April 2005.

served the purpose of setting out a transparent and logical process which the Evaluation Reference Group was able to review and comment upon for improvement.

28. As the attached TOR state the scope of the thematic evaluation was originally planned to cover WFP operations world-wide. In order to select countries for case study, a survey was designed, piloted and conducted to determine the volume and scope of all WFP COs' HIV and AIDS activities during the reference period 2004-5. The methodology of the survey process is set out in annex I.

    Data generated by the survey were analysed and processed to:

    - Inform on WFP HIV and AIDS objectives, activities, role(s) of food aid and how they are linked to each other
    - Quantify WFP HIV and AIDS activities in terms of food delivered, number of beneficiaries and expenditure in the 2004-5 period
    - Identify WFP categories of partners and their roles in implementing HIV and AIDS activities
    - Address the main issues noted by COs during the implementation of HIV and AIDS activities

29. Outcomes and analyses of the survey data were presented in an excel spread sheet and report by the Data Analyst in April 2007.[13] A summary of outcomes were also presented to the Evaluation the Reference Group in a workshop to collaboratively select case study countries in Rome on May 7 2007.

30. Following internal consideration by WFP, the team were informed that due to budgetary issues, the selection of case study countries was to be confined to Sub-Saharan Africa. The survey outcomes were then re-used to select countries based on the range of HIV and AIDS activities, different approaches, financial inputs, prevalence rates and regional context. These are set out for case study countries in annex E. On that basis the countries selected for case study were: Uganda and Tanzania in East Africa and Côte d'Ivoire and Burkina Faso in West Africa.

31. As two of the team members had participated in the 2007 MTE SA PRRO, relevant findings from that evaluation are incorporated into this report to include recent findings from Southern Africa. Fieldwork by two of the team members was previously conducted in Malawi, Mozambique, Lesotho, Namibia, Swaziland and Zimbabwe which are among the countries with the highest incidence of HIV and AIDS in the world.

32. The Information Officer Evaluation Manager and the Team Leader gathered documents relevant to the evaluation. Service Departments such as PDPH also submitted documentation. A Thematic Evaluation library was devised to organise documents that formed the basis of the desk reviews and supported the evaluation process. The Reference Group was requested to check the document list set out in the Inception Report to ensure that all key documents had been brought to the attention of the Information Officer.

33. The thematic evaluation was conducted using an approach combining document review, survey, formal and informal semi-structured interviews and focus group

13 Report on HIV/AIDS Thematic Evaluation Survey Results, Laura LoCicero for OEDE April 2007.

discussions. Pre-field desk reviews were carried out by all team members and interviews at WFP Headquarters conducted before and after fieldwork. This included a review of past WFP evaluations to inform on the themes arising from past findings and recommendations regarding WFP's HIV and AIDS activities and programming.

34. Fieldwork took place in two stages. Between 2 – 15 September the team worked in Uganda and Tanzania; and in Côte d'Ivoire and Burkina Faso between 22 September and 6 October 2007. As much as possible team members separated to conduct interviews, field visits, interviews and focus group discussions in the field. Most interviews with stakeholders, implementing partners and beneficiaries were held without the presence of WFP staff. Where necessary, independent translators accompanied team members.

35. Given that monitoring and evaluation data (M&E) were quite scant, the team with assistance from COs recruited local consultants to extract existing data from implementing partners' data bases to inform on the outcomes and impact of food assistance in response to HIV and AIDS.

1.6 Limitations of this evaluation

36. Opportunities for combining the information from Southern Africa were limited as only two of the team had been members of the 2007 Mid-Term Evaluation of the Southern Africa Protracted Relief and Recovery Operation (MTE SAPRRO). Additionally the TOR of the two evaluations differed considerably as did the nature of data collected.

37. In each country the budget determined that periods of fieldwork were between 4.5 and 6 days in length, which limited the geographical range and scope of work in each country. While the team was able to meet with the ODK team as the RB was situated in Kampala along with the selected Ugandan Country Office, this was not the case for ODD/Y. Because the regional bureau was outside the two West African case study countries and the budget did not enable a visit to Dakar, all interviews with ODD/Y were conducted by telephone and email.

38. Not only were WFP M&E data lacking, but viable IP data were found to be very few and unstandardised. This reduced the scope in which the team were able to draw concrete conclusions concerning the effectiveness of WFP's food and nutritional support in response to HIV and AIDS.

39. Due to staff turnover the team encountered many breaks in continuity and loss of institutional memory. In Tanzania, for example, there was no M&E focal point at the time of the evaluation visit and the HIV and AIDS focal person had left a matter of weeks before the evaluation team arrived in country. This not only reduced the efficiency and scope of information gathering, but placed remaining CO staff under considerable stress.

40. During the report drafting process the evaluation team learned that WFP's HIV and AIDS Service had been dissolved and that dedicated HIV staff had been reduced to two people at HQ. Due to budgetary and time constraints OEDE was unable to extend the evaluation to incorporate changes in HIV and AIDS human resourcing and organisation and raise the degree of utility and relevance of the report. The team has therefore had to adapt this report without detailed information on organisational change that occurred after the conclusion of interviews and fieldwork

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II. Evaluation Findings

2.I WFP Policy on HIV and AIDS

41. WFP policy on food and nutritional approaches to HIV and AIDS is set out in the 2003 Executive Board document Programming in the Era of AIDS: WFP's Response to HIV/AIDS.[14] This formalised activities that had been ongoing since 2000 set out in the Information Notes*: WFP, Food Security and HIV/AIDS*[15] (2001) and *Update on WFP's Role in the Fight against HIV/AIDS.*[16]

42. Policy adopted by the Executive Board in 2003 states that:

    a) WFP will incorporate HIV/AIDS concerns in all of its programming categories—Country Programmes, PRROs and EMOPs. Food insecurity driven by HIV/AIDS can be addressed directly through WFP programmes, and WFP activities can be used as platforms for other types of HIV/AIDS programmes, such as prevention education.

    b) WFP will work with local and international partners, NGOs, governments and United Nations agencies to ensure that food is incorporated into HIV activities when and where appropriate. WFP will work particularly closely with UNAIDS co-sponsors and the UNAIDS Secretariat in this regard.

    c) WFP will adjust programming tools such as needs assessments, vulnerability analysis, the design of rations and other nutrition-related activities as information and research results become available to reflect the new reality presented by HIV/AIDS.

    d) When HIV/AIDS threatens food security and influences mortality in ways similar to other disasters, WFP will consider HIV/AIDS as a basis for a PRRO, consistent with current WFP policy on PRROs.

43. Although Updates have been presented yearly to the EB on evolving approaches to the epidemic, WFP policy itself has not been updated to reflect evolving national and international approaches and emerging knowledge and technological advances.

44. WFP policy on food and nutritional approaches in response to HIV and AIDS is not guided by an overall logical framework, however, the WFP Strategic Objective Results Matrix of the 2006-9 Strategic Plan sets out expected outputs and outcomes for support to HIV infected people and AIDS affected households under strategic objectives (SO) 2, 3 and 4.

45. The WFP Indicator Compendium[17] provides guidance on indicators to be used by COs and RBs in monitoring its interventions and determining the effectiveness of outputs in relation to the Strategic Objective Results Matrix. However, weight gain and treatment adherence, the two indicators of outcome 3.4 "Improved quality of life of beneficiaries targeted in HIV/AIDS-supported programmes", are not mandatory, and consequently, data on these indicators were found to be very few in both the case

14 WFP/EB.1/2003/4-B. January 7, 2003

15 WFP/EB./2001/INF/18. October 17, 2001

16 WFP/EB.3/2002/INF/22. October 14, 2002.

17 WFP Indicator Compendium Biennium 2006-2007. December 2005.

study COs and those that participated in the MTE of the SA PRRO. Furthermore, no standards were in place for collection of data, and as such those identified by the team during fieldwork were of variable quality and not suitable for comparative purposes.

46. At the time of the evaluation, PDPH had produced a draft M&E document to support COs, which was about to be introduced. The Indicator Compendium directed COs and RBs to PDPH for further guidance on the piloting of these indicators. Given the recent reduction in dedicated HIV staff with the dissolution of the HIV and AIDS Service, it is unclear how the piloted indicators and draft M&E document will be developed and how field staff will be supported in their monitoring and evaluation of outcomes relating to WFP's approaches to HIV and AIDS.

2.2 External Coherence:

WFP's Role in the UNAIDS Division of Labour

47. Within the UNAIDS Division of Labour (DoL), WFP has the lead role on "dietary and nutritional support" with WHO, UNICEF and UNESCO as its main partners.[18] This was endorsed in the 2006 EB HIV update and further elaborated in the recent 2007 EB update on HIV and AIDS, where WFP's lead role in dietary and nutritional support for care and treatment programmes and in HIV food and nutrition policy and programming is acknowledged.[19] In addition to taking the lead within the UN for food assistance in response to HIV and AIDS, WFP takes the lead in nutrition support which includes nutrition assessment, along with nutrition education and counselling and treatment for identified nutrition problems, such as, weight loss, acute malnutrition and micronutrient deficiencies.[20]

48. WFP's leadership role in food and nutrition support with the UNAIDS DoL should be proactive and engenders the responsibility to coordinate the provision and/or facilitation of the technical support at the country level with partners in order to achieve improved nutrition support for PLWHA.[21] It also involves taking the lead in global discussions related to the delivery of food assistance and nutrition support, along with identifying the gaps in this at the county level, advising country-level stakeholders and stimulating demand for such services.[22] During interviews with the evaluation team PDPH defined this role to be ensuring that: food and nutritional support for PLWHA exists; counselling materials have been developed; and strategies to promote nutritional support have been integrated into national policies. Furthermore, the role of 'lead agency' was interpreted as relying on other agencies, such as, WHO and UNICEF for normative guidance in areas of their technical expertise, such as infant and young child feeding in PMTCT. WFP's DoL responsibilities include taking leadership, when needed, to ensure that operational and technical knowledge guides programming.

18 UNAIDS, UNAIDS Technical Support Division of Labour: Summary and Rationale, August, 2005.

19 WFP Rome, Global Task Team Recommendations on Improving AIDS Coordination Among Multilateral Institutions and International Donors, Policy Issues, Agenda item 5, May 3, 2006; WFP Rome, Five Years Later—An Update on WFP's Response to HIV/AIDS, Policy Issues, Agenda Item 5, June 1, 2006; WFP Rome, Time to Deliver—An Update on WFP's Response to HIV and AIDS, Policy Issues, Agenda Item 5, May 21, 2007.

20 This definition of nutrition support is adapted from: "Incorporating Nutrition and Food Assistance into HIV Care and Treatment Programmes: A Manual Prepared by the World Food Programme and the World Health Organization", April 2007 draft.

21 As defined in: UNAIDS Technical Support Division of Labour: Summary and Rationale, August, 2005.

22 Ibid, 4.

49. PDPH staff acknowledged that the "lead role" as currently defined in UNAIDS documentation is vague and, given its recent adoption of this role, WFP has little experience in this capacity. Further, the 2007 Report of the Global Task Team Independent Assessment reports several challenges, such as the lack of clarity over the roles and responsibilities of the lead organization and the unclear process of assessing technical support within the UNAIDS DoL.[23] The report also notes that assessing progress in implementing the UNAIDS DoL is limited by the lack of a clear system of management accountability both at the global and country level.[24] Thus, defining the lead role in "dietary nutrition support" at the country and global levels currently depends on the availability, capacity and commitment of WFP staff. Monitoring WFP in this role will be difficult unless standards and a system to measure progress toward achieving them is developed and implemented. It is doubtful that WFP has the capacity to fulfil its UNAIDS DoL role completely in all the countries where it is operational, particularly in light of the recent reorganization and specialist HIV and AIDS staff cuts.

50. Not all WFP's global partners both within and outside the UN support the selection of WFP in this role. And in some cases, it has been difficult for WFP to be recognized as the lead in "dietary nutrition support". For instance, leading up to the Eastern/Southern Africa Regional Meeting on Nutrition and HIV/AIDS in May 2007 in Nairobi, WFP requested a co-organizer role along with UNICEF and WHO. This was denied and WFP was offered a participant role along with the other UN Agencies. The explanation given was that the meeting was a follow-up to the 2005 meeting held in Durban organized by WHO and UNICEF. When this issue was explored by the evaluation team, UNICEF and WHO indicated that the overlap in the UN DoL responsibilities and the role of food and nutrition in treatment, care and support made it difficult for one agency to claim the lead role in "dietary nutrition support".[25]

51. Within the case study countries and those visited in the course of the MTS of the SA PRRO it was apparent that some sister agencies regarded WFP's mandate of food aid delivery not to be suited to address the nutritional support needs of PLWHA (and others affected by the pandemic) beyond addressing food insecurity through food assistance. Furthermore, concern was expressed by international partners that WFP's as the lead role in the UNAIDS DoL usurps many of WHO and UNICEF's traditional roles in nutritional support.

23 UNAIDS, 20th Meeting of the UNAIDS Programme Coordination Board, Geneva, Switzerland, 25-27 June 2007; Report of the Global Task Team Independent Assessment.

24 Ibid, 6.

25 Ceesay, Sana, WFP ODK, Note for the Record/Meeting Report for the Eastern and Southern Africa Regional Meeting on Nutrition and HIV/AIDS, Nairobi, Kenya, May 2-4, 2007.

52. This was echoed at the HQ level in the post-field interviews with sister agencies' HIV and AIDS specialists, many of whom questioned WFP's capacity to lead on nutritional responses to the epidemic. Many interviewees expressed concern that WFP did not have adequate in-house expertise to take the lead in nutritional approaches in response to the epidemic. Some sister agencies specifically expressed the view that WHO was the natural lead agency in HIV and infant nutrition and that UNICEF was better placed than WFP to provide a sound lead in nutrition and HIV. Overall a general consensus emerged from sister UN agencies that while WFP had the capacity to take the lead on food aid, it did not have the appropriate technical expertise to lead beyond this as it was effectively "stepping on the toes" of more technically appropriate sister agencies.

53. From interviews conducted in the four case study countries, the nutritional support component of WFP's UNAIDS responsibility is not clearly comprehended and embraced by all critical WFP staff, including HIV focal points and even more importantly senior management, such as, country directors and deputy country directors. For example, one country director interviewed by the evaluation team saw WFP's role as providing food assistance for PLWHA and not as providing the lead in dietary and nutrition support. Furthermore, few of the HIV and AIDS programme staff interviewed in the case study countries were aware of all the various components of nutritional support. This is understandable, as the role is relatively new; and little written guidance elaborating this role had been provided at the time of the evaluation mission, although the topic had been discussed at recent international meetings for HIV focal points. At the time of the evaluation process, PDPH in collaboration with WHO was producing a background document[26] to partially address this gap and support WFP field staff in this role.

54. At the time of drafting this report, it is not clear how WFP's role will be further interpreted and responsibilities shared, as the JUNTA (Joint UNAIDS Team on AIDS) development of the UNAIDS Division of Labour was just beginning in the case study countries. As part of this process, the JUNTA will review the UNAIDS Division of Labour roles in light of specific agencies' staffing and capacity at the country level.

55. Regarding, the responsibilities outlined in the UNAIDS DoL, that is, identifying the gaps in the provision of nutritional support, stimulating demand for this or ensuring an overall strategy for food and nutritional support, none of the case study countries appeared to have a systematic approach or plan and little progress in these areas was visible. Nevertheless, some activities in support of WFP's role within the DoL were observed. In Uganda, WFP funded a study on the role of nutrition in HIV and AIDS, which included gaps in HIV and nutrition service provision.[27] Uganda country office staff had also been involved in the development and dissemination of HIV and nutrition materials. The CO also supported studies such as those in collaboration with Makarere and Johns Hopkins Universities[28] to document the effectiveness of food assistance. It was also coordinating IPs' weight monitoring of HIV food assistance

26The document is entitled, "Incorporating Nutrition and Food Assistance into HIV Care and Treatment Programmes: A Manual Prepared by the World Food Programme and the World Health Organization".

27 Uganda AIDS Commission, A Study on the Role of Nutrition in HIV/AIDS in Uganda, Final Report, January 2007.

28 WFP, Impact of WFP Adjuvant Food Support on Nutritional Status and Clinical Outcomes in Women and Children receiving Highly Active Antiretroviral Therapy, Spicyn Natalie (investigator), Musoke Philippa and Mirembe Betty (supervisors), Project Period: June-August 2007, Version 1.0, 12 July 2007

beneficiaries. Up until recently the Côte d'Ivoire CO had not been involved in nutritional support, though they received funding from PEPFAR to train IPs in HIV and nutrition in 2008. In Burkina Faso, regular training for IPs on HIV and nutrition had been conducted.

56. A larger issue of lack of Government HIV and nutrition policy in two of the case study countries, Burkina Faso and Côte d'Ivoire, and lack of Government and UN capacity and resources to address HIV food and nutrition support in all countries studied has hampered and will continue to impede WFP's progress in their DoL role. National HIV and nutrition policy forms the basis for WFP's HIV, nutrition and food assistance programming; it also provides the platform for WFP and other stakeholders advocating for sufficient staff and resources for programme implementation and it therefore forms a critical foundation for WFP achieving its DoL role. Traditionally supporting the development of Government guidance on nutrition falls under WHO and UNICEF, however, given WFP's UNAIDS role, identifying the need for nutrition and HIV guidance and promoting its development has been interpreted to be WFP's responsibility by some country offices. For example, in the Central African Republic, WFP championed the formation of a nutrition and HIV technical working group which developed HIV and nutrition policy and guidelines. In other countries, such as, Rwanda, Uganda and Malawi WFP has been involved in supporting the development of HIV and nutrition guidance. Furthermore, the ODD/Y HIV Regional Strategy (2008-2010) encourages WFP COs to support the development of HIV nutrition and food security guidelines. (Table 1 sets out an overview of national HIV and nutrition policy, coherence between national and UN planning documents, together with nutrition capacity in the case study countries.)

	Burkina Faso	Côte d'Ivoire	Tanzania	Uganda
MoH Policy/Guidelines on HIV and Nutrition	None	None	Yes	Yes
MoH Guidelines on Infant feeding for HIV-exposed infants	Integrated in infant feeding guidance; short/out of date	None	Integrated in infant feeding guidance; short/out of date	Update in draft form
Government Nutrition Capacity	Nutrition unit within MoH; Weak	Nutrition unit just formed; weak	Nutrition centre provides services for MoH & nutritionists within MoH HIV unit; coordination problematic	Nutritionists in Family Health & HIV units
WFP Nutrition and HIV Capacity	HIV focal point w/MPH with multiple responsibilities; nutritionist for VAM not working with HIV though	HIV focal point is a nutritionist on short-term contract also nutrition focal point	HIV Focal point left in August 07; post filled by short term contractor w/other responsibilities; nutritionist devoted to MCHN on short-term contract	4 HIV staff and 2 nutrition staff, but overlapping work not well integrated
UNICEF nutrition capacity	National nutritionist not working on HIV	National nutritionists not working on HIV or coordinated with HIV unit	International and national nutritionists involved in HIV & nutrition	2 Nutritionists coordinated with HIV unit & involved in HIV and nutrition
Inclusion of "food assistance and support" in national planning documents of NACs	Yes	Yes	Yes	Yes
Inclusion of "food assistance and support" in UNDAF AIDS Work Plans	Yes	Documents not available	Yes	Yes

Table 1: HIV & Nutrition Policy, Nutrition Capacity and Coherence with National and UN Planning Documents in the Case Study Countries

57. For HIV stakeholders and programme implementers it is not only important to develop HIV nutrition policy and guidance, keeping it updated as the global guidance evolves with new evidence is also necessary. None of the countries studied had up-to-date policy on infant feeding in the context of HIV and AIDS[29]; which impacts the quality and effectiveness of the infant feeding component of PMTCT programmes. Further, Government HIV and nutrition guidance apparent in just two of the four case study countries (see table 1 above), only partially covered three important areas of nutrition support: nutrition assessment, and the treatment of acute malnutrition and micronutrient deficiencies among PLWHA.

Advocacy

58. WFP's advocacy has contributed to integrating food assistance and nutrition support into the national AIDS planning documents in 32 countries where WFP is operational, including the four case study countries in the course of the Thematic Evaluation.[30] Staff from all four country case studies actively participated in UNAIDS planning meetings. This was reflected in the inclusion of food assistance/nutrition support in the UNDAF 2007 Work Plans made available to the evaluation team by three of these COs. However, the exact meaning of "nutrition support" was not specified in these documents and thus whether the Work Plans assumed inclusion of activities beyond food assistance, such as, nutrition assessment, education and counselling is not clear. The recent ODD/Y HIV Regional Strategy (2008-2010) guided COs on working in this way. The document encourages country offices to support the integration of HIV, nutrition and food security in a broader range of strategic planning and documentation such as national HIV and AIDS plans PRSPs and ensuring inclusion in the national AIDS plan monitoring and evaluation reporting.

59. The extent of training for IPs on HIV and nutrition that was organised, provided by and/or funded by WFP varied from country to country in the four countries studied. In the limited time available during the evaluation mission in each country, it was not possible to determine whether WFP's training support reflected actual IPs capacities and needs or the importance placed by individual CO's on HIV and AIDS approaches. In Burkina Faso, yearly training for all IP staff on nutrition and HIV, eating well with HIV and how to address the signs and symptoms related to HIV and AIDS has been conducted in the previous three years. In the other countries, IPs reported providing nutrition information to HIV beneficiaries, however, such an ongoing and comprehensive training programme had not been undertaken by WFP. With the PEPFAR funds recently approved for WFP in Côte d'Ivoire, an assessment and more systematic approach to nutrition and HIV training may soon be initiated there.

60. An area of nutrition support not addressed by any of the case study countries at the time of the Thematic Evaluation was nutrition assessment of HIV patients to identify malnutrition and other nutrition-related problems, along with the appropriate counselling and treatment required based on the assessment results. This is due to lack of IP capacity in nutrition assessment and associated services. Leadership in this area is critically needed and would require WFP to work with UNICEF and WHO in addition to Governments and donors, such as USAID/PEPFAR.

29 In Uganda an updated version of guidance on HIV and infant feeding will soon be released.

30 WFP, Time to Deliver—An Update on WFP's Response to HIV and AIDS, WFP/EB.A/2007/5-B, May 21, 2007.

Coherence between WFP policy and the MOU with UNAIDS

61. The Memorandum of Understanding (MOU) between WFP and UNAIDS signed early in 2003 is coherent with WFP's policy of the same year. The MOU reflects central elements of the policy, however, it prescribes an expanded scope of collaboration in research and policy development as set out in section 13 of the MOU:

> Research and policy development: WFP and UNAIDS in collaboration with other UN system agencies and non-UN partners will support studies to investigate links between HIV/AIDS and household food security, including coping mechanisms and mitigation strategies during times of crop failure. The parties will regularly circulate information in order to develop a strategy for the UN system. Both parties will encourage the identification and promotion of best practices for mitigation strategies and activities which WFP may integrate into its on-going and future food assisted activities in order to reduce the impact of HIV/AIDS on the rural poor and promote sustainable livelihoods.

Box 1: Extract from the 2003 MOU between WFP and UNAIDS.

62. Although PDPH initiated and supported the promotion of best practices for mitigation strategies and activities such as those set out in the 2006 *Child Vulnerability and AIDS: Case Studies from Southern Africa*[31] and the 2007 *Cash and Food Transfers: A Primer*[32] there was no evidence that WFP had a substantial budget line for such research.

Sister agencies' understanding of WFP's mandate in the response to HIV and AIDS

63. Within the case study countries limited interviews with sister UN agencies illustrated a strong appreciation of the importance of food and nutritional support in response to the epidemic and particularly in enabling and optimising adherence and efficacy of drug regimens among food insecure people infected with HIV and TB. While WFP's mandate and approaches may be understood at the country-level, some sister agencies did not appear to fully appreciate WFP's presence in their own geographical areas of interest due to the different funding mechanisms. This was particularly voiced to the evaluation team by sister UN agencies in Uganda. Rather than employing the more visible implementation route through local authorities (as in the case of UNICEF for example) WFP's resources were implemented more through non-governmental partners. This route is of lower visibility to some sister UN agencies and requires a higher degree of co-ordination efforts between agencies to ensure that potential synergies are not lost.

64. Post-field semi-structured interviews were conducted in October/November 2007 with senior HQ HIV and AIDS officers of sister UN agencies in Geneva and New York. A number of relatively consistent themes emerged from the views expressed by specialist counterparts: Officers interviewed were all aware of WFP's policy relating to its response to HIV and AIDS. Some commented that the head of PDPH had been proactive in advocating the importance of food and nutritional responses to HIV and

31 This report, written by Stuart Gillespie, was produced in partnership with the International Food Policy Research Institute. See annex B for full reference.

32 WFP, Cash and Food Transfers: A Primer, prepared by Ugo Gentilini, Occasional Papers N° 18, Rome, 2007.

AIDS as well as WFP's role. A few remarked that WFP's dedicated public website (http://www.wfp.org/food_aid/food_for_hiv/) was informative.

65. WFP's presentations on some of its approaches at the 2006 Toronto IAC was also regarded to have established WFP more firmly in the HIV and AIDS arena and created interest in its innovative HIV advocacy and corporate responsibility approaches (see Box 6 in the section on advocacy). Most UN specialists interviewed reported relatively frequent contact with PDPH counterparts and collaborative efforts, such as co-reviewing WFP documentation relating to HIV and AIDS.

66. Other synergies with WFP were regarded not to be as strong as those between some other UN agencies. For example, opportunities for WFP to deliver other agencies' commodities such as condoms and safe delivery kits were regarded to be highly variable in different country contexts and a synergy that could be more fully exploited through WFP logistics and those of local implementing partners.

67. One emerging theme was that the 2003 WFP policy was regarded to have been advanced and innovative at the time, but was regarded to have become outdated and in need of revising and adapting to the evolving knowledge base.

2.3 Internal Coherence

Coherence between policy and operational activities

68. According to EB policy on HIV (2003), HIV and AIDS concerns will be incorporated into all of its programming categories—Country Programmes, PRROs and EMOPs.[33] Furthermore, the guidance specifies cooperation with partners in HIV education and prevention to incorporate such activities in all WFP development, recovery and emergency programs; and through partners the introduction of HIV prevention/awareness activities in School Feeding Programmes.[34] In the case study countries, other than the integration of HIV prevention and awareness in primary schools, little mainstreaming of HIV prevention activities was noted. In particular, it was absent from rural development programming, such as FFW or FFT. It was also absent from some MCHN programs; and it was not included in refugee or IDP programming in the four countries visited by the evaluation team

69. Prevention and awareness activities were more visible in countries visited in Southern Africa in the course of the MTE of the PRRO. In Lesotho for example a mobile advocacy vehicle had been adapted to accompany monthly food distributions. The Malawi CO, for example also had engaged more fully in protection activities surrounding food distribution, notably through its "No Sex for Food" message distributed on cards to food handlers and beneficiaries. The RB had also been active in highlighting the importance of HIV and AIDS policy in the region, which was made visible to all COs through the emphasis on the "Triple Threat"[35] concept.

33 WFP Rome, Programming in the Era of AIDS: WFP's Response to HIV/AIDS, Policy Issues, Agenda Item 4; lWFP/EB.1/2003/4-B, January 2003.

34 Ibid.

35 **"Triple Threat" refers to a UN concept of a combination of food insecurity, weakened governance capacity and HIV and AIDS in Southern Africa (Source: Organizing the UN Response to the Triple Threat of Food Insecurity Weakened Capacity for Governance and AIDS, particularly in Southern and Eastern Africa: August 2003).**

Policy mainstreaming

Needs assessments and vulnerability analysis

70. The 2003 policy also sets out that WFP will adjust all programming tools (for example needs assessments and vulnerability analysis) to reflect the reality presented by HIV and AIDS. At the time of the Thematic Evaluation, only one of the case study countries, Uganda, had included HIV and AIDS indicators in the assessments conducted by the VAM unit[36]: one Comprehensive Food Security and Vulnerability Analysis (CFSVA) from 2005 and two Emergency Assessments (EFSAs) from 2007. The Uganda CFSVA operates with indicators of chronic illness, disability and mortality as well as knowledge of HIV and AIDS. It uses chronic illness and mortality as proxy indicators of the prevalence of HIV and AIDS. The Emergency Assessments, however, operate with a single indicator of chronic illness/disability. Merging the two indicators into one indicator is, however, problematic, as chronic illness might be an indicator of HIV infection, whereas disability may not. The three other case countries (Burkina Faso, Côte d'Ivoire and Tanzania) had not included any HIV and AIDS indicators in their food security and vulnerability assessments. The VAM unit at headquarters has recently prepared a technical guideline on integration of HIV and AIDS into food security and vulnerability analyses.[37] These guidelines had not yet been shared with the RB and COs at the time of the evaluation mission.

HIV Prevention Education in Schools

71. WFP country offices are collaborating with ministries of education and health as well as with UNICEF to expand school HIV prevention education. As of 2007, WFP had integrated HIV awareness and prevention education into their school feeding programs in 18 countries, reaching 4.5 million children.[38] The integration of HIV prevention in school feeding programmes varied significantly among the Thematic Evaluation country case studies. For example, in Uganda, an HIV prevention education curriculum has been developed by the government and implemented with training in all primary schools. In Burkina Faso, the WFP CO had developed a module on HIV prevention and included this in the training provided for school directors. However, there is no follow-up with schools to determine if this information is passed on to classroom teachers and shared with students. In Côte d'Ivoire this was being rolled out through a partnership with UNICEF. Generally, efforts to included HIV prevention education in primary schools with WFP school feeding have been made, however, there was little follow-up with schools to ensure this. Furthermore, there was no evidence of monitoring to determine if (and how well) prevention education was being implemented.

Adaptation of rations to PLWHA's needs

72. Oil fortified with vitamins A and D was included in all four rations in appropriate quantities. Oil increases calories without adding volume to the diet and thus is used to increase caloric consumption. Oil and fats also enhance the absorption of fat-soluble

36 WFP.VAM. "Uganda Comprehensive Food Security and Vulnerability Analysis" (CFSVA). Conducted July-August 2005; "WFP Uganda: Emergency Food Security Assessment of IDP Camps and Settled Areas in the Northern and North-Eastern Conflict Affected Regions March-April 2007".Final Report August 2007; WFP Uganda Emergency Food Security Assessment of Karamoja Region. March-April 2007". Final Report 2007".

37 WFP VAM, Integrating HIV/AIDS into Food Security and Vulnerability Analysis. Vulnerability Analysis and Mapping Branch (ODAV). October 2007

38 WFP, Time to Deliver—An Update on WFP's Response to HIV and AIDS, WFP/EB.A/2007/5-B, May 21, 2007.

vitamins and improve the palatability of foods. These are important contributions for PLWHA who have eating difficulties and need to consume as much energy and nutrients in a limited number of small meals. However, this needs to be balanced against the problem of fat consumption contributing to diarrhoea in PLWHA. Thus, the quantity of oil consumed should be limited and WFP should ensure that IPs guide recipients and their carers on preparing and consuming meals containing oil. This underlines the importance of the provision of nutrition information for PLWHA.

73. To increase the protein and iron content of the ration, pulses are included. In two of the case study countries, Tanzania and Côte d'Ivoire, quick cooking and more easily digested pulses, yellow split peas and lentils were provided. This is helpful given the time and financial constraints AIDS-affected household face, as well as the digestion problems experienced by many PLWHA. However, this needs to be balanced against the acceptability of foods which may not be traditionally used, such as, yellow split peas in Tanzania. Acceptability of untraditional foods could be improved through nutrition and food preparation sessions.

Factors hindering and promoting policy implementation in case study countries

74. The pre-field Evaluation Desk study conducted through a survey of all CO's implementing HIV and AIDS activities revealed resourcing to be the primary constraint to the implementation of policy. This was further evidenced by the calculation that only 3-4 % of COs' resources were directed towards HIV and AIDS activities in the reference period 2004-5. Indeed, during the course of the Thematic Evaluation mission, the resourcing allocated appeared to be a severely limiting factor in implementing the HIV and AIDS policy. The second most frequently noted constraint was the capacity of IPs. In Uganda, for example the CO's limited pool of IPs specialising in end distribution of food was reflected in the poor monitoring of rations to HIV positive and TB infected refugees in Madi-Okollo Settlement in Arua district.

75. The primary impediment to WFP's HIV and AIDS policy implementation observed throughout countries in Southern, Eastern and Western Africa was the low priority afforded to in-house HIV and AIDS expertise. This is more fully discussed in the section focussing on Human Resources later in this report, which discusses human resourcing. In some cases the role of HIV and AIDS focal point had been allocated to staff with no prior knowledge or experience of this theme, which severely limited HIV and AIDS policy implementation, advocacy and representation of WFP's approaches in response to the epidemic at the national level.

76. In spite of the systemic human resourcing issues hampering HIV and AIDS policy implementation, many examples of well-motivated staff were found to inform themselves as best they could and to engage fully in operationalising the HIV and AIDS policy. In the course of the Thematic Evaluation some staff at the CO and RB levels expressed the opinion that the ongoing technical assistance provided by PDPH staff also helped them in implementing WFP HIV and AIDS policy.

77. WFP's general focus on and experience with providing food assistance to highly food insecure areas, which are most often rural areas, may have hampered optimal engagement in the HIV and AIDS programming, which is often most needed in higher prevalence urban and peri-urban areas. This is in spite of the issue being raised in a Policy Paper in 2002.

78. The 2002 Policy Paper "Urban Food Insecurity: Strategies for WFP", discussed features of urban food insecurity and programming challenges. It recommended a number of actions to enhance emergency and development programming in urban areas, such as taking into account rural-urban linkages; undertaking relevant partnerships, developing clear exit strategies and linking the interventions to safety net programmes, expanding the analysis food needs in urban settings, and further developing guidelines on urban programming.

79. Concerning the analysis of food needs in urban areas, the VAM units have started to include urban and peri-urban contexts in their assessments, for example in Liberia and Central Africa Republic.

80. In general, thus, although urban programming policy and some guiding manuals have been prepared at headquarters level, the focus on urban programming has only partly trickled down to CO and SOs levels, which have not fully adopted and implemented the policy recommendations, including exit strategies and relevant partnering.

81. One of the hampering factors with regard to targeting seems to be the lack of clear policies and strategic guidance on this issue from headquarters. For example the 2003 policy only refers to areas with high HIV and AIDS prevalence and high level of food security excluding urban areas and low-prevalence countries. This in turn also constrains the guidance provided by the RBs as they cannot refer to official corporate guidelines or policies when they advise the COs. According to ODD/Y, the Bureau received strong support from PDPH; PDPH for instance provided technical guidance through joint field missions and dissemination of the new Food Security Handbook. It is, however, the view of ODD/Y that PDPH should develop corporate tools for assessing the eligibility (based on food security and health status) of the beneficiaries of the HIV and AIDS programmes. Due to the lack of corporate tools for assessing eligibility, ODD/Y sought assistance from the Uganda CO and on this basis advised the COs in West Africa. In ODK in East Africa, the HIV and AIDS coordinator reported that the Bureau received considerable guidance and support from PDPH; however, there is a general consensus in the Bureau that there is room for improvement of the type, quality and timing of the guidance and support.

82. Findings concerning guidance are discussed more fully later in this report, however, many staff, even those whose responsibilities included HIV and AIDS focal person, commented that they found some of the available information, such as the EB Updates to be too long and difficult to absorb.

83. Overall, however, many HIV and AIDS focal points commented that they found the "Getting Started" guides (see annex B for references) to have assisted them in implementing policy, although many commented that their usability could be improved.[39]

84. Although rations in the 4 case study countries were tailored to reflect the nutritional needs of PLWHA, guidance to help standardize this, which is currently in draft form was needed earlier.

85. WFP's role as lead in the UNAIDS DoL on dietary and nutrition support includes ensuring that appropriate nutritional support for PLWHA is integrated into national policy. This was not always the case in the case study countries. For example, up-to-date policy and guidance on the issues of infant feeding in the context of HIV and

39 This is discussed in detail later in the Policy Guidance section.

AIDS was absent in all case study countries which impacted on the quality and effectiveness of the infant feeding component of PMTCT programmes, which in turn, potentially impacts on the survival of HIV positive patients. Further, the available HIV and nutrition guidance (in Burkina Faso and Côte d'Ivoire), partially or failed completely to cover two important areas: nutrition assessment and treatment of acute malnutrition and micronutrient deficiencies.

Internal consistency in policy interpretation and implementation

86. Among WFP HIV and AIDS focal staff there was a generally high degree of consistency in basic understanding of the 2003 policy and there was evidence that this had been supported by the annual Global HIV/AIDS Focal Points' Meeting, which brings all key staff together for information updates, exchanges and problem-solving.

87. Operational HIV and AIDS activities observed in the case study countries, like those of the 2007 Southern Africa PRRO MTE appear to be mostly in line with section 27 of the 2003 Policy Paper and subsequent EB information notes that set out the principles to be applied to WFP programming for HIV and AIDS, although IPs vary in their competence and capacity to realise these principles. Equally, variability in the capability and resources of WFP field staff to supervise IPs also mediated the implementation of WFP's HIV and AIDS activities in the field.

88. Variation in HIV prevalence in the different socio-cultural and economic circumstances of the countries visited by the evaluation team as well as the experience of the HIV focal officers were associated with different approaches observed in the case study countries. For example in Uganda, the Arua Sub-Office displayed a broad interpretation of WFP HIV and AIDS policy. It contributed under FFA to the construction of teachers' accommodation in rural areas where the lack of housing was linked to under supply of teachers that impacted negatively on children's access to education and therefore WFP food aid and associated HIV prevention activities (as well as impacting on longer-term livelihoods options). Although not directly in line with policy, the Uganda team responded to realities in the field and provided broader support at the micro-level to ensure the achievement of WFP's overarching objectives.

89. Not all operational activities were in line with the 2003 HIV and AIDS policy, which sets out that "…WFP will take HIV/AIDS into account in all of its programming categories…". For example, in Burkina Faso, the PRRO launched at the very beginning of 2007, while clearly aimed at addressing undernutrition, failed to integrate aspects of HIV and AIDS. The activities of the PRRO included the provision of supplementary rations for malnourished children under three, pregnant and lactating women, which could have been linked with prevention and sensitization activities to provide the added value of supporting national efforts to increase awareness and VCT.

90. Opinions of WFP staff interviewed in the field on the appropriateness of the policy and WFP's motivation for engaging in the response to the epidemic vary markedly. Some senior officers were highly committed – as was evident in the Uganda CO where there was a tangible history of a highly motivated CD who had made efforts to maintain a skilled HIV and AIDS team that regularly access training courses to enhance their capacities. In another country, however, other senior officers were of the opinion that WFP had no valid role, or appropriate expertise to engage in the HIV and AIDS response, which would be better addressed by certain sister agencies. One

senior officer argued that the organisation did not provide adequate resources for COs to seriously implement HIV and AIDS policy and approaches. Furthermore the officer expressed the opinion that this gave the impression that the organisation was not fully committed to the policy.

91. WFP's activities in case study countries and those visited in the course of MTE of the SA PRRO reflected principles of the WFP Gender Policy 2003-2007 and the UNGASS GIPA initiatives in their emphasis on selecting IPs initiated and led by women and where possible, HIV positive groups In the course of field work the team observed these groups to comprise some of the most innovative and energetic of the small sample of IPs encountered, NACWOLA in Uganda being a strong case-in-point.

92. Case study countries in West Africa reported a high level of support from the 2008-2010 regionally produced strategy on HIV and AIDS[40]. The objectives stated in the strategy were: 1) to support design, priority setting and improved implementation of HIV interventions; 2) to support the implementation of the WFP policies: 2003 policy, "Food Aid and HIV Ration Design Considerations", and the handbook "Food Assistance Programming in the Context of HIV"; 3) to provide framework for harmonization of regional efforts to promote recognition and incorporation of food and nutrition in HIV responses; and 4) to monitor and evaluate the HIV interventions to establish an evidence base for nutrition related activities in HIV. The document generally provides very good strategic guidance; for example regarding COs selection of intervention types, named axes of interventions (prevention and awareness; care and treatment, and impact mitigation) in relation to the HIV prevalence rate (cf. section on geographical targeting).

93. According to information from PDPH, a regional HIV strategy has been prepared by ODK. However, the strategy was not made available to the team during the evaluation mission; neither has it been possible to identify the strategy succeeding the mission (WFP web page, for instance). From the evaluation mission, it was clear that the policy implementation of the Tanzania CO would have benefited from more support and guidance from the RB. Although both of the two Regional Bureaux provided support and guidance to the COs, it appeared to be to different degrees. The ODD/Y HIV coordinator spent one week of each month visiting country offices in the region. The Côte d'Ivoire CO reported being visited last in December 2006, prior to the launching of the PPRO 2007-2009. A report with the recommendations from the visit was prepared, on the duration of food assistance, M&E and the ration design[41]. The mission and the report appear to have provided very good support to the HIV and AIDS programming in Côte d'Ivoire. ODD/Y also conducted support missions to 12 of the 14 countries in the region. Niger and Burkina Faso are the only countries, which so far have not hosted such missions, apparently due to timing problems and possibly also lack of priority given to HIV and AIDS programming as the missions have been postponed several times by the COs.

94. The ODK HIV and AIDS coordinator was also conducting support visits to the country offices in the region, although apparently on a less regular basis. At the request of the COs, the HIV and AIDS coordinator conducted two support missions to

40 "Regional Strategy on HIV. Implementation of Food and Nutrition Interventions in Response to HIV in the ODD/Y Region. 2008-2010. WFP, Dakar Regional Bureau for West Africa, Dakar, Senegal. Version 9: July 2007.

41 Recommendations sur la composante VIH/SIDA pour l'elaboration du PRRO 2007-2009 en Côte d'Ivoire". Date de la Mission 6-12 Decembre 2006, Prepared by Olivier Nkakudulu.

respectively Rwanda (June 2007) and Burundi (May 2006). The Rwanda support mission report included a description of the national HIV and AIDS situation and the response, the WFP HIV and AIDS programme and provided some overall recommendations.[42] The Burundi support mission report was more elaborated, both in terms of assessment of the HIV and AIDS programme and the recommendations.[43]

95. Both RBs conducted regional workshops for HIV and AIDS focal points. ODD/Y conducted a regional workshop for capacity building of HIV and AIDS and M&E Focal Points in 15-18 October 2007. The main subjects of the workshop were nutrition and M&E. The new FANTA/WFP handbook was introduced; however, the handbook was not dealt with in detail, as according to ODD/Y PDPH was at the time preparing training modules. ODK likewise conducted regional workshops for HIV and AIDS focal points in 2006 and 2007 respectively. One of the expected outcomes of the 2007 workshop was to "understand targeting criteria in HIV and AIDS programmes and exit strategies".

96. Findings concerning internal consistency in policy interpretation and implementation of WFP's HIV and AIDS in the Workplace (HAWP) policy as discussed in the following section.

HIV and AIDS in the Workplace (HAWP)

97. WFP subscribes to the 1991 United Nations HIV/AIDS Personnel Policy that is further elaborated in 2003 document "UN Policy on HIV/AIDS in the Workplace"[44] This prescribes that the UN will ensure that its staff and their families are informed to protect themselves and others from the virus. It sets out that UN staff is to be provided with updated information, education and other preventive health measures. On a practical level employees should be made aware of safe blood transfusion sources and have access to condoms and adequate, confidential VCT services from their duty stations. Current policy encourages all UN agencies to develop and implement an active staff education strategy for HIV and AIDS guided by the multi-lingual UN handbook developed by UNAIDS "Living in a World with HIV and AIDS".

98. The United Nations Learning Strategy on HIV/AIDS was developed by UNAIDS to guide all UN employees to respond at levels appropriate to their responsibilities. The Learning Strategy establishes expected outcomes to be achieved through minimum standards for HIV and AIDS in the UN Workplace. As a co-sponsor of UNAIDS, WFP has endorsed the UNAIDS Learning Strategy on HIV/AIDS.

99. WFP also subscribes to the ILO Code of Practice on HIV/AIDS in the World of Work. Published in 2001, the ILO Code of Practice was adopted by the UN to support its Personnel Policy on HIV/AIDS. It includes ten key principles that include the acknowledgement of HIV and AIDS as workplace issues, non-discrimination and gender equality and prerequisites for addressing HIV and AIDS, and employees' entitlements to prevention, care and support in the world of work.

100. The WFP Executive Director's (ED) 2004 memorandum[45] launching the WFP HIV and AIDS in the Workplace Programme (HAWP) committed WFP to the achievement

42 "Summary Report for Rwanda CO visit (15-22 June 2007)".

43 "Reorienting, downsizing and mainstreaming HIV/AIDS programming in Burundi". A Concept Note". Draft 02. Prepared by Sana M. Ceesay, ODK.

44 United Nations Secretary-General's Bulletin. Policy on HIV/AIDS in the workplace ST/SGB/2003/18 1 December 2003

45 ED Memo: Launch of the HIV/AIDS in the Workplace Programme, 19.05.04

and maintenance of the minimum standards set out in the UN Personnel Policy on HIV/ AIDS and to applying of the ILO Code of Practice on HIV/ AIDS.

101. At the launch of WFP's HIV and AIDS in the Workplace Programme the ED memo set out three objectives to ensure that WFP personnel policies meet or exceed the international standards set within the UN:

> To ensure that WFP personnel policies meet or exceed the international standards set within the UN. This will be an ongoing process. Harmonization of policies and practices will be undertaken in response to issues raised by the programme; and efforts to enhance access to care and treatment will be ongoing wherever WFP has staff.
>
> To support the development of HIV/AIDS Workplace initiatives in all regions. This objective will be achieved by pro-active facilitation and support to workplace initiatives by UNVs posted in each of the regional bureaus.
>
> To extend HIV/AIDS awareness training to all staff. All WFP staff and contract holders world-wide will have received HIV/AIDS in the Workplace training before the end of 2005; thereafter, HIV/AIDS in the Workplace structures and initiatives will keep the messages and the communications alive."

Box 2: extract from ED Memo: Launch of the HIV/AIDS in the Workplace Programme, 19.05.04

102. In support of these commitments in October 2004 WFP released its HIV and AIDS in the Workplace strategy document "Agents of Change - Conceptual Framework for Programme Design and Implementation". Known by the acronym AGENTS, the paper established roles and responsibilities within the organisation and adherence to the UNAIDS Learning Strategy on HIV/ AIDS five minimum standards for HAWP. These are set out in the box below:

> **Minimum Standards**
> As a Cosponsor to UNAIDS, WFP has endorsed the UNAIDS Learning Strategy on HIV/AIDS. The Learning Strategy establishes five minimum standards for HIV/AIDS in the UN workplace. WFP's 2004/5 AGENTS programme aims to meet or exceed the five minimum standards:
> Staff members must participate in a facilitated orientation session based on materials produced by UNAIDS and using the UN booklet on HIV/AIDS for UN employees and their families.
> Staff members must participate in a demonstration on the use of male and female condoms.
> Staff members must be provided with information on locally available services, including VCCT.
> Staff members must participate in a learning activity to raise sensitivity towards people living with HIV and to enhance awareness of everyone's vulnerability with regard to HIV.
> All UN offices must prominently display posters on HIV/AIDS, provided by UNAIDS.

Box 3: Extract from the 2004 WFP Agents of Change - Conceptual Framework for Programme Design and Implementation

Internal and External HAWP Policy Coherence

103. WFP HAWP is well aligned with broader UN policy and approaches on which it is based. Indeed in planning its workplace approaches, such as the two-day staff training curriculum, WFP consulted with sister agencies including ILO, UNAIDS, UNICEF, UNFPA, UNDP, WB and adapted their training materials for internal purposes. According to the training agenda, every participant received the UNAIDS information booklet "Living in a World with HIV/AIDS" as the main reference tool.

104. The high degree of involvement on the part of PDPH, HR and the WFP HQ Medical Services in the programme and training curriculum design, indicated a cohesive approach to developing a workplace programme specific to the circumstances encountered by WFP staff.

105. There is, however, an apparent lack of internal coherence in that the ED memo and the Agents of Change Conceptual Framework set out different goals and objectives. The ED memo defines objectives which are more comparable to outcomes (i.e. meeting the UN minimum standards, supporting the programme in all regions, etc.). Conversely, the Agents of Change Conceptual Framework is more goal-oriented in terms of final impact of the programme (i.e. reduction of HIV transmission, and mitigation of the impact of HIV and AIDS on WFP staff and their families) as the extract in the box below illustrates.

The goal of the AGENTS programme is reduction in HIV transmission, and mitigation of the impact of HIV/AIDS on WFP staff and their families and on the WFP workplace. With this goal, the programme aims to achieve durable improvements in staff well-being and lasting solutions for the workplace.
The four objectives of the programme are:
- To minimize HIV/AIDS-related risk-taking behaviour amongst staff and their family members.
- To motivate staff and their family members to access HIV counselling and testing.
- To motivate staff and their family members to seek and to adhere to appropriate care and treatment regimens.
- To transform the WFP workplace into a safe and supportive environment for staff who are affected by HIV/AIDS.

The four strategies to achieve the above objectives of the AGENTS programme are:
* information education and communication (IEC),
* access to care and treatment,
* policy harmonization, and
* bottom-up approaches.

Box 4: Extract from the 2004 WFP Agents of Change - Conceptual Framework for Programme Design and Implementation

106. The lack of coherence between the ED memo and the Agents of Change Conceptual Framework is likely to have generated some confusion which is reflected in a further lack of coherence between the various work plans over the years. For example, the 2004 work plan refers to the objectives provided by the Agents of Change Conceptual Framework, whereas subsequent work plans (2005, 2006 and 2007) refer to the objectives stated in the ED memo.

Results of HAWP Programme

107. In evaluating the actual achievements of the HAWP, the evaluation team encountered a lack of documentation and a disconnection in institutional memory as the Programme Coordinator left early in 2007.

108. The majority of documentation made available to the evaluation team on HAWP activities between 2004-6 focused on programme policies and plans of the programme. Apart from feedback on the "Training for All" component there is little evidence of reporting of activities and achievement during this phase done and achieved.[46] Annex F sets out WFP's planned activities and outputs according to the

46 A separate list of data sources on HAWP outputs and outcomes made available to the evaluation team is set out in the bibliography in Annex B.

four HAWP strategies stated in the Agents of Change Conceptual Framework to which the following findings refer:

109. Under the Information, Education and Communication (IEC) strategy of the Agents of Change Conceptual Framework, a training of trainers (TOT) workshop was planned in each region to provide trainers with specific information on UN and WFP approach as well as assistance with mastering the materials for the training. In terms of results, only ODD/Y [47] and ODK[48] reported specifically on this activity, although they focus the objectives and expected outcomes, rather than the achievement and actual outcomes.

110. Training of staff was designed as a global initiative to reach each employee at every level worldwide by December 2005 and continue training new staff in the following years. According to the 2006 End-of-year Report on HIV and AIDS in the Workplace Programme, by December 2006 93% of WFP workforce had received HAWP training.

111. There was evidence that WFP's HIV and AIDS in the Workplace (HAWP) policy had been implemented with varying degrees of rigour up to 2006 and a wide range of commitment was apparent in COs and SOs thereafter. In the Uganda CO, for example, all staff questioned who had been employed for two years or more had undergone HAWP training. The fact that more recent staff had not done so reflected the hiatus in HAWP implementation associated with the policy gap at HQ-level associated with the awaited joint UN approach. A lack of coherence between HAWP policy and practice, however, was apparent at the SO-level during the visit to Arua. No condoms were available in the men or women's toilets, in line with current policy. Subsequent discussion with SO staff indicated a gap in awareness of this policy requirement.

112. An overall lack of coherence between HIV and AIDS in the Workplace (HAWP) policy and practice was noted at both CO and SO levels in Tanzania. In the course of the field visit there was evidence of patchy and poor engagement in WFP's HAWP policy. Due to staff turnover, there was no designated officer responsible and as a consequence information could not be triangulated in the course of fieldwork. However, few of the staff interviewed had been provided with the HAWP training during its active period. The general lack of staff training in HIV and AIDS in the Workplace might have been linked to the relatively high reliance of the Tanzania CO on temporary contract staff, in whom investments in training tended not to be made.

113. Both the Man SO in Côte d'Ivoire, and the Burkina Faso CO had continued to make commendable efforts to sustain their commitment to implement the WFP HIV and AIDS in the Workplace Policy. The case studies in Annex E detail some of the innovative means used by the two offices.

Lack of Continuity in WFP HAWP Activities

114. In line with the Interagency Advisory Group on AIDS (IAAG) meeting of February 2006 WFP supports the harmonization of the various UN HIV workplace initiatives into one common UN programme known as "UN Cares". This provides a system-wide integrative package of prevention, care and support to UN personnel.

47 ODD/Y Evaluation Report on Training of Trainers (TOT) September 2004.

48 ODK Evaluation Report on Training of Trainers (TOT) November 2004

115. Reflecting findings in case study countries, interviews with PDPH, HR and the senior Medical Officer at HQ indicated that since 2006 there has been an organisation-wide tail-off in HAWP activities and engagement. Having completed Phase One of HAWP in 2006 the programme was no longer funded and between that time and completion of the evaluation team's data collection for this report in November 2007, there appears to have been a vacuum in HIV and AIDS in the Workplace activities, notably training of newly recruited staff and refresher training of established personnel.

116. Interviews with HR and other staff responsible for HAWP at WFP revealed personnel and resources to concentrated on preparation for the forthcoming UN Cares programme and a general neglect of responsibilities set out in the "UN Policy on HIV/AIDS in the Workplace", the ILO Code of Practice on HIV/AIDS in the World of Work and the UN Learning Strategy on HIV/AIDS-

117. As the case studies in annex E illustrate, during the field work phase of the Thematic Evaluation, the team found evidence of variable engagement at the CO and SO-levels in HAWP activities both within and between case study countries. This was apparent in some CO and SO staff recruited after 2006 not receiving any training. In some cases (in the Tanzania CO for example) temporary staff have been excluded from HAWP training. Information and resources on HAWP was found to be generally poor in the case study countries and there was a lack of practical information available in the workplace. These findings triangulated with the ODC HAWP Final Report, of December. 2005, prepared by the WFP Regional Coordinator, which stated that training of newly recruited staff and refresher courses were not implemented. Furthermore, the 2006 end-of-year HQ Report indicates that only a few COs world-wide were consistent in training for newly-recruited staff during Phase One of WFP HAWP.

118. Furthermore, the HAWP website on the WFP intranet appears not to have been kept updated. For example the link to the HIV/AIDS Tutorial from the Communication Initiative has expired.

119. In particular three of WFP's HAWP Minimum standards appeared from case study visits not to have been sustained; (MS2) "Information on the facts about HIV/AIDS…"; (MS3)"Interactive learning/ training activities conducted annually"; and (MS4) "Free access to male and female condoms [within the workplace] "

120. The 2003 UNDG Guidance Note[49] sent to all UN Resident Coordinators and Heads of United Nations System Agencies and Organizations at Country Level, clearly sets out that WFP, like all other sister agencies has a responsibility to implement UN HIV and AIDS in the Work Place Policy and Codes of Practice.

49 UNDG Memorandum (Mark Malloch, Chair) Operationalizing a Strengthened United Nations System Response to HIV/AIDS at Country Level, 19 November 2003.

The UN Country Team is expected to fully implement the UN System Personnel Policy on HIV/AIDS and the ILO Code of Practice on HIV/AIDS and the World of Work. This commitment includes a policy of non-discriminatory employment and ensuring all personnel are provided with adequate information and access to medical care and counselling.
The UN Country Team is expected to implement the UN learning strategy on HIV/AIDS. This includes learning related to HIV/AIDS in the UN workplace, as well as ensuring that professional staff are competent to implement initiatives related to supporting national responses to HIV/AIDS.

Box 5 Extract, UNDG Memorandum (Mark Malloch, Chair) Operationalizing a Strengthened United Nations System Response to HIV/AIDS at Country Level, 19 November 2003

2.4 Relevance and Appropriateness

Alignment between WFP objectives and government policies and national plans in case study countries

121. When the specialists of the evaluation team consolidated their findings on the alignment of WFP objectives with government plans and polices, it emerged that within case study countries government policies and national plans lacked coherence between the various sectors responsible for food security, nutrition and HIV and AIDS. Variation was also evident in the quality and existence of national policy frameworks and strategic plans relating to food security, nutrition and HIV and AIDS, with which the COs aimed to align their approaches. Given the different socio-political settings of the policy environments, it was not viable to draw overall conclusions regarding the alignment between WFP objectives and government policies in case study countries. Similarly it is not possible to make general comments regarding the degree of advocacy on the part of WFP staff in encouraging an enabling policy environment for cross-sectoral planning in this respect.

Food Security

122. In the four case study countries the overall objectives of WFP HIV and AIDS programmes were by and large aligned with government policies and national plans relating to HIV and AIDS and food security. In Tanzania, Uganda and Burkina Faso, WFP had been involved in preparation of the national food security policies. In Côte d'Ivoire no national food security strategy was in place during the evaluation mission. The only food security related policy was the Ministry of Agriculture "Global Plan for Agriculture 1995-2015". The overall plan, "The Special Programme for Food Security and Nutrition" (April 2000) was, however, developed with support from WFP and FAO.

123. During the course of the evaluation the team observed that although national policy on food security might have been prepared, it may not always be approved and implemented. In Tanzania, for example, although the national food security strategy dated back to 2004, at the time of the evaluation mission it had not been approved and released by the government. WFP Tanzania had been an active partner in the preparation of the "National Food Security Strategy" (draft 2004) together with other UN partners and NGOs, and as a consequence the CO's HIV and AIDS interventions were rooted in and compatible with National Food Security plans and draft plans.

124. In Burkina Faso a national strategy and programme for food security was prepared in 2003[50]. According to various sources in the CO, the strategy was, however, not in actuality guiding food security planning and action at various levels, due to a lack of government ownership of the strategy, which was prepared with donor support.

125. A common feature of the national food security policies, strategies and programmes in the case study countries was that they dealt superficially, if at all, with HIV and AIDS in terms of both analysis and intervention areas. The only exception was the ”The National Food and Nutrition Strategy” (2005) of Uganda. The policy is based on a rights-based approach to food, however, HIV and AIDS is mainstreamed in the policy strategy as one of several strategic focus issues contributing to vulnerability to food insecurity. With regard to HIV and AIDS interventions, the Strategy focuses on 1) advocacy for improved census to establish the number of infected and their location; 2) advocacy for creation of fund to support agencies caring for this vulnerable group (especially food and nutritional care services); 3) ensure that agencies provide care, in particular nutritional care for people living with HIV and AIDS, and 4) initiation of food accessibility and nutritional programme for HIV and AIDS infected. The WFP Uganda HIV and AIDS interventions are in line with 3) and 4).

126. In conclusion, although the WFP HIV and AIDS Programme was aligned with the national food security policies in the four case study countries, further work could be done to ensure that HIV and AIDS are integrated in the national food security policies and programmes as this aspect is only partly integrated in the analysis and intervention areas (apart from the case of Uganda).

Nutrition

127. In two of the four countries studied, Uganda and Tanzania, nutrition and HIV guidance had been developed by their respective Ministries of Health. The other two countries, Burkina Faso and Côte d’Ivoire had no guidelines on nutrition and HIV.

128. In Uganda and Tanzania, WFP activities are for the most part in line with the national policy on HIV and nutrition policy. In Uganda the CO participated in the development of the national policy and promoted its dissemination with partners. The CO also supported its IPs in implementing weighing of HIV patients, an important monitoring activity as well as a component of nutrition assessment.

129. The Tanzania CO had not been as proactive in policy development and the WFP HIV food ration was higher in calories than recommended in national guidelines.[51] In Côte d’Ivoire and Burkina Faso, the government had not developed specific HIV and nutrition policies.

130. It is difficult to assess the alignment of WFP’s objectives with the four countries’ nutrition and HIV policy, as such policy had not been developed in the two West African countries with lower prevalence of HIV, and, in turn, less resources and emphasis in this area. In the two East Africa countries, in Uganda where HIV programming had a higher profile, WFP’s objectives were more aligned with MoH

50 ”Strategie Opérationnelle et Programme de Sécurité Alimentaire Durable Dans une Perspective de Lutte Contre la Pauvrete”. Ministère de L’Agriculture de L’Hydraulique et des Ressoruces Halieutiques”. Burkina Faso. Unite-Progress-Justice. Avril 2003.

51 “National Guide on Nutrition Care and Support for People Living with HIV/AIDS”, MoH/Tanzania Food and Nutrition Centre, April 2007.

HIV and nutrition policy. (See section on WFP's role in UNAIDS DoL for further information on this.)

HIV and AIDS

131. The overarching HIV and AIDS policy environment apparent in the 2007 HIV Programme Guidelines – Uganda indicates the strong relevance of WFP's approaches to the national context. Food security and nutrition feature prominently in the 2007 HIV Programme Guidelines that were jointly produced by WFP and the Ugandan government. Uganda also provides an example of WFP's programming embedded in national plans, in that, the national AIDS Strategic Plan includes food and nutrition support as part of PMTCT. WFP Uganda's HIV and MCHN programme is effectively collaborating with MoH and UNICEF to provide food assistance with integrated ANC and PMTCT programming.

132. This was also echoed in dialogue with focal government bodies such as the Uganda AIDS Commission during the course of the evaluation mission. This indicates that WFP's advocacy and support to the drafting process of the national HIV Guidelines had been successful in raising the profile of food security and nutrition at the national level that was also evident in food security and nutrition policy documents.

133. In Tanzania, the WFP CO in common with sister UN agencies, has to contend with an outdated national policy document.[52] Within the Government of Tanzania's Multi-sectoral Strategic Framework on HIV and AIDS,[53] little consideration is given to the roles of food security and nutrition as aspects of the national response to the epidemic. In particular, food security and nutrition are not cited in sections of the framework that refer to impact, determinants and dynamics of the epidemic or response approaches. However, the WFP's CO's approaches set out in the Country Programme[54] converged with the national framework in terms of improving access of vulnerable to services as well as the joint focus on PMTCT and VCT.

134. In Côte d'Ivoire the national strategic plan[55] provides a good policy environment for the achievements of WFP's own strategic objectives in response to the AIDS epidemic. The *Plan Stratégique National de Lutte contre le VIH/SIDA 2006-2010* indicates an integrative approach of food and nutritional assistance to support people infected with HIV or affected by AIDS. Specifically it sets nutritional support as one of its six priority areas using the strategic approach of improving the nutrition and food security of PLWHA and AIDS-affected (particularly orphans and vulnerable children) together with the promotion of fortified foods. These objectives are approached through the provision of food and nutrition "kits", food and seed distribution, food fortification and sensitisation and the operationalisation of pilot experiences.

135. The Government of Côte d'Ivoire had also developed a strategic plan to address tuberculosis which sets out a partnership between the PNLT (the national programme to fight TB), PNN (National Nutrition Program) and WFP to provide a nutrition

52 National Policy on HIV/ AIDS. The Prime Minister's Office September 2001.

53 Tanzania Commission for HIV/ AIDS National Multi-Sectoral Strategic Framework on HIV/AIDS 2003-2007. The Prime Minister's Office January 2003.

54 WFP Tanzania Country Programme Action Plan CPAP 2007-10.

55 **Plan Stratégique National de Lutte contre le VIH/SIDA 2006-2010. République de Côte d'Ivoire. Conseil National de Lutte Contre le SIDA. Secretariat Technique. June 2006.**

supplement to all TB patients during the initial phase of treatment.[56] TB programming is included in the new PRRO, however, it had not been planned with the PNLT or PNN and thus the criteria for selection and graduation of beneficiaries are not aligned.

136. The Côte d'Ivoire PRRO 10372.0 was in line with the national strategic plan in its approach to supporting micronutrient fortified food (CSB and oil) in its interventions to food insecure people infected with HIV or affected by AIDS. The longer term food security approaches of the national strategy are also reflected in the current PRRO's (10672.0) objective of providing food support to enable to rehabilitation of productive assets in post-conflict Côte d'Ivoire. This complements the national strategic plan's objective of enhancing food security through seed distribution.

137. In Burkina Faso HIV infected and AIDS affected people were entitled to assistance from a designated financial and technical support programme known as PAMAC (Programme D'Appui au Monde Associatif et Communautaire). PAMAC, was attached to the NAC and provided services including VCT, community based care and support, legal aid, prevention services and support to HIV/AIDS and TB institutions. This provided a sound basis for implementing WFP's HIV and AIDS policy. In the National AIDS Council's strategy and operational plan nutritional support is included and WFP is one of their main partners in providing training in nutritional care and dissemination of nutrition information to community-based HIV associations.

WFP synergies with other partners in case study countries

138. Case study countries provided examples of collaborative activities with sister UN agencies, notably, UNICEF, UNHCR and NGOs. Some collaborations were in planning and others in implementing. One example from Uganda is the joint WFP/UNICEF/MoH ANC and PMTCT programming. In Tanzania, one NGO partner visited by the evaluation team, Sant Egidio, provided HIV treatment including comprehensive nutrition services, from assessment through treatment. Although Sant Egidio programme data were not available, staff reported food assistance provided to patients experiencing weight loss or malnutrition contributed to increased weights and improved compliance with medication. The programme also involved home visitors who, among other tasks, verified the need for food assistance and assessed when it was appropriate to discontinue. With complementary funding from Canada, Burkina Faso for the last several years, has been providing training in HIV and nutrition to their implementing partners to enhance the nutrition advice provided during counselling sessions; in addition, to support this, specific counselling cards on selected HIV and nutrition topics have been produced. Similar HIV and nutrition training is planned for Côte d'Ivoire in 2008 with PEPFAR funding. However, in all the case study countries, although nutrition information is provided to beneficiaries, there was little evidence of utilizing food assistance to complement and/or leverage nutrition assessment, counselling and treatment services.

139. UNHCR, together with UNICEF has collaborated with WFP to integrate food and nutrition support to HIV positive and AIDS –affected refugees in a number of countries. Although the limited time and geographical scope of case study countries did not enable a broad range of project visits, the Uganda CO arranged for the evaluation team to observe this partnership in Arua, where joint activities served a

56 République de Côte d'Ivoire/MSHP/PNLT, Plan Stratégique de la Lutte Contre la Tuberculose en Côte d'Ivoire, version 2006.

population of 54,000 refugees. WFP has also partnered with UNHCR and UNAIDS in publishing the 2006 *Development of Programme Strategies for Integration of HIV, Food and Nutrition Activities in Refugee Settings*. This provides a best practice guide for using food and nutrition-based interventions to support HIV prevention, care, treatment and support for PLWHA in refugee settings.

140. The most relevant UN partner for WFP in terms of the food security aspects is FAO. Unfortunately, due to timing constraints, it was not possible to meet with FAO in Tanzania and Uganda, whereas in Burkina Faso and Côte d'Ivoire the organization was met during the Evaluation Mission. The current and potential collaboration between WFP and FAO differed to a great extent in these two countries. In Côte d'Ivoire, there was a very good collaboration between the two organizations and there seemed to be a potential for synergy with regard to livelihood activities succeeding the phasing out from food aid for HIV infected and AIDS affected beneficiaries. Although not directly linked to HIV and AIDS programmes, FAO in Côte d'Ivoire has great competence with regard to livelihood activities at household and community levels. However, two HIV and AIDS projects receiving collaborative support from the two organisations were being implemented through the partners; IDE Afrique (community gardens) and Caritas (cooking and gardening sessions, distribution of seeds, demonstration gardens). In contrast to the FAO and WFP synergies in Côte d'Ivoire, the collaboration appeared generally weak in Burkina Faso. FAO was not implementing specific HIV and AIDS programmes, nor implementing/experimenting with labour-saving activities and food production methods relevant to the needs of AIDS affected households..

141. In common with findings in the course of the MTE of the SA PRRO, synergies between WFP are more direct HIV prevention partners were highly variable. Opportunities for combining IEC and condom distribution with that of food were observed to be frequently missed. This is often due to the faith-based nature of implementing partners, but is also linked to the lack of capacity and large geographical responsibilities of WFP SO staff.

142. Perhaps most importantly, however, are the synergies WFP has achieved with public and NGO health services. There was widespread evidence from beneficiary focus groups that by distributing food through clinical partners WFP encouraged demand for local health care, particularly VCT and ART demand and uptake. While encouraging food insecure people to health services to collect their rations, holding distributions at health centres also acts to reduce the visibility of AIDS affected beneficiaries and potential for stigmatisation.

143. In Uganda, which had the most substantial dedicated HIV and AIDS staff of all the WFP COs visited in the course of the combined SA PRRO and Thematic evaluations, some of the most innovative partnerships and synergies were observed. One example was with Makerere University-Johns Hopkins University, whereby WFP supporting a number of potentially high-profile research studies, which led to further collaborations such as the study spin-off collaboration with a Yale University PhD project.

144. Although due to the logistical constraints of short periods in the case study countries no visits to school feeding projects were able to be arranged, observations made during the MTE of Southern Africa PRRO underscored the importance of the schools as partners in HIV and AIDS prevention. School feeding and take-home rations in particular settings are an important approach to implementing WFP's HIV and AIDS

policy. The provision of food to schools linked with incorporation of appropriate HIV and AIDS information in the curriculum has the immediate potential for risk reduction among food insecure children as well as contributing to longer-term food security through encouraging children to attend school and improve their future livelihood options.

Appropriateness of the duration of food assistance

145. Neither the duration of WFP food assistance nor graduation or exit from food assistance are referred to in the 2003 Policy document. Graduation (or "exit" as it is termed) is first mentioned four years later in the 2007 Executive Board Paper: "Time to deliver – An Update on WFP's Response to HIV and AIDS". The need for exit strategies and guidance on graduation from food assistance to appropriate livelihoods support are increasingly appropriate as ART is being rolled out in Sub-Saharan Africa and sero-positive people are able to control their viral load and well-being. COs in the four case study countries had different strategies and practices with regard to the duration of food assistance, exit from food assistance and potential graduation from food to livelihood assistance. These are summarised in table 2 below.

146. The Uganda CO HIV Programme Guidelines[57] set out recommended standards for duration of food assistance for different beneficiary categories. According to the Guidelines, the appropriate period of support for programmes establishing ART was 12 months, TB in-patients should receive food assistance for 2 months, TB out-patients 9 months; and that women undergoing PMTCT should receive support for 24 months. With regard to OVC programming in Uganda, WFP set no specific standard for duration of food assistance. Support to OVCs in institutional care is determined by individual agreements with WFP, whereas individual children and young people in training receive food support until they have completed their training programme or education.

147. All the IPs in Uganda engaging in food support to the chronically ill, those establishing drug therapy and OVC programmes that were visited during the Evaluation Mission were found to be adhering to the standards for duration of food assistance. Some beneficiaries received food assistance for extended period of time if the second round of the eligibility assessment showed that they were still eligible to food assistance (cf. below).

148. Two countries, Burkina Faso and Tanzania, had developed standards for the duration of time for food assistance for different project types. In the case of Burkina Faso the standard for duration of food assistance was part of the training given to the HIV associations and is moreover well specified in the protocols signed between the IPs and WFP. With regard to Tanzania, the HIV and AIDS focal point had left the position a few weeks prior to the Thematic Evaluation and was not available for interview. However, a 2007 PowerPoint presentation of the Tanzania HIV and AIDS Component[58] indicated that standards for duration of food assistance for different beneficiary categories had been prepared by the previous HIV and AIDS focal point (these are listed in table 2). For HBC the standard for duration of food assistance was stated to be 6-9 months or until a sustainable source of income was deemed to be in

57 "HIV Programme Guidelines –Uganda. Contributing to a Comprehensive Package of HIV/AIDS Response". May 2007.

58 "Presentation on HIV/AIDS Country Programme Component". Power Point Presentation. 6 August 2007, Assumpta Rwechungura.

place. However, in both countries the IPs visited during the Evaluation Mission did not seem to know about or adhere to these standards for duration of food assistance. This was confirmed in both countries during interviews with food aid recipients, who indicated distribution to continue to the same recipients well beyond the standard periods, some receiving WFP rations over a period of several years.

149. In Tanzania, for instance the evaluation team visited two SOs and a number of IPs in Tanzania. One IP had recently started the food distribution for HBC beneficiaries and was planning to stop the food assistance for all current beneficiaries after 6 months (which was in accordance with the standards) The other partner visited reported that they had not been informed by WFP that beneficiaries of HBC projects should be phased out from the food assistance and no arrangements for doing so were in place. Some beneficiaries had been receiving food assistance from the beginning of the programme, i.e. for two years and there was no plan of phasing out these households. With regard to the OVC community programme, the visited partners were phasing out the food assistance when the beneficiaries reached the age of 18, which was in line with the discharge criteria for this programme type according to the "Guidelines for beneficiary targeting and food distribution" prepared by the CO.

150. In Côte d'Ivoire, the HIV and AIDS focal point had defined standards for duration of food assistance for different beneficiary categories for the new PRRO (July 2007-December 2008)[59], based on advice from the ODD/Y HIV and AIDS coordinator's support mission 6-12 December.[60] No written guidelines on standards for duration of food assistance had been developed at CO level; however, the HIV and AIDS focal point had at several occasions informed the SO and IPs about the standards and all IPs were trained in Results Based Management in June 2007. In practice, however, the HIV and AIDS programmes were not always implemented in accordance with the standards. Thus, the IP's visited during the Thematic Evaluation were not aware of standards for duration of time for food assistance. In Bouake SO in Côte d'Ivoire, the phasing out from food assistance was for example done according to partners' assessment of the general situation of the beneficiaries and not according to a specific standards or specific criteria. This led to some beneficiaries receiving food assistance for long periods of time. Two households were visited during the Evaluation Mission; the households had received food assistance for 6½ and 5 years respectively.

151. As shown in table 2, the four countries have slightly different programme categories, however, two important issues emerge from comparing the various case study countries' approaches to the duration of food assistance to AIDS-affected households. Firstly, it is only in the case of Uganda, that the duration of food assistance is formulated in guidelines. In the case of Burkina Faso standards were included in the protocols signed between WFP and the IPs; in the case of Côte d'Ivoire the standards were stated in the PPRO document. Secondly, maybe deriving from the lack of guidelines for the IPs, food assistance was only partly or not at all provided in accordance with the standards in the three countries (Burkina Faso, Côte d'Ivoire, and Tanzania).

59 "Regional Protracted Relief and Recovery Operation. PRRO 10672.0. Assistance to populations affected by the Côte d'Ivoire protracted crisis"

60 "Recommendations sur la composante VIH/SIDA pour l'élaboration du PRRO 2007-2009 en Côte d' Ivoire", Date de la Mission 6-12 December. Prepared by Olivier Nkakudulu.

Beneficiary Category	Uganda	Tanzania	Côte D'ivoire	Burkina Faso
HBC		6-9 months/until sustainable income in place		
ART/PHA	12 months	6 months	9 months	12 months
ART-TB		6 months		
TB			8 months	8 months
TB in-patients	2 months			
TB out-patients	9 months			
PMTCT	24 months	Up to 18 months after delivery	21 months	9 months
OVC (institution/family)	Continuously as long as institution receives food support or the individual finishes training/school	6-9 months/ until sustainable income in place	10 months	12 months

Table 2 Duration of food assistance by beneficiary category and country[61]

Graduation from food assistance

152. Uganda, which had the largest HIV and AIDS programme of the four case study countries in terms of number of beneficiaries and programme staff, also had the most elaborated system for graduation. The Uganda HIV and AIDS programme also used the eligibility form twice or thrice, firstly as a vulnerability screening for selection of beneficiaries for food assistance, secondly, after the defined duration of time for food assistance to assess whether the beneficiaries on ART were physically fit for taking up IGA/livelihood activities. Occasionally the eligibility form was used three times - prior, during and after the provision of food assistance.

153. In both Tanzania and Côte d'Ivoire, there seemed to be no plan for follow-up interviews to assess whether beneficiaries were ready to be phased out and no livelihood activities were planned succeeding the phasing out/graduation from food assistance. In Burkina Faso the visited partners did not seem to be aware of a finite duration for food assistance and no assessment was made to determine whether beneficiaries could graduate from food assistance. However, some other associations visited by the evaluation team in Burkina Faso were initiating and providing training in different IGA concurrently with the provision of food assistance.

61 Data Sources: Uganda: "HIV programme guidelines –Uganda. Contributing to a comprehensive package of HIV/AIDS response". WFP, May 2007.

Tanzania: "Presentation on HIV/AIDS Country Programme Component" Power Point Presentation . 6 August 2007. Prepared by Assumpta Rwechungura.

Côte d'Ivoire: "Regional Protracted Relief and Recovery Operation. PPRO: 10672.0. Assistance to populations affected by the Côte d'Ivoire protracted crisis".

Burkina Faso: "Action Plan for Country Programme 2006-2010, Burkina Faso".

154. In Burkina Faso, Côte d'Ivoire and Tanzania IPs were making use of discharge criteria for different programme types, for example HBC and ART beneficiaries recovering, getting married, moving out of the programme area or in the case of OVC programmes turning 18 years.. These discharge criteria were generally used as the exit strategy for individual beneficiaries; rather than referring to standard duration times for food assistance followed by assessments for graduation to livelihoods projects.

Appropriate linkage with Livelihoods, IGA and Vocational training

155. In the case of Uganda and Burkina Faso, the IPs were implementing IGA and livelihood activities as part of programme assistance to PLWHA and those on ART. The Burkina Faso HIV and AIDS programme primarily focused on urban and peri-urban areas, whereas the programme in Uganda focused on rural, urban and peri-urban areas. In the case of Tanzania and Côte d'Ivoire IGA and livelihood activities were only implemented to a much more limited extent.

156. In Côte d'Ivoire, none of the implementing partners visited in SO Bouake had consistently initiated livelihood or IGA during the period of provision of food assistance or immediately after. Two households visited in Bouake had received food assistance continuously for 5-6 years without any attempts by the IP to introduce livelihood activities. In another SO, Man, one partner (IDE Afrique) visited by the Evaluation Team was implementing a commendable combined package of IGA training and support, FFW and FFT targeting OVC with the overall objective of asset and livelihood strengthening. Another partner, Caritas, visited by the Evaluation Mission were graduating beneficiaries to a number of livelihood activities, for example pig breeding, charcoal and palm products. However, although both partners received some support from WFP, the livelihood component was supported by FAO. The two projects illustrate the strength of partnering with an organization with strong competence in livelihood, such as for example FAO.

157. With regard to graduation/phasing out from food assistance to livelihood activities in Tanzania, no initiatives to guide and develop this area were taken by the previous HIV and AIDS focal point, who had recently left the position at the time of the Evaluation Mission. It was therefore not possible to explore the background of the lack of implementation of livelihood activities. However, it should be noted that the Country Programme 2007-2010 document[62] does not mention graduation to livelihood activities. The Results and Resources Matrix includes a performance indicator: "percentage of people/households discharged from food assistance and self-supporting increase with 10 % per year". Yet, it is not clear how the beneficiaries are expected to become self-supporting. The IPs visited were found to have a low capacity with regard to livelihood programming and had not initiated any activities in this regard.

158. In Uganda, the CO was clearly more proactive in urging IPs to initiate livelihood projects while beneficiaries were receiving food assistance support in order to make the beneficiaries better prepared for the shift from food assistance to livelihoods, for instance by providing inputs such as seeds, livestock and training. However, due to lack of funding and technical capacity, this proved difficult for most of the IPs. However, one IP, NACWOLA-Arua, provided a good example of graduation from food assistance to livelihood activities. During the period of receiving food

62 "Country Programme – United Republic of Tanzania 10437.0 (2007-2010)". EB, WFP, Rome 6-10 November 2006.

assistance, beneficiaries were prepared for being phased out and using the time when they receive food assistance to plan and develop livelihoods activities. After being phased out all beneficiaries were graduated into livelihood projects such as training in tailoring, basketwork, gardening, bee-keeping or through the provision of seeds and "pass-on goats", for example. The beneficiaries had clearly been empowered through the project and had also gained from the livelihoods activities as explained by one female beneficiary: "earlier we would beg for vegetables, nowadays we grow the vegetables ourselves".

159. In Burkina Faso, about 75 % of the IPs were implementing IGA/livelihood activities according to the HIV and AIDS focal point. Indeed livelihoods and IGA capacities were one of the CO's criteria for selection of partners. The majority of the associations visited (five out of seven) were initiating/providing training in different IGAs such as soap production, sewing and weaving, drying mangoes, production of neem oil, production of bags/purses (made out of re-cycled plastic bags), batik, gardening, rabbit breeding, and soymilk production.

160. In Uganda, Tanzania and Burkina Faso OVC vocational training centres were visited by the evaluation team. One vocational centre in Uganda run by the association Rubaga Youth Development Association (RYDA) was substantial and impressive in terms of physical facilities and equipment and offered a number of different trades: carpentry, bricklaying and concrete practice, tailoring and embroidery, weaving and knitting, catering and home economics, motor vehicle maintenance, metal work art and design computer, and lastly agricultural practices. Five hundred students had completed the training within the previous four years and 65 % of them were successful in getting a job directly after finishing the training. According to the head of the centre, employers from the local area also approach the centre directly in order to employ the students as the centre has a very good reputation. The success of the vocational training centre to a large extent seemed to be the result of a highly committed and competent head as well as considerable donor funding. The contract with WFP concerning food assistance runs during the period 2004-2007. Due to the planned exit of the WFP food assistance, the head has initiated various IGA to support the centre, for instance a piggery, firewood, and farming projects. Apart from food assistance the centre had also received non-food items from WFP such as tools, equipment, training materials, clothing, sewing machines and carpentry tools.

161. The vocational training centres visited in Tanzania and Burkina Faso were smaller and more humble than the vocational centre in Uganda both in terms of facilities, equipment and the trades they are offering. The vocational centres in Burkina Faso and Tanzania both received WFP food assistance, but no support in terms of non-food items.

162. The Burkina Faso centre visited (VIVRE APED) also included support to OVC in families and had a total of 200 children attached to the centre of which 102 received food assistance from WFP. The centre offered training in the trades: mechanics, sewing and carpentry. The first batch of 15 students had just finished their four years of training; the leadership of the centre was trying to find partners for employing the students; at the time of the mission they had not yet been successful in identifying jobs and partners for the students.

163. The vocational training centre in Tanzania (Shukrani Vocational Training Centre) was located in Makete District, an area with a high HIV prevalence. A total of 200 students were living at the centre and offered training the carpentry, tailoring, and

batik. Since the centre is located in a remote area, the prospects for employment are not very good and hence the majority of the students become self-employed. After finishing the training a part of the students receive a soft loan for starting up private business; the loans are provided by the International Youth Association. According to information from the leadership of the centre the repayment rate is 100 %; the loans are paid back within one year. Hence the self-employed students appear to be relatively successful in establishing a business. The synergy between WFP food support to OVCs within a project that links a variety of inputs, not only provides immediate food security for OVCs, but longer term livelihoods options that are linked to HIV risk reduction.

164. One of the factors hampering the implementation of the IGA and livelihood activities for HIV infected and AIDS affected people is WFP's relatively limited capacity in this field. Although a Livelihood, Social Protection Unit (PDPS) was set up in headquarters in mid 2007, it was, however, dismantled in the restructuring process the same year (to be merged with other units). The Livelihood, Social Protection Unit included 5 specialists, of which at least 3 specialists were working with livelihoods. It is not known how many specialists will be in working at headquarters level with livelihoods under the new organizational structure. Moreover, WFP' has mainly experience with labour-demanding projects in rural areas (food-for-work activities, for example), which hampers the implementation of the HIV and AIDS interventions, including the IGA and livelihood activities, which to a larger degree are implemented in urban areas due to the higher prevalence in these areas..

165. Due to the low labour capacity of PLWHA, beneficiaries require support in developing IGA/livelihood activities, which have a low labour demand in contrast to WFP's food-for-work activities for which beneficiaries have to complete manual labour – which excludes some of the most vulnerable AIDS-affected people. WFP does not necessarily require a high degree of in-house technical expertise in IGA/livelihood activities; however, the organization must have sufficient HIV and AIDS expertise and capacity to be capable of selecting IPs with strong IGA/livelihood approaches suited to PLWHA, as well as being able to evaluate the activities of the IPs. The Uganda CO provided an example to the evaluation mission that this can be achieved with a strong HIV and AIDS team in the CO and a history of CD-level support for mainstreaming HIV and AIDS policy.

Targeting

166..According to the 2003 EB Paper WFP should focus on areas with high levels of food insecurity and high HIV and AIDS prevalence (geographical targeting) and within these areas, WFP should focus on households, whose food security is threatened by HIV and AIDS (beneficiary targeting). The 2003 EB Paper does not mention or refer to the fact that in many cases high prevalence is not necessarily found in areas with high level of food insecurity and that the high prevalence often is found in urban areas. The 2003 Paper does also not distinguish between different geographical targeting strategies in areas with low prevalence versus areas with high prevalence. In sum, the 2003 Policy only refer to one particular situation where high prevalence and high level of food insecurity is overlapping and does not provide policy guidance for any other type of situation.

167. The mission found evidence of confusion over targeting. In an earlier WFP Guidance Note (Dated 7 June 2001): "Food Security, Food Aid and HIV/AIDS" different situations of level of food insecurity and HIV and AIDS prevalence are listed

according to how they should be prioritized by WFP. According to this document, WFP should give highest priority to the most food insecure areas, which at the same time has high HIV and AIDS prevalence. The next priority should be given to areas, which are food insecure, but not necessarily the most food insecure, but which has relatively high HIV and AIDS prevalence. The last priority should be given to areas that are generally food secure, but which have high HIV and AIDS prevalence. However, although the reference to other situations in terms of food insecurity and HIV and AIDS prevalence is useful, the 2001 Guidance Note does not distinguish between different strategies for low versus high prevalence countries. Moreover, this prioritization of the HIV and AIDS interventions has not been incorporated into the 2003 Policy, which only refers to the first situation (high level of food insecurity and high HIV and AIDS prevalence). Hence, the above-mentioned prioritization of three different situations of HIV prevalence and food security cannot be regarded as WFP policy.

168. The confusion over targeting is reflected in a number of past evaluations in Sub-Saharan Africa reporting findings on weak targeting (2004 MTE of the Tanzania CP) and the lack of targeting criteria was raised in the 2005 Mid-Term Evaluation of the Development Project 10266.0.

169. The problem of weak targeting was also reported from a regional workshop arranged by ODK in 2007. The conclusions regarding targeting were: 1) CO HIV and AIDS programmes experienced problems in targeting due to the general need in the food insecure areas; 2) in some countries, for instance Djibouti, food aid is often sold on the open market due to the fear of stigmatization and marginalization (HIV and AIDS Programme beneficiaries are afraid to reveal that they have received food aid through these programmes) and 3) targeting is inefficient due to stigmatization and denial (HIV infected are afraid to reveal their HIV status). The workshop proceedings concluded that there is a need to target the beneficiaries in a different way[63].

170. However, very recently, in September 2007 a new handbook "Food Assistance Programming in the Context of HIV/AIDS" came out, prepared jointly by the Food and Nutrition Technical Assistance (FANTA) and WFP. Interviews with PDPH staff indicated that the new handbook was intended to serve as guidelines for targeting in the future. The book serves well as a handbook by presenting different implementation strategies, methods, cases and promising practices of different agencies. However, regional or country-specific guidelines regarding HIV and AIDS programming still has to be worked out.

171. According to information from the previous PDPH, a three-step dissemination plan for the FANTA/WFP handbook has been developed, including for instance workshops with the regional Bureaux and the IPs. Given the very recent developments in terms of the dissolving of PDPH it remains to be seen how meetings focusing on HIV and AIDS will be managed.

Appropriateness of the HIV Ration

172. Operational complexities and funding constraints, as well as context and timing, all factor into the actual rations designed; they also influence the composition of the ration provided by WFP. In the course of the Thematic Evaluation, it became

63 "Report of the 2007 Regional HIV/AIDS Consultative Meeting". ODK. Prepared by Namulondo Joyce Kadowe and Sana M. Ceesay.

apparent that during the ration design process it is not always possible gather or access information on specific target groups. In three of the four countries visited in the course of the evaluation, funding was identified as a factor constraining rations.

173. When evaluating the appropriateness of the food basket composition in regard to local contexts it is important to consider how the food basket has been developed. In some countries, the RB HIV/AIDS focal point with support from the RB nutritionist provides guidance on the ration and its development; and both the RB and HQ staff reviews rations as part of the country programme or PRRO review process. In some cases, tension exists between the regional office and country office regarding HIV ration size, foods included and the type of ration, i.e. individual or household. For example, the regional nutritionist in ODD/Y, given her experience with selective feeding and MCHN programs, which usually target individual beneficiaries, does not support the use of household rations for HIV beneficiaries although household rations are currently provided in ODD/Y country office HIV programs.[64] Both country offices in the West Africa region mentioned ODD/Y's role in limiting the overall ration size and the quantities of some food items, such as CSB. From ODD/Y's perspective they recommend harmonizing HIV rations with MCH rations and designing the HIV ration to cover the food gap between what beneficiaries have and what they need. ODK has been involved in advising country offices on their HIV rations with new projects starting at the end of 2006. It appears that Uganda staff had more influence over the ration design, given the programme start date. While in Tanzania, the ration utilized was the one suggested by the country programme development mission and assessment findings.

174. Interviews with PDPH revealed its guidance on the design of rations for HIV programming to be based on the same approach that guides the design of other programme rations. Thus, the HIV and AIDS service did not recommend standardized HIV rations, which field staff often requested; rather it supported developing HIV rations based on the objectives of food assistance and the identified vulnerability of the target population. This approach was based on WFP's experience in attempting to standardize rations in the 1999 Great Lakes Region programming and from their more recent work in the Southern Africa region where "common logic" in developing HIV rations was emphasized over a "common HIV ration". Recently this approach has been reflected in the draft ration design guidelines.

175. Given WFP staff turn-over and the fact that in three of the four countries the Country Programs/PRRO's were underway, it was difficult to discern the specific process for developing the HIV rations. From the information available, it appears that Côte d'Ivoire and Uganda utilized information from VAM and other information, such as, IPs assessments in Uganda to formulate the ration. In Côte d'Ivoire, the HIV regional focal point visited to support the development of the HIV programming, which included ration design, for the recent PRRO initiated in July 2007. In addition to utilizing the VAM information, the process outlined for developing a household ration in HIV affected areas as elaborated in a HIV and nutrition guide was utilized.[65]

64 Personal communication, Olivier Nkakudulu, WFP Regional Programme Advisor for HIV/AIDS West Africa.

65 The reference used was, FANTA, Academy for Educational Development, HIV/AIDS: A Guide for Nutritional Care and Support 2004, Washington, D.C., October, 2004.

176. No assessments targeted to potential HIV beneficiaries were conducted as part of the HIV programme and ration design in any of the four countries visited; and there did not appear to be use of secondary data to inform this process. An assessment of potential HIV beneficiaries is needed if sufficient information is not available from other agencies or partners, since a VAM assessment, unless it over samples in areas with high HIV prevalence and includes specialized questions for AIDS affected households will not provide sufficient information to support the design of the food ration. Another option would be to conduct a separate survey of members of HIV associations or treatment facilities for HIV and AIDS patients. This had begun at the time of the evaluation mission; for example, WFP recently conducted an assessment of potential HIV programme beneficiaries through a partnership with HIV Associations in the Central African Republic. This issue of HIV and assessment was being addressed by the new draft VAM and ODAV HIV guidance.

177. The draft HIV ration design guide[66] provides an iterative 5-step process for developing the ration; the first step relates to review of secondary data on the food security situation of the target population and the potential need to conduct a rapid assessment of the targeted population, however, this information is not linked to the VAM/ODAV HIV assessment guidance. Further within the guidance, the CP/PRRO review process, roles of the PRC and RB and how this supports and relates to ration design is not included.

66 WFP PDPH Service, Food Assistance in the Context of HIV Ration Design Guide, DRAFT, September 18, 2007.

	Burkina Faso	Côte d'ivoire	Tanzania	Uganda
Assessment of HIV beneficiaries to inform the ration design	No	No	No	No
Use of VAM & other information for ration design	No	Yes	No	Yes
Individual vs. Household (#'s of members)	1	5		3, 6 or 9 depending on HH size & resources
Iodized salt (in-country availability)	Yes	Yes	No	No
Oil fortified with vitamins A and D	Yes	Yes	Yes	Not available; no warehouse visited
Sugar	Yes	Yes	No	No
In country availability of iodized salt	Identified as a problem	unknown	Identified as a problem	Not a problem
Milling of cereal	Not yet, but starting	NA; fortified maize meal/ rice provided	No	Yes; but sometimes time doesn't allow
Fortification of cereal	Not yet, but starting	USAID Maize meal is provided	No	No
Expiration of CSB	November 2007	November 2007	November 2007	Not available/no warehouse visit
Beneficiary complaints about CSB	Yes	Yes	No	Yes
Food Storage Problems Identified	Yes	Yes	Yes	Not available; no warehouse visited
Post Food Distribution Monitoring of Beneficiaries	Starting next year	Started but only with seed protection beneficiaries	Not yet; though form developed	Yes, but no reports provided

Table 3: Food Ration Development, Milling/Fortification of Cereal, CSB Storage Issues and PDM

Food Distribution Modalities

178. Food distribution modalities are not mentioned in the EB HIV policy[67] or PDPH guidance, although it is briefly covered in the recently published WFP/FANTA handbook: "Food Assistance Programming in the Context of HIV".

179. Fieldwork in the four case study countries illustrated variation in HIV and TB infected and AIDS affected recipients' journey time and mode of conveying commodities between IPs' distribution points and their homes. These have strong implications for the energy expenditure and well being of recipients, particularly those who are infected with HIV and/or TB.

180. Modes of conveying food commodities from the distribution point to the home also varied. In some locations (Côte d'Ivoire, for example) recipients reported that they had access to bicycles and mopeds, although in most countries, access to public road transport was beyond the financial means of WFP recipients. In some other countries such as Burkina Faso, recipients reported limited access to both motorized and intermediate forms of transport such as bicycles, handcarts, and pack animals. Some recipients reported walking up to 11 km to the IPs' distribution point and then head loading commodities home. Some of these recipients also reported having being robbed on their journey to and from IP distributions.

181. Problems concerning recipients' movement of commodities to the home are intensified when seasonal access issues dictate three-monthly distributions to be necessary.

182. Problems concerning commodity transport were intensified when un-milled maize was provided by WFP to IPs (see below section on HIV Ration). Under these circumstances recipients have to find cash to pay for the milling process and means of conveying whole grain to the mill, which varied among interviewed recipients between half a kilometers to up to 16 km distance from the home.

67 WFP EB Policy Issues: "Programming in the Era of AIDS – WFP's response to HIV/AIDS". Rome, 5-7 February 2003.

Composition and suitability of rations

183. The EB Policy on HIV (2003) specifies that the ration be nutritionally balanced and provide sufficient protein, fat and micronutrients; and foods of higher nutritional quality, i.e. pulses, oil and fortified foods should be included.[68] It also recommends that staple foods should be milled and fortified, or blended food provided. When the four case study countries HIV programs were under development no written guidance on developing a ration to elaborate the EB policy was available from PDPH, although this topic has been covered at the yearly meetings for HIV and AIDS focal points.[69] However, all PRC (Program Review Committee) documents include a section on rations and PDPH staff were involved in reviewing every proposed HIV ration. In addition, PDPH field supported missions (and correspondence between PDPH and field staff) provided technical assistance in support of developing HIV rations.

Modalities

Different Ration Allocations for HIV Beneficiaries

184. Given the lack of ration guidance available when all four of the CP/PRRO were under development coupled with the varied case study country contexts, variations in the number of rations and their size are to be expected. For example, two countries, Uganda and Tanzania provide rations for different categories of beneficiaries, while the other countries do not. This may partially be attributed to the increased focus on HIV and AIDS in East Africa versus West African countries. More than one ration allows for additional tailoring based on the category of beneficiary, the specific HIV programme objectives and the ration's planned role. Although more rations may complicate logistics and programme implementation, they increase the potential to achieve programme objectives. Utilizing a variety of rations, tailored for the various categories of HIV-infected and AIDS-affected beneficiaries can conserve and better target limited resources.

185. Observations from the Uganda CO provide some examples. TB programme in-patients were allocated a ration which provides 120 percent of calories, which is appropriate given their increased caloric need and the fact that, it is their only source of food. ART patients (and others) living with their families, on the other hand, received a ration providing 60 percent of the required calories for up to a total of six to nine household members. The rationale for the variation in ration size for TB patients and PLWHA households is logical, in that, TB in-patients require more calories and lack access to other food. However, the household ration size was based on IDP assessments, which may be appropriate for that population, but not for PLWHA living in "home" communities.

186. There are also additional reasons for providing specialized rations. The Uganda CO also demonstrated the use of two different PMTCT rations to avoid stigma: One was allocated for PMTCT programs not co-located with MCHN programs, and the other ration was the MCHN ration that is offered to all MCHN programme beneficiaries regardless of HIV status.

68 WFP Rome, Programming in the Era of AIDS: WFP's Response to HIV/AIDS, Policy Issues, Agenda Item 4; WFP/EB.1/2003/4-B, January 2003.

69 Currently such guidance is under development, a draft entitled, Food Assistance in the context of HIV: Ration Design Guide is available from PDPH. Regional workshops of HIV focal points have recently taken place in East and West Africa to gather further input for this guidance.

187. The ration design guidance developed by PDPH, currently in draft form, clearly states and reinforces the importance of developing rations based on the specific objectives of the HIV programme and the role of the ration.[70] However, it does not mention or provide an example of a PRRO/Country Programme with several HIV components, such as, OVC THR (Take Home Ration), ART/PLWHA, TB inpatients, and PMTCT that would benefit from developing specific rations for each programme components. The benefits of providing different rations for the various categories of HIV and AIDS programme beneficiaries needs to be considered in light of human resource constraints and the potential increased costs, as well as the additional logistics, training, distribution time, etc.

Household Rations

188. The household ration size (which varied between 3-10 members) and how it was implemented also varied between countries. This is evident in Table 3 which sets out the ART/TB or standard ration provided and number of household members served in the four case study countries. Generally the rations provided are household rations, except for some of the specific rations provided to institutions for TB patients or participants in vocational training, or for PMTCT/MCHN beneficiaries. Through experience, the Uganda country office learned that a tailored PMTCT ration provided in the same geographical areas where MCHN programs existed was counter productive as it identified HIV positive pregnant women and caused stigma. Generally household rations were not always related to direct household food security objectives. Household and therefore ration size was based on VAM data or information from other WFP programs. Since HIV-infected and AIDS affected households often have different demographics from non-infected/affected households a pre-assessment is needed. Data on the demographics of the HIV-infected and AIDS affected households are included in the eligibility forms mentioned earlier.

70 WFP, Food Assistance in the Context of HIV: Ration Design Guide, Draft, September, August 2007.

Country	Household (HH) Ration Size	Cereal	Blended Food	Pulse	Oil	Sugar	Iodized Salt
Burkina Faso	Individual ration, but more than 1 HH member may be eligible.	400g (whole MM)	50 g CSB	60 g peas	25 g	20g (5 tsp.)	5g (1 ¼ tsp.)
Côte d'Ivoire	A ration for 5 persons per HH is recommended	150 g (milled, fortified MM)	100g CSB	50 g lentils	30g	10g (2 ½ tsp.)	3g (3/4 tsp.)
Tanzania	A ration for 5 persons is recommended when 1-7 in HH; a ration for 10 people when > 8 or more in HH	450 g (whole MM)	120 g CSB	60 g peas	25 g	No	No
Uganda	A ration for 3 persons when 1-3; a ration for 6 when 4-6; ration for 9 when more than 6 when funding allows	150 g (locally milled MM)	100 g CSB	60 g beans	20 g	No	No

Table 4 ART/PHA/TB Household Ration Size, Foods and Quantities (per Person per Day)

189. Uganda of all the case study COs, tailored the ration best to reflect household size; rations were provided based on the number of household members, i.e. for 3, 6 or 9 members, although recently with funding constraints, the largest household ration has been discontinued. In the Uganda programme, an objective to improve household food security was not included. The Burkina Faso programme included a livelihood objective and provides an individual ration, though more than one member of the same family can be eligible for food assistance. Thus, theoretically, the number of household members benefiting is flexible according to the needs and availability of resources. IPs in Burkina Faso observed in the course of the evaluation covered a larger number of households by giving a smaller number of rations than the number of household members. Similarly in Côte d'Ivoire one ration is provided for a family of 5 regardless of household size, even though the programme has a food security objective. Conversely in Tanzania, a ration for 5 persons was found to be provided by IPs for households of 1 to 7 members; and a ration for 10 people was provided when there are 8 or more members in households.

190. Overall little consistency was noted between countries in the number of household members covered by WFP rations. The number of household members included in the ration was not relative to the overall size of the individual rations. Further, when rations were linked with objectives to improve food security in addition to objectives to improve compliance with ART treatment, etc., these rations did not cover more household members or provide larger rations when compared to programmes without food security objectives.

Special Commodities Included in the HIV Ration

191. Usually the most critical components of an HIV food ration are the more specialized commodities, which are more nutrient dense, such as pulses, fortified blended foods and oil that complement the foods available to food insecure sub-Saharan African households. Including these foods in sufficient quantities allows rations to meet the special nutritional requirements and dietary needs of the HIV infected and affected. In addition, sugar and salt are often recommended for HIV rations. [71]

192. As table 3 illustrates, all case study countries included CSB in significant quantities, except for Burkina Faso where the CSB is half or less of the amount of other countries. CSB is an important component of HIV rations, since it usually is well accepted, is nutritious, cooks quickly and is easily digested. It is particularly helpful for PLWHA who are ill and/or suffer from HIV-related symptoms, such as, sore mouth, painful eating, digestive problems, lack of appetite and diarrhoea.

71 WFP, Food Assistance in the Context of HIV: Ration Design Guide, Draft, September, August 2007

193. To improve taste, and in turn, palatability of CSB porridge, the two case study countries in West Africa included sugar in small amounts in the ration. (See Table 4 for the quantities of sugar provided in the West Africa rations). This is particularly important for PLWHA with poor appetites and/or eating difficulties. Sugar also increases the caloric density of foods without increasing volume, which helps support increased caloric consumption. On the other hand, sugar can cause complications in advanced AIDS patients; and thus may be counter-indicated or judicious use advised. Nevertheless, depending on the context and cultural preferences, the acceptability of CSB can depend on sugar. For instance, in Côte d'Ivoire, CSB is reportedly not well consumed without added sugar. In Uganda and Tanzania sugar was not included in the ration due to financial constraints, yet beneficiaries reported that CSB was the preferred food and no complaints were voiced in focus groups regarding the lack of sugar in the ration.

194. Regarding the inclusion of sugar in the food basket, the draft HIV ration guidance appropriately recommends consulting with local HIV experts on whether to include sugar in the ration. Information about the acceptability of blended food porridge among HIV beneficiaries with and without the provision of sugar would also be helpful to include in ration guidance, as this varies by region and country context. It would also be helpful to include information regarding the availability and cost of sugar as they as well, can vary between regions and country. In two of the country case studies, Burkina Faso and Côte d'Ivoire, sugar was included in the HIV rations. In the case of Côte d'Ivoire, it was a difficult and lengthy process for WFP to import sugar, thus sugar was not always available for inclusion in rations as planned.

195. It would also be helpful to include information regarding the availability and cost of sugar. In two of the countries studied, Burkina Faso and Côte d'Ivoire, sugar was included in the HIV rations.

196. Iodized salt which improves palatability of prepared food, contributes to electrolyte balance in warm climates and increases iodine intake is included in the two West Africa case study countries. (See Table 4 for the quantities of salt provided in the West Africa rations.) Under its procurement policy, WFP requires that the salt provided as part of its food assistance be iodized. However, policy is lacking on when, and under what conditions, iodized salt should be included in the ration. Regarding the two East Africa case study countries, properly iodized salt is reportedly widely available throughout Uganda, however, this is not the case for Tanzania where iodine deficiency is endemic and only 44 percent of available salt is adequately iodized. Although iodized salt it is included in the PRRO ration, this is not the in the Tanzania Country Program's ration and represents a critical missed opportunity to address iodine deficiency.

197. The draft HIV ration guidance recommends considering the iodine deficiency level when deciding whether to include iodized salt in the ration. It would also be important to consider the availability of adequately iodized salt among the target population of food assistance, particularly as poorer households tend to utilize less expensive forms of salt that, in many countries, are not iodized or inadequately iodized.

198. Oil fortified with vitamins A and D was included in all four case study countries' rations in appropriate quantities. Oil, like sugar increases calories without adding volume and thus is used to increase caloric consumption. Oil or fats also enhance the absorption of fat soluble vitamins and improve the palatability of foods. These are important contributions for PLWHA who have eating difficulties and need to

consume as much energy and nutrients in a limited number of small meals. However, this needs to be balanced against the problem of fat consumption contributing to diarrhoea in PLWHA. Thus, the quantity of oil consumed should be limited and nutrition information for PLWHA should be provided that it should not be eaten alone. The IPs visited in the case study countries were not providing information on the appropriate consumption of oil.

199. To increase the protein and iron content of the ration, pulses were included. In two countries, Tanzania and Côte d'Ivoire, yellow split peas and lentils are provided, which are quick cooking and more easily digested than certain other pulses,. This is helpful given the time and financial constraints AIDS-affected household face as well as the digestion problems experienced by most PLWHA. However, this needs to be balanced against local acceptability of foods which may not be traditionally used, as was the case with yellow split peas in Tanzania.

Nutrition Composition of the Ration

200. A ration of 2,100 calories, based on the weighted average of all age and sex groups, is recommended and often used when planning general food distributions; and is adjusted depending on various factors, such as, the health and nutritional status of the beneficiaries. In the case of HIV infected and AIDS-affected beneficiaries some of the targeted activities are for particular sub-sectors of the population, such as, OVC (children), HBC (mostly adults), PMTCT (pregnant women) or TB (usually adults) for which the general planning figure of 2,100 may not be appropriate. According to WHO, when designing a ration for HIV beneficiaries, in particular, their additional caloric needs should be considered.[72] However, for a household ration, the 10 to 30 percent recommended increase for the 1-2 infected adult(s) increases the caloric value of the household ration minimally, that is, by 3-6 percent. The nutrition composition of the ART/PLWHA/TB ration varied in the case study countries and is set out in Table 5 below.

201. In the 4 countries visited, the HIV rations supplemented households' other food sources, thus a full ration was not necessarily needed. However, assessments of potential HIV beneficiary households were not conducted to confirm this. All four rations had been appropriately tailored given the general information available regarding the diets of food insecure PLWHA, in that higher protein and micronutrient content are provided relative to caloric content. All rations meet the recommended percentage of calories from protein and fat. As table 5 illustrates apart from the Burkina Faso ration, the iodine content of the rations were low, particularly in the Uganda and Tanzania which did not contain iodized salt.

72 According to WHO (2003), PLWHA when asymptomatic need 10 percent more calories and when symptomatic need 20 to 30 percent more calories. They do not necessarily need more protein or micronutrients than a balanced increase in calories would provide unless their usual intake is below what is recommended.

Country	Calories	Protein	Fat	Iron	Iodine	Vitamin A	Riboflavin	Vitamin C
Burkina Faso	2,092 (100%)	118% of requirement; 12% of calories	112% of requirement; 19.5% of calories	121%	103%	208%	82%	90%
Côte d'Ivoire	1,405 (67%)	78% of requirement; 11.6% of calories	97% of requirement; 25% of calories	77%	62%	352%	69%	182%
Tanzania	2,498 (119%)	143% of requirement; 12% of calories	122% of requirement; 17.5% of calories	128%	3%	292%	111%	210%
Uganda	1,298 (62%)	81% of requirement; 13% of calories	73% of requirement: 20% of calories	66%	1%	173%	47%	171%

Table 5 Nutrition Composition of the 4 Counties' ART/PLWHA Rations (per Person per Day)

Acceptability of the ration foods

202. For PLWHA the acceptability of the foods provided, which affects food use and consumption, is even more critical considering their nutritional vulnerability, lack of appetite and eating problems. Overall in the four case study countries, beneficiaries reported most of the foods provided in the rations acceptable. However, in Tanzania and Côte d'Ivoire the staples provided were not traditional; and thus generally not preferred. In Tanzania the yellow split peas provided were not traditionally consumed, but cook more quickly, requiring less fuel and are more easily digested than traditional dried beans, and were potentially more nutritionally appropriate for PLWHA. However, they may have been more acceptable if food preparation information had been consistently provided by IPs.

203. In Burkina Faso and Côte d'Ivoire, in focus group discussions beneficiaries complained that the CSB was inedible and in some cases infested with bugs; which may have been due to the recent hot, humid weather in both countries. Spoiled food is not acceptable for any WFP beneficiaries, however, this is even more critical for PLWHA, given their overall increased vulnerability and susceptibility to infections. In Burkina Faso, staff reported not hearing such complaints as the evaluation team heard; and conversely according to their monitoring, beneficiaries preferred CSB to other commodities. Unfortunately, in Burkina Faso, as in the other countries visited, additional information was not available to the mission from post food distribution monitoring reports of HIV beneficiaries.[73]

204. In the three countries where food storage was observed, Tanzania, Côte d'Ivoire and Burkina Faso, the CSB was near its expiration date of November of 2007. And in one country (Côte d'Ivoire), one IP reported regularly receiving CSB that had expired. The time lag in transporting CSB from Europe or the United States coupled with its limited shelf life (12 to 18 months depending on the supplier) and the in-country distribution mechanisms contribute to the problems reported and observed with the CSB.[74] There was also confusion regarding the expiration date among staff, as it wasn't printed on the many of the bags; and staff was unaware that the European produced CSB expires 1 year after its production date. This may be due to the variable information regarding this issue provided in WFP resources, such as, the Programme Design Manual and the Fortified Blended Food Recipes book.[75]

Milling and Fortification of the Cereals in the Ration

205. In addition to the 2003 EB HIV policy, there was also an EB policy on Micronutrient Fortification enacted in 2004, which states that "WFP will increase its efforts to meet micronutrient deficiencies among beneficiaries through the distribution of appropriately fortified food …paying particular attention to meeting micronutrient needs in emergencies and meeting the special needs of people living with HIV and

73Uganda reported conducted PDM, but reports have not been received; and in Tanzania and Burkina Faso it is planned. In Côte d'Ivoire, PDM of seed protection distributions are conducted, but reports for post food distribution for HIV beneficiaries were not located.

74 In one of the countries, food is sent from WFP central warehouses to IPs storage facilities 3 or 4 times each year and thus is often stored for several months under less than ideal conditions.

75 In WFP's Fortified Blended Foods Recipes: Facts and Practical Uses (July 2002), it states that the shelf life of most fortified blended food (FBF) is at least 6 months after the date of production. It also mentions that FBF from USAID and Europe has a shelf life of at least 12 months. Whereas, in WFP's Programme Design Manual it mentions that the shelf life of FBF is 6 to 12 months from their date of production.

AIDS."[76] Providing milled cereals is important, particularly for HIV infected/affected households since processing cereals requires additional time, on top of, the money required for transportation or the energy to carry the cereal to the mill and return home—an obvious additional burden for HIV impacted households. Alternatively when a mill is not available, energy and strength is required to pound the grain into flour. Commercially milled cereals have another advantage, as they are more finely ground and thus can be more quickly prepared and when consumed and can be more easily digested.

206. Commercial milling of cereal provides the opportunity to fortify the flour, which is a fraction of the costs of the milling process. However, milling operations that meet WFP specifications are not available in all countries; and it may require a financial and time commitment to build the capacity of local grain mills. WFP has provided regional training in the milling and fortification of cereals and information is available in the web-based Programme Design Manual; in addition, a complete manual on this topic has been developed. Even with the WFP's current level of support for this activity, when cereals are milled they are not always fortified; this was found to be the case in Uganda. In Tanzania, the cereal provided is not milled. Due to staff turn over it was not possible to obtain information regarding the decision to mill, but not fortify maize in Uganda or to do neither in Tanzania. In Côte d'Ivoire, USAID fortified maize meal was provided and in Burkina Faso milled and fortified maize meal will be available next year.

207. In Uganda that mills maize into corn meal, spoilage was reported to be an issue by one IP. The shelf life of locally milled maize is estimated at 1 to 1.5 months.[77] However, most commercially produced flours have longer shelf lives estimated at 3 to 4 months; and USAID fortified maize flour has a shelf life of one year.[78] When locally milled cereals are being considered for HIV rations, in addition to local capacity issues, the more complex and expensive logistics of more deliveries to IPs need to be planned and budgeted. Additional monitoring of IPs food storage facilities along with more beneficiary post distribution monitoring would also be needed. Identifying the additional funding for this may be necessary. Other options include home fortification products, such as, "sprinkles", which come in small packets and contain a blend of micronutrients in powder form and can be easily sprinkled on to prepared foods, thus increasing the micronutrient content of foods. They may be a more appropriate intervention in some contexts. At the time of the evaluation mission, this was being studied by PDPN.

76 WFP, Micronutrient Fortification: WFP Experiences and Ways Forward, /EB/.A/2004/5-A/Z, April 6, 2004.

77 WFP PDPH, Food Assistance in the Context of HIV Ration Design Manual, DRAFT, September 18, 2007.

78 Ibid, 27.

Enhancing the Use of the Ration: Food and Nutrition Education

208. Food and nutrition education provided by IPs focused on nutrition wellbeing and the appropriate use of the ration commodities is recommended in the draft ration guidance manual. Beneficiaries interviewed in all case study countries reported having been provided information on how to use the foods, however, although time did not allow for in-depth assessment, of the extent and quality of nutrition information provided. Only one case study country, Burkina Faso, provided yearly training for their IPs on food and nutrition. In Côte d'Ivoire, IPs were provided with training in nutritional care for PLWHA. However, IPs in Uganda and Tanzania informed the evaluation mission that they required more training in food, hygiene and HIV and nutrition.

Current and Emerging Issues

209. Currently for PMTCT programming, an adequate "complementary" food (or ration) for an HIV-exposed infant weaned or in the process of weaning from breastmilk (between 6 and 18 months) has not been adequately researched. PDPH/PDPN and the international nutrition community are aware of this gap in the knowledge base. In the interim, it will continue to be difficult to adequately support the nutritional status and growth of HIV-exposed infants and young children participating in PMTCT programs.

210. Similarly, as treatment continues to expand for HIV-infected infants and young children, a suitable ration (or foods) will need to be developed that considers their high caloric and micronutrient needs, if WFP plans to appropriately meet the needs of this category of beneficiaries. Development of a ration for HIV-infected children between 6 and 24 months may depend on the results of the operational research underway, nevertheless, a ration for older HIV-infected children may be possible to develop. In Uganda, such a ration was requested by a Paediatric AIDS Program, which referred and shared patients with a nearby therapeutic feeding program.

211. In the future, more coordination and overlap will be required as both Paediatric AIDS Programs and community-based therapeutic feeding programs (CTC) expand and protocols to test children with acute malnutrition for HIV are implemented. This will increase the need for specialized food products, such as RUTF (ready-to-use-therapeutic food). And as additional donors, such as, the Clinton Foundation and PEPFAR fund and/or provide RUTF at the country level for specific beneficiaries, WFP in collaboration with UNICEF and the governmental bodies will need to keep abreast of these developments to potentially to provide logistical support, avoid duplication and fill gaps. The expansion of Paediatric AIDS Programs and CTC also calls for increased collaboration and coordination between WFP HIV and nutrition programme staff at HQ, RB and in country offices.

Ration Constraints

212. Constraints were pointed out by staff in the case study countries regarding the ration: the primary one being resources. During the PRRO/CP review process, rations change due to funding; and with smaller rations and less expensive commodities, more beneficiaries can be covered. HIV rations are expensive, given the reliance on fortified blended foods along with milling and fortification; and that in most countries in sub-Saharan Africa, they are provided as household rather than individual rations.

213. The technical level of HIV focal points coupled with the time they have available to devote to HIV programme activities were also identified as problems. Much great technical background is needed to appropriately interpret the guidance and develop HIV rations than in other programmatic areas and HIV focal points need more specific guidance to develop HIV rations that the draft guidance provides.

2.5 Efficiency and Effectiveness

Geographical targeting

214. With regard to geographical targeting in the case study countries, the mission noted that areas with high levels of food insecurity might not necessarily overlap with areas of high prevalence of HIV and AIDS, which according to the 2003 Policy should be the priority areas for HIV and AIDS interventions. This was the case in Burkina Faso, where the most food insecure areas are found in the North and East, whereas the highest prevalence of HIV and AIDS is found in the West and more generally in urban or peri-urban areas.

215. The general problem with geographical targeting of WFP's HIV and AIDS programmes is that even within food secure areas, food insecure HIV and AIDS affected households can be present. This is most pronounced in urban or peri-urban areas, which often have high HIV and AIDS prevalence and include groups that are already food insecure or become food insecure due to HIV and AIDS. In Uganda, as a case in point, the HIV prevalence is generally high in urban areas. Urban slum-settlements for example contain food insecure households that are highly vulnerable to impacts of the epidemic. HIV and AIDS assessment and targeting therefore pose a challenge of operating in relatively food secure areas such as urban and peri-urban areas, also in terms of VAM tools, which are primarily developed for use in rural areas although some guidance regarding assessments in urban areas have been developed

216. The lack of overlap of high level of food insecurity and high HIV prevalence is particularly a problem in low-prevalence countries, where the prevalence of HIV and AIDS in some areas is so low that targeting HIV and AIDS infected and affected individuals and households might not be cost effective. A strategy of focusing on peri-urban and urban areas in such settings as Burkina Faso might be a more feasible and effective strategy in response to the dynamics of the epidemic and associated vulnerabilities of orphans and children.

217. In the high prevalence countries visited: Tanzania, Uganda and Côte d'Ivoire the geographical targeting strategy of the WFP COs to a greater extent corresponded to the strategy outlined in the 2003 Policy, i.e. focusing on areas with high levels of food insecurity and high HIV and AIDS prevalence. At the same time, the HIV and AIDS programmes in these three countries targeted beneficiaries in urban and peri-urban areas, which had the highest HIV prevalence.

218. ODD/Y had prepared a strategy on HIV[79], which relates what is termed "axes of interventions" (prevention and awareness; care and treatment, and impact mitigation) with the HIV prevalence rate. The strategy recommends that prevention and awareness activities are implemented in all countries regardless of the HIV prevalence rate; that care and treatment activities should be added for countries with prevalence rates over 1% and lastly that impact mitigation activities are implemented when the HIV prevalence rate exceeds 5% (together with the two other types of activities). The regional strategy prepared by ODD/Y was the only WFP strategy or guidance seen by the evaluation team that explicitly deals with different prevalence rates and recommends different interventions for different prevalence rates.

Targeting Efficiency

Beneficiary Targeting

219. Only one of the case study countries, Tanzania, had developed specific national guidelines for beneficiary targeting.[80] It was realized that the targeting mechanism in several districts was based only on HIV status and did not include socio-economic criteria.[81] Previously, there were no clear inclusion and exclusion criteria for selection and identification of beneficiaries. The targeting guidelines were developed in order to provide strategic guidance to partners and the community. The guidelines describe Community Managed Targeting and Distribution (CMTD), which are then slightly modified to the context of HIV and AIDS. More specifically, the guidelines describe the processes of wealth-ranking, prioritization of types of households, admission and discharge criteria. An eligibility form is then used to assess the combination of the above-mentioned factors.

220. Although the Tanzania targeting guidelines overall seem appropriate, they are not very logically structured and might not be easy understandable for SO and IP staff. The value of conducting a community wealth ranking procedure is not quite clear to the team; neither is it clear if and how the ranking procedure feeds into the eligibility form. On the other hand, the prioritization of type of households and the admission/discharge are clearly set out. The eligibility form is not fully described in the guidelines and hence the link between the different preceding stages and the eligibility form becomes unclear. According to the guidelines, the cut-off point is relative; i.e. there is no absolute score for eligibility. Instead it depends on the number of beneficiaries in each operation site; the beneficiaries with the highest score corresponding to the number given are then selected. The criterion for allocation of number of beneficiaries per operation site is presumably according to resources; however this is not clearly set out in the guidelines. .

221. Despite the above-mentioned shortcomings of the guidelines, targeting in Tanzania seemed to be implemented in accordance with the guidelines, although there were variations in the practices between different implementing partners. All partners visited by the evaluation team were using the WFP standard eligibility form for

79 "Regional Strategy on HIV. Implementation of Food and Nutrition Interventions in Response to HIV in the ODD/Y Region. 2008-2010. WFP, Dakar Regional Bureau for West Africa, Dakar, Senegal. Version 9: July 2007.

80 "Guideline for Beneficiary Targeting and Food Distribution under the Integrated Support to Food Insecure Households affected by HIV/AIDS – Country Programme Component- WFP Tanzania", 2006. Prepared by Assumpta Rwechungura.

81 "Appraisal Mission Report for the Tanzania Country Programme HIV/AIDS Component- Integrated Support to Food Insecure Households Affected by HIV/AIDS Project (10065.0ACT4/ACT5). Mid-Year Progress Report. January-June 2005".

selection of beneficiaries as well as the admission and discharge criteria. Targeting and selection of beneficiaries were done by village Food Committees, which were established under the Village Councils. The Food Committees, which normally consist of around 7 members, were all volunteers. Until very recently, the members of the Food Committees received food assistance similar to the beneficiaries. However, this practice stopped due to funding restrictions. With regard to the Food Committees visited, the members (or a number of them) have been trained in targeting/selection criteria and procedures and in use of the eligibility form either by the by WFP CO/SO or the IPs (for example, DSM Archdiocese and CSMR).

222. The Uganda CO prepared HIV Programme Guidelines, which include a short section on targeting, for instance explaining application of the eligibility form. However, the section cannot serve as a guideline on targeting for the IPs as it mainly describes the basic principles and does not as such provide guidance.

223. As in the case of Tanzania, WFP Uganda was found to be using objective vulnerability screening criteria for selection of beneficiaries in the form of a Partner Beneficiary Form with entry eligibility criteria focusing on household food security and body weight. The form is primarily used for PLWHA/ART and TB programmes. Based on recommendation from ODD/Y, the Burkina Faso and Côte d'Ivoire COs had prepared the same type of eligibility forms for selection of beneficiaries. The forms were not in use at the time of the evaluation mission. In the case of Côte d'Ivoire, the form had already been distributed to the IPs, but only one of the partners met by the team during the evaluation mission had started to use it.

224. In the case of Uganda, the eligibility form was used more comprehensively to assess the beneficiaries after enrolment, during and after receiving food assistance for the given duration of time; 9-12 months for TB-out patients, PLWHA and ART programmes.

225. The preparation and use of eligibility forms represent a significant improvement in terms of beneficiary targeting compared to the practice of targeting where the selection of beneficiaries was based on subjective assessments of the beneficiaries conducted by the IPs or other stakeholders. In Côte d'Ivoire, the Bouake sub-office, the IPs visited used social workers from the health centres to assess whether the person was eligible for food assistance. In Burkina Faso, the partners visited applied different strategies for selection of beneficiaries; either they would collaborate with the Ministry of Social Action to identify vulnerable households or the association would use their own social workers to do the assessment. In most cases the assessment would include interviews and household visits to verify the information given with regard to the vulnerability of the household. Although all the partners visited in Burkina Faso and Côte d'Ivoire seemed to be highly committed in their attempts to target the most vulnerable, objective selection criteria can reduce the risk of not targeting the most vulnerable as well as nepotism and favouritism in the selection process.

226. In Uganda, Tanzania and Côte d'Ivoire the clinical criterion used for selection of beneficiaries for PLWHA/ART programmes is to be tested HIV positive; for ART programmes obviously also to be on treatment. With regard to Burkina Faso, the clinical criterion for selection of beneficiaries is to be in the last stage of AIDS (whether on ART or not). The selection criteria for OVC programmes in Burkina Faso were also stricter than in the other three countries; hence in Burkina Faso only double orphans could be targeted, whereas in the other countries both single and

double as well as other vulnerable children could be targeted. The reason for applying these very severe criteria in Burkina Faso, according to the HIV and AIDS focal point, was the shortage of food stock.

227. With regard to OVC programmes visited in the four countries, the targeting procedures for OVC were different from the targeting procedures for beneficiaries of PLWHA and ART programmes. The programmes visited by the evaluation team included both OVC in institutions (vocational training institutions or OVC in family). In most cases, the OVC would be referred to the IP by community organizations/social workers/hospitals/health clinics, the IP would seek out the OVC, or the OVC would approach the IP.

228. No overall guidelines for targeting OVC had, at the time of the evaluation mission, been provided from HQ. This issue was also highlighted in the 2005 Mid-Term Evaluation of the Lesotho CO Development Project 10266.0. However, a "Getting Started" document for OVC was in development at HQ level. OVC issues have also been addressed and explicitly dealt with at global meetings for HIV and AIDS focal points. Moreover, VAM has provided guidance on targeting of OVC. Very recently, in 2007, a review of OVC programmes was prepared by the HIV and AIDS Service, WFP[82]. The report is based on a desk review of 20 countries, which at the time of the desk review were implementing OVC programmes. The four case study countries are all included in the desk review. One of the conclusions of the review was that in most cases the targeting criteria is not adhered to because of high numbers of OVC and hard decisions have to be made due to resource constraints.

Policy Guidance

229. *WFP's 2003 policy document Programming in the Era of AIDS: WFP's Response to HIV/AIDS* was reported by some focal points to be too long and to lack focus. Furthermore, there is confusion at the CO and SO-levels as to which EB papers are "policy" *per se* and which are updates.

230. Focal points reported varying degrees of support from RBs and HQ. This appeared to be dependent upon personal networks with regional and headquarters staff rather than other issues such as geographical proximity. In this respect the annual meetings WFP HIV and AIDS Focal Point meetings arranged by PDPH were highly valued by engaged focal points as they were regarded to be crucial to focal persons developing technical support networks.

231. Both RBs conducted regional workshops for HIV and AIDS focal points. ODD/Y conducted a regional workshop for capacity building of HIV and AIDS and M&E Focal Points 15-18 October 2007. The main subjects of the workshop were nutrition and M&E. The new FANTA/WFP handbook was introduced; however, the handbook was not dealt with in detail, as according to ODD/Y PDPH was at the time preparing training modules. ODK likewise conducted regional workshops for HIV and AIDS focal points in 2006 and 2007 respectively. One of the expected outcomes of the 2007 workshop was to "understand targeting criteria in HIV and AIDS programmes and exit strategies".

82 "HIV/AIDS and Children: A Review of WFP Food and Nutrition Support Programmes Targeting Orphans and Vulnerable Children (OVC)". Prepared by Gertrude Kara, HIV/AIDS Service. January 2007.

232. A number of guiding documents on programming in urban areas have been prepared at headquarters. One example is the 2004 EB Paper: "Programming Food Aid in Urban Areas: Operational Guidance". The paper provides very good background information on programming in urban areas, including assessing and analyzing urban poverty and food insecurity. A particular section deals with targeting in urban areas and lessons learnt. Moreover, the paper includes a section on HIV and AIDS. However, in general, the paper provides more of a comprehensive introduction to urban programming rather than guidance since it does not as such provide specific recommendations and guidelines. WFP Programme Guidance Manual (PGM) likewise includes a section on urban food intervention. The Manual provides good insight into the issue of programming in urban areas; the Manual for example presents a list of the economic and social topics, which are of paramount importance for planning and implementation of food interventions in urban areas. The Manual concludes that urban food interventions tend to be more comprehensive ("heavier") in terms of economic and social analysis and less difficult ("lighter") in terms of logistic compared to most rural food interventions. However, as in the case of the EB Paper, the PGM provides good insight and background information, but limited guidance on food assistance programming in urban areas.

233. The evaluation team considered WFP's "Getting Started" guides to provide user-friendly guidelines to support policy implementation. However, most staff interviewed in the case study countries reported them to be too long, not necessarily designed for field use and impractical in guiding programme design or implementation. Shorter guides which included a step-by-step approach to programme design with less technical information and link to technical resources were requested by field staff.

234. Important gaps in the "Getting Started" guides were identified, such as guidance on ration design for HIV infected and AIDS affected beneficiaries (currently under development); and how to access and advocate for funds for HIV programming within and outside WFP and for the inclusion of food and nutrition support for the HIV infected and AIDS affected. The need for updated guidance on PMTCT programming was also mentioned by field staff, which PDPH informed the evaluation team was also under development at the time.

235. Regional bureaux echoed the same concerns regarding the "Getting Started" guides in terms of length and practicality. The draft HIV ration guidance document was also reported to repeat these problems.[83] Staff reported that the draft HIV ration guidance was confusing for focal points as it is not specific enough considering focal points' level of technical expertise. The draft was also considered to compare poorly to WFP's ration guidance for other programs such as supplemental feeding. A concern voiced from ODD/Y regarding the French-speaking countries was the need to translate the guidance into French as quickly as possible.

236. It was also noted by RBs and PDPH staff that the several pieces of guidance under development or recently completed, for example, the draft HIV ration guidance or the draft Incorporating Nutrition and Food Assistance into HIV CARE and Treatment Programs, would require extensive training with staff help familiarize them with it and to support its appropriate use, however, at the time there was no explicit plan to do this.

83 WFP, Food Assistance in the Context of HIV: Ration Design Guide, Draft, September, August 2007

237. According to the 2007 WFP EB Update the first element of an exit strategy is inherent in the treatment package itself as most patients will be well enough after six to nine months of treatment and food/nutrition support to return to their former livelihoods and continue treatment without food support. The paper emphasizes that sustainability measures should be in place before the programme starts – special focus should be put on linking food distribution with other food security initiatives and development programmes. However, this was not observed to be the case in any of the countries visited by the evaluation team.

238. At the time of the evaluation no WFP global guidelines for exiting from food assistance or graduation from food assistance to livelihood activities were in place. Neither had standards been developed by PDPH for the duration of food assistance for different HIV and AIDS programme types. The new handbook "Food Assistance in the Context of HIV/AIDS" provides some guidance on exit and graduation strategies; primarily by elaborating the different concepts and presenting relevant questions and issues to be considered when planning graduation/exit from food aid. The section on graduation/exiting in the handbook presents different options regarding exit and graduation, but the actual approach/strategy still has to be worked out at regional or country level. Country-specific guidelines still have to be prepared by the COs.

239. VAM and PDPH at headquarters prepared thematic guidelines on integration of HIV and AIDS into food security and vulnerability analyses: "Integrating HIV/AIDS into Food Security and Vulnerability Analysis" (Draft October 2007). The guidelines were prepared in close collaboration with ODJ in Southern Africa in order to better reflect the situation of this region. The thematic guidelines is a substantial document (67 pages plus annexes) and gives a thorough introduction to how to integrate HIV and AIDS into food security and vulnerability assessments in terms of collecting and analyzing data for different beneficiary categories (HIV and AIDS affected households and OVC). The guidelines have as the first step identified WFP assisted countries with high HIV prevalence where the inclusion of HIV and AIDS issues are recommended. Due to the high prevalence in Southern Africa, inclusion of HIV and AIDS issues are recommended in all countries except Angola (3,7 %) and Madagascar (0,5 %). These countries are termed priority countries. Although the term "higher prevalence" is not defined, it appears that it should be interpreted as a relative term, i.e. higher prevalence within the region. The thematic guidelines have recently been released.

240. As mentioned above, the guidelines provide a detailed (and lengthy) introduction to inclusion of HIV and AIDS issues, for instance a discussion of the use of CFSVA (showing current status, difference between affected and non-affected household) and the limitations of the HIV and AIDS proxy indicators (chronically illness being the main indicator). The obvious limitations of the chronically ill indicator is that some chronically ill persons might be suffering from other diseases and that many people living with HIV and AIDS will be a-symptomatic being in the early stages of the disease or receiving treatment. One way to triangulate the HIV prevalence found through the VAM assessment would be to compare it with the prevalence rates provided by other sources, as suggested in the guidelines. The guidelines, moreover, include a very useful section on how the food security assessments can be linked to targeting and design of programmes. Generally, the guidelines provide a lot of useful background information and relevant discussions; however, to some extent at the expense of providing clear and user-friendly guidelines for VAM staff at CO and RB levels.

241. The HIV and AIDS guidelines have already been implemented in a number of VAM assessments including the Rwanda, Cameroon, Central African Republic, Democratic Republic of Congo and Haiti comprehensive food security vulnerability analyses (CFSVA). Rwanda CFSVA 2007 (conducted in rural Rwanda March-April 2006)[84] represents the first effort to integrate a HIV and AIDS component into the WFP Food Security and Vulnerability Analyses (CFSVA). The integration of HIV and AIDS issues was made possible due to the DFID funded UN programme on scaling-up of HIV and AIDS services for populations of humanitarian concern. The CFSVA focuses on HIV and AIDS as well as OVC and provides chapters on the prevalence of HIV and AIDS as well as OVC based on different sources. With regard to the prevalence of HIV and AIDS, the CFSVA operates with the proxy indicators "chronically ill adult household members (age 18-59) and "recent death of an adult household member due to chronic illness". In order to get a clearer picture of the correlation between chronic illness and food security, the health status of the household (affected/non-affected) is triangulated with data on food consumption, food access, coping strategies, and other food security indicators. With regard to the presence/absence of OVC, this issue has been cross-tabulated with food security indicators to understand the correlation of OVC presence/absence and household food security and vulnerability. Generally, thus, the Rwanda CFSVA provides a thorough analysis of how HIV and AIDS impact on food security and how affected/non-affected households and OVC/non-OVC households correlate with different food security indicators. The Rwanda CFSVA moreover included identification of "hot spots" (with high HIV prevalence and high food insecurity).

242. The guidelines were shared with all HIV and AIDS focal points at CO and RB levels at the Global meeting in Cairo 2007[85]. Moreover, a thematic page on HIV and OVC has been created as part of the VAM website with a brief background of the inclusion of HIV and AIDS in food security and vulnerability analysis. Although the guidelines have been prepared in collaboration with the ODJ and the main focus is this region, the guidelines are intended to apply to other regions as well and VAM advisers/officers in other regions have been informed about the specific guidelines. Moreover, the VAM unit at headquarters has been working closely with other countries outside the ODJ region in the last months (Central Africa Republic and Ethiopia). The dissemination of the guidelines is currently going on (2008).

Accessing Complementary Funding

243. Fieldwork in the four case study countries and interviews at HQ indicated that WFP is not fully exploiting complementary sources of funding of food and nutritional support to food-insecure people infected with HIV or TB, and affected by AIDS. For many COs the potential of PEPFAR as a complementary funding source is unclear. However, the Côte d'Ivoire CO has been commendably persistent in spite of administrative obstacles and is making progress to obtain additional funds from this source. Furthermore in 2007 the Mozambique CO was successful in securing USD 2,100,000 from PEPFAR for staff, direct and indirect support costs to strengthen its response to HIV and AIDS. The grant will enable the CO to scale up food support

84 WFP-VAM/EU/Rwanda INSR-SIR/SENAC: „Rwanda. HIV/AIDS and Food Security. Comprehensive Food Security and Vulnerability Analysis". Conducted in Rural Rwanda March-April 2006. February 2007.

85 A very informative and pedagogical power point presentation: "Mainstreaming HIV/AIDS into WFP Vulnerability Analysis and Mapping Activities" was presented at the workshop (prepared by Chiara Brunelli, Vulnerability Analysis & Mapping Branch/HIV& AIDS Unit).

to assist 10,000 new HIV positive clients in the establishment of and adherence to ART regimes. It will also resource WFP in developing a strategic programme of support to OVCs and assistance to an additional 12,500 children.

244. Information available to COs on how to tap complementary funds and which organizations to approach was found to be variable. ODD/Y produced guidance for COs in the region in the Regional Strategy on HIV[86], however, similar guidance was not identified to have been produced by ODK that might have supported COs' efforts to obtain additional funds in that region. PDPH informed the evaluation team that it sent emails to all RB HIV advisors before GFATM round and occasional updates on PEPFAR funding.

245. In the course of the evaluation funding from the GFATM was beginning to be accessed by WFP and some COs took an active role in GFATM national proposal drafting processes and encouraged the inclusion of food support in HIV and TB components of country proposals. However, fieldwork in Burkina Faso highlighted a gap in understanding of WFP operating mechanisms on the part of the GFATM Principal Recipient (PR). Since the role of PR for Burkina Faso graduated from UNDP to the Permanent Secretariat of the National AIDS Council (SP/CNLS), an issue surrounding WFP cost recovery of food support under the GFATM hampered the dispersal of funds and delivery of food and nutritional support to beneficiaries. The main issue surrounded the 7% WFP indirect support costs that the PR considered a contentious issue, and which delayed food support from these funds. Subsequently only 4% of the ISC were recovered from the GFTAM award. Although interviews to date indicated that verbal agreements have been reached between WFP and the GFATM to act as guidance to PRs in such instances, these have not been formalized.

246. The Central African Republic, Guinea Bissau and Liberia COs successfully included Nutrition and Food Security in the country proposals for Round 7 of the GFATM. The RB provided support by preparing of an orientation workshop in May 2007 jointly with UNAIDS and UNICEF and by providing technical support.

Human Resourcing

247. Findings from the case study countries of the Thematic Evaluation reflected those of the 2007 Mid-Term Evaluation of the Southern Africa PRRO which indicated that overall HIV and AIDS competence is not a human resource priority of WFP, but that the strength of staff competence in this theme is highly dependent upon individual CD's commitment to the organisation's HIV and AIDS policy. This was apparent in a high degree of variation in investment in staff capacity in COs, indicated by differences in the frequency with which staff were supported to attend in-service short-course training and to attend international conferences. In Uganda for example, four staff were assigned primarily to HIV and AIDS activities. All had attended courses within the last two years and two staff (a PO and a PA) attended the Toronto International AIDS Conference. However, in the other three case study countries, a single member of staff was responsible for HIV and AIDS activities. In two countries (Tanzania and Côte d'Ivoire) consultants fulfilled this role, which also hampered investment in their capacity building.

86 "Regional Strategy on HIV. Implementation of Food and Nutrition Interventions in Response to HIV in the ODD/Y 7Y Region. 2008-2010. WFP. Dakar Regional Bureau for West Africa, Dakar, Senegal. Version 9: July 2007.

248. Overall WFP's HIV and AIDS expertise in southern, eastern and western Africa was found to be concentrated in lower grades and temporary staff. Interviews with government and UN sister agencies indicated the low status of focal staff to impact upon sister agencies' perception of WFP's roles and competencies within the sphere of HIV and AIDS. This in turn constrains WFP's effectiveness in implementing its HIV and AIDS policy.

249. The WFP HIV and AIDS Focal Point global meetings arranged by PDPH each year are highly valued by the staff that are enabled to attend. Focal Points interviewed in the course of this evaluation reported that the annual meetings contributed to strengthening their capacities, problems solving and networking.

Positive CO responses to HR constraints

250. The Burkina Faso CO, in common with Lesotho, had used WFP's 2003 agreement with UNV to provide HIV and AIDS expertise from the inception of the partnership. This enabled the COs to mainstream the 2003 organisational policy with expertise provided at low financial investment. The Burkina Faso CO also acted to maintain its expertise and develop its status as a key agency in this theme by upgrading the UNV to the status of PO within two years of the original appointment.

251. In spite of the evaluation team's commendation of the HIV team expertise to the CO at the conclusion of the Burkina Faso fieldwork (see debriefing Aide Mémoire[87]) the team learned later that the HIV and AIDS focal point had been given notice. Subsequently the post was extended until December 2008 with funding from the UBW.

252. The Uganda CO strengthened its HIV and AIDS team by seconding an experienced officer from the Swiss Agency for Development and Co-operation. This enabled the CO to obtain a specialised PO at minimal cost to WFP.

253. While certain HIV and AIDS staff appeared to be ranked at a grade lower than their expertise and professional duties indicated to be appropriate, the Uganda CO provided an example of good practice in investment in local PAs by enabling them to attend training courses regularly and to enhance their skills and networks through occasional international conference participation.

254. A number of COs (Côte d'Ivoire, Burkina Faso and Uganda) had an active policy of peer training fellow staff once an officer had attended a regional or international course. This was deemed to be a good practice for maximising the learning potential of training investments.

255. One of the Tanzania SOs was innovative in response to the peer training logistics staff in basic HIV and AIDS issues and approaches towards bridging the human resourcing gap.

87 Aide Mémoire Presented at the conclusion of the Burkina Faso case study 1-6 October 2007 First Discussion Draft. Ouagadugou, Saturday 6 October 2007

Short-term CO coping mechanisms

256. At the time the evaluation team visited the Tanzania CO the focal point had recently resigned and the role been designated to an in-house consultant who had no background in the theme. Although all of the three other case study countries had temporary or fixed term staff with HIV and AIDS expertise, earlier work in the course of the Southern Africa MTE indicated that some COs in the ODJ region rely on inexperienced staff to act as HIV and AIDS focal points

257. Most countries visited in the course of the Thematic Evaluation concentrate their HIV and AIDS knowledge and expertise in a single member of staff. Staff movement, together with an organizational policy of rotation was found to leave COs without any HIV and AIDS human resources for several months at a time, which hampered the supervision of IPs activities in line with WFP HIV and AIDS policy.

258. Given that CDs are not always able to determine the professional profile of incoming international staff (beyond their grade) some have to rely on short-term consultants as focal persons and HIV and AIDS advisers. While this is a means of addressing the gap in HIV and AIDS knowledge at the country office level, it is a high-risk strategy as consultants have fewer incentives to remain long-term than fixed term staff.

Human resourcing concerns

259. While staff rotation is a necessary feature of any international organisation, the evaluation found the rotation procedure to be inefficient in maintaining staff skilled and experienced in food and nutritional approaches to HIV and AIDS in positions where they can sue their skills. Professional positions advertised on the WFP intranet specify the grade and location of posts for which rotating officers can apply, but have generic job descriptions. Given the scarcity of in-house HIV and AIDS expertise, WFP should urgently revise its rotation procedures to ensure that its small skill base is not diluted and used inefficiently.

260. As set out at the beginning of the report, after the completion of fieldwork, substantial changes took place in the organisation and human resourcing of dedicated HIV and AIDS staff at HQ. While it was deemed that further enquiry by the team was not in line with the TOR, it is important to highlight that an effective reduction in specialist staff and the effective dissolution of the HIV and AIDS Service are completely contrary to necessary actions indicated by the Thematic Evaluation. Given the inadequate human resourcing observed in case study countries and those in southern Africa, the team question why human resources have been reduced rather than supported and strengthened.

Monitoring and Evaluation

261. The M&E systems in the four case study countries have only been partly developed and implemented. As a consequence, the extent to which planned outputs of HIV and AIDS operational set out in the Strategic Objective Results Matrix activities had been achieved was unquantified.

262. In Burkina Faso the Country Programme document (2006-2010) refers to Strategic Objective 3: “Support the improved nutrition and health status of children, mothers and other vulnerable groups” as the objective for HIV and AIDS. Two corporate indicators were used to measure the outcome of the programme: “Protocol adherence of patients under TB treatment and mothers enrolled in PMTCT programmes is improved” and “The effects of HIV and AIDS on food security of the infected and

affected people targeted by WFP is reduced". Only the latter indicator is relevant in relation to food security. Surveys to assess the outcome of the programme activities were due to be conducted twice during the period of implementation of the Country Programme, first time in 2007 and then presumably toward the end of the programme. At the time of the Mission, the 2007 survey had been conducted, however, the report had not been finalised and hence it was not possible to assess the outcome. No baseline/survey was conducted in the first year of implementation. This is unfortunate as this would have allowed an assessment of the outcome of the HIV and AIDS programme activities during the programme implementation 2006 to 2010. However, it should be mentioned that the 2007 survey included WFP beneficiaries as well as a control group. Outcome indicators were collected and compared with the control-group indicators in order to measure the likely impact of the WFP assistance. Although making use of control groups can give an indication of the impact of the WFP assistance, working with a control group is difficult, as the control group should have the same cultural and socio-economic characteristics and living conditions as the group of beneficiaries to allow comparison. Baseline surveys are therefore preferable. Generally, conducting surveys on outcomes a couple of times during the implementation of the programme can not be compared to a comprehensive monitoring system collecting ongoing data.

263. In the case of Uganda a comprehensive and ambitious Monitoring and Evaluation plan had been developed. The Uganda M&E plan defines one outcome of the strategic corporate objective 2 ("Protect livelihoods in crisis situations and enhance resilience to shocks") as "Increased ability to manage shocks within targeted households in crisis situations or vulnerable to shocks". , A number of indicators are listed in relation to PLWHA/ART and OVC programme outcomes. The indicators for OVC programmes appear to be highly relevant and durable: "percentage of OVC trainees from NGO/CBO training programmes gainfully employed after skills training" and "number of persons who graduated from FFT trainings (for OVC in institutions)". However, with regard to PLWHA AND ART programmes, the four indicators set out in the Uganda M&E plan, are output and not outcome indicators. These indicators are:

    a. Number of income generating activities created as a complementary activity for beneficiaries targeted in HIV and AIDS supported programmes (by type)

    b. Number of participants in income generating activities created as a complementary activity for beneficiaries targeted in HIV and AIDS supported programmes (by type)

    c. Number of skills training activities/courses for beneficiaries targeted in HIV and AIDS supported programmes (by type)

    d. Number of participants in skills training activities/courses created as a complementary activity for beneficiaries targeted in HIV and AIDS supported programmes

264. Although the four above-mentioned indicators provide very important information on the extent of implementation of IGA/skills training courses and the number of participants, the indicators do not provide information on whether participating households have achieved an increased ability to manage shocks. Thus, the data do not provide evidence that the households have developed more sustainable livelihoods.

265. No M&E data were collected in Côte d'Ivoire during the implementation of the 2004-5 PRRO and it was not possible to assess whether the planned objectives had been achieved. In the case of the new PRRO (2007-2010) an M&E system with a log frame has been developed; moreover, the partners have been trained in the M&E system. The M&E system for the PRRO 2007-2010 has two outcome indicators under the Strategic Objective 2 ("Protect livelihoods, support rehabilitation of productive assets and enhance resilience to shocks"). Out of the two outcome indicators, one indicator is relevant for HIV and AIDS programmes: "Increased ability of targeted Ivorian households vulnerable to shocks to acquire and apply learned skills including households affected by HIV and AIDS". The performance indicator is: "Percentage of trained beneficiaries applying food transformation and/or conservation skills (should exceed 90 %)". The performance indicator is relevant as applying the skills taught indicate a higher ability to protect livelihoods; the performance indicator is moreover durable as data on the percentage of beneficiaries applying the skills taught can be collected. Thus, if collected in a systematic and regular manner, the data on livelihood can indicate whether Strategic Objective 2 is being achieved.

266. The opposite was the case with the CO in Tanzania, where an extensive M&E system has been developed. Generally, the system appeared to have been too ambitious, involving too much data, and beyond the capacity of the CO staff to implement. At the time of the Evaluation Mission, neither a HIV and AIDS focal point, nor a M&E specialist were in place, and the other staff members had not received training in the M&E system, which was not functional.

267. In summary, due to the lack of thoroughly developed and implemented M&E systems in the four case study countries, it was not possible on basis of the M&E systems to assess whether the objectives of the HIV and AIDS programmes had been achieved.

Advocacy

268. Given the relative recentness of the HIV pandemic and developing knowledge base on responses, the HIV and AIDS Service has had to gather information from the literature and WFP's field activities to effectively pioneer food support to HIV infected and AIDS affected people.

269. As the country case studies from this Thematic Evaluation (see Annex E) as well as those of the 2007 MTE of the Southern Africa PRRO illustrate, awareness of and advocacy on HIV and AIDS responses has been highly variable between COs and RBs. In 2007 ODJ, for example, produced two documents setting out the rationale and evidence base for WFP's engagement in the HIV and AIDS response in Southern Africa.[88]

270. Prior to recent organisational and HR changes, a single skilled officer in HQ working with both the Nutrition and HIV and AIDS units, took the lead in gathering and interpreting relevant research and information on food and nutrition approaches to HIV and AIDS which informed PDPH's activities. This knowledge base was

88 WFP, Social Protection and Human Security for Chronically Food Insecure Populations in Countries with a High Prevalence of HIV and AIDS, Southern Africa Regional Programme Policy Guidance, January 2007.

WFP – Southern Africa Regional Bureau, HIV and AIDS and OVC Beneficiary Profiles: Vulnerability Analysis from Six Countries in Southern Africa, Johannesburg, South Africa, January 2007.

processed by PDPH to inform global partners, and is evident in the annual EB Updates. On a more practical level, PDPH also produced in-house and commissioned publications to advocate for food interventions in response to the epidemic such as the 2006 Child Vulnerability and AIDS: Case Studies from Southern Africa,[89] the 2003 widening the Window of Hope[90] and the 2007 Social Protection in the Era of HIV and AIDS.[91] These are good examples of well processed research information combined with case studies and conclusions on the advantages and disadvantages of different approaches. They act as advocacy tools and at the same time guidance that might be used within the organisation as well as by others.

271. In recent years the HIV and AIDS Service has visibly increased its advocacy efforts using press releases a recent example being the WFP News Release *WFP Hunger, Health and HIV/AIDS:A Critical Connection*..[92] In the course of interviews with HIV and AIDS specialists of sister UN agencies, a number of respondents commented that WFP's engagement in the 2006 Toronto International AIDS Conference were successful in raising the profile of food and nutritional support in response to the epidemic as well as WFP's role and approaches. Indeed WFP presented in a number of different sessions on aspects of the response including food security and nutrition and the Wellness Centre model set out in Box 7. The impact of WFP's efforts towards advocating for food and nutritional approaches to the epidemic were evident in the inclusion of this theme in the closing remarks of Stephen Lewis, the UN Special Envoy for HIV/AIDS in Africa, an extract of which is set out in the box below.

> It is now accepted as unassailable truth that people in treatment need nutritious food supplements to maintain and tolerate their treatment. And yet, there is a growing clamour from People Living with AIDS that decent nutrition simply isn't available, leaving them in a desperate predicament. The World Food Programme released a study at this conference calculating the cost of food supplementation at 66 cents a day for an entire family; what madness is it that denies the World Food Programme the necessary money?

Box 6: Extract from remarks by Stephen Lewis, UN Special Envoy for HIV/AIDS in Africa, to the Closing Session of the XVI International AIDS Conference, Toronto, Canada.

272. The "Wellness Centre" model developed by WFP in a public-private partnership represents a highly innovative and rapid response to early indications regarding the potential for food and commodities movement to contribute to the diffusion of the HIV virus. PDPH should be commended on taking this successful concept forward in a timely manner. Furthermore, guidance provided by the 2006 document Getting Started: WFP support to HIV/AIDS Training for Transport and Contract Workers, provides other COs and outside organisations have been provided with an accessible road map to setting up wellness centres.

89 This report, written by Stuart Gillespie, was produced in partnership with the International Food Policy Research Institute. See annex XX for full reference.

90 Widening the 'Window of Hope': Using Food Aid to Improve Access to Education for Orphans and Other Vulnerable Children in Sub-Saharan Africa, prepared by Robin Landis, Occasional Papers N° 15, WFP Rome, 2003.

91 Author Kara Greenblott. See annex XX for full reference

92 28 November 2007.

Reducing the potential for HIV transmission associated with transport corridors: The Muyende Bwino Wellness Centre, Malawi:
In response to research linking transport hubs and corridors with demand for transactional sex and heightened HIV transmission risk, WFP launched a pubic – private partnership with the haulage company TNT, Sida, regional and local Road Transport Operators Associations, the Ministry of Health and the Malawi Business Coalition against AIDS, among others. The purpose was reducing risks associated with the long distance transportation of food assistance. The WFP transports food aid to Malawi from ports in Durban, South Africa and Beira, Mozambique through the border post of Mwanza. Seventy percent of all Malawi's road shipments enter the country through Mwanza, where truck drivers may remain for several days while awaiting customs and other border-crossing procedures. As Mwanza has become a commercial centre it has also attracted sex workers to meet the demand created by the transient population away from their families and regular sexual partners. To address the heightened risk of HIV transmission in such a setting, the partnership set up a counselling and health centre called Muyende Bwino ("Travel Well") Wellness Centre, which provides both the local and transient communities with basic treatment for sexually transmitted infections and minor ailments. It provides information on HIV and AIDS, safer sex and refers people for voluntary testing and antiretroviral treatment. This provides an especially important entry point for HIV and AIDS information, testing and treatment as many drivers are reluctant to visit such facilities in their home areas and prefer the greater anonymity offered by the Wellness Centre. Research shows long distance truck drivers to be at high risk of exposure to and transmission of the HIV virus and the Muyende Bwino Wellness Centre enables them to access information and advice in a location where they wait for several days for official clearance of their vehicles.
Monitoring and evaluation data record that between September 2005 and November 2007 28,480 clients were reached with reproductive health, STI and HIV and AIDS IEC materials at the Wellness Centre (of whom just over 13,000 were truck drivers crossing the border). Of the 3,785 referred by the Centre to specialists VCT centres, 2,123 were truck drivers (56%) and 276 (7%) were commercial sex workers. During this period the Centre also distributed 257,308 male condoms, 53% of which were accepted by truck drivers and 14% of which were accepted by sex workers.

WFP and its partners have opened similar wellness centres in Swaziland and Zambia and plan to scale-up the wellness centre model at other 'hotspots' in Malawi, Kenya, Namibia and Zimbabwe.

Box 7: Muyende Bwino Wellness Centre, Malawi (HIV Specialist's field notes Mwanza December 2006)

2.6 Connectedness and Impact

National partnerships to enhance national ownership, capacity and sustainability

273. The COs in all four case study countries were engaged in various strategic partnerships with regard to food security with the potential to enhance the sustainability of the investments. The Tanzania CO contributes to the building of a national strategic partnership by participating in the Tanzania Food Security Information Team (FSIT). The FSIT has an advisory role in relation to government and moreover has the objective of monitoring the food security situation.

274. WFP Côte d' Ivoire similarly participated in the Food Security and Nutrition Group with other UN agencies such as FAO, UNICEF, OCHA, UNDP, and government bodies such as the Ministry of Agriculture and Ministry of Health, as well as NGOs. At the time of the evaluation mission WFP was co-chairing the group together with FAO.

275. The Burkina Faso CO was likewise actively involved in the national work for food security and at various levels, both in the overall National Council for Food Security, and in the Technical Committee in which the Country Director of WFP was an active member. Moreover, the VAM Unit Programme Officer was an active member of the Working Group under the Council and the Technical Committee.

276. WFP Uganda also achieved a high degree of connectedness in its approaches by developing important strategic partnerships with a range of government institutions (Ministry of Agriculture, Animal Industry and Fisheries; Ministry of Gender, Labour and Social Development) in its PLWHA, ART and OVC programming.

277. All four case study countries were building local capacities (government and civil society) although to varying degrees. There was evidence during the evaluation mission in Burkina Faso that the CO worked hard to build capacities of government counterparts in the participative approach to developing the Food Security Technical Committee and Working Group. The CO also provided training of government technical staff in emergency assessments (4-5 days in 2005/2006). The CO moreover implemented a strategy of trying to involve government counterparts as much as possible in HIV and AIDS activities and most of the CO's food security activities were implemented through national counterparts for example in the development of a data base and conducting surveys, etc..

278. The Burkina Faso VAM unit's approach to participative planning of the 2008 Comprehensive Vulnerability Assessment also illustrates a very good understanding of how to build capacity and local ownership. The plan is that the government should take the lead in conducting the assessment, by establishing a governmental-led technical committee to monitor the planning and implementation of the assessment. The general principle is that the role of WFP is not to conduct assessments, but to capacity-build government partners to do so.

279. WFP Tanzania was also to some extent building vulnerability assessment capacities at government and civil society level. Due to time limitations, it was not possible for the evaluation mission to explore in depth the capacity-building aspects; however, it is likely that the collaboration between the CO and RB VAM units, the Food Security Information Team and the National Bureau of Statistics with regard to conducting assessments[93] will lead to some capacity building of the latter body, i.e. the National Bureau of Statistics. Through the involvement of the Village Council and trained Food Committees in the selection of beneficiaries and food distribution, capacity is being built at community level.

280. The above-mentioned strategic partnerships and capacity building efforts in the four case study countries mainly focus at building capacities with regard to food security in a long-term perspective; for instance by enhancing national capacities for improved assessments, methods and procedures and the coordination and implementation of various food security activities (agriculture, fisheries, etc.). The strategic partnerships and capacity building efforts might thus lead to enhanced food security assessments (and thereby possibly also enhanced targeting) and improved possibilities for feasible livelihood activities for HIV and AIDS infected and affected after graduating from food assistance. It is not likely, however, that the strategic partnerships and capacity-building efforts will lead to continuation of food assistance

93 "WFP VAM: United Republic of Tanzania. Comprehensive Food Security and Vulnerability Analysis (CFSVA)". Conducted in December 2005-January 2006.

for HIV-infected and AIDS-affected people after the phasing-out of WFP assistance, since none of the above-mentioned partners are involved in this kind of programming.

281. Collaborating with nutrition partners can enhance the integration of nutrition services, such as, the provision of nutrition education and information for HIV beneficiaries and assessment and treatment for nutritional problems. This, in turn, can improve treatment outcomes which support sustainability of programming. All of the case study countries visited by the evaluation mission had formed relationships with implementing partners to support these efforts. The Côte d'Ivoire CO had developed a relationship with a donor, PEPFAR, to support the provision of training to IPs in nutrition and HIV in 2008. In Burkina Faso WFP has supported training for IPs in nutrition and HIV for a number of years. Over all, the evaluation indicated that greater efforts are needed by COs to develop strategic partnerships to enhance nutritional aspects of approaches to HIV infected and AIDS affected beneficiaries. Greater effort is needed particularly to develop partnerships with donors, government MoH and AIDS councils to plan and implement nutritional support for PLWHA. Concerted efforts were also needed to ensure optimal working partnerships with UNICEF HIV and nutrition officers. WFP should ensure that it is part of, or where needed, initiates the creation of HIV and nutrition working groups.

282. It is difficult to assess the sustainability of nutrition training for health professionals in order to ensure nutrition assessment, treatment and counselling services as this had not been fully implemented in any of the four case study countries. Please see the section on UNAIDS Division of labour for further information on this issue.

Impact of Food Assistance in response to HIV and AIDS

283. Since 2004 PDPH reported on its efforts to advocate for and support operational research that would establish the effectiveness of food assistance in encouraging adherence to and outcomes of treatment schedules for HIV and TB patients, as well as supporting OVCs. For a number of reasons such as the ethical issues inherent in using control groups, lack of funding, and the length of time required to conduct research and analyze results, very little outcome data to indicate the effectiveness of WFP's approaches was available to the evaluation mission.

284. At the time of the evaluation mission a number of studies were underway in sub-Saharan Africa. Some such as that with MUJHU in Uganda (described in section 2) were collaborations between PDPH and research institutions to address critical gaps in evidence, such as the impact of food assistance on ART treatment outcomes. Other research was more driven by country level partnerships in which WFP provides food assistance. In spite of the encourage number of studies supported by WFP country offices, staff volume and capacity has hampered WFP's tracking progress and outcomes of IPs' data.

285. In order to assess the impact of food assistance, in the case study countries, the evaluation team extracted relevant outcome data from WFP's implementing partners' monitoring systems and records. In spite of working with local consultants in all four case study countries, only Uganda, had available data that could be extracted for processing by the evaluation team Data Analyst. These were limited to data recording the nutritional status of patients receiving food assistance over 6 months. However, baseline patient data on weight prior to the receipt of food assistance was extracted to inform the evaluation of the effectiveness of food aid within the very limited sample.

286. The following sections report on findings from the evaluation team's analysis of these data along with information from other studies, which to a limited extent, inform on the effectiveness of WFP's food assistance in treatment adherence and outcomes among PLWHA; and in supporting school enrolment and continuation for OVCs. The first section sets out anecdotal evidence regarding food assistance gathered from focus groups discussion and interviews with beneficiaries in the case study countries.

Anecdotal Reports of the Impact of the Food Assistance

287. In the four case study countries and particularly in the East African countries, beneficiaries expressed appreciation for the food assistance and attributed their improved health and weight gains to the food assistance. Some reported improved strength and quality of life; others remarked that prior to receiving food assistance they were bedridden and were subsequently ambulatory and able to work. In Burkina Faso, some beneficiaries informed the evaluation team that they would have preferred to eat more of the food provided, but it was necessary to share their food rations with family members.

288. Among the beneficiaries interviewed, food assistance was often provided to complement ART and TB treatment, and/or treatment for opportunistic infections, as well as through nutrition/health education and psycho-social support, and thus it is not possible to directly attribute beneficiaries' improvements to the food assistance. Given the limited time constraints of the evaluation mission, few home visits with recipients were possible; and those who attended focus group discussion were ambulatory, which naturally biased the findings.

Quantified evidence linking WFP food assistance to improved their nutritional status of ART patients

289. One study exists from Zambia (not yet published) that reports a significantly higher increase in weight among food insecure HIV patients on ART after 12 months of receiving food assistance compared to a similar control group.[94] One limitation in this study was that it was not powered to show significance when using cluster analysis methods. Thus, although the results suggest a positive impact of food assistance on patients undergoing ART, further studies are needed that are appropriately designed and powered.

94 Megazzini, Karen, "Nutritional Supplementation for Food Insecure Patients on Antiretroviral Therapy: Impact of a Pilot Programme in Zambia". CIDRZ and University of Alabama at Birmingham, power point presentation, August, 2006

290. From the limited IP data extracted during the course of the evaluation mission and analysed by the Thematic Evaluation Data Analyst, results emerged from two WFP IP clinics in Uganda with 126 female HIV patients indicate modest weight gains (average weight gain was 1 kg.) over a six month period starting with their initiation of food assistance and ART.[95] Further, an average increase in body mass index (from 19.18 to 19.46) in women patients from the beginning of the 6 month period to the end was reported,[96] however, this did not change their nutritional status since the initial and follow-up body mass indexes were both within normal range according to international classification of adult underweight, overweight and obesity.[97] No data were available from a control group not receiving food assistance for comparison.

Quantified evidence linking WFP food and Nutrition Support with Increased Uptake and Adherence to ART and DOTS Regimens

291. Analysis of data from the Zambia study presented at the International AIDS Conference in Toronto on the timeliness of pharmacy visits as an indicator of ART treatment adherence, indicated that patients receiving food assistance were on average significantly less late (1 day) for pharmacy visits than control patients.[92] While these data indicate a positive impact of WFP food and nutritional support on proxy indicators for drug adherence, the quality of these data cannot be guaranteed and the study was not powered to show significance with cluster analysis methods.

292. WFP supported a study conducted in Tajikistan in 2005 on the use of food assistance as an incentive to improve tuberculosis treatment.[98] The study did not include a control group or provide any outcome data prior to implementing the food intervention for comparison; rather it compared the treatment outcomes of patients who received food assistance with those who did not. However, the comparison groups were not similar in socio-economic characteristics as food recipients were selected based on assets and food security screening; and those determined to be food insecure (79 percent of patients) were provided with food assistance. The study results indicated that patients receiving food had higher cure rates (88 percent) compared to 63 percent for those not receiving food.[99]

293. In the Tajikistan study treatment default, failure and mortality rates were reported to be lower among food aid recipients, compared to non-recipients. The study also indicated that the availability of food influenced defaulter rates, specifically, when logistical problems disrupted food distributions, TB treatment defaulter rates increased 1.9 times.[100] The study concluded that food assistance provided to food insecure patients improved treatment outcomes, but that a more comprehensive study would be needed to prove this.

95 WFP OEDE, Laura LoCicero, HIV and AIDS Thematic Evaluation in Africa—Uganda Case Study Analysis Report, DRAFT, October 29, 2007; and personal communication Yvonne Diallo, Programme Officer, HIV/AIDS WFP Uganda.

96 Ibid., 31.

97 WHO, Physical Status: the Use and Interpretation of Anthropometry Report of a WHO Expert Committee, WHO Technical Report Series 854, WHO, 1995.

98 Mohr, T. et al, Using Incentives to Improve Tuberculosis Treatment Results: Lessons from Tajikistan, CORE, Tuberculosis Case Study, Project HOPE, March 2005.

99 Ibid., 31.

100 Ibid.,32.

294. In Burkina Faso, WFP partners with the National TB Programme to provide food assistance to all TB patients. The data from the MOH TB programme indicate that adherence to treatment increased with food assistance, though only half a year of data is available since the programme covered all TB clinics. "Baseline" data from 2003, the National TB programme reported a 66 percent cure rate, however during the first half of 2006 when WFP food assistance was provided in all clinics, a cure rate of 72 percent was reported.[101] Programme staff expressed the opinion that a combination of food assistance, improved quality of treatment services, which include defaulter tracing and ongoing staff training, contributed to the to improved treatment outcomes.

295. No WFP programme M&E data or studies on the effectiveness of food assistance in PMTCT programs was identified by WFP staff. Therefore the evaluation team were unable to determine the quantitative indications of the effectiveness of food and nutritional support to such programmes.

Quantitative Iindications that WFP's THR Contributes to Increased School Enrolment and Continuation for OVCs

296. Two of the four case study countries, Tanzania and Uganda, had THR programs that ended in the year before the evaluation mission, however, with staff changes and inadequate programme monitoring and evaluation, no baseline and follow-up data on school enrolment for participating OVCs was available in the country offices. Similarly, the OVC THR desk review did not yield objective evidence from the two countries' programs though documents reported that the food assistance supported school continuation among recipient OVCs.

297. A 2007 PDPH review of HIV/AIDS and Children reports an increase in school attendance to 96 percent in 2005 among OVCs participating in a WFP supported programme in Ethiopia compared to a baseline (conducted prior to the food intervention) of 80 percent in 2003/04.[102] Furthermore recent programme monitoring data from Ethiopia for 2006 reveal attendance levels similar to those in 2005 (95 percent) indicating that the higher level of OVC attending school was maintained.[103] The monitoring data also show a similar pattern in regular school attendance (defined as 80 percent or higher) for 2005 and 2006 compared to the baseline data.[104] Lastly, drop-out rates for 2005 and 2006 were shown to have decreased compared to baseline data.

298. A recent WFP/UNICEF study on the outcomes of the THR programme targeting girls and double orphan boys in Malawi reports that the programme appears to work well in supporting the primary education objectives of increasing participation, progression and retention of children in education.[105]

101 This data was provided by Dr. Michael Sawadogo, Medical specialist in Public Health, Burkina Faso Programme National Tuberculose.

102 WFP PDPH, Gertrude Kara, HIV/AIDS and Children: A Review of WFP Food and Nutrition Support Programmes Targeting Orphans and Vulnerable Children, January 2007.

103 Extracted OVC Programme monitoring information provided by Mary Njoroge, Programme Advisor WFP PDPH.

104 Ibid., 36.

105 Edstrom, J et al, What after the Children Bring Home the Food? A Study of the Outcomes of Take-Home Food Rations (THR) for Orphans and Vulnerable Children in Communities Affected by AIDS in Malawi, WFP/UNICEF, Final draft, October 31, 2007.

299. In 2006, a WFP and USAID baseline and evaluation survey of a food support programme for PLWHA and OVCs in Cambodia was conducted. The report concludes an impact of the food assistance in preventing and mitigating the effects of HIV/AIDS on schooling.[106] Specifically girls in intervention areas living in PLWHA households had shorter durations of missed school in years (1.5 years) that girls living in similar situations in non-intervention areas (3.1 years).[107] A similar pattern was noted for OVC households, 1.2 years of school was missed in intervention areas compared to 5.9 years in non-intervention areas.[108] Further, in intervention areas a higher percentage of OVCs (girls) are currently enrolled (90 percent) compared to 75 percent in non-intervention areas.[109]

300. Although the limited data available from a few studies and IP records analysed by the evaluation mission suggest positive effects of WFP food and nutritional support in terms of the 2006-9 corporate Strategic Objectives 2, 3 and 4, WFP needs to more fully report and disseminate sound M&E data as well as supporting and encouraging research to provide a sound evidence base on the effectiveness of different food and nutritional approaches in response to HIV and AIDS in different contexts. Although PDPH has exerted considerable efforts to improve the operational research on the effectiveness of food assistance in improving treatment outcomes for PLWHA and for mitigating the effects of HIV among OVCs, the evidence base is still lacking, particularly in the areas of the impact of food assistance in PMTCT and ART treatment outcomes. This reflects a number of challenges to developing an evidence base, including ethical issues related to control groups.

III. Conclusions

301. The essence of WFP's HIV and AIDS policy complements that of sister UNAIDS cosponsors and provides a basic response to identified drivers of the AIDS pandemic. However, although WFP HIV and AIDS policy was innovative when first introduced in 2003, it is in need of urgent revision in light of emerging evidence and approaches since that time. The relatively "young " nature of HIV as a public health concern and the fast pace of development of clinical, social and economic responses requires that an organisation such as WFP has adequate structures to update policy and strategy to reflect the realities and results emerging from the field. Clearly further assessment is needed of how the changes in the staffing and organisation of HIV and AIDS specialists and services impact upon WFP's capacity to mainstream its own policy as well as its roles and responsibilities within the UN DOL.

302. PDPH had made commendable steps in preparing programming guidance documents and problem solving for focal points at the annual meetings. Given the marked reduction in HQ specialist staff, there is concern as to the timeliness and efficiency with which some of the guidance documents in development will be taken forward and disseminated. Equally the reduction in technical staff that might be expected will reduce the ability of specialist HIV and AIDS staff to support day-to-day field needs, to respond to technical questions and provide inputs documents under development.

106 Thwin, Aye, Food Support to PLWHA and OVC with Home-based Care Evaluation and Baseline Survey—2006, Cambodia, USAID/WFP/KHANA: September, 2006.

107 Ibid., 39.

108 Ibid., 39.

109 Ibid., 39.

303. Although WFP subscribes to the UN Policy on HIV/AIDS in the Workplace there was a notable lack of visible, sustained corporate commitment to the policy and principles of HIV and AIDS in the Workplace Policy since the end of 2006. This further contributes to question WFP's obligations and responsibilities in responding to HIV and AIDS.

304. WFP is beginning to access complementary funding in countries where specialist staff are part of the CO and have the knowledge to make funding proposals and to work in partnership with national bodies to ensure that emerging funding sources are approached for food and nutritional support as part of national AIDS responses. By strengthening in-house expertise at the CO level, WFP would be in a position to ensure that HIV and AIDS funding sources (such as the GFATM and PEPFAR) are successfully mobilised to include food and nutritional support to orphans, and food insecure AIDS and TB patients. Such an investment might incrementally relieve WFP in its funding allocation to HIV and AIDS focussed activities.

305. In terms of the sustainability and long-term impact of WFP's food assistance to HIV infected and AIDS affected people, the evaluation team was concerned about the low degree of consideration given to graduation of beneficiaries from food aid to livelihoods and IGA support. These are key factors mediating the sustainability of WFP's investments in terms of the epidemic response in Sub-Saharan Africa. The commendable effort of the Uganda CO appears from wider experience in the MTE of the SA PRRO and desk reviews to be the exception rather than the norm. Better co-ordination and planning with agencies specialising in livelihoods development and IGA would assist recipients to graduate to self-sufficiency as their nutritional status and health improve. In this way fewer AIDS-impacted people would circulate back into food assistance.

306. Overall WFP corporate policy on targeting and graduation/exit from food assistance is weak without clear objectives and guidance on strategic direction. Exit or graduation from food assistance was first raised in an EB Update in 2007. The late guidance on exit strategy can partly be explained by the fact that in 2003 when the policy was drafted, there was little need for an exit strategy due to the lack of availability of treatment. Now that the situation regarding ART and DOTS treatment has improved, there is a need for a more elaborated exit/graduation strategy for recipients of WFP food assistance.

307. WFP beneficiary targeting is not optimal for food insecure HIV infected and AIDS affected people. Geographical targeting of food insecure areas, often rural, do not always overlap pockets of higher prevalence and associated food insecurity in different country settings. Policy needs to be more flexible to enable CO's to meet the food security needs of vulnerable people, such as young people orphaned by AIDS, who migrate to urban areas where, due to their food insecurity and poverty they may be at increased risk of infection or abuse.

308. Food distribution management and modalities, the ration composition and the duration of food aid were highly variable and in some cases inappropriate to meeting WFP's corporate objectives. In one case, however, the development of separate rations for PMTCT and MCHN programs was determined to be counter productive as it fostered stigma when the programs were in the same geographical area. This reflected the inadequate capacity in nutrition, HIV and AIDS at the CO and SO levels.

309. The thematic Evaluation indicated that WFP does not afford HIV and AIDS sufficient resource priority to enable COs to mainstream the policy and adequately fulfil WFP's role as the lead agency for food and nutritional support within the UNAIDS DOL. This was particularly evident in the lack of in-house nutrition, HIV and AIDS expertise, and the poor deployment and management of HIV and AIDS-experienced staff within WFP staff rotation mechanisms.

310. Although the evaluation team were not mandated to assess the impacts of recent reorganisation of the HIV and AIDS Service, PDPH, certain aspects of this flag concerns. At the time of writing, there was no longer representation of HIV and AIDS expertise within the WFP at an adequately senior level, as the post of Director of PDPH had been dissolved along with the unit. This raises the question of how WFP will represent food and nutritional approaches to HIV and AIDS in the international arena and ensure resource allocation from within the organisation as well as the UNAIDS UBW. The team observed in COs visited throughout southern, western and eastern Africa that in-house HIV and AIDS expertise was concentrated at lower levels such as programme assistants and UNVs, and relied heavily on temporary consultants as short-term solutions to corporate HR policy. These mechanisms have led to a very fragile capacity base and high leakage of expertise as specialist volunteers and consultants take more secure and career-enhancing posts offered by other organisations. In spite of the challenges, the evaluation team encountered highly motivated staff at all levels in the field, who devised a variety of means to mainstream HIV and AIDS in spite of a lack of resources or autonomy to engage the necessary specialist staff.

311. Given the low degree of nutrition, HIV and AIDS expertise in the field, the evaluation team was concerned to learn near completion of the Evaluation of the dissolution of PDPH and the marked reduction in specialists at HQ. This raises questions as to how in future, WFP will provide adequate technical support to COs and RBs, such as that provided by the annual focal points' meetings and equally importantly, how experience and lessons learned from the field will be consolidated and reflected in policy development.

312. The existence of an HIV and AIDS Service at HQ with representation of a Chief also enabled senior representation in the international arena, which in recent years has raised WFP's profile as a UNAIDS cosponsor and an important actor in the response to the epidemic. Some of the unit's advocacy work has been innovative and in the case of the truck drivers' wellness centre, provided ground-breaking models of corporate responsibility and integrative approaches to directly reducing diffusion of the virus in the course of delivering commodities and food assistance.

313. Given the lack of priority given to specialist human resources, it was not surprising that the evaluation found poor monitoring, evaluation and reporting of the outcomes of WFP's HIV and AIDS approaches. However, as WFP is pioneering food responses to the epidemic in Sub-Saharan Africa it is essential that adequate monitoring and evaluation of efforts are enabled to inform policy and strategy development. Equally, reporting and dissemination of the outcome of these approaches are essential for advocacy and to inform dialogue with the wider humanitarian and development community of practice. Donors are generally ill-informed about the value of food and nutritional support in response to the epidemic and would be more likely to have confidence in funding WFP's approaches if presented with more concrete results.

3.1 Overall Assessment

314. The World Food Programme has a distinctive role with the UNAIDS Division of labour as the lead organisation for food and nutritional support in response to HIV and AIDS. As such it requires appropriate human and financial resource allocations to enable staff to fulfil its responsibilities within the DOL as well as to achieve WFP's own corporate objectives (specifically SOs 2, 3 and 4). Throughout the Thematic Evaluation the team encountered evidence of inadequate human resources particularly regarding HIV and nutrition expertise as well as in livelihoods and IGA. Given that in recent weeks, post-evaluation, restructuring at HQ has led to a reduction in dedicated HIV and nutrition staff, it is crucial that WFP examines its commitments and resource allocation to its own and wider UN objectives in response to the epidemic and its impact on nutrition, food security and wider social and economic factors such as the school access of children affected by AIDS.

315. In the course of the evaluation process, observations made and documentary evidence indicated that with stronger human resourcing inputs - specifically an adequate volume of dedicated HIV and AIDS staff and frequent investment in their professional development – COs may achieve better results in mainstreaming of WFP HIV and AIDS policy. For example, the Uganda CO had substantially more contracted HIV and AIDS-dedicated staff than the other three case study countries. As a consequence, it was enabled to develop a portfolio of approaches to mainstreaming WFP HIV and AIDS policy as well as collaborating in international research to on the impact of food assistance to HIV-infected patients and developing and disseminating of HIV and nutrition materials. Although other case-study COs had highly dedicated staff, they were much fewer. In two of the four case-study COs, the HIV and AIDS focal points were temporary consultants, which gave the impression that this aspect of policy was not regarded to be a priority. The team also observed how a lack of priority given to appropriate HIV and AIDS expertise can undermine representation within national HIV and AIDS working groups and faith in WFP's ability to fulfil its roles within the UNAIDS DOL.

3.2 Key issues for the future

316. The progression of the HIV epidemic in Sub-Saharan Africa continues to exert a profound negative effect on the productivity and food security of some of the poorest and most vulnerable people and communities in the world. Equally, poverty and food insecurity have emerged as key drivers of the epidemic in the region, and the prevalence rate of the virus in some countries has reversed development efforts and poses a threat to economic stability and wider security. The unique and 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 growing number of children orphaned by the virus. Emergency food support to households rendered food-insecure by the impact of the virus has a clear role in response to the AIDS epidemic in the region. However, to ensure the recovery of household economies and the future security of children made vulnerable by AIDS, it is essential that food and nutritional responses have a sustained impact and that assistance is designed to support future food security and self-sufficiency.

317. With progress in the therapeutic management of the viral load and the enabling effect of funding mechanisms such as the GFATM on the roll-out of anti-retroviral therapy, treatment for opportunistic infections and DOTS for TB, infected people in the

region are increasingly able to recover their health and economic capacities. Clinical and field experience indicates sufficient food and adequate nutrition to be fundamental to the tolerance and outcome of TB and AIDS drug therapies. It is therefore crucial that the UN family adequately and appropriately responds to the special nutritional needs of households made food insecure by the epidemic, to ensure sustained recovery.

IV. Recommendations

318. Specific recommendations relating to offices that participated in the country case studies are set out in Annex E. In this section overarching recommendations are presented according to the various aspects of the evaluation set out in the TOR and expanded in the Evaluation Matrix in annex C.

WFP Policy on HIV and AIDS

319. WFP should update its 2003 policy on HIV and AIDS to reflect recent global thinking and practice in response to the epidemic. Policy and objectives should be clarified in this revision process.

320. The overall scope of WFP HIV and AIDS policy should be reduced and adapted to enable COs to respond to local needs and the realities of their budgets. In this way COs might be enabled to achieve a higher quality of measured outputs, albeit within a reduced scope. It is suggested that WFP, in addition to mainstreaming HIV into existing programs, focus on establishing effective programming models in response to HIV, AIDS and TB that enable short-term yet sustained investment though graduation from food support to appropriate livelihoods activities (either WFP FFT, for example, or through liaison with specialist partners).

321. WFP's HIV and AIDS policy and guidance should be adaptable to HIV prevalence and other socio-cultural, political and economic contextual factors that shape responses in different country settings. For example a "menu" style of policy might serve the different contexts in which COs are required to mainstream policy into existing programs as well as implement HIV/AIDS programmes. .

Policy Guidance

322. WFP should ensure that indicators relating to HIV and AIDS activities are rapidly developed, made mandatory and to the extent possible, standardized. In this way WFP will be able to better gauge the effectiveness of its inputs and make informed programming adjustments. Training on collection of data, particularly of weight measurement should be ensured and standards for data collection developed and incorporated in operational activities. Given confounding variables and lack of data available on "control" patients, adherence to ART treatment, attendance at PMTCT appointments and follow-up appoints to HIV-exposed infants may provide more meaningful monitoring indicators. Therefore adherence monitoring indicators need to be standardized and included in the Indicator Compendium for ART, PMTCT and TB patients.

323. Within the post-evaluation restructuring, WFP should ensure that adequate support is available to CO and RB staff in fully developing and competently conducting monitoring of the outcomes of activities responding to HIV and AIDS in line with focus on results set out in the 2006-9 Strategic Plan.

324. Revised policy should be accompanied by a logical framework. This would provide a tool for setting out an accountable results chain for WFP HIV and AIDS operations. For each SO relating to HIV and AIDS, it would provide a logical progression linking interventions and activities to outputs contributing to outcomes.

325. Focal points should be encouraged to provide structured feedback to HQ on the unmet needs in terms of their policy understanding and operational approaches to policy mainstreaming. In response to the main priorities identified by this feedback process WFP should formalise of lines of technical support at both RB and HQ levels and initiative appropriate and cost-efficient responses to meet focal points' unmet technical support needs.

326. A concise overview of WFP HIV and AIDS policy together with key relevant points from EB Updates should be formulated and provided to focal points in the suggested "Starter Packs" set out in the human resourcing recommendations (see below).

327. WFP should ensure that the thematic guidelines on integration of HIV and AIDS into food security and vulnerability analyses prepared by the HQ VAM unit is shared with RBs and COs as soon as possible

328. A short and more reader-friendly (step-by-step) manual based on the guidelines: "Integrating HIV/AIDS into Food Security and Vulnerability Analysis" (Draft October 2007) should be prepared for the VAM officers at CO and RB levels.

329. The current indicator of chronic illness/disability in Emergency Assessments in Uganda should be separated into two indicators in order to give an indication of the level of HIV and AIDS (the proxy indicator: chronic illness).

330. During the course of the Thematic Evaluation it was apparent that a substantial body of guidance on HIV and AIDS programming had been recently drafted or completed by PDPH. This included guidance on; rations; the integration of HIV and AIDS into Food Security and Vulnerability Analysis; incorporating nutrition and food assistance into HIV and AIDS care and treatment programs; revised PMTCT "Getting Started" guidance; draft "Getting Started" guides for TB and OVC guidance, etc. Given the recent dissolution of PDPH and specialist staff cuts in HQ, WFP must ensure that draft documents are completed, rolled out and accompanied by adequate and appropriate training.

Fulfilling WFP's role in the UNAIDS Division of Labour

331. WFP should reconsider its position as lead agency in the UNAIDS DOL and whether it has the means to raise capacity in the prerequisite human resources to provide appropriate leadership in nutritional approaches to HIV and AIDS at the global, regional and country-levels. While WFP has the capacity to lead food aid responses to HIV and AIDS, other agencies are better placed to lead more general food and nutritional approaches in response to the epidemic.

332. Given the lack of clarity in UNAIDS lead roles, the new structures that have assumed PDPH's roles within WFP should clearly and realistically define WFP's UNAIDS lead role in dietary nutrition support at the global and country office levels. A menu of specific measurable activities (potentially sequenced) to be implemented by

responsible HIV and AIDS officers at HQ and in country offices should be developed along with implementation and monitoring guidance on fulfilling WFP's role within the UNAIDS DOL. At the country level, this process will require an initial reassessment of HIV and nutrition policy, training and programming.

333. Given the close partnerships needed between WFP, UNICEF and WHO in implementing the UNAIDS DoL, discussions on optimising working together at the global, regional and country levels need to take place. This should be followed by updating the UNICEF global MOU in light of the UNAIDS Division of Labour roles. As the JUNTAs' reviews are released on the UNAIDS DoL roles at the country level, it may also be necessary to update or develop country level MOUs between WFP and UNICEF.

334. In countries that do not have HIV and Nutrition Technical Working Groups (TWGs) within the government MoH, NACs or nutrition coordination structures, WFP should advocate for their creation. In some cases they may exist, but may need to be strengthened and WFP in its role within the DOL should ensure that the HIV and Nutrition TWGs take responsibility to develop, update and implement HIV and nutrition policy and guidance.

335. WFP should lobby to ensure that adequate funds are budgeted to support studies to investigate links between HIV and AIDS and household food security, including coping mechanisms and mitigation strategies during times of crop failure. It should also ensure adequate financial allocation to sharing and circulation of information generated by supported research.

Strengthening appreciation within the UN family of WFP's mandate in the response to HIV and AIDS

336. WFP should make continued efforts to optimize opportunities for developing synergies with sister UN agencies at the field level. Locally and centrally, WFP should encourage IPs and its own networks to ensure that all opportunities are fully exploited to distribute sister agencies' IEC materials, condoms and safe delivery kits.

337. Given recent restructuring and accompanying specialist HIV and AIDS staff changes it is recommended that as soon as possible, WFP shares both internally and externally its plans for fulfilling its mandates with regard to HIV and AIDS responses. This is crucial both to maintaining external confidence in the organisation's ability to fulfil its UNAIDS roles as well as its own stated policy.

Strengthening Monitoring and Evaluation

338. RBs should assist COs to revise and enhance their M&E systems to incorporate relevant and durable indicators. This should be carried out as a global revision to ensure that data collection and presentation are harmonised to facilitate organisation-wide data compilation and analyses.

339. COs should be encouraged to use logical frameworks (log frames) as planning tools to ensure that operations are conducted to enable results-based thinking and management. This may require the adaptation of existing training materials to provide a simple review of log frames to ensure their confidence use by CO staff.

Enhancing internal coherence

340. HIV prevention and awareness education should be mainstreamed in all WFP development and relief programs, such as, FFW, FFT, MCHN, TF/SFP and GFD through developing partnerships with organizations competent in this area.

341. Timely training should be planned for VAM staff in the new VAM guidelines regarding integration of HIV and AIDS into food security and vulnerability analyses.

342. To create synergy and increase programme effectiveness, when feasible WFP should plan to integrate MCHN programs with PMTCT services and move toward phasing-out food assistance for stand-alone PMTCT programming.

343. In revising its HIV and AIDS policy, WFP is advised to prepare more flexible policy enabling COs to tailor programming to local contexts.

344. All RBs should prepare a regional strategy on HIV and AIDS. Enhanced sharing of "good practice" strategic documents such as that produced by ODD/Y should be more actively shared between RBs.

WFP responsibility for mainstreaming HIV and AIDS in the Workplace

345. To remain in line with UN practice and organizational policy, WFP should renew efforts to follow the Regional Workplace Co-ordinators' recommendation for continued mainstreaming of HIV and AIDS and ensure continuity of activities.

346. While it is appreciated that budgetary constraints hamper annual refresher training and that of new and previously untrained employees, WFP should reassess its commitment to the wider UN HIV and AIDS in the Work Place policy and principles and ensure the maintenance of training both to temporary and fixed-term employees.

347. WFP should take responsibility for ensuring employees' access to current, accurate and local information in line with UN directives. The dedicated HIV and AIDS in the Work Place website on the WFP intranet should be immediately and consistently updated.

348. The inconsistencies in implementation activities and staff training must be addressed immediately, regardless of when the common UN Programme "UN Cares" becomes effective within WFP.

Improving beneficiary targeting

349. WFP should develop elaborated geographical targeting criteria for HIV and AIDS programming, including OVC programmes, applying to different situations of high/low prevalence and different levels/patterns of food insecurity (cf. for example the regional strategy prepared by ODD/Y).

350. WFP HQ should prepare an easily understandable, step-to-step manual for urban programming for COs and SOs (based on the guidelines already prepared). Training should be provided at country level for CO, SO and IPs relating to the local context (HIV prevalence, socio-cultural and economic factors, for example) and be based on the experiences of the IPs.

351. WFP should conduct training for all HIV and AIDS focal points in targeting (based on the new FANTA/WFP handbook: "Food Assistance Programming in the context of HIV") and preparation of country specific targeting guidelines. To make the training efficient and useful, it should be tailored to the specific country context, by being based on operational field experiences.

352. COs should prepare national targeting guidelines in collaboration with IPs in order to build on field experiences and to ensure that the guidelines are feasible and usable for the partners. The guidelines should be based on the use of the eligibility form. SO staff and IPs should be trained in applying the new targeting guidelines.

Improving Food Distribution Modalities and Rations for HIV and AIDS beneficiaries

353. WFP should encourage and support IPs to examine the potential for reducing the distance between their distribution points and homes of recipients infected with HIV and/or TB or affected by AIDS.

354. WFP should encourage its IPs to devise innovative and cost-effective responses to transport issues encountered by recipients at the micro-level and liaise with NGOs and other organizations specializing in motorized and non-motorised forms of transport for the poor.

355. To inform ration design and size of household rations, WFP should use secondary data if available or conduct small representative surveys of PLWHA and other HIV beneficiaries to determine food security and vulnerability, the types of food available in their households, food preferences, food intakes and family demographics. This is not recommended as a stand-alone activity, but should be incorporated into the HIV programme assessment process and VAM assessment whenever possible.

356. Prior to finalizing the draft guidance on HIV ration design, WFP should consider incorporating more specific information on the appropriate macro and micronutrient composition of HIV rations along with examples of ART or OVC THR rations and how to develop them. Additional information should be provided to IPs on determining the composition of household rations and their size.

357. Consistency in WFP publications on the shelf life of CSB is needed to clarify confusion in the field. Enhanced training and closer of supervision IPs, particularly as this relates to storage of CSB in warm, humid climates is needed.

358. WFP should provide, via its RBs, stronger guidance to country offices on the storage of milled/fortified cereals. It should ensure that policy regarding the milling and fortifying cereals is followed when possible; and that the decisions taken regarding milling/fortification of cereals take into account planning and budgeting for the additional logistic and processing costs.

359. Structures that have taken over the responsibilities of PDPN/PDPH should determine the feasibility of providing home-based fortification products to HIV infected, AIDS–affected and other beneficiaries when cereals can not be fortified prior to distribution.

360. WFP should also continue to advocate for and, as possible, support research on appropriate weaning foods for HIV-exposed infants. Appropriate foods and/or rations for HIV-infected young children also need to be investigated

361. Better coordination and collaboration between HIV and nutrition staff at the levels of HQ, COs and RBs is needed to ensure optimal use of the nutrition expertise required in planning, implementing and monitoring HIV rations and the overlap of HIV beneficiaries served in nutrition programs, such as, therapeutic feeding programs.

362. Country offices should investigate ways to provide more consistent food and nutrition training for IPs so that the use of the food and the effects of the food assistance can be enhanced.

Enhancing programming and sustainability of WFP's inputs

363. WFP through IPs should integrate small scale gardening and livestock projects as context appropriate into its programming to promote increased consumption of vegetables, fruits and protein rich foods in order to complement the HIV ration, improve household diets and to support livelihoods.

364. The draft update of PMTCT guidance to support increased integration of MCHN programming with VCT and PMTCT programs should be strengthened.

365. WFP guidance on therapeutic and supplemental feeding should be updated to include information about HIV and acute malnutrition; it should include information on the integration and/or referral of patients with acute malnutrition for VCT.

366. To further support nutrition and HIV and AIDS programme integration, closer working relationships are needed for specialist HQ staff (previously PDPH and PDPN) and HIV and AIDS focal points and nutritionists at country offices. This may be more easily facilitated now that the HQ nutrition and HIV units have been merged. At the country level, when possible nutritionists with expertise in HIV should be hired to oversee both the nutrition and HIV programmes. In countries where different staff are responsible for HIV and nutrition programs, regular meetings to ensure integration is recommended.

367. WFP headquarters and/or RBs should provide training for all HIV and AIDS focal points in graduation and livelihood/IGA based on the FANTA/WFP handbook: "Food assistance programming in the context of HIV". Country specific guidelines should be prepared by focal points, supported by RBs and HQ specialists. This would have been an important role of PDPH. Since its dissolution, however, it is unclear to the evaluation team how HQ will continue to provide specialist support to COs and RBs, however, WFP must ensure that adequate specialist backstopping is provided.

368. HIV and AIDS focal points should be capacity-built to have sufficient expertise to selecting strong IPs and feasible IGAs as well as being able to assess the activities of the IPs.

369. As well as preparing national graduation guidelines with clear graduation criteria, COs should adapt the eligibility assessment form used for selection of beneficiaries to local conditions and ensure that it is used as a tool to determine beneficiary suitability for phase-out and graduation from food assistance, by repeating its application during the period of food assistance. In this way beneficiaries might move from food assistance to IGA/livelihood support in an informed manner.

370. The preparation of guidelines and adaptation of eligibility forms should be conducted in collaboration with IPs in order to build on field experiences and to ensure that the guidelines are feasible and usable for implementing partners.

371. Collaboration between HIV and AIDS programme staff and food security/livelihood/FFA/FFT staff at headquarters, RB, CO and SO levels should be strengthened to improve synergies and capitalise on the competencies of dedicated staff.

372. At the commencement of the report drafting process the team recommended that at headquarters, collaboration between PDPH and PDPS should be enhanced. As these two service departments have been recently dissolved, it is recommended that WFP ensures that the roles fulfilled by these two units are continued and that staff collaboration is enhanced.

373. Remaining livelihoods and HIV and AIDS officers at headquarters should collaborate to develop technical expertise in low-labour-input IGAs in urban areas to strengthen the sustainability of HIV and AIDS programming and support to IPs.

374. In order to facilitate graduation from WFP food assistance in ART/DOTS and HBC programmes, WFP should develop linkages with in-country social safety net programmes for non-able bodied beneficiaries, who are not capable, or do not have the means of initiating IGA/livelihood activities.

375. To enable beneficiaries who have established their ARV/DOTS regimens and recovered adequate production capacity to graduate to more sustained food security, WFP should explore possibilities to further strengthen the IGA/livelihood activities and develop linkages with line ministries/national institutions, multi- and bilateral donors, NGOs/CBOs, or other partners with expertise in this field. In each country it is recommended contracting a consultant for the task with the more specific objectives of:

- assessing the feasibility of and market for the most commonly implemented IGA/livelihood activities as well as exploring alternative feasible activities
- assessing the capacity of current partners in this regard and develop plans for training
- identifying, if possible, organizations/institutions with technical expertise in IGA/livelihood activities with whom WFP can partner
- preparing guidelines for the IGA and livelihood activities to be initiated by the implementing partners

376. COs should continue to explore the possibilities of supporting partners (technically and in terms of funding) in operating with a continuum from food assistance to livelihood projects and adopt a more flexible approach regarding the shift from food assistance to livelihoods support.

377. COs should explore the possibilities for providing non-food commodity support to IPs in order to enhance the IGAs, as the evaluation mission observed in Uganda.

378. WFP COs should further advocate for the inclusion of HIV and AIDS in the analysis and intervention areas of national food security policies and programmes.

Responding to Human Resourcing realities and requirements

379. It is recommended that WFP invest in the development of a “Starter Pack” to provide focal points with basic training and information resources to enable those with no HIV and AIDS expertise to function in their role with an improved level of confidence and effectiveness. It is suggested that such a pack might contain a CD Rom training course, similar in style to that used for UN security training purposes. This would provide cost-effective and immediate training for staff as soon as they take up their duties as focal points. It is also recommended that packs contain the following:

(i) Basic information on HIV and AIDS; nutrition and HIV; accessing information and resources; the roles of partners and other UN agencies;

(ii) Roles and responsibilities of focal points;

(iii) Contacts of in-house specialists at the RB and HQ levels.

380. To effectively fulfil their responsibilities, HIV focal points should be offered a programme of continuous in-service training to ensure that that appropriate skills are developed and maintained throughout staff changes.

381. CDs should be enabled to fill vacant positions with specialist HIV and AIDS human resources as required, rather than by generalists. Where required, staff should be selected based on adequate technical background in nutrition and HIV and the appropriate experience needed to adequately represent WFP and implement its UNAIDS role.

382. To provide technical support it is also suggested that new structures in HQ that have taken over the roles of PDPH consider the feasibility of providing "Help-Point" or consultation days, whereby focal points are given specialist contacts and times or days at which they might have their queries answered. This might be conducted through various media including E-mail and teleconference and could be held one day a month and rotated among existing WFP HIV and AIDS specialists

383. To enable staff specialised in food and nutritional support in response to HIV and AIDS to maintain a progressive career within the organisation and to more efficiently use in-house expertise, WFP should ensure that job descriptions for rotating staff are more specific when posts for HIV and AIDS Focal Points and other designated position are advertised. The creation of a technical "pool" similar to that used for VAM specialists should be considered for HIV focal points and nutritionist specialists.

Optimising Complementary Funding

384. Information already produced by RBs on securing complementary funding should be consolidated and distributed to focal points in all regions. Positive outcomes of initiatives such as Côte d'Ivoire and Mozambique's efforts with PEPFAR should be shared with other COs to expand the submission of grant applications.

385. COs should strengthen their participation in national proposal drafting processes to agencies funding country responses to HIV/AIDS and TB.

386. COs should continue liaison efforts with complementary funding organizations in order to strengthen their understanding of WFP's role in supporting national responses to HIV/AIDS and TB.

387. Agreements with the GFATM concerning WFP cost recovery need to be formalized to prevent the issue of WFP non-food costs from hampering financial disbursement and delivery of food support to identified beneficiaries as was the case in Burkina Faso.

Enhancing advocacy and improving donor support

388. WFP should continue its HIV advocacy of food and nutritional responses to the HIV epidemic in sub-Saharan Africa. Given the recent dissolution of PDPH, WFP should consider how these approaches will receive senior representation in the future. Given on-going UN reform and common funding mechanisms, WFP needs to maintain senior and skilled representation to ensure the visibility of food and nutrition within the global HIV and AIDS response and that WFP's approaches receive adequate budget allocations.

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

AUGUST 8, 2008

The Thematic Evaluation highlighted a constellation of factors that constrain staff in operationalising WFP's HIV and AIDS policy and fulfilling its roles and responsibilities as a lead agency within the UNAIDS Division of Labour (DOL). It found that in spite of resourcing challenges in the years following the adoption of an HIV and AIDS policy, WFP has made headway in raising the profile of food and nutritional responses to HIV and AIDS among food-insecure people.

Although the policy *Programming in the Era of AIDS: WFP's Response to HIV/AIDS* was pioneering and grounded in the evidence base in 2003, the document requires revision in line with emerging knowledge and technical advances, best practice and evolving national responses. It would also benefit from inclusion of a results framework as the current policy is not guided by an overall logical framework, although, the WFP Strategic Objective Results Matrix of the 2006-2009 Strategic Plan sets out expected outputs and outcomes for support to people living with HIV and AIDS-affected households under strategic objectives (SO) 2- 4.

Specific HIV and AIDS activities are implemented in more than half of all countries assisted regularly by WFP and represent approximately 4% of the agency's overall food deliveries and 2% of the total assisted beneficiaries. The majority of WFP HIV and AIDS activities are implemented in Africa within the frame of PRROs and a major proportion of WFP HIV and AIDS resources are invested in mitigating the impacts of the epidemic.

While WFP recognises its weaknesses in providing robust and systematic evidence of results,[110] monitoring and evaluation (M&E) has not been adequately developed to enable WFP to fully assess the effectiveness and impact of its HIV and AIDS interventions.

The Thematic Evaluation made recommendations to WFP management concerning updating the policy; strengthening human resources and adapting staffing mechanisms to enhance and maintain adequate in-house HIV and AIDS expertise.
WFP has been undergoing organisational change since completion of this evaluation. Although the Thematic Evaluation was not mandated to extend the scope of work beyond the TOR to incorporate these changes, it became apparent that the HIV and AIDS Service (PDPH) had been dissolved after the evaluation was completed. Although a number of staff

110See page 8 of the WFP Strategic Plan 2006-2009

were absorbed into the Policy, Planning and Strategy Division there was an initial 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 maintain and strengthen its role in the response to the AIDS epidemic.

BACKGROUND

Context

1. Some 33.2 million people worldwide are infected with the Human Immunodeficiency Virus (HIV). According to the latest AIDS Epidemic Update, 76% of AIDS-related deaths are estimated to have occurred in Sub-Saharan Africa and AIDS is the primary cause of death in the region. Apart from the grave public health concerns, the impact of the epidemic upon productive members of society and increasingly women, has major and long-term consequences for human, social and economic development. The food and nutritional needs of people infected with HIV and TB, and the social protection of those affected by AIDS, particularly orphans and other vulnerable children, 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 and the treatment of opportunistic infections such as TB.

WFP's HIV and AIDS Policy and Operations

2. WFP has been actively engaged in the HIV and AIDS response since 2000 and in 2003 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 activities and advocacy in over 40 countries[111] and internal mainstreaming through its *HIV/AIDS in the Workplace Programme*.

3. The stated goal of WFP's HIV and AIDS initiatives is to provide food and nutritional support to food-insecure individuals and families who are infected with the virus and affected by AIDS. Main activities are the provision of food and nutritional support to treatment and care programmes, support to orphans and children affected by AIDS, school feeding, Food-for-Work and Food-for-Assets programmes and linking prevention education with relief operations activities. The establishment of effective partnerships and gender mainstreaming are important elements in all WFP's HIV and AIDS activities.

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

111 Report on HIV/AIDS Thematic Evaluation Survey Results, Laura LoCicero for OEDE April 2007.

5. During the Thematic Evaluation survey reference period (2004-2005) HIV and AIDS activities were implemented in 54% of countries that were assisted regularly by WFP. This represents 4% of WFP's overall food deliveries and 2% of the total assisted beneficiaries in that time period. The majority of WFP HIV and AIDS activities were implemented in Africa within the frame of PRROs and a major proportion of WFP HIV and AIDS resources were invested in the mitigation of the impacts of HIV and AIDS.[112]

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 to the Executive Board and other stakeholders, the evaluation had the stated purpose of serving learning functions and offering recommendations to contribute to WFP's evolving programming in response to food insecurity among people living with HIV and AIDS-affected people.

7. The evaluation was conducted in a collaborative manner. At all stages evolving documents and surveys were shared with related departments, particularly PDPH and the Evaluation Reference Group and their feedback incorporated. The process also involved document reviews, interviews with governments, bi-lateral and multi-lateral stakeholders, NGOs, CBOs and food aid recipients, as well as WFP staff at HQ, Regional Bureaux, Country Offices and Sub-Offices. Due to budgetary constraints, fieldwork was conducted in four case study countries in East and West Africa: Uganda, Tanzania, Côte d'Ivoire and Burkina Faso. Recent complementary information on WFP activities in Southern Africa collected by two of the Evaluation Team members in the course of the 2007 Mid-Term Evaluation of the Southern Africa PRRO was also used. This provided information on WFP HIV and AIDS activities in Zimbabwe, Malawi, Mozambique, Lesotho and South Africa.

8. The scarcity of monitoring and evaluation data made it difficult for the evaluation to draw conclusions regarding the effectiveness and impact of WFP's HIV and AIDS interventions. In order to comment on the efficacy of WFP approaches, the team with assistance from COs, recruited local consultants to extract existing data from implementing partners' (IPs) data bases 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 Executive Board in 2003. It prepared the ground for WFP to firmly incorporate HIV and AIDS issues in all programming categories. In stating that in situations when the epidemic places food security at risk, WFP would consider HIV and AIDS as a basis for a PRRO,[113] the policy raised the profile of the epidemic as a humanitarian issue. It clarified that food insecurity driven by the epidemic could be addressed directly through WFP programmes, and that activities can be used as platforms for other types of HIV and AIDS activities, such as

112 Full details are presented in the Thematic Evaluation survey: Report on HIV/AIDS Thematic Evaluation Survey Results, Laura LoCicero for OEDE April 2007.

113 Protracted Relief and Recovery Operation.

prevention education. It committed the organisation to adjusting programming tools to reflect the realities presented by HIV and AIDS. The policy also defined WFP's role in advocating for the inclusion of food in national responses to the epidemic in partnership with local and international partners, NGOs, governments and sister UN agencies. The policy is not guided by an overall logical framework or results frame, however, the WFP Strategic Objective Results Matrix of the 2006-2009 Strategic Plan sets out expected outputs and outcomes for support to people living with HIV and AIDS-affected households under strategic objectives 2, 3 and 4.

10. Although updates have been presented yearly to the EB, WFP 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 the policy was written it 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 broader UN HIV and AIDS in the Workplace policy, WFP launched its own *HIV/AIDS in the Workplace Programme* (HAWP) in 2004. Although this was well-aligned with UN policy and approaches, there was an apparent lack of internal coherence between key internal documents[114] and a further lack of coherence between the various HAWP work plans.[115] The evaluation team encountered a lack of institutional memory of HAWP since 2006, after which there was evidence of an organisation-wide tail-off of activities and engagement. This was reflected in some COs 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 efforts have contributed to the integration of food assistance and nutrition support into the national AIDS planning documents in 32 countries where it is operational.[116] This was also apparent in three of the case study countries where WFP actively participated in UNAIDS planning meetings and was reflected in the inclusion of food assistance and nutrition support in some countries' 2007 UNDAF Work Plans. However, the exact meaning of "nutrition support" was not specified in any of the national documents seen and it was unclear 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. However, section 13 of the MOU prescribes an expanded scope of collaboration in supporting research that is not reflected in policy, widely in practice or embraced by many staff interviewed.

14. Within the UNAIDS Division of Labour, WFP has the lead role in "dietary and nutritional support" with WHO, UNICEF and UNESCO as its main partners. This leadership role applies to global discussions related to the delivery of food assistance and nutrition support along with identifying gaps at the country level, advising national stakeholders and stimulating demand for such services. However, the

114 Specifically, the WFP Executive Director's 2004 Memorandum launching HAWP and the Agents of Change Conceptual Framework which set out different goals and objectives.

115 For example, the 2004 work plan refers to the objectives provided by the Agents of Change Conceptual Framework, whereas subsequent work plans (2005, 2006 and 2007) refer to the objectives stated in the EB memo.

116 Out of the 41 countries in which WFP has engaged in HIV and AIDS activities and advocacy during the Survey reference the period of 2004-5.

definition of the lead role in UNAIDS DOL documentation remains vague. Fieldwork highlighted that some senior officers appear not to fully support WFP's HIV and AIDS policy or role within the UNAIDS DOL. Indeed, some sister UN agencies, while fully endorsing WFP's lead role in food support, questioned its capacities in dietary and nutritional support.

15. However, interviews conducted with staff working for sister UN agencies in case study countries and at HQ illustrated a strong appreciation of the importance of food and nutritional support in response to the epidemic, particularly in enabling adherence and optimising the efficacy of drug regimens among food-insecure people infected with HIV and TB.

16. WFP has collaborated with sister UN agencies, notably in the field of integrating food and nutrition support to HIV-positive and AIDS-affected refugees with UNHCR and UNICEF. WFP also partnered with UNHCR and UNAIDS in publishing the 2006 *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, beyond the integration of HIV prevention and awareness in primary schools, little mainstreaming of HIV prevention activities was observed. The 2003 policy furthermore calls for the adjustment of all WFP programming tools (for example needs assessments and vulnerability analysis) to reflect the reality presented by HIV and AIDS. Among the four case study countries Uganda was the only CO observed to have made progress in this regard.

Relevance and Appropriateness:

18. The 2003 Policy document's lack of reference to the duration of food assistance and beneficiary graduation was reflected in variation in strategies and practices in the case study countries. The period of food assistance was formulated in guidelines only in the case of Uganda.

19. Linkage with partners and projects specialising 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. Although a Livelihood, Social Protection Unit was set up in WFP headquarters in mid-2007, it was, however, dismantled in the restructuring process the same year.

20. In the different case study countries there was variability in the food basket and its nutritional composition. Follow-up with HQ established that the HIV and AIDS Service did not recommend standardised HIV rations, which field staff often requested; rather it supported COs in developing HIV rations based on the particular objectives of food assistance and the identified vulnerability of the target population. This approach was informed by WFP's experience in attempting to standardize rations in the 1999 Great Lakes Region programming and from more recent work in the Southern Africa region where "common logic" in developing HIV rations was emphasized over "a common HIV ration". Recently this approach has been reflected in the draft ration design guidelines.[117] The evaluation agreed that developing rations based on the objectives of food assistance and the vulnerabilities of the target

117 WFP Food Assistance in the Context of HIV Ration Design Guide, DRAFT, September 18, 2007.

population should continue as policy. In addition, COs that may not have the nutrition expertise to confidently implement this alone should receive extra support. The draft ration design guidance and recent efforts to strengthen the HIV and AIDS component of VAM assessments are expected to provide support to this approach.

21. Food distribution modalities are not mentioned in the WFP HIV and AIDS policy document or in previous PDPH guidance, although it is briefly covered in the recently published WFP/FANTA[118] handbook: *Food Assistance Programming in the Context of HIV*. Observations in the case study countries highlighted variation in food distribution mechanisms and their consequences upon the well-being of HIV and TB-infected and AIDS-affected recipients. The main report indicated that in case study countries food transportation issues related to the distance of end distribution points from beneficiaries' homes and the cost and effort involved in milling whole grains reduced programme effectiveness and efficiency.

Efficiency and Effectiveness

22. Targeting of assistance was identified to be an area of weakness in WFP's HIV and AIDS interventions in Sub-Saharan Africa. Geographical targeting is problematic for HIV and AIDS interventions as areas with high levels of food insecurity do not necessarily overlap with areas of high HIV prevalence. However, at the time of the evaluation mission the Vulnerability Analysis and Mapping (VAM) unit at headquarters was in the process of preparing technical guidance on integrating HIV and AIDS issues into food security and vulnerability analyses.[119]

23. Although WFP has some highly qualified and well-motivated staff, observations during fieldwork in Southern, Eastern and Western Africa highlighted that low priority was given to in-house HIV and AIDS expertise, which was further diluted by staff rotation mechanisms. Most Country Offices concentrated their HIV and AIDS knowledge and expertise in a single member of staff and some assigned the role of HIV and AIDS Focal Point to junior and temporary staff with no prior knowledge or experience of this theme. Staff rotation procedures were inefficient in maintaining staff experienced in food and nutritional approaches to HIV and AIDS in positions where they might use their skills. This constellation of factors severely limits HIV and AIDS policy implementation, advocacy and representation of WFP's approaches in response to the epidemic at the national level.

24. Regarding the results of HIV and AIDS activities, the M&E systems in the four case study countries were only partly developed and implemented. There was consequently very little evidence of analysis and reporting of results to inform on the effectiveness of interventions and to guide the on-going development of approaches.

118 Food and Nutritional Technical Assistance.

119 WFP VAM, Integrating HIV/AIDS into Food Security and Vulnerability Analysis. Vulnerability Analysis and Mapping Branch (ODAV). Draft October 2007

25. Other challenges to the implementation of WFP HIV and AIDS policy were identified to include funding constraints and the limited capacity of IPs. This was due in part to a limited choice of IPs at the local level, as well as to broader IP capacity issues. The evaluation survey of all WFP COs implementing HIV and AIDS activities revealed resourcing to be the primary constraint to the implementation of policy, as only 3-4 % of COs' resources were directed towards HIV and AIDS activities.[120]

Impact

26. The WFP Indicator Compendium provides guidance for monitoring interventions and determining the effectiveness of outputs. However, the collection of data that might inform on impact of HIV and AIDS interventions, for example weight gain and treatment adherence data, were 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 Strategic Objective Results Matrix[121]) had been achieved was largely unquantified. It was therefore difficult for the Evaluation to assess the impact of WFP approaches in regard to stated goals and objectives. However, during the course of the evaluation PDPH was already 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[122] reports a significantly higher increase in weight and adherence to treatment among food-insecure HIV patients on ART after 12 months of receiving WFP food assistance compared to a similar control group. Quantitative data also indicate that WFP take-home rations contribute to increased school enrolment and attendance among orphans and vulnerable children.

28. At the time of the thematic evaluation further WFP-assisted studies were underway in Sub-Saharan Africa. For example, WFP's collaboration with the Makerere University Johns Hopkins University Project aimed to address critical gaps in the evidence base, such as the impact of food assistance on ART treatment outcomes.

29. In addition to the lack of analysed programme monitoring data, the evaluation team found very little viable raw data to inform on the impact of WFP HIV and AIDS interventions on beneficiaries' quality of life.[123] In response to OEDE's request, in the course of the mission in East and West Africa, the evaluation team identified some relevant data from two WFP IP clinics in Uganda, which were extracted and processed in Rome. Analysis of data from126 female HIV-positive patients indicated modest weight gains (average 1 kg.) and increase in body mass index (average of 0.28) over a six month period starting with the initiation of food assistance and ART.

120 During the evaluation survey reference period 2004-5.

121 Of the WFP Strategic Plan 2006-2009.

122 Megazzini, Karen, "Nutritional Supplementation for Food Insecure Patients on Antiretroviral Therapy: Impact of a Pilot Program in Zambia". CIDRZ and University of Alabama at Birmingham, power point presentation, August, 2006.

123 Weight gain and treatment adherence are two indicators of Outcome 3.4 "Improved quality of life of beneficiaries targeted in HIV/AIDS supported programmes". See WFP Indicator Compendium (Biennium 2006-2007).

CONCLUSIONS AND RECOMMENDATIONS

Overall Assessment

30. The World Food Programme has a distinctive role in providing food and nutritional support to food-insecure people living with HIV and AIDS-affected households. As such it requires appropriate human and financial resources to enable staff to fulfil its responsibilities within the UNAIDS DOL as well as to achieve WFP's own corporate objectives (specifically Strategic Objectives 2, 3 and 4).

31. Although WFP has some well-qualified senior HIV and AIDS and nutrition specialists, at the country and sub-office levels capacities are often inadequate to fully meet WFP's corporate responsibilities as well as the responsibilities it holds as a UNAIDS cosponsor. Given that restructuring at HQ in the weeks following the evaluation led to a reduction in dedicated HIV and nutrition staff, it is crucial that WFP examines its commitments and resources allocated to achieving goals related to the HIV and AIDS response.

32. In the course of the evaluation process, observations made and documentary evidence reviewed indicated that with stronger human resourcing inputs - specifically an adequate volume of dedicated HIV and AIDS staff and frequent investment in their professional development – COs might achieve better results in mainstreaming WFP's HIV and AIDS policy. For example, the Uganda CO had substantially more contracted HIV and AIDS-dedicated staff than the other three case study countries. This enabled it to develop a portfolio of approaches to mainstreaming WFP HIV and AIDS policy as well as collaborating in international research on the impact of food assistance to HIV-infected patients and developing and disseminating HIV and nutrition materials. Although other case-study COs had highly dedicated staff, they were fewer in number. This was even the case for southern Africa COs visited, where the HIV prevalence rate is much higher. In two of the four case-study COs, the HIV and AIDS Focal Points were temporary consultants, which gave the impression that this aspect of policy was not regarded to be a priority. The evaluation team also observed how a lack of priority given to appropriate HIV and AIDS expertise can undermine representation within national HIV and AIDS working groups and faith in WFP's ability to fulfil its roles within the UNAIDS DOL.

33. While the WFP HIV and AIDS policy was innovative when first introduced in 2003, it is in need of urgent revision in light of current best practice and approaches that have evolved in the context of the global response. Although WFP subscribes to the UN Policy on HIV/AIDS in the Workplace there was a notable lack of visible, sustained corporate commitment to the policy and principles since the end of 2006. This must be addressed in line with wider UN policy on informing and protecting staff and to enhance capacities to fulfil obligations and responsibilities in responding to HIV and AIDS.

34. WFP needs to address a number of issues raised by the evaluation relating to targeting of beneficiaries, food distribution management and modalities to improve effectiveness and efficiency. Improved monitoring and evaluation of HIV and AIDS initiatives and approaches will inform this process as well as enhancing the knowledge base on operational food and nutritional support in response to the epidemic. This will provide the essential basis on which donors might make informed decisions regarding investment in innovative approaches and address certain resource mobilisation issues that WFP has identified.124

Key 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. Equally, poverty and food insecurity have emerged as key drivers of the epidemic in the region, and the prevalence rate of the virus in some countries has reversed development efforts and poses a threat to economic stability and wider security. The unique and 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 growing number of orphaned and vulnerable children. Support to households rendered food-insecure by the impact of HIV and AIDS has a clear role in response to the epidemic in the region. However, to ensure the sustained recovery of household economies and the future of children made vulnerable by AIDS, it is essential that short-term food and nutritional assistance be linked to government and specialist partners' social protection programmes and livelihoods initiatives to support future food security and self-sufficiency.

36. With progress in the therapeutic management of the viral load and the enabling effect of funding mechanisms such as the GFATM and PEPFAR on the roll-out of anti-retroviral therapy, treatment for opportunistic infections and DOTS for TB, infected people in the region are increasingly able to recover their health and economic capacities. Clinical and field experience indicates sufficient food and adequate nutrition to be fundamental to the tolerance and outcome of TB and AIDS drug therapies. It is therefore essential that the UN family adequately and appropriately responds to the special nutritional needs of households made food-insecure by the epidemic, to ensure sustained recovery.

Recommendations

The report provides detailed recommendations in response to critical findings and specific issues in case study countries. Overarching recommendations are made below:

37. **Recommendation 1**. The Thematic Evaluation recommends that WFP's HIV and AIDS Policy be revised to reflect the realities, experience and knowledge base that have evolved since 2003. Policy objectives and a results framework should be clarified in the revision process. Furthermore, the strategy should be refined to make optimal use of limited resources and adapted to enable COs to respond to local needs and the realities of their budgets. In this way COs might be supported to achieve a higher quality of measured outputs, albeit within a reduced scope.

124 The WFP Strategic Plan 2006-2009 notes that: "Resource mobilization has been hindered because WFP is not well known to the public or in donor countries".

38. **Recommendation 2.** Indicators relating to WFP HIV and AIDS activities should be rapidly developed, made mandatory and, as far as possible, standardized. In this way WFP will be able to better gauge the effectiveness of its inputs and make informed programming adjustments. Adequate resources should be allocated to train IPs and WFP CO and SO staff on the collection of monitoring data to inform on adherence to ART and DOTS and attendance of PMTCT appointments. Where appropriate, baseline and subsequent body weight measurements should be taken of beneficiaries participating in WFP programmes supporting treatment and care (for example, ART, DOTS and home-based care) as an indicator of the effectiveness of approaches towards Strategic Objective 3.[125]

39. **Recommendation 3.** Given the lack of clarity regarding UNAIDS DOL lead roles, the new structures that have assumed PDPH's roles within WFP should clearly and realistically define WFP's role as the lead organisation in dietary nutrition support at the global and country office levels. A menu of specific measurable activities to be implemented by responsible HIV and AIDS officers at HQ and in country offices should be developed along with implementation and monitoring guidance.

40. **Recommendation 4.** As the MOU[126] with UNAIDS 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 to support studies to investigate links between HIV and AIDS and household food security, including coping mechanisms and mitigation strategies during times of crop failure. It should also ensure an adequate financial allocation to sharing and circulation of information generated by research it supports.

41. **Recommendation 5**. WFP should reassess its commitment to the wider UN *HIV and AIDS in the Work Place* policy and principles and ensure the maintenance of training both to temporary and fixed-term employees. WFP should take responsibility for ensuring employees' access to current, accurate and local information in line with UN directives. The dedicated HIV and AIDS in the Work Place website on the WFP intranet should be updated. The inconsistencies in implementation activities and staff training must be addressed immediately, regardless of when the common UN Programme "UN Cares" becomes effective within WFP.

42. **Recommendation 6.** HIV prevention and awareness education should be mainstreamed in all WFP development and relief programmes, such as, FFW, FFT, MCHN and TF/SFP through the development of partnerships with competent local organisations.

43. **Recommendation 7.** Prior to finalizing the draft guidance on ration design in HIV and AIDS programming, WFP should consider incorporating more specific information on appropriate macro- and micronutrient composition. Additional information should be provided to IPs on determining the composition of household rations and their size.

125 SO 3: Support the Improved Nutrition and Health Status of Children, Mothers and Other Vulnerable People

126 Section 13.

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

    a) the structures that have taken over the responsibilities of PDPN/PDPH should determine the feasibility and effectiveness of providing new specialized food products and commodities, such as home-based fortification products, ready-to-use-supplemental foods, and improved blended foods to beneficiaries in order to better address the nutritional needs of different groups, especially PLHIV when cereals can not be fortified prior to distribution.

    b) Country Offices should investigate ways to provide more consistent food and nutrition training to IPs to optimise the use of rations by recipients.

45. **Recommendation 9**.To enhance programming, WFP guidance on therapeutic and supplemental feeding should be updated to include information about HIV and acute malnutrition; and on the integration and/or referral of patients with acute malnutrition for Voluntary Counselling and Testing (VCT).

46. **Recommendation 10**.To further support nutrition and HIV and AIDS programme integration, closer working relationships need to be developed between specialist HQ staff (previously PDPH and PDPN) and HIV and AIDS Focal Points and nutritionists in country offices. At the country level, when possible, nutritionists with expertise in HIV should be engaged to supervise the nutrition components of HIV programming.

47. **Recommendation 11**.The evaluation recommends a number of measures to ensure that interventions focus on short-term, yet sustained investment though graduation from food support to appropriate livelihoods activities, either as WFP activities (for example Food-for-Training; Food-for-Skills, etc) or through liaison with specialist partners:

    a) each WFP CO should strengthen linkages with line ministries, national institutions, multi- and bilateral donors, NGOs/CBOs, and other partners specialising in livelihoods to develop mechanisms by which beneficiaries graduate from food assistance to appropriate and sustainable livelihoods.

    b) COs in collaboration with IPs should prepare local guidelines with clear criteria to facilitate beneficiary graduation from food assistance to livelihoods support in an informed manner.

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

a) WFP invest in the development of a "Starter Pack" to provide Focal Points with basic training and information resources to enable those with no HIV and AIDS expertise to function in their role with an improved level of confidence and effectiveness. It is suggested that this might contain a CD Rom training course, similar in style to that used for UN security training. This would provide cost-effective and immediate training for staff as soon as they take up their duties as Focal Points. To complement this, HIV Focal Points should be offered a programme of continuous in-service training to ensure that appropriate skills are developed and maintained throughout staff changes and as new guidance documents are introduced.

b) human resourcing mechanisms should be adapted to enable Country Directors to fill vacant positions with specialist HIV and AIDS human resources as required, rather than by generalists.

c) for more efficient use of in-house expertise, WFP should ensure that job descriptions for rotating staff are more specific when posts for HIV and AIDS Focal Points and other designated positions are advertised. The creation of a technical "pool" similar to that used for VAM specialists should be considered for both HIV Focal Points and nutrition specialists.

Overall response from Evaluation Mission
Many thanks to reviewers for their comments. A degree of misunderstanding is apparent concerning the process and nature of feedback required at this stage, which may reflect the post-evaluation reorganisation and recent staff changes. Some comments raised issues relating to methods and findings that were previously discussed and concluded in the review and revision of the full Technical Report. This was circulated by OEDE together with a reviewers' comments matrix and responses from the evaluation team. OEDE states the purpose of the Summary Report to be to: "convey the main messages of the evaluation in a synthetic document ... When necessary, explicit reference can be made to the more detailed evaluation report, from which it draws." Confined by a strict 5,000 word limit, reference needs to be made to the full Technical Report for additional details. New information arising since the evaluation process and approval of the Technical Report cannot be added at this stage - this is one of the weaknesses of an evaluation of an evolving process and changing structures. However, presentation of these issues at the EB would be an excellent and appropriate platform on which to highlight recent and rapid progress.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
General Comment	There appear to be a bias towards nutrition activities and less on food security (mitigation) although the latter comprise 78 % of total tonnage and 93 % of total beneficiaries according to the pre-evaluation survey. We are not sure whether this can be rectified at this late stage, however, we suggest that it should be noted as a limitation of the thematic evaluation.	PDSD	Robin Landis	Unclear if this comment relates only to The Summary Report or the full Technical Report that has already been approved . PDSD's comments on the technical Report were received and incorporated. The main questions in relation to food security/mitigation regarded targeting and post-food aid sustainability. The first draft of the Summary Report included an additional recommendation on targeting, which was cut at PDSD's request . Recommendations remain regarding sustainability of food security initiatives.
General Comment	The document is now better structured, summarizes key elements and	UNHCR	Gebrewold Petros	Thanks.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
General Comment	UNHCR has sent the first batch of comments on 19 May 2008(attached). These comments are still valid for UNHCR.The document could have contained more on UNHCR /WFP collaboration on food aid, and HIV and AIDS among refugees. The draft summary did not incorporate our comments; at least some of these comments could have been set as recommendations or incorporated into other recommendations..Given a long standing working relationship with UNHCR and WFP's massive engagement in displacement/conflict settings, UNHCR would expect this important aspect to be reflected in the earlier bigger document as well as in this summary. We think this important both for UNHCR and WFP	UNHCR	Gebrewold Petros	UNHCR's comments, where possible, were addressed in the full Technical Report. The comments matrix circulated by OEDE listed the Evaluation Team's responses regarding the limitations placed on individual COs in planning fieldwork to include a range of programming categories and observation of UNHCR/WFP collaboration. Agree that this is an important collaboration and have included this, albeit briefly.
General Comment	There is a need to be consistent in using HIV and AIDS terminology.	UNHCR	Gebrewold Petros	Agreed, however, due to different approaches for HIV-infected and AIDS-affected recipients, it is not always correct to use the common term "PLHIV" when it is only those who are beneficiaries or patients that are being referred to. The precise terms used in the reports were agreed early in the evaluation process and were approved in the Technical Report.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Executive Summary	The executive summary does not capture the main thrust of the evaluation: what are the key strengths and weaknesses of WFP's food and nutrition supported HIV activities or overall involvement in the HIV field?	PDSD	Robin Landis	Agree that with a half page limit, it is not possible to provide much detail. Opinion noted, however, the executive summary follows the OEDE guidance and was approved in the quality check. It was also previously approved by PDSD.
Executive Summary	Throughout the evaluation the use of "some" and "many" (senior WFP staff, UN agencies) to reflect the views of interviewees makes the document too subjective and heavy on individual opinion . May consider rephrasing to reflect, perhaps the fact that low HIV prevalence countries have different program priorities	PDSD	Robin Landis	Unless there was a correlation between staff comments and contextual factors such as prevalence, these terms have been used to provide an indication of the degree to which certain views were expressed.
Executive Summary	Use People living with HIV (PLHIV) instead of HIV infected people become to comply with the UNAIDS terminology guideline.	PDSD	Robin Landis	Where the term is appropriate it is used. Otherwise more precise phrasing to enable specific reference to beneficiaries, patients etc, are used as agreed early in the evaluation process - these are in line with 2008 UNAIDS Terminology Guidelines.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Executive Summary	1. On the executive summary (page one) and also in the report, we suggest you briefly list the limitations of this independent evaluation. For us, these include: a) greater focus on nutrition which consists less than 12 % of the activities according to the pre-evaluation survey; b) the pre-evaluation survey period – 2004 to 2005 does not capture the progress that has been made since 2006 nor does it reflect the rearrangement of HIV/AIDS objectives in the new Strategic Plan.	PDSD	Robin Landis	These issues are set out in the main report. OEDE guidelines and template for Summary Reports does not include a section on limitations, which may be due to the word limit. The design of the pre-evaluation survey was conducted in collaboration with PDPH and the evaluation Reference Group - such issues might have been constructive addressed if raised at that time. The TOR define the scope of the evaluation to be 2003-2006 - these were also circulated prior to commencement of the evaluation. During the course of the evaluation the 2006-9 Strategic Plan was current.
Executive Summary	Para 2. of Executive Summary: Consider making reference to the old and new Strategic plan 2008-2011. Recommendations should also be made in the light of the new strategic plan to make them more relevant and contextualised in the new global economy which has impacted WFP's way of doing business (such as rising food prices, climate change, flexible and innovative response not only based on food assistance (and not called food aid), capacity building..)	PDSD	Robin Landis	This document was not published during the evaluation. See also comments regarding TOR.
Executive Summary	Para 3. of Executive Summary Page one – make reference to sub-Saharan Africa (SSA) instead of just Africa	PDSD	Robin Landis	This is a description of where the majority of resources are focussed.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Executive Summary	Para 6.of Executive Summary: Reference to dissolution of PDPH. There is no overall reduction in the dedicated numbers of staff – the main change is that the HIV work has since been placed in two divisions: 'policy work' in Policy Planning and Strategy Division and 'Programme support work' in Programme Design and Support Service. Furthermore a new HIV cluster has been created in Johannesburg to champion advocacy, programme support and research in HIV and AIDS.	PDSD	Robin Landis	This is not in line with the information provided to the evaluation team and was not challenged in the full Technical Report on which the Summary Report is based. It no doubt reflects the evolving situation. Plans for the new Services in Jo'burg would be constructively raised at the EB to inform on progress since the evaluation took place.
Executive Summary	Re-organise the executive summary: merge para 2 with para 5.	PDSD	Robin Landis	This would change the meaning - no supporting argument given. Declined.
Executive Summary (Para 3)	It should be noted that these numbers don't actually give the whole picture. For example, in SA just about all WFP programs are HIV related.	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	The survey, with PDPH's involvement, determined the proportion of resources that focussed directly on HIV and AIDS programming. Language has been adapted to clarify that reference is to specific HIV and AIDS programming.
Paragraph 1	I would also mention social protection programs here, especially for OVCs	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	Agreed. Amended.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
para 2:	WFP has been involved in HIV and Aids response much earlier than 2000. I recall in Burundi, prior to 2000 we had activities in the regional great lakes PRRO to support people affected by chronic diseases, among which was HIV and Aids. At the time we were not using specifically HIV and AIDS but rather chronic diseases. Retrieving the Great Lakes PRRO doc could provide a more accurate timeframe	RB	Thomas Yanga	Several COs worked on HIV-related activities before 2000 - some of these were cited in the May 2000 Policy Issues paper "Emerging Issues Relevant to WFP" which won the EB's support and launched the official WFP response. 2000 is referred to in numerous EB documents including the 2003 HIV and AIDS policy.
Paragraph 3	Para 3. The listing of HIV activities as it is vague. We suggest using the main HIV programming categories and linking them to WFP activities (as in the pre-evaluation survey) For example, OVC could be implemented either through school feeding programmes, Food for training/work/assets or support to HH; ART/TB could be just food and nutrition support and/or food for training or food for work; home based care could be food for work/assets, food for training etc. This para mention about gender mainstreaming but there is very little focus on it in the document – a critical omission given that over 60 % of those affected in SSA are women. In the para, please replace orphans and vulnerable affected by AIDS with just “orphans and vulnerable children” which is the recognised programming category.	PDSD	Robin Landis	The Summary report has a strict word limit and is therefore highly condensed - this paragraph aims to provide a very brief overview. The programming categories you mention are set out in Fig.2 of the Technical Report. Gender issues are mentioned briefly in the introduction, but to reflect the TOR details are confined to the Technical Report. OVC - typo amended.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Paragraph 5	On para 5, please list briefly a breakdown by % of HIV activities (by beneficiaries or tonnage), according to the pre-evaluation survey. In this para, briefly list the limitations of the survey.	PDSD	Robin Landis	As this is a Summary Report information is condensed. Footnote provides reference for the Survey Report. See OEDE guidance on required Summary Report structure.
para 7, last sentence:	WFP never had HIV and AIDS activities in South Africa, unless they are referring to the HIV@work activity for staff in the regional bureau;	RB	Thomas Yanga	The team conducted interviews with HIV and AIDS specialist staff in the Regional Bureau (ODJ).
Paragraph 10	Para10. Last sentence is not clear. Link the first and last sentence by indicating that also, very little was known about exit strategies when 2003 policy was formulated. Also delete “on which sustainability of results depends”.	PDSD	Robin Landis	This paragraph is specifically about the need to update policy to reflect knowledge and experience since 2003.
Paragraph 10	I think it is important to mention that sustainability issues are most relevant in treatment programs and when the paper was written WFP had no treatment programs nor PMTCT programs. Also as this kind of programming was brand new, we didn’t have experience at that time to answer questions about sustainability, graduation to other programs, and duration of food support	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	Agreed. Rephrased to clarify this point.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Paragraph 13	1. Para 13, last sentence. Research would have different meaning to different category of staff – for example at HQ level, research may be understood in the traditional sense whereas at country level, it may be linked to operational research, monitoring and evaluation. PDPH carried out a research on OVC and also had links with research institutes e.g universities, IFPRI etc. Pls delete “many in the last sentence (or quantify)”	PDSD	Robin Landis	Agreed - these are detailed in the main report. The term "many" was selected to reflect the responses obtained by the evaluation team.
Paragraph 14	Para 14: Elaborates on the UNAIDS Division of Labour and views WFP's role rather critically. Recommendation 4 makes reference to the MOU with UNAIDS, but does not come up with a recommendation regarding the observations in para 14 ("... sister UN agencies,..., questioned its capacities in dietary and nutritional support.")	OMXD	Hildegard Tuttinghoff	This issue is addressed in Recommendation 3.
para 14 and 15:	I see some contradiction in the statements at end of para 14 and beginning para 15, could be clarified;	RB	Thomas Yanga	The former concerns some sister agencies' perceptions of WFP's capacities, the latter comments on appreciation of the role of food and nutritional support in response to the epidemic.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Paragraph 15	This last sentence could be reworded for clarity. 'particularly in enabling attendance to health centres, optimizing….etc' (as worded it's not clear what is being enabled)	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	Agreed. Re-worded.
Paragraph 16	Para 16: Incorporation of HIV concerns in all programming categories may not always be possible. It depends on the context e.g national prevalence, government priorities, presence of partners, otherwise the sentence appears to contradict the then proposed reduction in scope for WFP in para 36.	PDSD	Robin Landis	The evaluation was required to evaluate the extent to which the 2003 policy has been implemented. This makes the point that there is a gap between policy and what is achieved. That is precisely why the evaluation recommends policy revision to reduce scope in para 36.
Paragraph 16	This may be true especially since some of the countries are not high enough prevalence but if you look at the countries included in the southern Africa eval you definitely see that both needs assessments and vulnerability assessments have taken this into account. Worthwhile to mention this.	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	Again, this is an issue of the requirements of the 2003 policy vs. contextual realities.
Paragraph 17	It was not reflected in the policy since at the time we didn't know this would be an issue. It is reflected in one or more of the EB updates, and definitely in the guidance material we are making available to the COs	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	Exactly. That is why the evaluation recommends the policy be revised. The situation reported reflected the information that COs had and applied at the time of the evaluation.
Paras 19 & 20	Para 19 and 20. The expert opinion of the evaluation in these two para is not clear. Pls indicate.	PDSD	Robin Landis	Agreed and amended.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Paragraph 20	Para 20. Second para – pls replace and use “people living with HIV” and “households affected by AIDS”. Last sentence – “energy expenditure” not clear – is it kcal expenditure or fuel for the lay person?	PDSD	Robin Landis	It is necessary to be broader than "PLHIV" as references is made to AIDS-affected and TB patients who were not necessarily HIV-*infected.* Energy expenditure has been clarified in the text.
Paragraph 20	WFP /FANTA handbook is considered as WFP guidance so would just say it is not mentioned in the WFP policy but in one of the main guidance pieces.	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	This is clear. Added the term "previous" to clarify.
Paragraph 24	Para 24. The challenges highlighted are specific to HIV programming. For example, donors see HIV programming needs as chronic and therefore afraid to commit resources, despite WFP’s clear existing entry point of food insecurity where support is for specified period of time., HIV requires specialised IPs with expertise in this field Capacity of IP has implications on targeting, monitoring and reporting.	PDSD	Robin Landis	This paragraph summarises the analysis of constraints reported by COs in the survey.
Paragraph 24	A more relevant statistic (if available) would be the % resourcing of programmes…as it’s difficult to say exactly what proportion of CO resources SHOULD BE directed to HIV and AIDS activities, 2-4% doesn’t mean much to me	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	3-4%. The survey design, analyses and statistics were shared with PDPH and the Evaluation Reference Group in the course of the process. At the time it was deemed useful to determine the proportion of WFP resources directed specifically towards HIV and AIDS activities.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Paragraph 24	Para 24: In this connection I believe the role of the HIV and AIDS Unit needs to be reviewed from a more critical angle. What guidance has been given to the COs with regard to suitable indicators? Other technical units such nutrition and school feeding have been much more active in this regard.	OMXD	Hildegard Tuttinghoff	This paragraph reports on the constraints to policy implementation.
Paragraph 25	Para 25. Second sentence is incorrect. Weight gain and adherence are indicators in the 2006-2007 indicator compendium (see page 37 and 38 of the compendium, also see footnote 14 in this EB summary). However, broader issues in M&E in the context of HIV hinder effective data collection and interpretation. This include: stigma, expectation of different outcomes depending on the stage of the disease, lack of understanding on the interaction between food support and health status, IP capacity (especially the health sector where WFP has no prior experience ..), robustness of indicators, analysis and interpretation of data once its collected. Third sentence: not correct - there is data at output level but not at outcome level.	PDSD	Robin Landis	This paragraph clearly states the issue to be that while indicators are set out in the Indicator Compendium they are *not mandatory*. Consequently, the dearth of reporting. Details concerning M&E have been confined to the full Technical Report. Error in third sentence corrected.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Paragraph 25	As we have said previously we feel this paragraph is misleading. We feel it should also explain the reason why these indicators were not mandatory…i.e. because there is no international agreement on such indicators, WHO does not put forward such indicators, and there are concerns about the specificity of such indicators in relationship to food as just one input among many…		Robin Jackson & Andrew Thorne-Lyman	The lack of internationally agreed indicators does not justify a complete lack of monitoring - this is borne out by the fact that they are cited in the Indicator Compendium - even though currently optional. Pioneering programming requires monitoring to evaluate and inform evolving approaches - its part of the learning process.
Paragraph 26	Para 26. In this para, pls indicate the good attempts that have been made document impact. Last sentence – kindly quote the reference of this study (Malawi take home ration study carried out by WFP and UNICEF). Also, mention about the outcome results of the Community Household Survey in Southern Africa.	PDSD	Robin Landis	There reference is already given in full in the footnote.
Paragraph 26	…. reports a significantly higher increase in weight "and adherence to treatment"	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	In the Technical Report. Added here.
Paragraph 27	This seems to contradict the statement several pages earlier about not engaging in research (was in the para on the UNAIDs MOU)	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	This is not contradictory Earlier comment is made that section 13 of the MOU is not reflected in policy, nor widely in practice. This paragraph reports examples of research that was underway at the time of the evaluation mission.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Paragraph 28	Para 28 – reference is to monitoring data, not evaluation. Please delete the rest of the para as it does not fit in the overall thematic evaluation. (Indeed, the analysis of these data from Uganda shows how inconclusive findings can be, especially in linking the BMI-cause and effect to food support i.e. is it contribution or attribution?, no controls. BMI is useful at individual level but not at programme level hence debateable and yet to be recommended within WFP.	PDSD	Robin Landis	Agree with issues regarding such data, controls etc. This was raised with OEDE, which specifically requested that the team search for and analyse raw data to provide some information on the impact of these activities - which was part of the evaluation TOR. This is set out and contextualised in the Technical Report. Please refer to the OEDE criteria for Summary Reports. Feedback is expected on the extent to which the Summary Report captures the main points of the full report. Comments on original findings and analyses were solicited by OEDE and feedback incorporated at that stage - that included comments from PDSD.
Paragraph 30	Para 30. Again, incorrect and gives wrong first impression to the outside reader- there is no reduction of staff dealing with HIV and nutrition but re-configuration of the responsibilities in two divisions as stated above in para 6. First sentence – pls quantify the "some".	PDSD	Robin Landis	The first part of this section clearly refers to CO and SO-levels, which we understand remained much the same at the time. See comment on HQ staffing changes issues above.
para 30 under conclusions & recommend ations	The statement on the reduction of dedicated HIV and nutrition staff should be checked with relevant units as e.g. I know that some reduction at HQ has been compensated with the creation in OMJ of a new HIV and AIDS Unit; also I have seen a number of HIV and AIDS related positions created in other units in HQ as well.	RB	Thomas Yanga	This information was gathered from interviews at the conclusion of the evaluation. The RB did not raise comment on this original finding circulated in the full Technical Report. As suggested above, recent and planned increases in staff in OMJ might be positively highlighted at the EB.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Paragraph 33	Para 33 – the para is too general. What are the issues in targeting, food distribution, food distribution management, etc? Please note that footnote 15 is not entirely correct (especially in the context of rising food prices..). As indicated donors have issues in funding HIV activities mainly because it's a new field and needs are seen as long term.	PDSD	Robin Landis	This is a concluding section and as such does not repeat previous information - these issues are set out earlier in paras 20 and 21. Specific issues regarding CSB management were cut following review of the draft Summary Report. Footnote 15 is a direct quote from the stated reference.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Paragraph 34	Para 34. Key issues for the future - Para need to be revised. First sentence - mention impact of the HIV epidemic on livelihoods (i.e. different human, financial, social natural capitals), intra-generational impacts, instead of mentioning productivity and food security. Second sentence – poverty and food security are not only key drivers of HIV but also consequences… show the linkage between these two. Third sentence – impact of “AIDS” as opposed to HIV? OVC, not children made vulnerable and orphaned by the “virus”. “Emergency food support” – why emergency if the needs are protracted? Need to link WFP’s assistance to national government structures and policies, and especially the under the framework of social protection – social transfers – cash, food, vouchers as appropriate. Also, kindly capture the new thinking about WFP’s responses to hunger as reflected in the new strategic plan (attached).. New HIV policy to define new tools for WFP responding to the epidemic.	PDSD	Robin Landis	Livelihoods included. Details requested here are too lengthy for a Summary Report with a 5,000 word limit. "Second sentence – poverty and food security are not only key drivers of HIV but also consequences" - absolutely that is what the first and second sentences state - even though the semantics differ. "Third sentence – impact of “AIDS” as opposed to HIV?" - this is not what is written. ""“Emergency food support” – why emergency if the needs are protracted?" - it is a protracted emergency. "Need to link WFP’s assistance to national government structures and policies, etc” is covered in the full Technical Report – added here. "New strategic plan etc ..." released after the evaluation and therefore beyond the scope set out in the TOR, Inception Report and Full Report.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Paragraph 36	Para 36. Recommendation one – first sentence ok. Second and third sentence – this is the first time that reduction of "scope" of activities is being mentioned – it was not in the technical report or making it clearer see para 16 and 36 otherwise we suggest taking it out.	PDSD	Robin Landis	Rephrased. Unclear why "see para 36..." this *is* para 36.
Paragraph 36	There is no recommendations on how the priority settings and the process that should be followed to ensure engagement on partners at national level. We feel that this is more important than "reducing scope". Overall, the evaluation is silent on how WFP should engage with national governments and operate under the wider UN obligations such as the requirements of the "three ones".	PDSD	Robin Landis	The full technical report sets out that with adequate specialist staff WFP at the CO-level WFP will be better placed to support national approaches and contribute to global initiatives. Details of WFP engagement with national governments is discussed in sections 56-58 and 125 - 137 of the main report. This includes an analysis of national government and WFP CO HIV and nutrition capacities in countries visited by the evaluation mission. The Annex E discusses this in the context of the four case study countries. In line with the TOR WFP's operations were evaluated in respect to the UNAIDS Division of Labour. Recommendation 11 of the Summary Report also addresses this issue.
Paragraph 35	I would also mention PEPFAR just after GFATM.	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	Agreed. Added.
Paragraph 36	What does the scope reduced mean? Pls clarify. Strategic choices on how best to use limited resources?	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	Rephrased.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Paragraph 37	Para 37. Recommendation two. First para, not all HIV indicators should be mandatory. It depends on the activities implemented in a specific country. In the new strategic plan, there will be mandatory corporate indicators for HIV activities but only the ones that sufficiently robust and comparable across different contexts. Second sentence – pls delete – training is not enough, resources have to be made available. The recommendation should not only focus on ART, TB and PMCTC but also on mitigation activities which comprise 78 % of total tonnage and 93 % of total beneficiaries according to the pre-evaluation survey.	PDSD	Robin Landis	Naturally, this applies to the M&E activities of HIV and AIDS programming. Added that resourcing needs to be allocated for training. As the full Technical Report has already been approved and the Summary Report has to reflect its contents and the situation when the evaluation was conducted, the EB would be a good forum in which to highlight the mandatory indicators that will be introduced and how these relate to the new Strategic Plan. This will provide additional positive information on how WFP has taken issues forward. This recommendation is specifically about the M&E of this particular programming - food security indicators already exist.
Paragraph 39	Para39 – second last sentence – replace “crop failure” with shock	PDSD	Robin Landis	See section 13 of the MOU which specifies crop failure. This is highlighted in Box 1 of the full technical report.
Paragraph 39	Agree in terms of the need to ensure funds but we aren’t convinced that the stated research question is the one that such funds would be best utilized for…a lot of money has already gone into exploring such linkages…what we feel is most needed now is to profile specific groups (those going onto treatment for example), and to demonstrate impact of different commodities and interventions…	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	Agree with your point - however, this recommendation relates to WFP's compliance with the MOU with UNAIDS. The point is that no budget was allocated to enable that part of the MOU to be realised from WFP's side.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Paragraph 41	Para 41. We do not agree – mainstream according to the national prevalence and context. In reality, this can only be done in country with high HIV prevalence or where there is need e.g in concentrated epidemics.	PDSD	Robin Landis	Precisely - that *is* according to prevalence and context.
Paragraph 41	Strengthened ? instead of mainstreamed since it does exist in a number of countries already	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	There seems to be a lack of consensus on this issue between former PDPH and PDSD - see comments above.
Paras 42-45	Para 42 to 45. Four recommendations on nutrition activities which comprise less than 15 % of WFP assisted activities. Again we feel that the focus should have been more on food security i.e mitigation activities such as HBC, OVC and support to households affected which are not mentioned…	PDSD	Robin Landis	Please see earlier comments on this issue in response to previous PDSD inputs and details in full Technical Report.
Paragraph 43 a)	There are other options in addition to home-based fortification which should be explored…can this be reworded to more generically explore the potential options for different types of programmes? i.e. to say something like 'feasibility and effectiveness of different new commodities such as home based foritification, RUSF's, improved blended foods, etc. for addressing nutritional needs of different groups	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	Yes - amended.

Location in Text	Comments Received	Unit	Name	Response from Evaluation Mission
Paragraph 46	Recommendation 11: Perhaps this para could be put in a broader perspective of an "Exit and/or hand-over strategy"	OMXD	Hildegard Tuttinghoff	Given the nature of recovery of livelihood capacities with HIV and TB treatment and OVC needs, the evaluation specifically selected the term "graduation" rather than "exit" or "handover".
Para 47 a)	The large number of guidance documents which are either being finalised or have been finalised should be mentioned here. Training would be the best way to make sure this guidance is used	Former PDPH	Robin Jackson & Andrew Thorne-Lyman	Added.

Annex A: Terms of Reference

Terms of References
Thematic Evaluation of WFP's HIV and AIDS Intervention[127]

1. Introduction

WFP is active in 41 countries[128] in response to the HIV and AIDS pandemic and undertakes intensive advocacy efforts, including at the corporate level. The goal of these initiatives, as outlined in the policy paper "Programming in the Era of AIDS: WFP's Response to HIV/AIDS", approved by the Board in February 2003, is to provide food and nutritional support to individuals and families who are affected by food insecurity and HIV and AIDS. Main activities are the provision of nutritional support to treatment and care programmes, support to orphans and children affected by HIV/AIDS, and linking prevention education with school feeding programmes and relief operations. The establishment of effective partnerships and gender mainstreaming are important elements in all of WFP's HIV and AIDS activities.

WFP has worked in the area of HIV and AIDS since 2000 and under the framework of an approved policy since February 2003. Given the importance of the topic, the attention it gets on the international agenda and within WFP, as well as the resources spent on HIV and AIDS activities within WFP, an independent evaluation is well justified. Also, the Executive Board (EB) has requested WFP to move from project and programme evaluations to thematic ones, the evaluation of large relief operations, as well as real-time evaluations. Undertaking this evaluation is well justified and has been planned for some time.

The evaluation will be conducted with the support of the Swiss Agency for Development and Cooperation (SDC). This support will be provided technically and financially through a SDC expert on HIV and AIDS made available for the evaluation (evaluation Team Leader).

2. Purpose, Objective and Scope

The evaluation will serve both accountability and learning purposes. It will provide accountability to the Executive Board and other stakeholders and at the same time give the opportunity to learn from what has been undertaken to date and help shape future programming and policy setting.

The objectives are four-fold:

- assess the extent to which the objectives outlined in the Policy Paper "Programming in the Era of AIDS: WFP's Response to HIV/AIDS" (WFP 2003) as well as those outlined in the EB information Notes circulated to the WFP EB (2004, 2005 & 2006) have been achieved,

127 Including associated TB interventions

128 According to the OEDE survey conducted over the period 2004-2005

- assess the Relevance, Coherence, appropriateness, effectiveness, efficiency, outcomes/impact and connectedness of objectives laid out in the strategy,
- produce recommendations which will help to shape WFP's future HIV and AIDS programming, and
- provide accountability to the Executive Board and other stakeholders.

3. **Scope and Key Issues**

The overall scope of the evaluation will be the consideration of HIV and AIDS policies, policy mainstreaming, activities, partnership mechanisms and project operations undertaken by WFP at corporate as well as country/local level in the period of 2003 – 2006, starting from the time when the strategy was approved. [129]

The evaluation will address the following key issues and any others identified as relevant by the evaluation team:

a) Policy - General

The evaluation will examine whether WFP have a clear policy (or corporate strategy) regarding HIV and AIDS .

It will study whether and how this policy (or corporate understanding of what was a WFP de-facto policy) has been changing/evolving over the years. It will also determine the reasons for the evolution of the policy, and how WFP HIV and AIDS activities have evolved in keeping with the overall policy changes.

The team will also examine, whether the WFP policy/strategy refers to a logical framework, as well as to an explicit monitoring and external evaluation plan with indicators, targets, etc…

b) Coherence, Relevance & Appropriateness

Coherence:

Definition: The need to assess security, developmental, trade and military policies, as well as humanitarian policies, to ensure that there is consistency and, in particular, that all policies take into account humanitarian and human-rights considerations.

(i) External Coherence

The WFP HIV and AIDS strategy will be examined for coherence within the framework of the UNAIDS Division of Labour and the related plans and programmes of sister UN agencies (more particularly other UNAIDS Cosponsors and secretariat), and the policies and programmes of other major partners. In this respect, the evaluation will also verify whether the WFP policy is in line with the latest collective thinking/best practice.

Related to this, the evaluation will also assess the coherence of the WFP Policy with the Memorandum of Understanding (MOU) signed with UNAIDS Secretariat.

The evaluation will examine whether or not a clear role has been assigned to each major partners and this more particularly for UN agencies. The specific role given to WFP vis-à-vis other UN agencies as well as the division of labour between major actors will be looked into.

129 The survey on WFP activities was conducted on the period 2004-2005

The evaluation will assess the extent to which any noted changes in the WFP policy on HIV and AIDS has been carried out in consultation with partners?

The evaluation will also examine whether WFP has a clearly known and agreed strategy for determining when, where and with whom WFP has a role to play.

(ii) Internal coherence

The WFP HIV and AIDS strategy will be examined with reference to WFP's strategic priorities[130] and the consolidated framework of WFP policies, as well as with reference to the programme and activity reported in the logical framework (if any) set-up for the evaluation exercise.

The mission will also study whether the HIV and AIDS operational activities implemented by WFP are coherent with the set policy (2003 Policy Paper and following EB information notes).

The mission will assess to what extent the policy mainstreaming was implemented at the various design stages of WFP operations/projects, as well as for non-operational activities (advocacy, resources mobilization, etc…) It will also study what has hindered/promoted the implementation of the policy (institutional, capacity, political, socio-cultural factors, etc….)

It will assess to what degree is WFP's interpretation or understanding of the policy is internally compatible and consistent within headquarters, as well as at Country Offices and Regional bureaus levels?

Further, the mission will analyze whether the same coherence exists regarding WFP non-operational activities (such as advocacy, HIV and AIDS in the workplace, and any other initiatives) and this policy.

Relevance:

Definition: Relevance is about assessing whether the overall goal of the policy is in line with local needs and priorities (as well as with country strategy donor policy)

The team will examine whether, at the country level, activities are based upon explicit needs assessments, and whether the stated objectives of the WFP activities at the local level are in keeping with the assessed local needs and priorities. It will also study whether these objectives should be in some way adjusted/fine-tuned in order to better match local needs.

It will also assess whether at the operational level, the overall objectives set for WFP HIV and AIDS activities are in line with government policies and national plans, as well as with donors' strategies. Likewise, it will assess the degree to which WFP HIV and AIDS interventions at country levels are firmly rooted in and compatible with national plans and policies. In this respect, the evaluation team may wish to look into the CHAT (Country Harmonization and Alignment Tool) to have some ideas on the result of its piloting.

The mission will assess to what degree the HIV and AIDS interventions/activities at country level are synergistic with those of other partners (NGOs, UN Agencies, etc…). In this respect, the mission will examine whether the WFP interventions might be modified to achieve greater and more effective synergies with partners' interventions.

130 WFP's Strategic Plan (2004-2007) is the basis of the evaluation as it was in place during the period covered by this evaluation.

Appropriateness:

Definition: Appropriateness is about assessing whether the planned inputs and activities of the operation are in line with local needs and priorities.

The evaluation will examine whether the HIV and AIDS activities applied in WFP operations and projects are appropriate to the local context including their linkages with national AIDS plans and priorities..

The mission will also examine the extent to which the designed targeting is appropriate. It will study whether WFP has an explicit policy and strategy regarding the targeting approaches applied for HIV and AIDS activities.

The evaluation will also study whether the composition and the distribution modalities[131] of food aid rations applied to HIV and AIDS activities is satisfactory for addressing the beneficiary needs and achieving the stated objectives. In this respect, the mission will study the extent to which the food basket applied for HIV and AIDS activity is specific enough in comparison to the food baskets used for non HIV and AIDS activities.

The evaluation will examine the composition, suitability and acceptability of the food rations under each of the implemented activities.

c) Efficiency

Definition: Efficiency measures how economically the inputs were converted to outputs. This generally requires comparing alternative approaches to achieving quantitative or qualitative outputs, to see whether the most efficient approach has been used.

In view of the difficulty encountered by WFP to assess costs and taking into consideration that WFP is still a relative new comer in the area of HIV and AIDS, it is deemed advisable for the evaluation mission not to pay much attention to costs but rather to focus on the extent to which planned outputs have been achieved in the framework of the various HIV and AIDS implemented activities. Consequently, the mission will more particularly focus attention to the following issues:

The evaluation will determine whether HIV and AIDS guidelines exist regarding the policy implementation and if they are sufficiently detailed to provide appropriate guidance to Regional Bureaus and Country Offices. Likewise, the mission will study how efficient (clarity and user-friendliness) have corporate guidance and guidelines have been in facilitating the implementation of the policy.

The evaluation team will also examine the extent to which the HIV and AIDS policy and/or strategy on targeting has been efficiently implemented. The mission will look into this matter in order to determine whether the targeting should be adjusted or adapted to different situations

The evaluation team will study the extent to which HIV and AIDS activities have been appropriately funded to maintain a reasonable level of operation, and assess the efficiency of the management of the pipeline of HIV and AIDS operational activities. The efforts made by WFP in accessing complementary funding mechanisms, such as for instance that of the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) will be assessed.

The evaluation will assess to what extent the WFP human resources were efficient in their management and monitoring of HIV and AIDS operational activities. It will also determine how adequate have been these human resources in the policy mainstreaming and the

131 More particularly, take home rations for OVCs distributed under school feeding operations, needs to be investigated.

establishment of a monitoring and evaluation system. In this respect, the evaluation will also identify what have been the factors limiting the efficiency of these human resources (staff rotation policy, budget limitation, organizational set-up, etc…).

d) Effectiveness

Definition: Effectiveness measures the extent to which the policy achieves its purpose (outcome) or whether this can be expected to happen on the basis of the noted level of output achievements.

The mission will evaluate whether/how operations contributed to the established WFP corporate objectives. It will also study whether operations own objectives were achieved and how those objectives compared to the WFP corporate objectives.

The mission will assess the extent to which the planned outputs of the HIV and AIDS operational activities have been achieved and more especially these planned outputs had an impact upon the planned objectives.

The mission will attempt to determine how effective the WFP advocacy and increased knowledge base on HIV and AIDS have been, as well as the efforts undertaken to assure that WFP is recognized as an effective partner in the fight against HIV and AIDS.

The mission will identify what have been the various limiting factors that have prevented WFP from achieving its planned objectives.

The evaluation team will look into opportunities for improving the effectiveness of WFP HIV and AIDS operational activities, including but not limited to, adjusting the food basket, use of micronutrients such as fortified blended products, eventual creation of new nutrition oriented activities, etc….

e) Connectedness & Impact

Connectedness:

Definition: Connectedness refers to the need to ensure that activities are carried out in a context that takes longer term and interconnectedness problems into consideration

In this connection, the team will study whether the WFP policy refers to the issue of sustainability and will assess whether there is room for improvement in this area.

The evaluation will assess the extent to which WFP operational activities are taking into consideration long term objectives.

Likewise, it will examine how through strategic partnership (with HIV and AIDS major actors such as the UNAIDS family Nd key NGO and donor partners), WFP might enhance the extent to which its activities are linked to a longer-term and sustainable perspective

The evaluation mission will also examine the extent to which local capacity (government, civil society and other partners at various levels) is supported and developed by WFP in order to ensure that the effects of the WFP interventions are not lost

Impact:

Definition: This evaluation criteria looks at the intended and/or unintended wider effects of the activity – social, economic, technical, environment – on individuals, gender- and age-groups, communities and institutions.

The evaluation team will study whether the WFP policy includes the issue of impact of interventions and will analyze whether room for improvement exists in this area.

As far as possible, the evaluation team will endeavour to assess the impact of the WFP programming activities on beneficiaries.

4. Methodology

4.1 Principles

The evaluation will be conducted according to the following underlying principles:

- Independency and impartiality: in this respect, the evaluation will be conducted by external consultants;
- Transparency (involving stakeholders – at global and country levels) refers to openness about findings and methodology, dialogue, consultation with stakeholders and debriefing. In order to ensure maximum transparency of the evaluation process an evaluation matrix will be elaborated at the start of the evaluation process in order to identify clearly which questions and sub questions as well as the indicators and sources of information (see Section 4.4 b);
- Using multiple approaches/triangulation (document reviews, participatory assessments, surveys, focus groups, workshops); and,
- Applying the evaluation norms and standards established by the United Nations Evaluation Group more especially for evaluation criteria, principles and quality control (available from the UNEG website: http://www.uneval.org/).

4.2 Stakeholders and Users

The following stakeholders will be closely involved in the evaluation:

- WFP at corporate level: Policy and Programme Support Division (PDP), and the HIV/AIDS Service (PDPH) in particular; the Operations Department (OD); TPSS
- WFP at local level: Regional Bureaus (RBs) and Country Offices (COs);
- International level: all UNAIDS Cosponsors, UNAIDS Secretariat, UNICEF, WHO and international NGOs;
- National level (case study countries): Governments at country, districts and local levels; national NGOs; UN agencies; bilateral donor agencies; civil society; community leaders; and ultimate beneficiaries.

Stakeholders will be involved in the evaluation through briefings, debriefings and review of evaluation outputs (TOR and draft reports).

The main users of the evaluation are the Policy and Programme Support Division (PDP), and of this the HIV and AIDS Service (PDPH) in particular, WFP COs, and WFP's donors. The evaluation is expected to indicate whether the WFP policy on HIV and AIDS should be strengthened in a way or another, and how to improve the efficiency and effectiveness of the

related WFP operational activities. It is also expected to assist donors to have a better grasp of the role to be played by WFP in the fight against HIV and AIDS, and make clearer how WFP should operate more effectively with partners. Moreover, from its inception stage the evaluation will be regarded as a learning and capitalization process on WFP's approaches and experiences in the field of food support to people infected with and affected by the virus.

4.3 Evaluation Process

The evaluation process will include:

- Elaboration of the evaluation TORs
- Identification of team members and team leader
- Briefing of Evaluation Team Leader
- If possible, preparation of a logical framework for WFP's HIV/AIDS interventions through literature review and discussions with evaluation stakeholders,
- Elaboration of an inception report with an evaluation matrix (if the logical framework cannot be developed, it is expected that the evaluation matrix will be used in substitution)

Briefing of evaluation team at WFP headquarters (HQ) - all team members, desk review of primary and secondary data and literature;

- Case studies with in-country briefing and debriefing sessions and presentation of Aide-Mémoire (including key recommendations) at the end of each visit,
- Preparation of an overall Aide-Mémoire (including key recommendations) and presentation to key stakeholders in a workshop at WFP HQ to discuss findings, conclusions and recommendations, as well as to facilitate the preparation of the management response,
- Preparation of reports:
    - Preparation of first draft technical report with inputs from all team members,
    - Review of first draft technical report by WFP internal peer reviewers and external reviewers,
    - Preparation of second draft technical report by the team leader with inputs given by all team members as necessary,
    - Sharing of second draft technical report by internal and external peer reviewers ,
    - Preparation of final draft technical and draft EB summary report (including recommendations tracking matrix) by the team leader with inputs given by all team members as necessary,
    - Review of draft EB summary report by WFP and external stakeholders and external peer reviewers, and preparation of management response by relevant WFP players,
    - Preparation of second draft EB summary report by the team leader with inputs given by all team members as necessary,
    - Finalization of technical and EB summary report by WFP editors.

    For transparency's sake, all comments will be shared between internal and external reviewers. While processing text revisions in relation to comments

received, if requested changes are not considered valid, the Team Leader will explain the reason why the changes suggested in the received comments have not been taken into consideration.

- Discussion of EB summary report at the WFP Executive Board (team leader).

4.4 Outputs

The expected evaluation *outputs* are:

a. **Inception Report** (20-40 pages)

The inception report will outline how the evaluation team will implement the TOR. If possible, it will include a draft logical framework for WFP's HIV/AIDS interventions (including goal, objectives, activities, outputs, performance indicators, assumptions and constraints; developed on the basis of WFP's EB documents listed below), a summary of the desk review, a stakeholder analysis, the proposed detailed methodology for achieving the evaluation objectives, the criteria for selecting the sample of countries and projects to be evaluated and visited, a detailed work plan for completing the work (including tentative mission schedule), the estimated number of beneficiaries to be contacted during the case study visits, an outline of the technical report (including team members' responsibilities for certain contributions), and a listing of opportunities, challenges and constraints related to the evaluation process and the fulfilment of the TOR. It should have a length of 20-40 pages and will feed into the final technical report.

b. **Evaluation Matrix**

Based on the final TOR, the team leader will, in consultation with the team members, prepare an evaluation matrix. This matrix will include all evaluation questions listed above as well as others, indicators, data required and data sources, and it will indicate each team member's responsibility for addressing respective questions. All indicators to be used in the evaluation should be included in the matrix. The matrix should be shared and discussed with the stakeholders involved at the onset of the evaluation. Evaluation questions should be organized in a hierarchy, pointing out main ones and sub-questions. The following matrix format has proven to be effective and is suggested also for this mission:

Evaluation Criteria/Question		
Sub-question	Performance Indicator	Data collection method and information sources

c. **Case study Aide-Mémoires** (about 10 pages) and their in-country presentation

d. **Case study reports** (max. 20 pages each)

e. **Overall Aide-Mémoire** (about 10 pages) covering all case studies and its presentation at HQ, with RBs and COs being connected via conference call

f. **Draft and final technical report**, including executive summary (not exceeding 60 pages, excluding annexes)

g. **Draft and final EB summary report**, including one-page executive summary (maximum 5,000 words including a one-page summary)

h. **Draft and final management response matrix** (max. 2,000 words, including management responses, with the number of key recommendations not exceeding a dozen and being prioritised; additional subsidiary recommendations can be contained in the full technical report)

i. **Presentation of the final report** to the EB (team leader).

4.5 Data collection methods and data sources

The evaluation will take a closer look at how WFP's policy has affected its operations, staff and beneficiaries in three or four countries yet to be selected. The criteria for the selection of countries will be developed by the team leader at the onset of the evaluation.

Secondary data are a key source of information and include Country Programme, PRRO and EMOP documents, Standardized Project Reports (SPRs), data from CO's M&E systems, studies undertaken by the COs visited, recently conducted evaluations with HIV and AIDS components (such as for instance Ethiopia, Haiti, etc…) and studies undertaken by country level partners. Information on beneficiaries' views and perceptions should in principle be derived from M&E data, cross-checked and supplemented by beneficiary contacts undertaken during case study field visits. Should there be a need, extra data will be collected in selected countries by national consultants, and this more especially regarding data relative to effectiveness/impact assessment.

The evaluation will review all relevant in-country project documents, reports, agreements and studies, and consult key country level stakeholders (individually as well as during a stakeholder workshop) on the implications, challenges and achievements of the HIV and AIDS interventions. In addition, the evaluation will review corporate materials, guidelines, staffing and mechanism in order to assess the cohesion and complementarity of these with the HIV and AIDS policy.

Analysis will build upon triangulating information obtained from PDPH, COs and various other stakeholders with secondary data and documentation reviewed by the team. A mix of quantitative and qualitative methods will be used including techniques such as direct observation, informal and semi-structured interviews and focus groups, where feasible. Visits to project areas will help validating findings and triangulating them with beneficiaries' views through household and focus group discussions.

The team leader will establish a list of data needed from the COs well in advance to the case studies and the COs will make this data available to the team well prior to the in-country mission to ensure that the team can spend the time in-country with analyzing and validating data with the CO, sub-offices, beneficiaries and partners.

While maintaining independence, the evaluation will seek the views of all parties. It will complement and not duplicate evaluations undertaken by other agencies or programs.

4.6 Quality Assurance

The quality assurance components include:

- External peer reviews of the draft TOR and reports, with the external peer review group providing a sort of 'quality stamp' to the reports (inception, full & summary reports).

- A reference group consisting of WFP internal staff members with relevant expertise who will provide inputs to process. The reference group will play an advisory role and assist the evaluation team in having a better understanding of the WFP context. This group will be consulted at all stages of the evaluation process, namely: at the briefing stage, the debriefing stage taking place after each field trip (Africa, Asia & Latin America), as well as on the TORs and draft reports (inception, full & summary reports)
- Adherence to the Norms and Standards for Evaluation established by UNEG mentioned above
- Adherence to the quality proforma for evaluation methods and reports developed by the Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP), which can be downloaded from their website (www.alnap.org).

Evaluation Schedule

The tentative evaluation schedule is as follows:

Activity	Output	Responsible	Date
Review timeline and check on Survey developments	Issuance of new timeline	**Kate Molesworth**	12-16 February 2007
Review timeline and check out survey developments	Issuance of new timeline	**Kate Molesworth**	12-16 March 2007
Preparation for HIV/AIDS thematic evaluation	Various meetings & Documents gathering and reading	**Kate Molesworth**	19-23 March 2007
Timeline Revision	Remittance of updated version to Director, OEDE	**Alain Cordeil**	25 March 2007
Recruitment Food Security Expert	Pernille Sørensen contracting process initiated	**Alain Cordeil**	By 26 March 2007
Development of evaluation matrix	Very First Draft	**Kate Molesworth**	26-30 March 2007
TORs Revised in the light of Director, OEDE's comments and circulated for review by reference group	Circulation of TORs to reference group and external peer reviewers	**Alain Cordeil**	30 March 2007
Draw up estimated budget for the evaluation	Remittance of first draft budget to Director, OEDE	**Alain Cordeil**	30 March 2007
Decision on Recruitment of CRIS expert and/or statistician and/or M7E expert	Decision made on recruitment of a CRIS expert and/or statistician and/or M&E expert	**Kate Molesworth**	By 30 March 2007
Recruitment of a CRIS expert and/or statistician	Recruitment contracting process initiated	**Alain Cordeil**	By 31 March 2007

Activity	Output	Responsible	Date
Closing of Survey Exercise	None	**Laura LoCicero**	By 31 March 2007
TORs Review	TORs finalized and circulated to Reference Group	**Alain Cordeil**	Early April 2007
Development of Evaluation Matrix	Second draft remitted to OEDE for information	**Kate Molesworth & Pernille Sørensen**	4-8 April 2007
Recruitment of remaining team members (if any)	All team members recruited	**Alain Cordeil**	By 10 April 2007
Survey Analysis	Remittance of Survey Analysis	**Laura LoCicero**	16 April 2007
Review of TORs	Circulation revised TORs	**Alain Cordeil**	17 April 2007
Writing of inception report and completion of evaluation matrix	Remittance of inception report with Evaluation matrix	**Kate Molesworth**	16-27 April 2007
Consultation with PDPH on TORs, criteria selection and country case studies	Half-day workshop or meeting with PDPH	**Alain Cordeil, Kate Molesworth and PDPH**	23 or 24 April 2007 (tbc)
Review of Inception Report	Circulation of Inception Report to Ref. group and external peers	**Alain Cordeil**	29 April-16 May 2007
Team leader's completion of preparation for evaluation	Meetings, gathering and reading documents	**Kate Molesworth**	6-11 May 2007
Liaising with COs to develop field activity schedules and pre-field documentation	Field visit agenda	**Laura LoCicero**	01-30 May 2007

Activity	Output	Responsible	Date
Consultant work on CRIS	Issuance of Report	**TBD**	01-30 May 2007
Revision of Inception Report on basis of received comments	Issuance of revised version	**Kate Molesworth**	18-25 May 2007
Pre-field meeting at Headquarters for all mission members	Various meetings and documents reading	**Evaluation Team**	28 May-01 June 2007
Mission of Evaluation	Implementation of evaluation First Part (probably Africa)	**Evaluation Team**	02-22 June 2007
Writing report on first mission (Africa)	First Draft report	**Evaluation Team**	09-13 July 2007
Mission of Evaluation	Implementation of evaluation Second Part (probably Asia	**Evaluation Team**	20-30 July 2007
Writing report on second mission (Asia)	First Draft report	**Evaluation Team**	01-05 August 2007
Mission of Evaluation	Implementation of evaluation Third Part (Latin America/ Caribbean	**Evaluation Team**	06-15 September 2007
Writing report on third mission (Latin America/ Caribbean)	First Draft report	**Evaluation Team**	17-21 September 2007
Evaluate HIV in the work place + WFP Programming tools and advocacy	Various meetings at Headquarters	**Evaluation Team**	07-16 October 2007
Debriefing at Headquarters	Debriefing meeting with Reference group	**Evaluation Team**	17 October 2007
Writing report on mission at WFP Headquarters + Full Report Writing	First draft report on last part of mission + first draft of full technical report	**Kate Molesworth**	22 October-16 November 2007
Review of first draft of Full technical report	Report Circulation to	**Alain Cordeil**	19 November – 02

Activity	Output	Responsible	Date
	Reference group & external peer reviewers		December 2007
Summary Report writing	First draft Summary Report issuance	**Kate Molesworth & Evaluation Team**	19 November – 02 December 2007
Revision of full technical report	Receipt of all comments on full technical report and circulation to Evaluation Team for revision	**Alain Cordeil**	02 December 2007
Adjust Summary report in the light of comments received on full report before first circulation for review	Revision of draft summary report	**Kate Molesworth**	03-05 December 2007
Review of first draft summary Report	Circulation of first draft of Summary Report to reference group and external peer reviewers	**Alain Cordeil**	06 December 2007
Revision of full technical report	Remittance of revised version	**Kate Molesworth & Evaluation Team**	06-09 December 2007
Review of second draft full Report	Circulation of 2nd draft technical report shared with internal & external peer reviewers	**Alain Cordeil**	12 December 2007
Review of second draft summary Report	Comments from internal and external peer reviewers on report	**Alain Cordeil**	07 January 2008

Activity	Output	Responsible	Date
Revision of both reports (full & Summary)	Remittance of final version of both reports (full & summary)	**Kate Molesworth**	08-17 January 2008
Initiation of EB process	EB summary report and recommendations tracking matrix submitted for editing	**Alain Cordeil**	End-January 2008
Capitalization Project	Workshop with selected stakeholders	**SDC (TBC)**	May 2008
EB summary report presented to EB.A/2008	Presentation to EB.A/2008	**Kate Molesworth**	June 2008

4.8 Reporting Framework

The technical and EB summary report should include the following elements: an executive summary, a profile of the activity evaluated, a description of the evaluation methods used, the main findings, conclusions, recommendations, implementing recommendations, lessons learned, unit responsible for the implementation of recommendations together with a timeline for all activities.

The report structure should follow the logic of the TOR and evaluation matrix. All evaluation questions listed in the TOR and evaluation matrix, as well as additional ones that may come up during the evaluation process, should be addressed in the full report. Progress towards key performance indicators at output and outcome levels should be presented using the designed logframes as a basis. This should also be presented in table format.

Conclusions and recommendations should be firmly based on evidence and analysis, be relevant and realistic, with priorities for action made clear. Findings, conclusions, recommendations and lessons learnt should be clearly distinguished. The presentation of conclusions, recommendations, the unit responsible for implementation of recommendations and timeline should also be done in table form for easy reference.

Recommendations given in the technical report should be grouped by intended users, such as the WFP COs, national stakeholders and/or partners, the RB, WFP HQ and donors.

Data should be presented in graphic form to facilitate reading and understanding. Boxes should be used to highlight key issues.

The technical report should include as annexes an annotated bibliography, list of acronyms, the TOR, evaluation matrix, activity logframes, list of people met and interviewed (with names and functions), a brief background to evaluation team members and external reviewers, as well as the technical report on logistical issues.

The team leader will ensure that the final technical and EB summary reports read well and in one flow. She will make adjustments of team members' inputs as necessary to achieve that objective. Changes in the content of team members' technical reports will be done only in agreement with those.

5. Team Composition and Responsibilities

This section needs to be finalized after the desk review and the preparation of the inception report, which will outline the methodology of the evaluation. Below is an indication of the expertise needed and an estimate of time required.

- Team Leader (Kate Molesworth): Technical expertise - Estimated number of working days: 195. Team Leader to participate in all case studies.
- Team member (international) - M&E expert (to be identified): Estimated number of working days: 75.
- Team member (international) - food security expert (Ms. Pernille Sorensen): Estimated number of working days: 90.
- Team member (international) – Statistician Expert (Mr. Ngounou), Estimated number of working days: 40
- Team member (international) Support and Data Analyst (Ms. Laura LoCicero) – Estimated working days 90

- Team member (national) - one each for each case study country. Number of working days to be determined.
- Collaboration with institution from the South: to be determined.

6. Budget

The estimated WFP evaluation budget amounts to 150,000 US$ and will be covered the OEDE 2006 PSA budget. The estimated SDC budget amounts to xxx US$.

7. Background Documents

Basic Documents to be reviewed during the desk review phase include:

WFP Executive Board documents:

- Programming in the Era of AIDS: WFP's Response to HIV/AIDS, WFP/EB.1/2003/4-B (Policy document)
- Five Years Later - An Update on WFP's Response to HIV/AIDS, WFP/EB.A/2006/5-D/1 (Information Note)
- Update on WFP's Role in the Fight Against HIV/AIDS, WFP/EB.3/2002/INF/22 (Information Note)
- WFP, Food Security and HIV/AIDS, WFP/EB.3/2001/INF/19 (Information Note)
- Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, WFP/EB.A/2006/5-D/2 (document for endorsement)

Other documents:

- Food and Education: WFP's Role in Improving Access to Education for Orphans and Vulnerable Children (OVC) in Sub-Saharan Africa, Strategy and Policy Division, September 2002
- OEDE evaluation reports 3003 – 2006
- Project Activity summaries, PLANOPS, MOUs for all evaluation case study countries

A CD-ROM with all the above-mentioned documentation will be burned and remitted to the evaluation team prior to conducting the evaluation mission. The CD-ROM will also gather any other documentation related to the UN system support to AIDS.

Annex B: Bibliography

Documents produced by the evaluation team

WFP Thematic Evaluation of WFP's HIV and AIDS Interventions in Sub-Saharan Africa: Aide Mémoire Presented at the conclusion of the Burkina Faso case study

1-6 October 2007 First Discussion Draft. Ouagadugou, Saturday 6 October 2007.

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WFP Thematic Evaluation of WFP's HIV and AIDS Interventions in Sub-Saharan Africa: Aide Mémoire Presented at the conclusion of the Tanzania case study
9-15 September 2007 First Discussion Draft discussed 15 September Dar Es Salaam and sent to WFP Tanzania 25 September 2007.

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Annex C: Evaluation Matrix

Responsibilities:
ET = evaluation team
TL= Team Leader
FS = Food Security Specialist
NS = Nutrition Specialist
DA/IO = Data Analyst/Information Officer
LC = Local Consultants

1. **Evaluation Question on General Policy:** Does WFP have a clear policy (corporate strategy) regarding HIV/AIDS and how has it evolved?			
Sub-question	**Performance Indicator**	**Data collection method and information sources**	**Respo nsible**
1.1 Does WFP have a clear policy (corporate strategy) regarding HIV/AIDS?	Stated policy and strategy on HIV and AIDS	Review 2003 Policy documents, Strategic Plan, IC.	ET
1.2 Has this policy been changing/evolving over years?	Evidence of evolution of policy in documents released after 2003.	Review of EB Information Notes post-2003	ET
1.3 If yes, how and why? 1.4 Has this evolution been clearly explained within WFP ?	Evidence of policy evolved in response to changing contexts and knowledge base.	Document review as above, discussion with PDPH and Programme Adviser	ET

1.5 How have WFP HIV and AIDS activities evolved in keeping with the overall WFP policy changes?	Evidence of implementation of activities at the field level in accordance with policy changes	Document review, RB and CO discussions, field visits	ET
1.6 Is WFP policy/strategy guided by a logical framework? If not, is there some logic in this policy implementation?	Evidence of log frames in project documents and their use to guide country-level activities.	HQ, RB and CO-level project documentation	TL
2. Evaluation Question: Coherence ***External coherence***: Is WFP's HIV and AIDS strategy coherent with the framework of the UNAIDS Technical Support Division of Labour and the related plans and programmes of sister UN agencies (more particularly other UNAIDS Cosponsors and secretariat), and the policies and programmes of other major partners? ***Internal coherence***: Is the WFP HIV and AIDS strategy in coherence with WFP's strategic priorities[132] and the consolidated framework of WFP policies, as well as with reference to the programme and activity reported in the logical framework (if any) set-up for the evaluation exercise?			
Sub-question	**Performance Indicator**	**Data collection method and information sources**	
External coherence 2.1. Is WFP's HIV and AIDS strategy coherent with the framework of the UNAIDS Technical Support Division of Labour and policy in line with the latest collective thinking/best practice within HIV/AIDS?	Coherence between WFP HIV and AIDS strategy, the UNAIDS Technical Support Division of Labour framework and current evidence base.	Review UNAIDS Technical Support Division of Labour document, related plans and programmes of sister UN agencies. Review evidence base.	TL
2.2 Is the WFP HIV/AIDS policy coherent with the Memorandum of Understanding (MOU) signed with UNAIDS Secretariat?	Consistency in policy statements and MOU	Review policy and MOU, interviews with PDPH, PDE & partner organisations	TL

132 WFP's Strategic Plan (2004-2007) is the basis of the evaluation as it was in place during the period covered by this evaluation.

2.3 Has a clear and specific role been given to WFP vis-à-vis other UN agencies within the Technical Support Division of Labour?	Evidence of a clear role within the UNAIDS Technical Support Division of Labour.	Review UNAIDS Technical Support Division of Labour, interviews with PDPH, PDE & partner organisations	TL
2.4 Has the noted changes in the WFP policy on HIV and AIDS been carried out in consultation with partners?	Consistency in statements from Policy Department and partners and documentation.	Interviews with PDPH and partners. Document Review	TL
2.5 To what extent do sister UN agencies and other stakeholders appreciate WFP's mandate and the value of its approaches in response to HIV and AIDS	Evidence of a clear understanding of WFP's mandate among partners	Interviews with RBs, COs, PDPH, PDE & partner organisations	TL
2.6 To what extent is WFP's *HIV and AIDS in the Workplace* policy in line with broader UN policy and approaches?	Coherence between WFP and wider UN policy on HIV and AIDS in the Workplace and mainstreaming.	Interviews with ADHC, review of WFP *HIV and AIDS in the Workplace* policy documentation and training materials, review of selected UN materials	DA/IO TL
Internal coherence 2.6 Are the HIV and AIDS operational activities implemented by WFP coherent with the set policy (2003 Policy Paper and following EB information notes)?	Consistency in policy statements and programme planning and implementation	Review Strategic Plan (2004-2007), 2003 HIV and AIDS Policy and following EB Updates. Interviews with WFP staff at CO and RB level and PDPH	ET

2.7. To which extent was the policy mainstreaming implemented at the various design stages of WFP operations/projects, as well as for non-operational activities (advocacy, resources mobilization, etc…) in the selected case study countries? And also in other WFP divisions (FD for instance).	Evidence of coherence with most recent policy updates, and accommodated appropriately in the WFP advocacy activity and to the WFP funding mechanisms and principles (mainly with the Full cost recovery principle)	In case study countries interviews with COs, government and co-operating partners. Visits to selected projects and discussion with field monitors and implementers. Focus group discussions with beneficiaries + focus group with FC and FD	ET
2.8. What has hindered/promoted the implementation of the policy (institutional, capacity, political, socio-cultural factors, etc….) in the case study countries?	Triangulation of informants opinions with broader national data.	In case study countries interviews with COs, government and co-operating partners. Visits to selected projects and discussion with field monitors and implementers. Focus group discussions with beneficiaries	ET
2.9. To which degree is WFP's interpretation or understanding of the policy internally compatible and consistent within headquarters, as well as at Country Offices and Regional Bureau levels? To what extent are WFP's HIV and AIDS activities coherent with WFP's *Gender Policy 2003-2007*?	Consistency in the understanding of the HIV/AIDS policy at headquarter, CO, and SO levels	Review WFP HIV/AIDS policy; Interviews with PDPH,PDPN, PDPF, PDPG, ODO and PDPT COs and RBs	ET DA/IO

2.10. Are WFP non-operational activities (such as advocacy, HIV and AIDS in the workplace, and any other initiatives) coherent with the policy? How relevant and appropriate is WFP's HIV and AIDS in the Workplace Programme? How consistent is implementation of the programme?	Consistency in policy statements and programme planning and implementation of non-operational activities	Review WFP HIV/AIDS policy; interview with WFP HQ staff, PDPH, ADHA, ADHC and case study CO and RB staff.	ET DA/IO
3. Evaluation Question: Relevance and Appropriateness: **Relevance** Are the activities based upon explicit needs assessments and are the stated objectives of the WFP activities at the local level in keeping with the assessed local needs and priorities in the selected case study countries? Should these objectives be adjusted/fine-tuned in order to better match local needs? **Appropriateness** Are the HIV and AIDS activities applied in WFP operations and projects in the selected country case studies appropriate to the local context including their linkages with national AIDS plans and priorities? Is food aid the right input to be used to achieve the planned policy and activities objectives ?			
Sub-question	**Performance Indicator**	**Data collection method and information sources**	
Relevance 3.1 Are the overall objectives set for WFP HIV and AIDS activities in line with government policies and national plans, as well as with donors' strategies at the operational level in the selected case study countries?	Coherence between WFP's HIV and AIDS objectives and national priorities, plans and strategies	Review government policies and national plans, donor national strategies. Interviews with donors, NAC, MoH, I/NGOs.	ET

3.2 To which degree are the WFP HIV and AIDS interventions at country levels firmly rooted in and compatible with national plans and policies in the sample countries?	Consistency between WFP's HIV and AIDS interventions and national priorities, plans and strategies	Review government policies and national plans, donor national strategies. Interviews with donors, NAC, MoH, I/NGOs	ET
3..3 To what degree are the HIV and AIDS interventions/activities at country level synergistic with those of other partners (NGOs, UN Agencies, etc…) in the selected case study countries? For example, when WFP food is utilized in HIV care and treatment programs, does it complement and potentially leverage other services, such as, nutrition assessment and counselling?	Evidence of synergies with efficient and effective partner approaches.	Review selected UN (e.g. UNDAF) and NGO documentation on national approaches and activities Interviews in country.	ET DA/IO
3.4 To what extent are WFP's approaches relevant to end beneficiaries' needs and requirements? For example, are there clear graduation criteria for HIV affected households and beneficiaries provided food assistance? Has an exit strategy for phasing out or phasing over food assistance been developed? If so, it is being implemented?	Consistency between needs identified by beneficiaries and WFP's activities and approaches	Policy and programme review. Visits to projects in case study countries. Focus group discussions with beneficiaries, field monitors and implementing partners	ET
3.5 To what degree are WFP's HIV and AIDS policy and approaches consistent with global humanitarian, development and HIV and AIDS priorities, guidance and policy?	Consistency between WFP's policy and approaches and global approaches.	Review of UNAIDS, UNGASS, MDG, ALNAP and IASC goals, objectives and guidelines.	TL
Appropriateness 4.1. Is the targeting design appropriate? Does WFP have an explicit policy and strategy regarding the targeting approaches applied for HIV and AIDS activities?	Targeted population by vulnerability category Explicit and consistent WFP targeting policy and strategies	Review of WFP HIV/AIDS Policy and strategies and national targeting guidelines Beneficiary/focus group discussions; interview staff, CPs	FS ET

4.2. Is the composition and the distribution modalities (e.g. heavy bags of food distributed to sick patients for transport to their homes) of food aid rations applied to HIV and AIDS activities satisfactory for addressing the various categories of beneficiaries' needs and achieving the stated objectives? Has the food ration been tailored appropriately given the nutritional needs and eating problems experienced by PLWHA?	Compatibility between evidence base and WFP food basket	Examination and nutritional analysis of the food basket and rations in case study countries. Review current research, guidelines and best practice on food support for the various categories of beneficiaries in response to HIV and AIDS	NS
4.3. Is the composition, suitability and acceptability of the food rations under each of the implemented activities appropriate?	Evidence that beneficiaries consider the food commodities and quantities to appropriately meet their needs.	Focus group discussions with beneficiaries, HBC volunteers, social workers, other carers and field implementers and monitors. Review post food distribution monitoring reports	NS
4.4 To what extent do WFP HIV and AIDS activities correspond to the local factors driving the epidemic and impacting upon food insecurity?	Compatibility between WFP's HIV and AIDS approaches and the local context of food insecurity and epidemic drivers	Ethnographic exploration among beneficiaries. Focus group discussions. Interview with NAC. Review country specific food security studies and other pertinent reports. Interviews with CO WFP VAM staff and other food security and HIV experts.	TL FS NS

5. Evaluation Question: Efficiency and Effectiveness

Efficiency

Do HIV and AIDS guidelines exist regarding the policy implementation and are they sufficiently detailed to provide appropriate guidance to Regional Bureaux and Country Offices? How efficient (clarity and user-friendliness) have corporate guidance and guidelines been in facilitating the implementation of the policy?

Effectiveness

Have WFP operations contributed to WFP's HIV and AIDS policy objectives, and if yes, in which way? Were the operations own objectives achieved? How did these compare to the WFP corporate objectives?

Sub-question	**Performance Indicator**	**Data collection method and information sources**	
Efficiency 5.1 Has the HIV and AIDS policy and/or strategy on targeting been efficiently implemented? Should the targeting design and methods be adjusted or adapted to different situations?	Planned and actual number of beneficiaries by food security and health/nutrition status Target design consistent	WFP HIV& AIDS policy and strategy Project documents Field visits, focus group discussions and beneficiary interviews, WFP and CP staff interviews	FS
5.2 Do guidelines exist regarding WFP's HIV and AIDS policy implementation and how clear and user friendly they are considered to be by regional and country officers?	Existence of user friendly guidelines, for example, "Getting Started" guides for HIV and AIDS programming.	Interviews with PDPH, RB and COs. Review of documentation relating to guidance and existing guidelines.	ET

5.3 Has WFP made efforts to access complementary funding mechanisms, such as for instance that of the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) or PEPFAR? Has WFP adjusted its funding mechanism and principles in order to accommodate GFATM contributions via recipient governments or to receive PEPFAR funding ?	The inclusion of food support and indirect support costs in applications and processes to obtain complementary funding.	Review of Country GFATM Proposals and PEPFAR proposals. Interviews with COs, CCMs in case study countries.. Interview with FD	TL DA/IO
5.4 How have CO's addressed human resourcing issues?	Evidence of innovative responses to HR constraints	interviews with RBs, COs and PDPH	ET
5.5. Were the human resources allocated for policy mainstreaming?	Adequate trained staff	interviews with RBs, COs and PDPH	ET
5.6. What have been the factors limiting the efficiency of these human resources (staff rotation policy, budget limitation, organizational set-up, etc…)?	Emerging themes from multiple sources on limiting factors.	interviews with RBs, COs and PDPH.	ET
Effectiveness 6.1. To what extent have planned outputs of the HIV and AIDS operational activities, set out in the Strategic Objective Results Matrix, been achieved? What organisational and local factors that have hampered or facilitated the achievement of these objectives?	Outputs listed detailed in the Annual Performance Reports and Standard Project Reports	Review of M&E reports, Annual Performance Reports and Standard Project Reports. Interviews with RBs, COs and PDPH	ET

6.2 How effective has WFP advocacy and increased knowledge base on HIV and AIDS been, as well as the efforts undertaken to assure that WFP is recognized as an effective partner in the response to HIV and AIDS? In particular, how effective has WFP's advocacy for the inclusion of food and nutrition support in the HIV comprehensive treatment and care package at the country, regional and international levels?	Evidence that WFP's advocacy efforts have raised informed awareness regarding the inclusion of food security interventions in partners' planning their contributions to the national HIV and AIDS response. Evidence that WFP's advocacy efforts have contributed to the inclusion of food and nutrition support in the HIV comprehensive treatment and care package at the country, regional and international levels.	Interviews with NAC, MOH, development partners and COs, WFP Regional Bureau staff, UN co-sponsors, USAID/PEPFAR staff.	ET
6.3 To what extent have WFP activities benefiting food insecure people infected with HIV and affected by AIDS contributed to overarching WFP corporate objectives?	Outputs listed detailed in the Annual Performance Reports and Standard Project Reports	Review of objectives set out in Strategic Plan.	ET
6.4. How appropriate is the food basket? To what extent are local, traditional and new food products included that might benefit food insecure people infected with TB, HIV or affected by AIDS. How nutritionally adequate is the food basket?	Evidence of the appropriateness and nutritional adequacy of the food basket and optimal use of local, traditional and new foods.	Interviews with Ministry of Agriculture and Food and Ministry of Health. Review of the nutritional analysis of the food basket. Beneficiary and CP focus group discussions.	NS

7. Evaluation Question: Connectedness and Impact

Connectedness
Does the WFP policy refer to the issue of sustainability? Is there room for improvement in this area? To which extent do WFP operational activities take into consideration longer term objectives?

Impact
What are the impacts of the WFP programming activities on beneficiaries?

Sub-question	**Performance Indicator**	**Data collection method and information sources**	
Connectedness/Sustainability 7.1. What efforts are made to enhance strategic partnerships (with HIV and AIDS major actors such as government and national health authorities, the UNAIDS family and key NGO and donor partners) linked to a longer-term sustainability?	WFP support the capacity-building and formation of new strategic partnerships to enhance sustainability of investments.	Review of CO project documents. Interviews with COs and partners	ET
7.2. To what extent is local capacity (government, civil society and other partners at various levels) supported and developed by WFP in order to ensure that the effects of the WFP interventions are not lost?	Workshops supported to develop National partner's capacity to maintain the impact of WFP inputs beyond programme completion	Review of CO project documents. Interviews with COs and partners	ET
7.3 What are the positive and negative impacts of WFP's HIV and AIDS activities on household and local economies?	Consistent themes emerging from a range of interviews	Interviews with COs, local leaders and beneficiaries	FS
7.4 What evidence is there that WFP's food and nutritional support of PLWA improves their nutritional status?	Increased weight gain of PLWA receiving WFP nutritional support.	CO M&E data and reports. Analysis of CP's data and records of beneficiaries' weight changes in the course of WFP food support.	DA/IO LC ET

7.5 What evidence is there that WFP food and nutrition support increases uptake and adherence to ART, TB DOTS and PMTCT?	Increased uptake of ART, TB DOTS and PMTCT in programs where food is provided compared to programs without food. Increased adherence to ART regimens when food is provided compared to programs without food. Increased continuation of PMTCT when food is provided. Increased completion of TB DOTS treatment when food assistance is provided.	CO M&E data and reports. Analysis of CP's data and data from similar programs not providing food assistance.	DA/IO LC ET
7.6 What evidence is there that the take-home-ration (THR) contributes to increased enrolment and continuation for OVCs?	Comparison of OVC enrolment and continuation in schools before and after the THR was provided.	CO M&E data and reports. Analysis of CP's data	DA/IO LC ET

Annex D: Methodology – Extract from the Inception Report

Desk reviews

49. All team members were allocated a desk research phase to review key documentation. Desk reviews were staggered throughout the evaluation to focus on particular tasks, for example an initial review was made to support the Data Analyst's development of the survey structure and methodology to inform the country case study selection and provide a data base to support the overall evaluation process. Upon recruitment all team members undertook a review of WFP's HIV and AIDS policy and other key documents that form the foundation of the evaluation. A review was also undertaken of past evaluations to capitalise on the combined information they might offer on WFP's HIV and AIDS interventions in Africa.

Documentation Management

50. Given that a substantial volume of documents were gathered, it was deemed necessary to systematically identify and order pertinent documents. To this purpose OEDE engaged a consultant Information Officer at an early stage in the evaluation process, who in collaboration with PDPH and other relevant departments, gathered documentation. To manage the substantial volume of documentation, the Information Officer organised documents indicated by OEDE and other departments to be essential to the Thematic Evaluation. All evaluation documentation was stored in an electronic library to serve the evaluation process. This enabled all team members to access documents when on-line. The Thematic Evaluation Reference Group members were provided with a list of materials gathered and requested to ensure that all pertinent documents had been shared with the Information Officer.

51. Working with RBs and COs the Information Officer created document packs for each team specialist prior to field visits.

Interviews, focus groups and discussions

52. The evaluation was designed to make best use of the time and budget available and to this end was flexible in its methods to address the evaluation questions set out in the Inception Report and elaborated in the evaluation matrix. Where key informants and personnel were more readily available, in Rome and in COs visited for example, face-to-face meetings and interviews were held. Teleconferencing and email correspondence were used to interview and gather information from more distant WFP offices and personnel, such as ODD and sister UN personnel in Geneva and New York.

53. The three core evaluation team members visited all case study countries as a team, maintained a flexible approach regarding visiting particular projects and locations in the field. To optimise time use and evaluators' key fields of expertise, they visited different projects and sites on occasion.

Evaluation process in case study countries

54. During the east Africa visits the team began with the RB in Uganda before working with the COs and in the field, however, due to budgetary constraints no visit was able to be made to ODD and interviews were conducted remotely.

55. In each case study country the team began the first few days working with the COs and in focus groups with CPs. Visits was pre-arranged with key national government,

non-government organisations, HIV and AIDS support groups and donors. The forum for focus group discussion with beneficiaries was determined by individual situations informed by COs and CPs. Beneficiaries, field implementers and monitors was interviewed in the course of activities such as food distribution, visits to clinics and project sites.

56. It was originally intended that the team would have scheduled writing days to consolidate and reflect on information after each country visit. In view of budgetary and time constraints the team will incorporate discussion periods into each country visit during which individual team members will share their specialist contributions to the other team members. Following discussion and lesson learning from the each field visit, the team may adapt its approaches. Each team member has scheduled five writing days at the end of each period of field visits in east and west Africa. The Team Leader will begin to consolidate inputs from all team members towards the final report.

57. As set out earlier in this report, the evaluation team intends to add value to the evaluation process and supporting the knowledge base generated by WFP's approaches in response to HIV and AIDS. In countries where CPs maintain records on, for example weight gain in beneficiaries receiving WFP food assistance, but have not completed analysis and reporting, the evaluation team will work with local consultants identified by COs to extract simple data to be analysed by the evaluation team Data Analyst in Rome. In collaboration with the evaluation team and COs, the Data Analyst will manage the national data collectors to provide simple data for analysis on the impact of WFP inputs combined with other CP services including ART and DOTS. The scope of analyses will be determined by the range, quality of records and accessibility of data in each case study country.

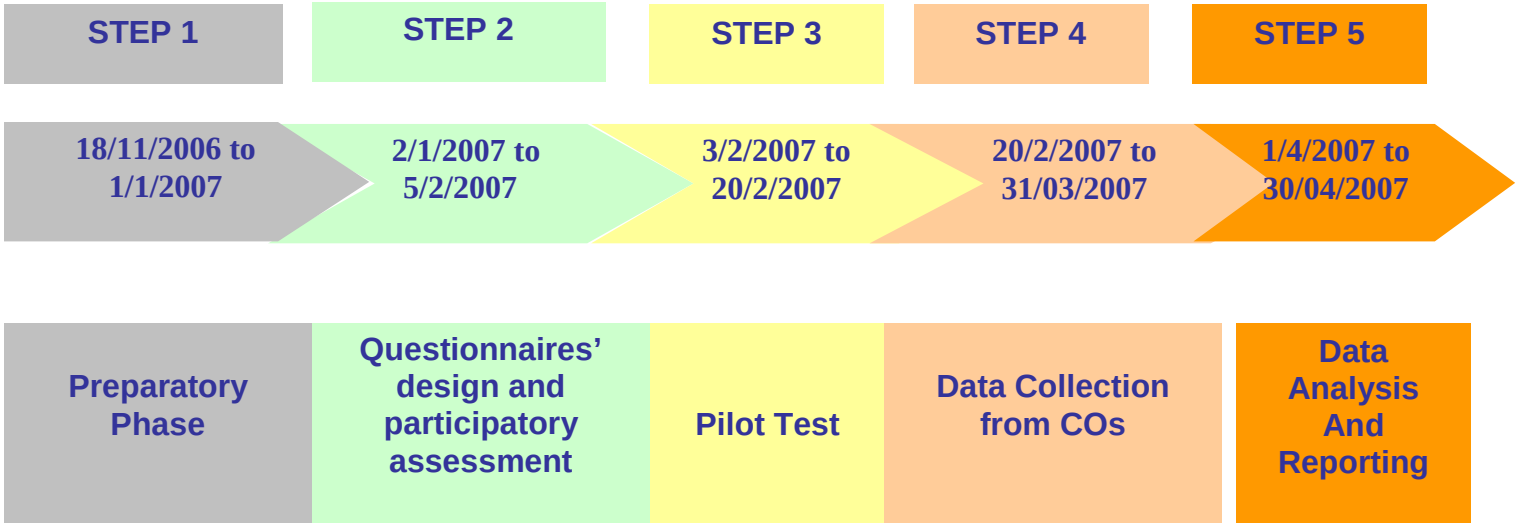
Survey of WFP's HIV and AIDS activities world-wide to inform Country Case Study Selection

58. To provide concrete in-country data to contextualise information obtained from the desk review, past evaluations and interviews with HQ personnel, a sample of four country case studies will be conducted. The approaches, outcomes and lessons learned from the selection of country programmes will be studied in-depth, including field visits of approximately seven days each. The purposeful sampling process of selecting the countries for case studies is structured according to the following steps:

59. **Methods and analysis**

Seventy-four countries were selected from the WFP country portfolio to participate in the pre-evaluation survey. The survey was conducted of all WFP COs to determine the volume and scope of their HIV and AIDS activities during the reference period 2004-5. The methodology of the survey process is summarised in the following diagram.

Diagram 1. Summary of the Survey Method



60. B). Data collected from the survey were analysed and processed to:

- Inform on WFP HIV and AIDS objectives, activities, role(s) of food aid and how they are linked to each other
- Quantify WFP HIV and AIDS activities in terms of food delivered, number of beneficiaries and expenditure in the 2004-5 period
- Identify WFP categories of partners and their roles in implementing HIV and AIDS activities
- Address the main issues noted by COs during the implementation of HIV and AIDS activities

61. C) Following analysis of the survey data, the process and outcome were presented by Laura LoCicero in April 2007.[133] This was also summarised in her presentation to the Reference Group at the Rome meeting on May 7 2007

133 Report on HIV/AIDS Thematic Evaluation Survey Results, Laura LoCicero for OEDE April 2007.

Annex E WFP Country case-studies

Uganda case study (2-8 September 2007)

Introduction

Limitations of the evaluation process in country

1. Field work in Uganda included visits to HIV and AIDS implementation sites in Kampala, Soroti and Arua and meetings were held with WFP RB, CO and Sub-office staff in two locations as well as with government and non-government partners. Thus field work was extremely limited and the team was unable to visit the northern part of Uganda where most of WFP's emergency activities are implemented. The team also held a limited number of meetings with MoH and UN Agency staff. Unfortunately, meetings could not be scheduled with several of critical partners and sister UN agencies and personnel such as the UNICEF nutrition section and FAO.

2. Further, the evaluation also includes a component on assessing the effectiveness of the food assistance. With support from HIV staff, consultants are in the process of extracting data from WFP partners which is hoped to enable some degree of assessment of the effectiveness of the food assistance. Data are currently being gathered and the results of further analyses will be included in the final evaluation report.

Findings and Recommendations

3. Due to the lack of time following dispersed activities, the team have not had the opportunity to consolidate findings. In response to this and to facilitate team members presenting their own, yet overlapping, areas of focus, findings and recommendations are structured and presented by each specialist's perspective. It is intended that this initial draft will provide a useful tool with which to clarify and sharpen the evaluation team's perceptions gained from the limited time in country. Feedback from the RB, CO and national partners are a crucial part of this process.

HIV and AIDS specialist's findings and recommendations

Policy implementation

4. WFP HIV and AIDS activities of the Uganda CO under the PRRO 10121.1 were originally planned and guided using the logical framework tool as evidenced in the 2004 PRRO Document.[134] The Country Programme Action Plan,[135] however, used an adapted Results and Resources Framework. This framework, by its nature, does not fully detail the performance indicators or means of verification required to guide monitoring and evaluation. M&E staff reported that over time the CO has managed evolving activities within its Monitoring and Evaluation Plan which logically sets out indicators, data sources and collection methods HIV and AIDS activities.

[134] WFP/EB.1/2005/7-B/2. 22 December 2004.

[135] Draft copy made available (WFP CPAP 2006-2010)

Coherence

5. Within the time constraints and limitations of the in-country phase of the case study of Uganda, the CO's HIV and AIDS strategy appears to be coherent within the framework of the *UN Division of Labour for the AIDS Response in Uganda* (October 2006). This indicated that the CO strategy is in line with both WFP corporate policy and the UN framework. Specifically WFP takes the lead in food and nutrition support to food insecure people infected or affected by HIV and AIDS together with UNICEF, FAO and WHO as main partners. Furthermore, WFP policy of supporting lead agencies in broader aspects of the response such as governance, IEC and prevention ensures that food and nutritional support is integrated within the country response to the epidemic.

6. Limited interviews with sister UN agencies illustrated a strong appreciation of the importance of food and nutritional support in response to the epidemic and particularly in enabling and optimising adherence and efficacy drug regimens among food insecure people infected with HIV and TB. While WFP's mandate and approaches may be understood, some sister agencies may not fully appreciate WFP's presence in their own geographical areas of interest due to the different funding mechanisms. Rather than employing the more visible implementation route through local authorities (as in the case of UNICEF for example) WFP's resources are implemented more through non-governmental partners. This route is of lower visibility to some sister UN agencies and requires a higher degree of co-ordination efforts between agencies to ensure that potential synergies are not lost.

7. Operational HIV and AIDS activities implemented by WFP Uganda appear to be in line with section 27 of the 2003 Policy Paper and subsequent EB information notes that set out the principles to be applied to WFP programming for HIV and AIDS: However, requirements dictated by realities in the field illustrated how broader support by WFP might be required at the micro-level to ensure the achievement of WFP's overarching objectives. For example the Arua Sub-Office contributed under FFA to the construction of teachers' accommodation in rural areas where the lack of housing was linked to under supply of teachers that impacted negatively on children's access to education.

8. WFP's activities in the Uganda CO reflect principles of the WFP Gender Policy 2003-2007 and the UNGASS GIPA initiatives in its emphasis on selecting as IPs HIV positive groups and those initiated and led by women. In the course of field work the team observed these groups to comprise some of the most innovative and energetic of the small sample of IPs encountered, NACWOLA being a strong case-in-point.

9. Random questioning of staff provided evidence that WFP's HIV and AIDS in the Workplace (HAWP) policy had been implemented during its active period in the Uganda CO. All staff questioned who had been employed for two years or more had undergone HAWP training. The fact that more recent staff had not done so reflects the current hiatus in HAWP implementation associated with the policy gap at HQ-level associated with the awaited joint UN approach.

10. A lack of coherence between HAWP policy and practice was noted by the HIV and AIDS specialist at the SO-level during the visit to Arua. No condoms were available

in the men or women's toilets, in line with current policy. Subsequent discussion with SO staff indicated a gap in awareness of this policy requirement.

11. The pre-field Evaluation Desk study conducted through a survey of all CO's implementing HIV and AIDS activities revealed resourcing to be the primary constraint to the implementation of policy. This was further evidenced by the calculation that only 3% of the Uganda CO's resources were directed towards HIV and AIDS activities in the reference period 2004-5. The second most frequently noted constraint was the capacity of IPs. The CO's limited pool of IPs specialising in end distribution of food was reflected in the IP's poor monitoring of rations to HIV positive and TB infected refugees in Madi-Okollo Settlement in Arua district. In the course of the evaluation visit it was evident that the small volume of people on ART (35) and DOTS for TB (4) who were entitled to a 100% ration were only receiving the 80% general distribution ration. Given the discreet size of this group and the fact that the IP ran the settlement clinic where these cases were registered, it represents a complete oversight of the needs and entitlements of people infected with TB and/or HIV on the part of the IP.

Relevance

12. The national policy environment apparent in the 2007 *HIV Programme Guidelines – Uganda* indicates the strong relevance of WFP's approaches to the national context. Food security and nutrition feature prominently in the national HIV Programme Guidelines as well as in dialogue with focal government bodies such as the Uganda AIDS Commission. This indicates that WFP's advocacy and support to the drafting process of the national Guidelines has been successful in raising the profile of food security and nutrition at the national level.

Efficiency and Effectiveness

13. Interviews at all levels in Uganda from the RB to the SO revealed that designated HIV and AIDS officers regard WFP policy documents on HIV and AIDS to be too long to be effectively taken on board by all WFP staff. Feedback to the evaluation team indicated that staff would find shorter and more direct guidance documentation to be more effective in transmitting WFP's HIV and AIDS policy throughout the field level of the organisation.

14. The number HIV and AIDS officers in the CO provided evidence of a recent history of importance given by senior CO management to this theme within WFP. Compared with single HIV and AIDS focal points noted in many COs in southern Africa, the four dedicated officers in the HIV and AIDS unit of the Development and Recovery section illustrated a positive human resource investment at the CO-level.

15. The HIV and AIDS officers were found to be highly motivated and innovative in the range of collaborations they had encouraged in the country; the MUJHU research collaboration being a case in point. However, interviews with government and UN partners revealed the "Programme Assistant" status of officers to limit their effectiveness in influencing more senior officials in partner organisations.

16. The CO has been effective in addressing the human resourcing issues observed earlier among certain COs in the ODJ region. WFP has effectively enhanced the volume of dedicated HIV and AIDS officers by tapping into staff secondment from bilateral

agencies. Once of the two HIV and AIDS Programme Officers is funded by the Swiss Agency for Development and Cooperation which enables the CO to increase dedicate staff at minimal cost.

17. This approach also enabled strengthening of the CO's competence in the theme of food and nutrition support to the HIV and AIDS response as the position specifically advertised for an officer with HIV and AIDS experience. The CO has further enhanced its HIV and AIDS capacity by enabling the training of dedicated officers who joined with more general expertise. All officers are found to have attended at least one HIV and AIDS training course within the last two years of service.

18. CPs visited in Arua appear to be missing opportunities for HIV prevention and AIDS awareness by their lack of IEC materials in project waiting areas such as those at clinics and food distribution points. Although the period of time spent with the SO was too short to triangulate information and verify the root cause, initial information indicates the lack of correction of such IP oversights to be related to inadequate field monitoring resourcing at this level.

19. The CO made evident efforts to secure food and nutrition support within the GFATM Country Proposal for various categories of food insecure people infected or affected by the virus by (for OVCs in round 4 for example). Although the HIV and AIDS component of the GFATM proposal was not successful, through this exercise WFP enhanced the profile of food and nutritional support in response to the national epidemic. This was achieved through the participation of the Head of the CO Development and Recovery Co-ordination and engagement a consultant mandated to ensured these approaches were included in the drafting process of the Country Proposal.

20. The effectiveness of the CO in achieving the HIV and AIDS objectives of the Country Programme and PRRO could not be determined on the basis of existing M&E data, which lack baseline information by which to measure progress. It is crucial that the CO focus its M&E activities to inform on the effectiveness of its activities as certain donors and development partners regard WFP's approaches in response to HIV and AIDS to lack assessment. As donors are also concerned about that food and nutritional support in response to the epidemic might be unsustainable, it is important for WFP to disseminate information as to ways in which it contributes to longer-term food security.

21. WFP is visible as a partner in the national HIV and AIDS response via its technical support to the drafting of the National HIV Programme Guidelines and the National Strategic Framework for HIV/AIDS. It has strengthened its own position within the HIV and AIDS theme at the same time as advocating for food and nutrition approaches to HIV and AIDS by supporting a number of studies including the high profile research of Makarere University-Johns Hopkins University, including further study spin-off collaboration with a Yale University PhD project.

22. While at the national level WFP has ensured its identification in the response to the epidemic, there has been an apparent gap in senior corporate representation at major regional thematic events such as the PEPFAR meeting of HIV and AIDS Implementers in Rwanda.

Recommendations

- WFP should endeavour to increase its visibility to sister UN agencies in order that opportunities for synergies are not missed.
- The WFP CO should ensure that the HIV and AIDS in the Workplace principles are translated at the sub-office level – particularly it should require SOs to make condoms freely and discretely available to all staff.
- Designated HIV and AIDS staff should provide HQ with feedback on existing policy documentation and how it might be presented more concisely to effectively inform all officers of WFP's HIV and AIDS approaches and principles.
- To enhance the status of its HIV and AIDS approaches the CO should consider upgrading the status of HIV and AIDS staff positions.
- To ensure a comprehensive approach to HIV and AIDS, the capacity of SO human resources should be enhanced to enable effective monitoring and technical advice to IPs lacking an HIV focus.
- M&E of WFP's HIV and AIDS approaches must ensure the establishment of baseline data by which to measure effectiveness.

Best Practice

- Enabling staff to build their capacity in HIV and AIDS approaches through funded courses.
- Tapping secondment agreements to enhance the technical capacity and volume of human resources at minimal cost to WFP, while enhancing donor relations within the theme of HIV and AIDS.
- Enabling two officers to attend the International Aids Conference: this not only addressed CO HIV and AIDS capacity but by including the CO presence at a meeting of international importance raised WFP's profile and that of food and nutritional approaches to the epidemic.
- Addressing micro-level unmet needs to strengthen the achievement of core objectives.
- Collaborating through the provision of food and nutritional support to cutting-edge, high profile research such as the MUJHU PMTCT projects.
- By providing support in the early stages of clinical research into the effectiveness of food and nutritional support to different drug regimes (ART and PMTCT) and acting as a referee for follow-on research funds, WFP has enhanced MUJHU's potential to access more substantial funds to expand the knowledge base.
- By working in collaboration with MUJHU, WFP will ensure that IP's data are credibly and appropriately analysed to inform on the outcome of combined approaches to food insecure people infect or affected by the virus.

Nutrition Specialist's Findings and Recommendations

Internal Coherence

23. From review of the program documents and sites visits in Kampala and Soroti, the HIV and AIDS activities are, for the most part, coherent with the EB policy. Food assistance has been appropriately integrated with PMTCT and ART programs, in that clients are selected based on medical criteria and food insecurity; and they are phased-

off/graduated according to criteria. Nutrition information is included as a program component. Linkages between nutrition programs, such as MCHN and PMTCT have been forged. Further WFP has developed HIV programme guidelines with the GoU that define the need and programming rationale, along with comprehensive guidance on how to plan, implement and monitor HIV and nutrition interventions.[136]

24. The one area of HIV programming that is not entirely consistent with the EB guidance is the OVC component. In addition to supporting OVCs receiving vocational training and families supporting OVCs, which complies with the guidance, orphanages caring for young children are supported. WFP guidance encourages supporting OVCs being cared for by families rather than in orphanages. Staff reports that it has been difficult to identify partners working with OVCs at the community level. Recently in response to an expanding caseload, resource limitations and WFP HQ guidance on OVC programming, WFP Uganda is in the process of developing a new strategy to support OVCs. (For information on OVCs and vocational training see the food security specialist section, paragraph)

25. The current GoU/WFP school feeding program, 2005-2009 includes HIV/AIDS prevention training. The project includes a strong nutrition/health education component, including HIV/AIDS awareness. HIV and AIDS prevention education is required in all primary and secondary schools 3 times per week throughout the school year; to support this, curricula have been developed. However, an indicator of HIV prevention education is not specifically included in the school feeding project log frame, although sex education is included.

26. Strong support for HIV programming from the former country director and head of programming along with sufficient staff resources and technical capacity have supported the implementation of the HIV policy. The large overall country budget, due to the IDP PRRO operation in Northern Uganda has supported implementation of the policy. The overlap of UNICEF and WFP programming areas, e.g. the MCHN and PMTCT programs, has also contributed to implementation of the policy.

Relevance

27. Uganda was one of the first countries to develop overall guidelines on Nutritional Care and Support for PLWHA in Uganda; in 2006 the MoH with stakeholders' input revised the earlier edition. WFP's HIV and AIDS activities are consistent with the guidelines, which cover nutrition assessment, counselling and education as well as food assistance and livelihood support. WFP's participation in the development of the guidelines was acknowledged, however, a more engaged role was requested for the food security and food assistance sections.

28. Further, WFP supports the implementation of the HIV and Nutrition Guidelines through their collaboration with their partners. Last year through their quarterly meeting forums a plan was formulated for tracking heights, weights and BMI for HIV patients on ART and/or TB. Since October 2006, at least two of their partners have initiated this activity. The evaluation team was unable to obtain information on which of WFP partners include nutrition education and counselling to address in their HIV

[136] Republic of Uganda/World Food Program, HIV Programme Guidelines-Uganda, Kampala, Uganda: May 2007.

treatment programs, however, their largest partner, TASO does so. With the time constraints it was not possible to evaluate the quality of the nutrition information or nutrition counselling provided by implementing partners.

29. WFP's HIV and AIDS interventions are compatible with national plans and policies. For example, the latest draft of the National HIV and AIDS strategic plan includes food and nutrition support as part of prevention (PMTCT), treatment and social support objectives; it also includes nutrition support and food assistance target indicators under the HBC and sustainable livelihoods and economic empowerment objectives.[137] There is also significant overlap between GoU/UNICEF's Country Programme and WFP's interventions in OVC and PMTCT support; and to date there has been excellent collaboration between WFP and UNICEF with their PMTCT and MCHN programming.[138] Further, WFP's THR for OVCs to support school enrolment and completion for OVCs is consistent with the National Strategic Programme Plan of Interventions for OVCs, which calls for improved education for OVCs.[139] The National Food and Nutrition Strategy also supports WFP's HIV programming, in that, it calls for initiating food access and nutrition programs for PLWHA.[140]

30. Under the leadership of the MoH STI/ACP nutritionist, a first draft of the comprehensive strategic plan for nutrition and HIV is being drafted. This will be a critical document as it will define and elaborate HIV and AIDS food assistance and nutrition care and support along with the role of stakeholders. WFP support for a consultant to finish writing the first draft was requested.

31. WFP's partnership with MoH DHOs and UNICEF in jointly implementing the MCHN with VCT and PMTCT provides an excellent example of program synergy. WFP's and UNICEF's support for training of MoH technical staff in delivering quality ANC services which proceeded the roll-out of the MCHN (food assistance for pregnant/postpartum women and infants from 6 to 24 months) has improved the quality of antenatal, postnatal and infant care provided according to MOH DHO staff. Data provided by UNICEF shows increased participation in MCH clinic sites with the inception of food assistance, which also provide routine HIV testing and counselling. And, in turn, these data show increased numbers of pregnant women tested for HIV and participation in PMTCT programs, particularly in sites with co-located services.

32. The collaboration between WFP, UNICEF and the MoH has been seen as a model to be replicated within the government's HIV programs. Similar to WFP's support to NGO HIV partners, the MoH STI/STD ACP would like WFP (and UNICEF) to support government HIV clinics with food assistance, training for nutritionists, etc.

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[137] Uganda AIDS Commission, National HIV and AIDS Strategic Plan 2007/8-2011-12, Final Draft 1a, Kampala, Uganda: July 11, 2007

[138] UNICEF/GoU, Government of Uganda—UNICEF Country Programme 2006-2010, Kampala, Uganda: January, 2006.

[139] Republic of Uganda MoG,L&SD, National Strategic Programme of Interventions for Orphans and Other Vulnerable Children Fiscal Year 2005/6-2009/10, Kampala, Uganda: November, 2004

[140] Ministry of Agriculture, Animal Industry and Fisheries/Ministry of Health, National Food and Nutrition Strategy, Kampala, Uganda: November, 2005.

33. To date, although some of WFP's partners are providing nutrition counselling and education, the food assistance has not been used to leverage complementary nutrition services, such as, nutrition assessment and treatment for malnutrition.

34. In the three program sites visited by the nutritionist, partner staff and beneficiaries had a clear understanding of how long the beneficiaries would receive food and the graduation criteria. PLWHA requested more livelihood support and IGA programming to support the graduation and phase-out process. However, in Soroti, a second year of livelihood programming to support food beneficiaries as they phase-out from food assistance has recently started. Of note, two beneficiaries mentioned receiving seeds (maize and beans) in the first year that didn't germinate.

Appropriateness

35. Due to scheduling constraints, the nutrition specialist was unable to visit an HIV food distribution or review post food distribution monitoring reports. In lieu of this, she conducted a focus group discussion with beneficiaries in one program site (Soroti) and discussed the ration and the modalities of food distribution with two implementing partners in Kampala and one in Soroti. In the urban area where stigma is more pervasive, the clients bring containers and repackage the food products and oil prior to transporting. Transportation is potentially more of a problem in the more dispersed areas outside of Kampala, however, partners accommodate this by locating food distribution points as close as possible to beneficiaries. Distributions occur monthly to promote adherence to medical treatment and to facilitate transport for others HIV programs, such as, OVC. The limited number of beneficiaries interviewed in the course of the evaluation did not report transportation of food to be a problem.

36. The food rations, in as much as could be determined, appear to address the various categories of beneficiaries' nutritional needs and to support program objectives. Partner staff reported that the food assistance improved attendance at clinic visits for PMTCT and ART patients; and adherence to ART regimens. ART beneficiaries at one program site (Soroti), praised the food ration and commented on how helpful the CSB and oil porridge was during their initial participation when many were recuperating from illness and malnutrition. There are basically 5 rations: one for PLWHA/ART/TB out patients/OVCs in homes/MTCT+; a larger or full ration for TB in patients; another for women receiving PMTCT services at co-located MCHN sites which is the same as the MCHN ration (to avoid stigma); and the last two for the two types of OVC schools—boarding and day schools. Generally, the rations appear to be appropriately tailored given their objectives and uses, as well as, the nutritional needs of the beneficiaries. One could question whether the OVC ration should be based on the nutritional needs of HIV patients, given that most OVCs are not HIV positive. However, OVCs, whether HIV+ or not are nutritionally vulnerable.

37. The nutritionist also visited two TFCs given the overlap between HIV positive children and children in treatment for severe acute malnutrition. The caretaker ration was reported to support the mothers when staying with the child during his/her recuperation and the child ration during the later phase of treatment supported the child's recovery and transition to a food-based diet.

38. Most of the foods in the food basket are consumed locally, such as, maize meal, oil and pulses. CSB is not a local food, however, it is quickly cooked into a tasty porridge; and porridge is a popular locally consumed food. The CSB was regarded to be the most important food in the food basket as CSB (and oil) porridge supported their nutritional rehabilitation. When beneficiaries became stronger they reported being better able to eat more of the other commodities. Of the beneficiaries interviewed, all liked and consumed the foods provided. Beneficiaries and partner staff praised and expressed gratitude for the food assistance.

39. One concern related by recipients and the IP was the "off"-flavoured or bitter tasting maize meal that was occasionally distributed. Another problem with the ration was the distribution of whole grain maize. Two sites reported that this occurs approximately 10 percent of the time with additional maize sometimes provided to compensate for the milling costs. WFP staff report that the ration specifies milled maize, however, sometimes pipeline delays do not allow sufficient time for milling prior to distribution. In Soroti, inadequate mills produce poor quality ground maize meal; this in turn, influences the ability of the HIV beneficiaries, particularly the bedridden, to consume (and digest) the cooked maize meal. Managing the transportation of whole grains for milling was also reported to pose difficulties for people whose health was compromised by TB and HIV infection.

40. The ration, as it includes provision for household members, makes it possible for beneficiaries to have enough food to share with their family without compromising their food intake. Recently due to budget constraints the maximum number of household members included in a household ration is 6, however, WFP food distribution guidelines recommend providing rations for the actual number of household members up to 9 wherever possible however, three ration sizes (3, 6, and 9) are often used to facilitate food distributions. In one site, Soroti, the nutritionist interviewed several female heads of households with more than 8 children living in their households. This finding was confirmed by partner staff.

41. Implementing partners reported conducting nutrition and health education at food distribution sites. However, it was not possible to assess how widely this was implemented and if food demonstrations were included. Simple and inexpensive recipes to prepare CSB were requested by an IP.

Efficiency

42. Regarding WFP's HIV guidelines, such as, the "Getting Started" guides, they are considered to be too long and not necessarily designed for field use. Shorter guides which included a step by step approach, potentially with other resources which include the more technical information were suggested. Important gaps in the "Getting Started" guides were identified, such as, guidance on ration design for HIV infected/ affected; and how to access funds for HIV programming and to advocate within and outside WFP for inclusion of food and nutrition support for HIV.

43. Recently due to the relationship between severe acute malnutrition and HIV which interfaces in therapeutic feeding centres, WFP HIV and nutrition staff have started to work more closely at the CO level; this was not the case in the past. This also reflects national efforts to more fully integrate nutrition into HIV and AIDS programming. At

the sub-office level, given that field monitors cover both HIV and nutrition program components, this may have more naturally evolved. With the initiation of CTC (community based therapeutic care) and planned expansion of treatment for children with severe acute malnutrition coupled with the need to treat acute malnutrition in HIV infected adults, WFP HIV and nutrition staff collaboration is called for, as it could improve program quality and decrease duplicative efforts.

44. This past lack of working together depicts some of WFP's difficulties in mainstreaming HIV. The recent PRRO evaluation noticed this as well, as it calls for coordination between the various programmes at the CO level to avoid duplication and to enhance synergy.[141]

Effectiveness

45. WFP HIV staff participated in the several stage process of developing the National HIV and AIDS strategic plan. When an early draft appeared with little inclusion of food assistance and nutrition support, in collaboration with the Uganda AIDS Commission (UAC), WFP funded a study on nutrition and HIV in Uganda. The latest draft of the NSP includes food and nutrition support as part of prevention (PMTCT), treatment and social support objectives; it also includes nutrition support and food assistance target indicators under the HBC and sustainable livelihoods and economic empowerment objectives. The inclusion of food and nutrition support in the NSP represents an advocacy success that WFP contributed to.

46. The HIV ration is based on the IDP ration and was designed by a WFP Uganda staff person, trained as an international nutritionist, with input from HIV staff. In designing the ration, the nutritional needs and diet quality of HIV patients were considered, in that, the ration for most HIV beneficiaries, supplies only 60 percent of the calories, but is high in micronutrients. However, an assessment of a sample of HIV beneficiaries' households to determine the availability of foods, dietary habits and inter-household distribution was not conducted. This could have added to the limited information on food intake in HIV infected/affected households, as well as, supported the ration design.

47. CSB was included in the ration to increase the protein and micronutrient density and provide an easily digested food that both bedridden and ambulatory HIV beneficiaries could consume. The ration meets the guidelines for macro nutrient composition with at least 17 percent of calories from fat (20 percent) and between 10 to 12 percent of calories from protein (13 percent). Overall in Uganda, average caloric deficits between 75 and 90 percent are reported along with protein and fat deficits of 33 and 20 percent respectively.[142] Thus, a ration higher in protein and fat compared to calories may be needed. A full ration of 2,100 calories plus per person, i.e. including the additional needs of HIV clients, was deemed inappropriate, for most HIV

[141] WFP Uganda, Report of the Evaluation Mission for the Uganda WFP PRRO 1021.1 Targeted Food Assistance for Relief and Recovery of Refugees, Displaced Persons and Vulnerable Groups: September, 2007.
[142] Ministry of Agriculture, Animal Industry and Fisheries/Ministry of Health, National Food and Nutrition Strategy, Kampala, Uganda: November, 2005.

beneficiaries, given that food insecure households have access to some amount of food; and dependence on the ration was to be discouraged. It was not possible to review post distribution monitoring reports or to visit the homes of beneficiaries to assess how well the food ration was utilized and complemented the foods available to households.

48. The exception is the ration for TB in-patients, which appropriately includes slightly over 100 percent of caloric need. Time did not allow a visit to an in-patient clinic was to assess if other foods may be provided to in-patients; and to assess the acceptability and quantity of the food ration.

Connectedness and Impact

49. WFP's strong relationship with TASO, particularly as they work on supporting clients graduating from food assistance and developing small self-sufficient farms. However, more training was needed in complementary program areas, i.e. nutrition and hygiene, which would support greater self-sufficiency.

50. Other than to health centres providing MCHN programming, little training for government staff was noted. The recent PRRO evaluation reported a limited GoU; and attributed this due to a lack of awareness of the role of food and nutrition support in the context of HIV and AIDS. To ensure the integration and sustainability of food and nutrition support into HIV programming, the government health sector needs to be more involved in planning and monitoring HIV activities.[143]

51. Regarding training for NGO partners, although they are provided trained related to food assistance, training in nutrition education and counselling has not been provided.

52. Through the forum of partner quarterly meetings, WFP HIV staff has supported the monitoring of heights, weights and quarterly BMIs of HIV patients on ART and/or TB treatment. Two of the partners are piloting this and another partner (MUJHU) will analyze the data according to research guidelines approved by Mekere University. In addition, WFP with support of WFP HQ and other collaborators is supporting a study of the effect of food assistance on body composition of HIV patients. Further, one of WFP partners, MUJHU is in the process of analyzing PMTCT program data to compare weights of infants and women who received food assistance to a retrospective cohort that did not receive food. It is anticipated that these results will help demonstrate the effectiveness of food assistance for HIV infected beneficiaries.

53. The M&E system includes outcome indicators for the more medical related food support are appropriate, in that they include adherence to ART, improved nutritional status for malnourished ART patients, HIV infected pregnant women adhering to ANC/PNC and HIV-exposed infants being tested for HIV at 18 months of age. However, baseline data has not been collected and little ongoing data is available yet.

[143] WFP Uganda, Report of the Evaluation Mission for the Uganda WFP PRRO 1021.1 Targeted Food Assistance for Relief and Recovery of Refugees, Displaced Persons and Vulnerable Groups: September 5, 2007.

54. Beneficiary interviews and focus groups provided anecdotal evidence on the positive effects of food assistance. Beneficiaries noted that the food assistance supported their recovery, particularly for the bedridden and formerly malnourished. Many attributed the CSB to their improved health and weight gains (for some even their lives). However, among the beneficiaries interviewed, food assistance complemented ART treatment and treatment for OIs, nutrition/health education and counselling and psycho-social support. Ngo staff noted that the food support has encouraged more people to access HIV treatment services thereby increasing detection rates, as well, it has supported adherence to treatment regimens.[144]

Short case studies

55. One HIV infected man noted the importance of food assistance and ART treatment- formerly he was too weak to work. He needed food to take with the drugs. Now he is strong enough to return to his former work of repairing bicycles.

56. One HIV infected man receiving food assistance and ARTs from TASO noted that his wife and child aged 5 are also infected. Since starting on ART and receiving food assistance, his wife has been able to return to her small business of selling vegetables and he is now strong enough to volunteer as a community AIDS adherence counsellor.

57. An HIV infected mother caring for 4 of her own children and 5 orphans, reported that her weight and CD4 count are both improving. She is not on ART; and since initiating food assistance she has been able to garden and plant 1 acre of cassava with her children.

58. An HIV infected woman reported gaining 30 kg. since receiving food assistance. She has been able to return to her small business of buying and selling cassava and baked goods.

Emerging Issues

- WFP partners, TASO, in particular have become more interested in nutrition assessment which would include at a minimum determining BMI. This would enable partner health staff (trained in nutrition assessment, etc.) to identify, counsel and treat or refer patients with severe acute malnutrition or those with other identified nutrition problems, such as, anaemia or weight loss. Integrating this component within HIV care and treatment is obviously not the sole responsibility of WFP however, advocating for this as it falls within "nutrition support" is critical as a component of nutrition and food support.

[144] WFP Uganda, Report of the Evaluation Mission for the Uganda WFP PRRO 1021.1 Targeted Food Assistance for Relief and Recovery of Refugees, Displaced Persons and Vulnerable Groups: September 5, 2007.

- The need for nutrition interventions to target children infected with HIV/AIDS has been identified by WFP staff, the HIV evaluation team and the PRRO evaluation.[145] Staff at the two TFCs visited in referral hospitals in Kampala and in Soroti report high rates of HIV among their case load (40-50 percent). One of the referral hospitals requested a food ration for the PIDC in her hospital as many of the patients lived in areas without a nearby MCHN program.[146] A ration for paediatric aids beneficiaries ideally would be provided to all children with HIV receiving treatment through PIDC to support their high caloric needs[147] and/or adherence to ART. Given the recent initiation of ART for children there may be limited experience with food support for this population.
- In HIV-exposed infants, the progression of HIV and AIDS along with the difficultly of implementing the recommended infant feeding options for contributes to the development of severe acute malnutrition. The MoH's HIV and infant feeding guidelines have recently been revised, however, training for PMTCT and ANC program staff will be needed to support their dissemination. To decrease malnutrition among HIV-exposed infants, enhanced early detection is needed through expansion of PMTCT programming along with improved infant counselling during pregnancy, and infant follow-up which includes adequate infant feeding support for mothers and regular infant weights. Although it is not WFP's role to take the lead on nutrition issues, such as, infant feeding for HIV-exposed infants, advocating through the HIV, Health and Nutrition Cluster and other for appropriate services for this population is encouraged to prevent malnutrition and to complement food assistance provided to PMTCT and TFC programs.

Recommendations

- When opportunities present, WFP should participate more proactively in the development of HIV, food and nutrition guidelines to ensure that the food security and food assistance sections are well developed and reflect current evidence on food security and the role of food assistance in HIV treatment, care and support.
- WFP should consider taking a more proactive role in advocacy for, as well as, in planning and supporting trainings to utilize the MOH's nutrition and HIV materials and other nutrition and/or hygiene training as needed.
- WFP should train IPs in conducting food demonstrations and nutrition education at food distribution sites as needed. Further, utilizing ACDI/VOCA's CSB recipes and HIV and nutrition materials developed for food distributions may also be warranted.
- If resources allow, WFP should consider including the MoH HIV clinics in food assistance. This may also involve nutrition training and building staff capacity.

[145] WFP Uganda, Report of the Evaluation Mission for the Uganda WFP PRRO 1021.1 Targeted Food Assistance for Relief and Recovery of Refugees, Displaced Persons and Vulnerable Groups: September 5, 2007.

[146] WFP's MCHN program intentionally targets Health Centres in geographically areas determined to be food insecure, thus referral hospitals located in urban areas are not included.

[147] Children with HIV/AIDS, when symptomatic have increased caloric needs of 50 to 100 percent. (WHO, 2003)

- It is recommended that WFP financially support the MoH in their development of a comprehensive strategic plan on nutrition, HIV and AIDS so that a first draft can be more quickly completed.
- WFP should utilize available opportunities to ensure that MoH DHOs are aware of and understand the implementation of the HIV and nutrition policies and guidelines.
- More coordination and closer working relationships between the HIV and nutrition staff at the CO are needed to enhance HIV mainstreaming and to more fully exploit the potential of program integration.
- Within the HIV, Health and Nutrition Cluster and other forum, advocate for training on the new infant feeding guidelines for HIV-exposed infants along with more comprehensive follow-up and support for HIV positive mothers and their infants. In addition, advocate for a complete HIV nutrition care and support package, which includes adequate training for NGO and MoH health staff (nutritionists) in nutrition assessment, counselling and treatment of malnutrition.
- It is recommended that WFP Uganda phase-over their support to orphanages to the GoU or NGOs/CBOs where possible; and when this is not possible develop exit strategies with the remaining orphanages. Further, WFP should continue to develop a new strategy for OVCs, and in particular for OVCs under 5 years old and school-aged children cared for by families. It may be possible to utilize some of the same partners, such as, TASO to support OVCs as many of the beneficiaries receiving HIV and AIDS treatment are also caring for orphans. Many of these households are particularly vulnerable.
- WFP Uganda should consult with the RB HIV focal person and PDPH staff on WFP's global experience in providing rations for HIV infected children in light of the request made by a PIDC.
- WFP Uganda should consider increasing the maximum number of household members to receive rations from 6 to 9 as was done in the past.
- WFP Uganda in collaboration with WFP HQ should continue to support research on the effectiveness of food assistance for PHA as these results are critically needed for advocacy and program design. Further their efforts to increase the capacity of partners to collect anthropometric indicators should continue.

Best Practices

- Advocacy for the inclusion of nutrition and food support in the NSP on HIV and AIDS through supporting a consultancy to report on the role and effectiveness of nutrition and food support in HIV and AIDS.
- The MCHN program collaboration with the MOH at the national and districts levels and with UNICEF's support for VCT and PMTCT programming.

Food Security Specialist's Findings and Recommendations:

Coherence

59. The HIV and AIDS activities implemented by WFP Uganda are generally coherent with the WFP policy on HIV and AIDS, i.e. the 2003 Policy and the following EB information notes. WFP Uganda is for example one of the few countries visited,

which are performing well in terms of graduating/phasing out from food assistance to livelihood projects. The targeting of beneficiaries for HIV and AIDS programmes on the basis of food insecurity status (through the use of eligibility forms) is also in line with the 2003 policy.

60. HIV and AIDS has been mainstreamed into food security and vulnerability assessments conducted in Uganda; hence HIV and AIDS proxy indicators have been included in the 2005 Comprehensive Food Security and Vulnerability Analysis (CFSVA) and the two Emergency Assessments conducted in 2007 ("Emergency Food Security Assessment of Karamoja Region" and Emergency Food Security Assessment of IDP Camps and settled Areas in the Northern and North-Eastern Conflict Affected Regions") although to a different extent. The CFSVA operates with indicators of chronically illness, disability and mortality as well as knowledge of HIV and AIDS. Using the proxy indicators "chronically illness" and "mortality" can give an indication of the prevalence of HIV and AIDS. The Emergency Assessments only operate with one indicator, i.e. chronically illness/disability. Merging the two indicators into one indicator is, however, problematic, as chronically illness might be an indicator of HIV or AIDS, whereas disability generally is not.

61. Although Uganda CO as noted above is doing well in terms of phasing out/graduating from food assistance to livelihood projects; the graduation process can be improved in terms of a more flexible shift from food assistance to livelihood activities. The Uganda CO has urged the IPs to make an effort to initiate livelihood projects when the beneficiaries are still receiving food assistance support in order to enhance the preparedness for the shift from food assistance to livelihood assistance, for instance by providing input (for instance seeds and livestock) and training. However, due to lack of funding and technical capacity, this has proved difficult for the IPs. It should be noted though that Uganda CO and its partners are still performing relatively well in terms of implementing livelihood projects succeeding the graduation from food assistance.

62. The Uganda CO interpretation and understanding of the HIV and AIDS policy is generally compatible with the understanding of the policy at headquarters. Due to the lack of guidelines from HQ and ODK on for instance targeting/selection of beneficiaries, and phasing out/graduation, Uganda CO has been compelled to develop their own guiding principles in these areas. Uganda CO has not received any technical assistance from headquarters and ODK regarding these issues, according to information from the HIV and AIDS team.

Relevance

63. WFP's food security activities in Uganda are generally in line with the overall policy, that is "The National Food and Nutrition Strategy" (2005), prepared by the Ministry of Agriculture, Animal Industry and Fisheries and the Ministry of Health. The policy is based on the right to food and operates with a rights-based approach. This approach is, however, less prominent in the work of WFP. HIV and AIDS is mainstreamed in the policy strategy as one of several factors (strategic focus issues) contributing to vulnerability and HIV and AIDS affected and infected are included as one vulnerable group. The Strategy sets out plans for intervention and actions for addressing the various strategic focus issues. With regard to HIV and AIDS interventions, the

Strategy focuses on 1) advocacy for improved census to establish the number of infected and their location; 2) advocacy for creation of fund to support agencies caring for this vulnerable group (especially food and nutritional care services); 3) ensure that agencies provide care, in particular nutritional care for people living with HIV and AIDS, and 4) initiation of food accessibility and nutritional programme for HIV and AIDS infected. The WFP Uganda HIV and AIDS interventions are in line with 3) and 4).

64. The WFP OVC programme is coherent with the overall policy for OVCs: "The National Orphans and Other Vulnerable Children Policy" from 2004 implemented under the Ministry of Gender, Labour and Social Development. The OVC includes four blocks; of these WFP supports the first Building Block "Sustaining livelihood (with regard to food security & nutrition and care & support) as outlined in the "National Strategic Programme Plan of Interventions for Orphans and other Vulnerable Children. Fiscal year 2005/6-2009/10" (November 2004). In general, as in the case of the "Food Security and Nutrition" strategy, working with human rights and the rights based approach is more prominent in the OVC policy and programme than in WFP's work with OVCs.

65. Food assistance generally seems to be a highly relevant tool for beneficiaries affected and infected by HIV and AIDS. There was a very high appreciation of food assistance among the beneficiaries met during the mission. Many PHA/ART programme beneficiaries for example narrated how they due to the food assistance had gained weight and strength again.

66. The duration of time for different categories of beneficiaries is outlined in the HIV Programme Guidelines prepared by the CO[148]. The duration for food assistance for ART/PHA beneficiaries is for instance 12 months, whereas there is no specific period indicated for OVCs as the period of food assistance depends on the agreement with the institution supported; in the case of individuals, support will be given until the person finishes the training programme/education.

67. In the case of ART/PHA beneficiaries, the earlier mentioned eligibility form is used to assess the beneficiaries after receiving food assistance for 12 months. If the person by the second assessment has recovered or the food security situation has improved significantly, the person will graduate from food assistance to livelihood projects (cf. below). As mentioned earlier, the CO has advised the partners to initiate livelihood activities already during the provision of food assistance, as some beneficiaries will be well enough to start up activities.

68. One partner, NACWOLA-Arua, provides an example of how the organization is preparing the beneficiaries for being phased out from food assistance. Continuously during the period of receiving food assistance, the beneficiaries are being told "that they have to control their own food in the future" as one beneficiary put it, thereby preparing themselves for being phased out and using the time when they receive food assistance to plan for the future. After being phased out all beneficiaries are being targeted for livelihood projects, for instance training in tailoring, basketwork,

[148] "HIV Programme Guidelines – Uganda. Contributing to a comprehensive package of HIV/AIDS response". WFP. May, 2007

gardening, and beekeeping or through provision of seeds, pass-on goats, etc. The beneficiaries of NACWOLA-Arua had clearly been empowered through the project and had also benefited from the livelihood activities as explained by one woman: "earlier we would beg for vegetables, nowadays we grow the vegetables ourselves".

69. The partners visited were implementing relevant and feasible livelihood projects under or in continuation of ART or PHA programmes or as vocational training for OVCs. Examples of partners implementing relevant and feasible vocational training or livelihood activities are: RYDA, Meeting Point Kampala, NACWOLA-Arua (cf. above). The enabling factors for the relatively successful livelihood/vocational training activities are partners with relatively high capacity, which are being provided technical assistance from relatively highly skilled staff in the HIV and AIDS unit at CO level.

70. One vocational training centre run by the association RYDA was visited during the Evaluation Mission. The centre was huge and impressive in terms of physical facilities and equipment and offered a number of different trades: carpentry, bricklaying and concrete practice, tailoring and embroidery, weaving and knitting, catering and home economics, motor vehicles, metal work art and design computer, and lastly agricultural practices. Five hundred students had finished the training within the last four years (with a certificate); 65 % of the students were successful in getting a job directly after finishing the training. According to the head of the centre, employers from the local area also approach the centre directly in order to employ the students as the centre has a very good reputation. The success of the vocational training centre to a large extent seemed to be the result of a highly committed and competent head as well as considerable donor funding. The contract with WFP concerning food assistance runs during the period 2004-2007. Due to the planned exit of the WFP food assistance, the head has initiated different IGAs to support the centre, for instance a piggery project, collection of firewood, and farming. Apart from the food assistance the centre has also received non-food items from WFP such as tools, equipment, training materials, clothing, sewing machines, carpentry tools). The provision of non-food items in HIV and AIDS interventions point to high priority of the HIV and AIDS programme at CO level (none of the other case study countries provided non-food items to the partners).

Appropriateness

71. No global targeting guidelines exist and the headquarters has not provided any strategic guidance in this regard. The Uganda CO has not received any strategic guidance on targeting from the Regional Bureau. In general, the collaboration between the Uganda CO and the Regional Bureau seems to be relatively limited with regard to HIV and AIDS activities. According to PDPH in HQ, the new handbook "Food Assistance Programming in the Context of HIV/AID", which came out in September 2007, is going to serve as the global strategic guidelines for targeting in the future.

72. Uganda CO has not developed specific targeting guidelines as such, but targeting is included in the earlier mentioned HIV Programme Guidelines. CO organise training on targeting procedures and selection criteria for partners**.** According to the Guidelines with regard to geographical targeting, priority should be given to areas

with high level of food insecurity and high HIV prevalence. The Guidelines, however, emphasizes that high HIV prevalence often do not correspond to high level of food insecurity. The areas with the highest prevalence of HIV are found in the Central, Kampala and North Central regions.

73. The Uganda HIV Programme is targeting 26 districts in Uganda in the Northern, Eastern, Northern-Eastern, South-western, Central and North-Western regions. The programme is hence partly covering some of the regions with the highest HIV prevalence. The HIV prevalence is significantly higher in urban areas (10.1%) than in rural areas (6%) for the age group 15-49 years. The Guidelines does not mention the patterns of food insecurity in the country. However, according to the CFSA 2005[149] the Acholi strata, the Karimojong strata and the Lango strata in the North and North-Eastern part of the country are the most food insecure and vulnerable regions. In general, thus, the Uganda HIV and AIDS programme seems to target the most food insecure regions.

74. As part of the beneficiary targeting process, Uganda CO has developed the Partner Beneficiary Evaluation Form, which is assessed and revised (if needed) on a quarterly basis in collaboration with the SOs and the partners. The Partner Beneficiary Evaluation Form generally seems to be a relevant tool for targeting in particular for ART and PHA programmes by establishing entry eligibility based on household food security and weight indicators. The form operates according to a score system, where the beneficiaries have to have more than 21-25 points to be eligible for food support. Higher score indicates higher vulnerability. The score required to be eligible for food support varies between different parts of the country, which is a sensible strategy as the food security situation varies throughout the country. All the partners implementing PHA/ART programmes visited during the Thematic Evaluation were using the form[150].
75. The HIV Programme Guidelines does not indicate any targeting criteria and procedures for OVC except from stating that OVC per definition are considered food insecure, at least until they have finished their formal/informal education and/or are able to make a living. The Guidelines does not indicate specific targeting criteria for OVC – all are regarded vulnerable. Targeting all OVC in an area is presumably not possible due to funding shortage and the more specific targeting procedures and criteria will thus be determined by the IPs. This is problematic as it leads to differing practices of different IPs and also makes it more difficult to prevent favouritism and nepotism.

76. Two partners implementing OVC programmes were visited during the Thematic Evaluation, Meeting Point and RYDA. In the targeting process, RYDA would make use of different referral systems, for instance the government, other WFP partners, and community outreach programme. In some cases, children would approach the organization themselves.

[149] "WFP-VAM/SENAC: "Comprehensive Food Security and Vulnerability Analysis (CFSVA)", Conducted July-August 2005.

[150] The partners visited by the food security specialist were: Reach Out, Meeting Point, NACWOLA-Mbuya, TASO-Mulago, MUJHU, NACWOLA-Arua.

Efficiency

77. The Partner Beneficiary Evaluation Form seemed to be widely used by the IPs; all partners visited during the mission were using the form for targeting of beneficiaries for food assistance; some partners had also computerized the data from the forms. In general, thus the targeting design seemed to be efficiently implemented.

78. No global guidelines for the process of phasing out/graduating beneficiaries from food assistance existed at the time of the Evaluation Mission. According to RB, the strategic guidance can be found in the document EB Policy Issues Paper: "Time to deliver – an Update on WFP's Response to HIV and AIDS" from 2007. However, the less than one page description of "how, when and where to exit" does not provide guidance for phasing out/graduating as it merely states the need for doing so and mentions a couple of examples.

79. The new handbook "Food Security Assistance in the Context of HIV", give some guidance on implementation of the HIV and AIDS policy, hereunder also phasing out/graduation. Uganda CO has contributed to the section on "Sustainability and Exit strategies" in the new "handbook by providing the example of TASOs Economic Empowerment Framework.

80. Likewise, no global guideline on livelihood activities has existed prior to the new publication of the handbook. Uganda CO has contributed to the handbook by a presenting a case project of linking livelihood and HIV programming implemented by TASO. In general, Uganda CO seems to have contributed more to the HQ's effort in enhancing graduation from food assistance to livelihood for HIV and AIDS infected and affected than the other way around.

81. With regard to vulnerability assessments, more strategic guidance has been provided from headquarters and the RB level than in the areas of targeting, graduation and livelihood projects for HIV and AIDS programming. The reason for this is probably that vulnerability assessments traditionally has been a core component in WFP, whereas HIV and AIDS programming is relatively new for WFP and the technical capacity for development programming is generally low in the organization.

82. Uganda CO receives strategic guidance on assessment from the Regional Bureau, which then receives strategic guidance from the VAM unit at HQ level. RB provides technical assistance and training for the CO staff, and also conducts quality screening of the assessments reports. Previously, the RB conducted the analysis of the assessment data, however after the COs have received training in this area, the analysis is now done at CO level. RB is currently conducting training in the newly developed "Food Security Monitoring System" for the COs in the regions. The Food Security system is going to function as an Early Warning System conducted on a quarterly basis. Moreover, the RB conducted training of CO and SO staff in relation to the recent Emergency Assessment (in March- April 2007).

83. There has been no involvement of the VAM units of the RB and Uganda CO in the guidelines on integration of HIV and AIDS in food security and vulnerability assessments prepared by the VAM Unit at headquarters. Neither the RB nor the CO

VAM unit have been involved in the preparation of the new Guidelines or the "Food Security Assistance in the context of HIV and AIDS" handbook.

84. The VAM unit in Uganda CO has suffered from shortage of staff. Due to recruitment problems, only one staff member has been in place since April 2007; the unit is normally staffed with three persons. Although the lack of staff has hampered the performance of the unit, it has to some extent been compensated for through assistance from the RB, for instance with regard to analysis of the assessment data.

Effectiveness

85. CO Uganda has developed a very comprehensive and ambitious Monitoring and Evaluation Plan. Related to the Strategic Objective 2: "Protect livelihoods in crisis situations and enhance resilience to shocks" is the outcome: "Increased ability to manage shocks within targeted households in crisis situations or vulnerable to shocks". Related to PHA/ART and OVC programmes, a number of indicators are listed. The indicators for OVC programmes appear to be highly relevant and durable: "% of OVC trainees from NGO/CBO training programmes gainfully employed after skills training" and number of persons who graduated from FFT trainings (for OVC in institutions). With regard to PHA/ART programmes, four indicators are listed:
    - Number of income generating activities created as a complementary activity for beneficiaries targeted in HIV and AIDS supported programmes (by type)
    - Number of participants in income generating activities created as a complementary activity for beneficiaries targeted in HIV and AIDS supported programmes (by type)
    - Number of skills training activities/courses for beneficiaries targeted in HIV and AIDS supported programmes (by type)
    - Number of participants in skills training activities/courses created as a complementary activity for beneficiaries targeted in HIV and AIDS supported programmes

86. However, although the four above-mentioned indicators provide very important information on the extent of implementation of IGA/skills training courses and the number of participants, the indicators are output and not outcome indicators and do not provide information on whether the households have achieved an increased ability to manage shocks. Thus, the data do not provide evidence that the households have developed livelihoods, which are more sustainable and more resilient to shocks.

Connectedness and Impact

87. WFP collaborates with the Ministry of Agriculture, Animal Industry and Fisheries with regard to a number of concrete activities, in particular in the North, which by both parties have been identified as the main food insecure area. The Ministry generally appreciated WFP's work in the North, however, due to the improved security situation in the area, the Ministry regarded it to be time for WFP to move away from food assistance and assist in developing sustainable solutions.

88. With regard to WFP's collaboration with the Ministry, one particular project deserves attention although the project currently does not directly target HIV and AIDS affected and infected and the collaboration is between the Food-for-Asset Programme and the Ministry (not including the HIV and AIDS Unit). The Food-for-asset programme includes two components, which are relevant for HIV and AIDS affected

and infected due to the low labour and land input in these projects, i.e. fish farming and IGA, for example bee keeping, poultry, piggery, and animal rearing. The activities are implemented in all areas of Uganda; through WFP it was also introduced in West Nile. Currently, there is no direct collaboration between the Food-for Asset programme and the HIV and AIDS unit at CO level.

89. WFP likewise collaborates with the Ministry of Gender, Labour and Social Development; and according to the Ministry the collaboration is very good. The two parties collaborate at policy level; WFP thus participated in the preparation of the OVC policy and programme. WFP furthermore contribute to the implementation of the OVC programme by building capacities at lower levels; i.e. by capacity building NGOs implementing the programme.

90. In general, thus, the CO Uganda has developed important strategic partnerships with the government institutions with regard to both PHA/ART and OVC programmes and are also contributing to capacity building, for instance of NGOs.

91. Due to the lack of impact data, it is not possible to assess the impact of the HIV and AIDS programme on household food security and local economies.

Tanzania case study (9-15 September 2007)

Introduction

Limitations of the evaluation process in country

1. During the mission to Tanzania, visits were made to HIV and AIDS implementation sites in Dar Es Salaam, Tanga, Arusha, Dodoma and Makete. Meetings were held with the WFP CO and Sub-office staff as well as with government and non-government partners. Thus field work was extremely limited. The team also held a limited number of meetings with MoH and UN Agency staff. Unfortunately, meetings could not be scheduled with several of critical partners and sister UN agencies and personnel such as the MoH AIDS Programme nutritionist and the Ministry of Agriculture, Cooperative and Food Security and FAO.

2. Just two weeks prior to the arrival of the evaluation mission, the HIV and AIDS focal point for the Tanzania CO resigned. As she was the main source of the CO's HIV and AIDS technical expertise and knowledge base, this constrained the evaluation process in country as did the vacant position for M&E within the CO.

3. Further, the evaluation also includes a component on assessing the effectiveness of the food assistance. With support from HIV staff, consultants are in the process of assessing and extracting data from WFP partners which is hoped to enable some degree of assessment of the effectiveness of the food assistance. Data are currently being assessed for extraction and the results of any possible analyses will be included in the final evaluation report.

HIV and AIDS specialist's findings and recommendations

Policy implementation

4. WFP HIV and AIDS activities of the Tanzania CO were planned and guided using the logical framework tool as evidenced in the PRRO 10062.2 and Country Programme 10437.0 documents.[151]

Coherence

5. Within the time constraints and limitations of the in-country phase of the case study in Tanzania, the CO's HIV and AIDS strategy appears to be coherent within the framework of the Tanzania UNDAF (2007-10). In common with sister UN agencies, WFP has to contend with an outdated national policy document.[152] In terms of the GoT Multi-sectoral Strategic Framework on HIV and AIDS,[153] there is little evidence of consideration to the roles of food security and nutrition in terms of the epidemic or national response. In particular, food security and nutrition are not cited in sections of the framework that refer to impact, determinants and dynamics of the epidemic or response approaches. However, the CO's approaches set out in the current Country Programme[154] converges with the national framework in terms of improving access of vulnerable to services as well as the joint focus on PMTCT and VCT.

6. HIV and AIDS activities implemented by WFP Tanzania appear to be in line with section 27 of the 2003 Policy Paper and subsequent EB information notes that set out the principles to be applied to WFP programming for HIV and AIDS. Indeed the Country Programme Action Plan CPAP 2007-10 provides an excellent example of a well-written and broad scope, good rationale and exit strategy – well integrated with other partners and government. However, there are clearly gaps between the CPAP and its implementation. Following the recent resignation of the HIV and AIDS focal person, the question is also raised as to how the CO might keep its CPAP on track in the absence of specific technical competence.

7. An overall lack of coherence between HIV and AIDS in the Workplace (HAWP) policy and practice was noted at both CO and SO levels in Tanzania. In the course of the field visit there was evidence of patchy and poor engagement in WFP's HAWP policy. Due to staff turnover, there was no designated officer responsible and as a consequence information could not be triangulated in the course of fieldwork. However, few of the staff interviewed had been provided with the HAWP training during its active period. This might have been linked to the relatively high reliance on staff on temporary contracts in whom investments in training tend not to be made. Further shortfalls in realisation of WFP's HAWP were evident in the lack of condoms available for to staff in their rest rooms. None were found at the CO and only an empty cardboard dispenser was found at one of the SOs visited.

Relevance

8. A good rapport and working partnership was evident between WFP and the MOH in responding to the recovery of food insecure TB patients undergoing treatment. Staff interviewed in the MOH had a firm understanding of the importance of food support

[151] WFP/EB.2/2006/8/2 24 July 2006.

[152] National Policy on HIV/AIDS. The Prime Minister's Office September 2001.

[153] Tanzania Commission for HIV/ AIDS National Multi-Sectoral Strategic Framework on HIV/AIDS 2003-2007. The Prime Minister's Office January 2003.

[154] WFP Tanzania Country Programme Action Plan CPAP 2007-10.

to ensure that the most vulnerable were able to benefit from treatment and regain their productive capacity in a timely way. WFP has supported the MOH's efforts to enhance treatment and care of TB patients by providing its technical expertise in determining and delivering appropriate rations in a pilot area in Korogwe, NE Tanzania. However, the MOH reported a lack of regular meetings with WFP at the central level that might hamper working relationships and knowledge-sharing.

9. Limited interviews with government agencies suggested a lack of a regular functioning partnership with WFP that is tangible in the *Multi-sectoral Strategic Framework on HIV and AIDS.* Interviews with the CD revealed a point of view that WFP's purpose in Tanzania was to feed refugees and that WFP's HIV and AIDS policy and approaches represents an over commitment for which the organisation is under-resourced at the country-level. However, interviews conducted with TACAIDS indicated that government was open to information and knowledge sharing on the support that food and nutrition can provide in the national response. This would indicate that more concerted efforts are needed towards WFP's advocacy and support to the GOT to raise the profile of food security and nutrition at the national level. While the difficulties perceived by the CD in working with the culture of the GOT is appreciated, it is also recognised that advocacy on the part of WFP is needed to ensure that food and nutritional support are adopted as part of the national approach to the epidemic, to ensure that the needs of the food-insecure are met.

10. Although the CD expressed the view that as a food secure nation Tanzania was not in need of WFP support, it was clear from field visits that issues raised in the 2006 VAM report are realities on the ground. In Dodoma district, for example, there is a high level of both food insecurity and HIV[155] prevalence that render people highly vulnerable to a downward spiral in terms of their health, earning capacity and nutritional well-being. In this respect it was apparent that WFP's approaches in response to the epidemic as its affects the food insecure are relevant to the needs of people in the sites visited. Furthermore, it was clear from discussions with home-based carers in Mvumi Makulu village in Makete District that only a proportion of food insecure people who would benefit from WFP support to establishing their ART regimens actually receive it due to resourcing constraints. Given that the HIV and AIDS Specialist's findings triangulated with that of other team members concerning the lack of graduation from food aid to livelihoods initiatives and that some recipients had received rations for two years, this issue could be at least partially alleviated by applying appropriate graduation criteria.

[155] Tanzania: Comprehensive Food Security and Vulnerability Analysis (CFSVA), November 2006

Efficiency and Effectiveness

11. Interviews both at CO and SO levels in Tanzania revealed that in common with WFP Uganda, in Tanzania officers implementing HIV and AIDS activities consider WFP policy documents on HIV and AIDS to be too vague and lengthy. There was a pervasive impression that all levels of the CO perceived WFP's policy on HIV and AIDS to be actioned in a "top down" manner that lacks technical support to enable country-level staff to confidently implement activities to meet WFP's HIV and AIDS objectives and principles. Staff used examples of HQ supporting the drafting process of PRRO and CP documents by ensuring the inclusion of HIV and AIDS principles and approaches, however, practical guidance on how to implement these activities was lacking.

12. Certain staff working at the SO level were found to be highly motivated to maximise their effectiveness in implementing WFP's HIV and AIDS policy. One member attributed his working knowledge on the theme to regular use of *WFP Go* to access HIV and AIDS policy documents and *Getting Started* guides. However, it was again reported that information accessible through this route needs to be more concise and easily digestible for field staff who are not HIV and AIDS specialists.

13. Discussions with the CD indicated that the CO was experiencing a high degree of pressure on its very limited human resources. As a consequence, the CD indicated it would be unlikely to fill the gap left by the last HIV and AIDS focal person unless a suitable UN Volunteer could be engaged. UNAIDS in line with the UNDG's directives, is in process of formalising the Joint UN Team on AIDS in the next few months. A consequence of this is that each agency must nominate an officer who will be accountable for WFP's HIV and AIDS activities and M&E. If a suitably experienced replacement is not engaged to act as HIV and AIDS focal point, there is a threat that WFP will not have adequate technical expertise to fulfil this commitment. Furthermore, if the CO does not have the technical competence to fully represent WFP's HIV and AIDS approaches, it will not be in a position to ensure that food and nutritional support are prioritised in the allocation of pooled UN resources.

14. The Dodoma SO has been innovative in its response to insufficient HIV and AIDS technical capacity by peer-training more numerous logistics colleagues in order that they may provide an additional pool of support as needed. This led to a meeting with other SOs that identified gaps in monitoring of HIV and AIDS activities. The CD supported this "bottom-up" initiative by releasing resources for capacity-building logistics personnel in M&E as they are ideally placed, visiting end-delivery-points, to regularly support IP's M&E activities.

15. In the course of field visits in Dodoma District it was apparent that the approaches of some of WFP's IPs were not effective in fulfilling the principle stated in the 2003 EB Policy Issues paper of using WFP food distribution as a conduit for the dissemination of HIV and AIDS prevention messages and information. In common with the observations made during field sites in Uganda, there was a complete lack of capitalisation on opportunities for HIV prevention and AIDS awareness. Further enquiry indicated that although the position on condoms of many faith-based IP's might constrain the preventions materials and messages they would be prepared to display, it does not rule it out.

16. Interviews with GOT and the CO were at odds in terms of the degree of engagement of WFP in the process of preparing the GFATM Country Proposal in order to secure food and nutrition support for food insecure people infected or affected by HIV and TB. However, it was apparent from reviewing past GFATM proposals that food and nutritional support had not been incorporated into earlier proposals.

17. Although the team is continuing to search for existing data sources with IPs, none have been found to date to enable evaluation of the effectiveness of the PRRO and CPAP in achieving the HIV and AIDS objectives From the M&E data available from one IP it appeared that there had been a lack of effective monitoring to determine progress towards HIV and AIDS objectives. As the M&E officer had resigned prior to the arrival of the evaluation team's arrival in country, it was not possible to triangulate findings from documentation. This situation, however, highlights a shortfall in institutional mechanisms for ensuring that effectiveness be monitored to guide activities and approaches.

18. Review of IP's M&E data also indicated a lack of rigorous and competent monitoring to inform on the effectives of approaches to support food insecure TB and HIV patients. CMSR Tanzania's *Report on Baseline Data Survey for People Living with HIV/ AIDS, Orphans, Chronically Ill Patients and Volunteer Groups*[156] provides a case in point. Data collected from WFP-supported activities in Dodoma district comprised basic listings of numbers of various categories of beneficiaries and there were no data providing indicators of the effectiveness of food support in the adherence of patients to drug regimes, or changes in their body weight, etc. Clearly stronger specialist supervision of M&E activities are needed with a particular, informed focus on indicators relating to the effectiveness of WFP's HIV and AIDS approaches.

19. The small sample of IP field operations visited revealed reliance on a failed mechanism of food support to people treated with ART and DOTS. Those visited had distributed WFP rations to patients undergoing drug therapy on the premise that during the period of support, they would be able to save small sums to start their own enterprises once their health recovered. In spite of the observation that very few families were able to save cash during periods of food and nutritional support, IPs were continuing with the approach. Furthermore, there was an absence of linking with existing and emerging livelihoods development projects such as those initiated by the Office of the Prime Minister that are aimed specifically at people recovering their strength following the initiation of drug therapy.

Recommendations:

- WFP should endeavour to engage more fully with GOT partners to raise the profile of food and nutrition in improving the adherence, drug tolerance and efficacy of food insecure people requiring ART and drug therapy for TB.

[156] Dated September 2003.

- Although there is currently a gap in HAWP leadership at HQ and new joint UN approaches are awaited, the Tanzania CO should ensure that WFP's *HIV and AIDS in the Workplace* principles are translated at both the country and sub-office level in line with UN practice to protect staff members and their families. At the very least, the CO should require all offices to make condoms freely and discretely available to all staff.
- Staff should provide HIV and AIDS HQ with feedback on existing policy documentation and in particular how information might be presented to more effectively inform all officers of WFP's HIV and AIDS approaches and principles.
- To ensure that HIV and AIDS activities are on track the CO should prioritise the engagement of an experienced HIV and AIDS staff member to fill the gap in technical competence resulting form the recent resignation of the focal point.
- The CO should explore the potential of staff secondment agreements with bilateral agencies to relieve the HR issues surrounding HIV and AIDS expertise. In this way the CO might obtain dedicated, experienced HIV and AIDS expertise at minimal cost.
- Regional and HQ mechanisms for providing HIV and AIDS technical assistance to CO and SO staff needs to be considered and rapidly implemented. At the very least, in-country staff require a point of contact that they are entitled to use for technical assistance.
- The CO should consider offering staff at CO and SO levels the opportunity to attend short courses in HIV and AIDS to strengthen technical capacity necessary to realise WFP's HIV and AIDS policy. In this way the capacity of human resources might be enhanced to enable effective monitoring and technical advice of IPs.
- Having strengthened its technical capacity in the theme of HIV and AIDS, WFP should make a concerted effort to encourage IPs to capitalise on opportunities for prevention and awareness-raising activities that are presented by food distribution processes.
- The CO should more fully engage in the process of developing future national HIV and AIDS and TB funding proposals, such as the GFATM, to ensure that funds for food and nutritional support and its associated costs are included to support the treatment and recovery of food insecure patients.

Best Practice

- Working in partnership with the MOH to pilot food and nutritional support to food insecure TB patients undergoing treatment in Korogwe.
- Innovative and cost-effective response of the Dodoma SO to increase HIV and AIDS technical capacity by peer-training logistics colleagues who regularly visit end-delivery-points which dovetails well with supporting IP's M&E activities.

Nutrition Specialist's Findings and Recommendations

Coherence

20. WFP's is the lead organization for "dietary nutrition support" in the UNAIDS Division of Labour with UNICEF, WHO and UNESCO as the main partners. Dietary nutrition support has been reworded as food and nutrition support; although food support is understood, a common understanding of what is included in nutrition

support is not clear to all WFP staff and their stakeholders.[157] UN partners do not see WFP as taking or sharing the lead with UNICEF and WHO in "nutrition support". This was the case in Tanzania as well. Stakeholders appreciate WFP more recent involvement in technical areas, such as, HIV and nutrition, but at the same time express concern due to WFP's lack of technical staff, capacity and resources devoted to this. Tanzania illustrates this with its current vacancy in the HIV position and the nutritionist is on contract.

21. The MCHN program initiated with country program (2007-2010)[158] included a module on HIV and infant feeding as part of the training-of-trainers WFP provided to regional and district health staff. This provides an excellent example of mainstreaming HIV within WFP programming. Unfortunately the MCHN program is located at health clinic sites that do not offer VCT or PMTCT services; further, collaborating with UNICEF to support such programs was not possible, given that the two organization's operational areas do not overlap. However, in the future, with the joint UN programming, implementation is planned in the same geographical areas.

22. Given time constraints and the recent departure of the HIV focal person, it was not possible to determine if WFP had supported the inclusion of HIV prevention education in schools implementing School Feeding Programs. However, this was not specifically mentioned in the latest Country Programme or School Feeding Program documents.

23. The overall lack of resources both in terms of staff devoted to HIV, resources for staff and partner training and the quantity of food aid available has hindered the implementation of the WFP's HIV policy. Further some of the critical guidance for HIV programming has not as yet been finalized. For example, two guides currently being finalized by PDPH, one on TB programming and the other on HIV and ration design would have been particularly helpful. From reviewing the program materials and visits to project sites, inadequate guidance and support from PDPH and/or the RB may also have hindered program implementation, however, this was not possible to confirm given the recent vacancy in the HIV position.

24. WFP staff and stakeholders commented on the complexity of the HIV interventions along with the large quantity of work required for a relatively small program (7,000 primary beneficiaries and their households) that will reach only a small percentage of the food insecure HIV infected and affected. One stakeholder commented, "Is it worth the effort?" WFP staff question whether there is added value of food assistance in HIV programs, and if so, what has it been. Further, one stakeholder questioned the effectiveness of such a small program if it has not been planned and implemented with the GoT so that effectiveness can be measured and those deemed effective scaled-up by the government.

Relevance

[157] Nutrition support includes nutrition assessment, education, counselling on specific eating behaviours, prescription of targeted nutrition supplements (e.g. micronutrient supplementation) and linkages with food based interventions and programs.

[158] County Program—United Republic of Tanzania 10437.01 (2007-2010). WFP Executive Board, November 2006.

25. A second draft of the guidelines on nutrition care and support for HIV/AIDS, which includes sections on food security and the role of food assistance, is in the process of being reviewed. WFP though involved in the Nutrition Working Group, has not been asked to review and comment on the guidelines. For the most part, WFP's HIV interventions comply with the guidelines included for food assistance. However, the food ration is higher in calories and not all of WFP's HIV programming includes complementary livelihood interventions as recommended.[159]

26. To improve HIV treatment outcomes, the MOH guidelines also promote nutrition assessment, counselling and education, (a complete nutrition package), for PLHIV. Only one partner, Sant Egidio, of the three partners providing medical treatment visited, includes a comprehensive nutrition package.

27. In addition, the MoH Guidelines for Home Based Care also include a section on nutrition care and support for PLWHA. Training for HBC workers in nutrition and HIV, food support, improving household food security, monitoring nutritional status and provision of nutrition education and counselling are all briefly included in the HBC guidelines. WFP provides food assistance and often HBC staff provides some nutrition education, however, IPs need to broaden and improve their "nutrition support" to be consistent with the HBC guidelines.

28. The UN Joint program document on HIV and AIDS includes "nutrition" as a component of the essential package for universal access to HIV and AIDS prevention, care, treatment and support.[160] Nutritional support is included as an indicator for persons on ART, though the funding level is low at $215,000. In addition, in the UNDAF document, a food security related outcome: increased food availability and access for those infected/affected by HIV and AIDS is included.[161] However, food and nutrition support is not included in the TACAIDS National Multi-Sectoral Strategic Framework on HIV/AIDS (2003-2007). Thus WFP HIV programming is integrated and compatible with UN planning documents however it is not as yet included in government HIV strategic plans.

29. On the other hand, others government documents also include and refer to HIV and nutrition. Further, in the National Nutrition Strategic Plan[162], calls for more attention to nutritional support for PLWHA and improved access to "nutritional care" for persons living with HIV and AIDS is specified, again this is not defined for clarification.

30. It was not possible to find clear written graduation guidelines for the ART, PMTCT and TB/ART programs, which would define the graduation criteria, relate them to medical conditions and explain the phasing-off process. This was reflected in the

[159] "National Guide on Nutrition Care and Support for People Living with HIV/AIDS", MoH/Tanzania Food and Nutrition Centre, April 2007.

[160] UN Tanzania, One UN Joint Programme on HIV and AIDS 2007-2008-Tanzania Mainland-Final draft: September 6, 2007.

[161] UN Tanzania, One UN Pilot Programme: Tanzania Joint Programme on HIV and AIDS September 2007-December 2008: Final draft September 3, 2007.

[162] URT/MoH&SW, National Nutrition Strategic Plan (2006/7-2009/10) Draft: March, 2007

confusion around graduation from food assistance noted during the field visits to Selian Hospital ART program and the pilot TB site. In the ART site, beneficiaries had been graduated after participation for 1 year, although the Country Program Summary mentions phasing-off beneficiaries after 6 months. Further, beneficiaries did not understand one of the objectives of the food aid, i.e. in promoting self-sufficiency, in that they hoped to return to the program in the future.

31. Further, clear guidance on eligibility and graduation criteria for OVCs in vulnerable households and HBC beneficiaries was not found. In one program visited, Mandizi Parish that had started earlier this year, phasing out of or OVC households was planned after 6 months of participation. In another program, UHAI Centre, OVC and HBC households receive food assistance for 1 year.

32. Regarding the TB pilot site, the program coordinator was strictly following the criteria that had been provided. All TB beneficiaries were graduated when they completed their DOTS treatment at 6 months. TB beneficiaries treated for 8 months were terminated prior to the completion of their treatment. Further, patients diagnosed with TB and HIV are not started on food assistance until the ART treatment is initiated, which on average takes 2 to 3 weeks, nevertheless, they are graduated after 6 months of TB treatment.

33. TB Program beneficiaries and staff commented that patients often have not regained their strength when they finish DOTS treatment, thus it is difficult for them to fully resume their livelihood activities when food assistance is discontinued. They requested food assistance for a longer period and assistance with IGA, which is compatible with the PDPH draft guidance on TB programming.[163]

34. Currently WFP is not supporting a partner implementing a PMTCT program, although some of the ART clinics supported include some PMTCT patients. Criteria for PMTCT patient graduation are included in project documents, however, it was not possible to assess if this is followed. In addition, some Paediatric AIDS patients are receiving assistance as OVCs, however, graduation guidance, eligibility criteria or ration specific for paediatric AIDS patients has not been developed.

Appropriateness

35. In some cases the periodicity of planned distributions conflicts with the objectives of the program. For example, for the Selian Hospital ART clinic food assistance is distributed every 3 or 4 months and in the past food rations were provided twice a year. Not providing rations along with monthly clinic visits compromises one of the objectives of food aid as an incentive to attend clinic appointments. However, when discussed with two groups of beneficiaries (one ART and the other HBC, OVC) their preference was for distributions every 3 or 4 months to limit transportation costs. They also reported that storage of 3 or 4 months of food was not an issue. On the other hand, monthly distributions at clinic visits would enable at least some beneficiaries (and their families) to transport the food themselves. Transporting large quantities of food was not identified as a problem among the beneficiaries met.

[163] WFP PDPH Service, Getting Started: WFP Food Assistance in the Context of Tuberculosis Care and Treatment, Draft, June, 2007.

36. The ration has been tailored to reflect the increased caloric requirements, higher nutrient density, cooking constraints and eating difficulties experienced by PLWHA. The CSB is a high nutrient dense food, at the same time it is easily digested and quickly cooked when prepared as porridge. The yellow split peas are more easily digested and cooked when compared to dried beans.

37. According to beneficiary focus groups, the food rations are well accepted. There are basically two rations: one for ART/TB/PMTCT beneficiaries and the other for OVCs. The ART/TB/PMTCT and OVC rations include the same foods and have similar nutrient compositions, however, the ART ration provides 120 percent of caloric need while the OVC ration provides about 80 percent. They are distributed as household rations for 5 members for HHs with 1-7 members; and for households with 8 or more members, a double ration is provided. The composition of both rations have been appropriately tailored considering the needs of the two beneficiary groups, however, considering that the ration, in most cases, is not the family's sole source of food, the increased risk of creating dependence and resource constraints, the ration is large, particularly for families with 8 or more members.

38. Two of the foods in the food basket are not local, i.e. the CSB and the yellow split peas. According to beneficiary reports, the CSB is the preferred food. Beneficiaries attribute their recovery to eating CSB porridge. On the other hand, the yellow split peas and yellow maize are not acceptable to some beneficiaries who prefer the traditionally consumed beans and white maize. Nutritional value, digestibility and cooking time are also important to consider. Yellow split peas require less cooking time and are more easily digested when compared to most beans; and yellow maize contains more vitamin A than white maize.

39. Food storage and warehousing: In two of the partners' buildings (TAWG TB and Mlandize Parish) CSB was stored past its expiration date. Program staff was unaware that this was a problem. Further at one site, TAWG TB, oil wastage was reported during food distribution when cans are divided. And most of the canned oil was not appropriately labelled with vitamin A content.

40. Although partner staff is trained in how to properly store, track and distribute commodities, one warehouse visited (TAWG TB) did not follow appropriate storage and tracking procedures. This was particularly problematic as fewer beneficiaries were enrolled and thus large quantities of food were stored. WFP staff was not unaware of the problem prior to the recent visit. The former HIV focal point had visited the program twice however this was the first visit by sub-office staff.

Efficiency

41. The user friendliness of WFP's HIV and AIDS policy and guidelines was difficult to assess as the HIV focal point had recently left; her responsibilities had recently been assumed by a consultant who was juggling other duties as well. In the Arusha sub-office, the only guidelines available were on targeting.

42. WFP Tanzania should be commended for addressing gaps in technical staff, such as, contracting with a nutritionist. However, the lack of a nutrition staff position to provide continuity to nutrition (MCHN and HIV) advocacy and programming was noted both by WFP staff and stakeholders. This is especially critical with the vacancy in the HIV position, which a consultant (junior) without technical expertise or training in this area is temporarily filling.

43. The head of the Arusha sub-office was provided training in the HIV and AIDS workplace and training on HIV beneficiary targeting. Unfortunately the consultant temporarily managing the HIV programs will not be attending the upcoming regional HIV focal point meeting as within WFP, consultants work as staff, yet they are not often provided training.

Effectiveness

44. An extensive monitoring and evaluation framework and data base for the HIV program has been developed for the initiation of the new country program. However, the overall system appears to be beyond the capacity of WFP to implement and requires more data collection than necessary, particularly for the PMTCT and ART programs. Currently there is no staff person dedicated to CP M&E or HIV M&E and no reports were provided for review. Training on the system was not conducted for WFP staff or partners before the JPO who developed it left; and the HIV data base is not functional. Tri-yearly partner reporting forms have been developed along with beneficiary contact monitoring (BCM) and some training has been provided. One sub-office reported they have not had time to conduct BCM with partners.

45. WFP, along with UNICEF, HKI and WHO has played an important role in advocating for the nutrition (and nutrition and HIV) agenda, although results, thus far, has been slow due to the GoT's nutrition structures. The MoH&SW nutrition division sits outside of the Ministry and thus is not directly accountable while the NACP with their nutritionists falls under TACAIDS. To date, there are two nutrition coordinating groups, in which WFP actively participates, though a technical working group on nutrition and HIV has not yet been formed. Through the efforts of both groups, nutrition and HIV resources have been developed. A coordinated approach (and strategy) is lacking along with critically needed funding for training and implementation of nutrition and HIV interventions; however, this has been partially addressed through the draft National Nutrition Strategic Plan (2006/7-2009/10).

46. Further, although the TFNC/MOH published guidelines on nutrition care and support for HIV/AIDS in December of 2003, nutrition stakeholders concurred that it has been difficult until recently to convince policy makers of the importance of food and nutrition support for PHA. The roll-out of ART, advocacy, and at the same time, the increasing evidence base of nutrition interventions for PHA has strengthened support for food assistance (for the food insecure) and has also increased interest in nutrition assessment, counselling and education for PHA.

47. The food basket or ration is appropriate to the extent possible given WFP's donor and funding constraints. As mentioned the basket includes local foods (maize and oil) and CSB, which is a nutritious, easily digested and also a preferred food among HIV beneficiaries. Both food rations comply with WHO guidance on nutritional requirements and the dietary composition for PLHA, in that, they provide additional

calories and are within the recommended percentages of protein and fat.[164] The ART ration provides 100 percent or more of most micronutrients; the OVC ration also provides 100 percent of many micronutrients (see Annex for the nutritional composition of the rations). However, as mentioned in section 4.2 the ration is larger than needed for most beneficiaries, particularly as additional rations are provided to household members, and further, a similar, but smaller ration could be designed to complement locally consumed food.

48. Iodine deficiency is endemic in Tanzania with a national prevalence of 7 percent with over 20 percent in one of WFP's operational areas, i.e. Iringa region.[165] The Tanzania DHS 2004/2005 reports use of iodized salt at 73 percent, however, only 44 percent of the salt is adequately iodized; with rural areas reporting only 34 percent of households using adequately iodized salt. Adequate iodine is particularly important for pregnant women, infants and children. Given this, along with WFP's overall programming objectives it would be advisable to include iodized salt in the ration until adequately iodized salt is more widely available.

Connectedness and Impact

49. From limited discussions with MoH&SW staff, there have not been ongoing efforts to develop and strengthen relationships with government partners, such as, TB program or Ministry of Social Welfare staff. This was difficult to assess with the recent departure of the HIV focal point, however, when queried government counterparts noted little ongoing contact with WFP staff. On the other hand, UN nutrition partners, such as, UNICEF reported a strong ongoing relationship.

50. WFP's HIV partners have received little if any training in activities other than beneficiary selection, program monitoring and food storage and distribution. Training for one of the partner's HBC volunteers in the MoH 3-week HBC training was funded by WFP, though little nutrition was incorporated into this training. From focus group discussions and interviews with partner staff, some of the partners provide basic nutrition information however more nutrition training is needed to improve the nutrition education and counselling component. Only one of the partners providing ART, PMTCT and TB treatment provides nutrition assessment, counselling and education.

[164] WHO, Nutrient Requirements for People Living with HIV/AIDS, Geneva: 2003

[165] URT/MoH&SW, National Nutrition Strategic Plan (2006/7-2009/10) Draft: March, 2007

51. From discussion with partner staff and beneficiaries significant anecdotal evidence of the effectiveness of food assistance was documented. Beneficiaries noted improved strength, health and quality of life. Some reported that the food assistance saved their lives; others related that prior to food assistance they were bedridden and now they are ambulatory and fit to work. One report noted quicker recovery from OIs and fewer complaints of stomach pain from patients after receiving food assistance. In addition, other positive effects of food assistance were reported, such as, less stress and improved mental outlook for household heads (with HIV) when receiving food assistance for their families. Along with food assistance many of the beneficiaries also received medical treatment, ART and psycho-social support, thus what improvements may be attributed to increased dietary intake is not clear. Program staff reported increased uptake of VCT, ART and PHA support groups, increased visibility for their program and reduced stigma in their communities since food assistance started.

52. One project (Evangelical Lutheran Church in Tanzania, Arusha Region) reported that 60 percent of their patients on ART gained weight with food support, though the gains were low from (3-4 percent). Monthly attendance at ARV clinics increased from 79-91 percent after food assistance started and adherence rates according to counsellors improved.

Emerging Issues

53. As ART treatment for children continues to be rolled out, more HIV-infected children will be identified and treated. Currently some children receiving ARTs are being supported with food assistance as OVCs. However, as mentioned the length of support is not clear; and the nutritional needs of OVCs are high, i.e. 50 to 100 percent above calorie needs for their age and sex.166

Recommendations

- Ongoing work is needed to ensure WFP's input into the MoH nutrition and HIV guidelines, as well as to continue advocacy for a HIV and nutrition working group and to move the overall nutrition agenda in Tanzania forward. Within the current CP's funding and with WFP's hiring freeze, continuing an international nutritionist with experience in HIV on contract may not be possible.
- Continuing to integrate HIV and infant feeding within the MCHN program as it is implemented. When joint UN programs is planned and implemented, partner with UNICEF, the GoT MoH&SW (and WHO) to offer VCT and PMTCT services at Health centres with MCHN programs. The work with the nutrition and HIV partners on developing IEC/BCC materials should also continue.
- Given the overall food and financial resources provided for HIV programming to improve program quality, monitor appropriately and measure effectiveness, simplifying the program is warranted. This may be accomplished through fewer target groups and/or concentrating the program in fewer geographical areas.

[166] WHO, Nutrient Requirements for People Living with HIV/AIDS, Geneva: 2003

- Piloting one type of HIV intervention, such as, food assistance to ART beneficiaries would be easier to manage allowing for improved monitoring and evaluation. If this were implemented in close collaboration with the MoH&SW and NACP, potentially it could be scaled-up with GoT funds if determined to be effective. This would also dove-tail with an HIV program exit strategy.
- Similar to the integration of HIV in MCHN programs, seek opportunities to "mainstream" HIV into other CP components, such as, school feeding or food for assets. This may require less staff and food resources and also plays a role in HIV prevention and mitigation.
- Program eligibility and graduation criteria need to be more fully developed into guidelines for staff and partner use. Whenever possible linking food assistance with livelihood support is recommended. (See food security specialist section for further information.)
- Some of the beneficiary categories for food assistance, such as, TB may need to receive food assistance for longer to ensure adequate recuperation following the completion of DOTS treatment. Three to 6 months is usually provided for this. It is also recommended that when a TB patient tests positively for HIV that they be immediately eligible for food assistance and that the more severely affected patients on DOTS treatment for 8 months receive food assistance for the full 8 months.
- Clarifying and prioritizing the objectives of the food assistance for the various program components is also recommended. If the primary objective is compliance to treatment for beneficiaries on ART, then it may be advisable to consider distributions along with monthly clinic visits when possible.
- Given their nutritional requirements and medical treatment, Paediatric AIDS patients and the families which support them may require longer (and more) assistance than households caring for orphans not infected with HIV. This should be considered when developing guidelines for such support.
- Both of the HIV food rations should be decreased in size, but at the same time retain similar macronutrient composition and high nutrient value. Adding iodized salt to the ration should also be considered. This will promote greater self-reliance and allow for more beneficiaries to participate. If possible rations provided should be based on actual household size or potentially be provided in 3 rather than 2 sizes. Rations for 3, 6 or 9 household members are used in other countries. Local beans would be more acceptable to beneficiaries than the yellow split peas, though the peas cook faster and are easier to digest. Prior to making this change, more review is needed.
- The storage of expired CSB was identified as a problem. More training of warehouse staff may be needed, as well as, improved tracking and rotation of CSB supplies**.**

Best Practices

- Working with nutrition partners to advocate for the nutrition and HIV and nutrition agenda.

Food Security Specialist's Findings and Recommendations

Coherence

54. WFP Tanzania implements OVC, PMTCT, ART/TB, and PHA/ART through the Country Programme 10437.0 (2007-2010) and the PPRO 10062.2. Due to time limitations, only the Country Programme, which has the largest HIV and AIDS component was visited during the Evaluation Mission. It was found that the HIV and AIDS programme in Tanzania is only partially implemented in accordance with the overall WFP HIV and AIDS Policy, i.e. "Programming in the Era of AIDS: WFP's response to HIV/AIDS" and the following EB papers. Hence, as elaborated below, serious gaps with regard to phasing out from food assistance or graduation from food assistance to livelihood projects were found. It should be noted, though, that the 2003 Policy Paper and the following EB information papers are very general and provide very little, if any strategic guidance for the planning and implementation of the interventions.

55. The implementation of the graduation/phasing out from food assistance to livelihood projects seemed to be hampered by the lack of strategic guidance from WFP HQ level. In other areas, such as for instance targeting, this gap had been compensated for by the development of guidelines at CO level. With regard to graduation/phasing out from food assistance to livelihood activities in Tanzania, no initiatives to guide and develop this area were taken by the previous HIV and AIDS focal point. The focal point had resigned shortly before the Evaluation Mission and thus it was not possible to explore the background of the lack of implementation of livelihood activities. However, it should be mentioned that the Country Programme 2007-2010 document[167] does not mention graduation to livelihood activities. The Results and Resources Matrix includes a performance indicator: "percentage of people/households discharged from food assistance and self-supporting increase with 10 % per year". Yet, it is not clear how the beneficiaries are expected to become self-supporting. The IPs visited were found to have a low capacity with regard to livelihood programming and had not initiated any activities in this regard.

56. Generally, there seems to be a lack of consistency and coherence between the WFP HQ and the Tanzania CO/ SO's understanding of the HIV and AIDS policies as the headquarters seem to work at a very broad level, which pays little attention to the operational aspects, which, however, are pivotal at CO and SO levels.

Relevance

57. The overall food security related objectives of HIV and AIDS component of the Country Programme is "improved coping capacity of vulnerable food insecure household affected by HIV/AIDS". This objective is in line with the "National Food Security Strategy" (draft, 2004) prepared by Ministry of Agriculture, Cooperatives and Food Security and its broad objective: "ensuring availability, accessibility and utilization of adequate, safe and nutritionally balanced food for all on a sustainable basis. The National Food Security Strategy is generally consistent, comprehensive and well designed. However, the relationship between HIV and AIDS and food security is

[167] "Country Programme – United Republic of Tanzania 10437.0 (2007-2010)". EB, WFP, Rome 6-10 November 2006.

only superficially dealt with both in terms of analysis and intervention areas. The only (but very valid) point raised in relation to HIV and AIDS is the importance of developing labour-saving technologies for infected and affected households.

58. WFP Tanzania has been an active partner in the preparation of the National Food Security Strategy together with other UN partners and NGOs. The Ministry of Agriculture, Cooperatives and Food Security; Ministry of Livestock and Ministry of Marketing provided the framework for the strategy, which was prepared by a consultant. The strategy was then shared and reviewed by different UN partners and NGOs as well as the district level. However, although the draft strategy dates 2004, it has not yet been approved and released by the government. WFP HIV and AIDS interventions are hence rooted in and compatible with National Food Security plans; however, it is yet to be seen how and if the strategy will be implemented.

59. Generally, the provision of food assistance in ART/PHA and OVC was found to be relevant to beneficiaries. All beneficiaries met during the mission expressed a great appreciation of the food assistance and also preference for food rather than cash transfers. However, in the case of the Shukrani Vocational Training Centre in Makete District, the students met during the mission reported that many students did not eat the pulse provided (yellow peas) as they traditionally were eating fresh green peas and had problems in digesting the yellow peas. The students requested to be provided beans instead, and possibly also occasionally rice.

60. The fact that whole grain maize instead of milled grain (requiring both labour and cash input) is being distributed to sick and poor beneficiaries can also be questioned. In the sites visited, the food assistance was distributed to the beneficiaries every 3-4 month. Due to problems with moisture in the houses, many beneficiaries would take out the maize grain for drying to prevent the maize from putrefying. This obviously is a burden for a household, which is already strained in terms of labour.

61. Regarding graduation/phasing out from food assistance, a huge gap was found both in terms of guidelines and implementation. It is not known whether the previous HIV and AIDS focal point had received strategic guidance on graduation and phasing out of food assistance beneficiaries from the HQ and RB levels. No strategy for graduation or phasing out has been prepared in the Tanzanian CO. With regard to phasing out or graduating the PHA/ART beneficiaries from food assistance to other activities, it was clear from visiting the two SOs and a number of IPs (CSMR and DSM Archidiocese) that they have not received any strategic guidance on how to deal with graduation or phasing out in relation to PHA/ART programmes (cf. below). It should be noted that the development of a beneficiary graduation strategy was one of the recommendations of the appraisal of the Country Programme 2007-2010[168]

[168] "Appraisal Mission Report for the Tanzania County Programme HIV/AIDS Component. Integrated Support to the Food Insecure Households affected by HIV/AIDS". By Robert M. Mhamba; Assumpta Rwechungura; Frederick Macha and Jean Ndyetabura". January 2006.

62. Regarding the duration of food assistance, a presentation of the HIV and AIDS Component[169] prepared by the previous HIV and AIDS focal point stipulate the duration of food assistance for different beneficiary categories. For PHA/ART programmes the duration of food assistance is stated to be 6-9 months or until sustainable source of income is in place. Visiting two SOs and a number of IPs in Tanzania revealed that the duration of food assistance was not known by all partners. One IP, DSM Archidiocese, had recently started the food distribution for PHA/ART beneficiaries and was planning to stop the food assistance for all current beneficiaries after 6 months (which was in accordance with the guiding principles).

63. The other partner visited, CSMR, had not been informed by WFP that beneficiaries of PHA/ART programmes were planned to be phased out from the food assistance and no arrangements for doing so were in place. Some beneficiaries had been receiving food assistance from the beginning of the programme, i.e. for two years. There seemed to be no plan for follow-up interviews to assess whether the beneficiaries were ready for being phased out and no livelihood activities were planned succeeding the phasing out/graduation from food assistance. This long-term support of households, which were supposed only to be supported during a recovery period, is obviously not in accordance with the overall objective of the PHA/ART programme.

64. With regard to OVC community programme, the visited partners were phasing out the food assistance when the beneficiaries were the age of 18. Being 18 is one of the discharge criteria for this programme type according to the "Guidelines for beneficiary targeting and food distribution" prepared by the CO. According to the earlier mentioned presentation of the HIV and AIDS component prepared by the focal point, the duration of food assistance for OVC is 6-9 months or until sustainable income is in place. Thus, there seem to be a tendency to confuse graduation and discharge criteria.

Appropriateness

65. A "Guideline for Beneficiary Targeting and Food Distribution under "The Integrated Support to Food Insecure Households Affected by HIV/AIDS" – Country Programme Component –WFP Tanzania" was developed by the previous CO HIV and AIDS focal point in 2006. It is not known whether the CO has received guidance in targeting from the RB and HQ levels. The guidelines were developed according to Mid-Term Review recommendations and after it was realised that the targeting mechanism in several districts was based on HIV status and not included socio-economic criteria[170]. In general, previously, there were no clear inclusion and exclusion criteria for selection and identification of beneficiaries.

66. The Targeting Guidelines were developed in order to provide strategic guidance to partners and community. The guidelines describe Community Managed Targeting and Distribution (CMTD), which are then slightly modified to the context of HIV and AIDS. More specifically, the guidelines describe the processes of wealth-ranking,

[169] "Presentation on HIV/AIDS Country Programme Component". Power Point Presentation. 6 August 2007, Assumpta Rwechungura.

[170] Integrated Support to Food Insecure Households Affected by HIV/AIDS Project (10065.0ACT4/ACT5). Mid Year Progress Report. January-June 2005.

prioritisation of types of households, admission and discharge criteria. An eligibility form is then used to assess the combination of the above-mentioned factors. Training in targeting was conducted in 7 districts, 6 districts in Kilimanjaro Region and 1 district in Iringa Region. The training focused on admission and discharge criteria, household categories, formation of eligibility and food distribution committees and use of WFP eligibility form.

67. Although the guidelines overall seem appropriate, there are inherent problems and generally, the guidelines do not seem to be very logically structured and easy understandable. The value of conducting a community wealth ranking procedure is not quite clear; neither is it clear if and how the ranking procedure feed into the eligibility form. On the other hand, the prioritisation of type of households and the admission/discharge are clearly set out. The eligibility form is hardly described in the guidelines and hence the link between the different preceding stages and the eligibility form becomes unclear. According to the guidelines, the cut-off point is relative; i.e. there is no absolute score for eligibility. Instead it depends on the number of beneficiaries given for each operation site; the beneficiaries with the highest score corresponding to the number given are then selected. The criteria for allocation of number of beneficiaries per operation site is, however, not clear.

Efficiency and Effectiveness

68. The CO guidelines for targeting seemed to be relatively efficiently implemented; however, there were variations in the practices between different partners. All partners visited were using the eligibility form for selection of beneficiaries as well as the admission and discharge criteria. Targeting and selection of beneficiaries is done by village Food Committees, which are established under the Village Council. The Food Committees, which normally consist of around 7 members, are all volunteers. Until very recently, the members of the Food Committees were receiving food assistance similarly with the beneficiaries. However, this practice stopped due to funding problems. With regard to the Food Committees visited, the members (or a number of them) have been trained in targeting/selection criteria and procedures and in the eligibility form either by the by WFP CO/SO or the IPs (DSM Archidiocese and CSMR).

69. The two partners visited had different practices with regard to family rations. One partner, DSM Archidiocese, distributed rations according to household categories of 1-4 persons and 5 +, whereas the other partner, CSMR, distributed family rations of 5+ for all households regardless of the size.

70. The mission's visit to the Shukrani Vocational Training Centre in Makete evolved irregular distribution of food assistance to the centre. Hence, the food assistance, which was distributed on an annual basis, had been delayed by two to three months, which obviously put the centre in a very difficult situation. In 2006, for instance the food assistance was distributed in April, whereas in 2007, the food assistance was not distributed until July, leaving a gap of two months. WFP supplies food for one meal per day for the about 200 students. The training centre was found to be constrained in terms of working tools and materials, and this might affect the quality of the training.

71. The human resource situation in Tanzania CO is highly critical as the office is going through a process of downsizing due to the ending of the PRRO. At CO level this is for example reflected in the fact that the HIV and AIDS focal point, who had recently resigned at the time of the Evaluation Mission, might not be replaced. The VAM unit consists of only one staff member, who is, however, well-qualified and has a Master in Agriculture from the UK. The gaps of the permanent staff in fulfilling the work task is being compensated for by employing Junior Programme Officers or Internals, who become responsible for central and critical tasks in the office. Although this might solve the immediate problems, it is obviously not a long-term and sustainable solution to the human resource problems of the CO.

Connectedness and Impact

72. WFP Tanzania has contributed to the building of strategic partnership through its active participation in the Tanzania Food Security Information Team (FSIT), established in 2000. FSIT has an advisory role in relation to government and moreover has the objective of monitoring the food security situation. The Team is coordinated by PMO and includes partners such as Tanzania Food and Nutrition Centre, FAO, UNICEF and other international agencies and NGOS. FSIT in collaboration with Disaster Management Department (PMO) and the National Food Security Division (Ministry of Agriculture, Cooperatives and Food Security) conduct Rapid Vulnerability Assessment Reports in food secure areas on an annual basis[171]. The assessment focuses on the districts, which have been identified by Ministry of Agriculture, Cooperatives and Food Security to be likely to experience food shortage in the season in question.

73. WFP Tanzania is to some extent building capacities at government and civil society level. Due to time limitations, it is was not possible to explore in depth the capacity-building aspects; however, it is likely that the collaboration between the CO/ RB VAM units, the Food Security Information Team and the National Bureau of Statistics with regard to conducting assessments[172] will lead to some capacity building of the latter body, i.e. the National Bureau of Statistics. Through the involvement of the Village Council and trained Food Committees in the selection of beneficiaries and food distribution, capacity is being built at community level.

74. Due to the lack of data collection on impact indicators for food security, it is only possible to assess the impact on anecdotal basis. From a couple of household visits, there was no doubt that the food assistance had improved the immediate food security situation at household level, in particular for PHA/ART households receiving food assistance for about 2 years, and for household selected for OVC programmes. However, due to the lack of graduation/phasing out from food assistance to livelihood/IGA interventions, the enhanced food security is likely to be temporary and not sustainable although the provision of food assistance during the period of recovering might have prevented/diminished asset base erosion.

[171] "Rapid Vulnerability Assessment Report on Food Insecure Areas in Tanzania for the 2005/2006 Marketing Year". Coordinated by the Disaster Management Department of the Office of the Prime Minister and the National Food Security Division of the Ministry of Agriculture Food and Cooperatives. In collaboration with Tanzania Food Security Information Team, August 2006.

[172] "WFP VAM: United Republic of Tanzania. Comprehensive Food Security and Vulnerability Analysis (CFSVA)". Conducted in December 2005-January 2006.

Côte d'Ivoire case study (22-29 September 2007)

Introduction

1. Côte d'Ivoire was selected from the pre-evaluation survey as under HIV and AIDS activities it had the highest number of beneficiaries and expenditure in the ODD/ODDY region and the second highest tonnage of food distributed during the 2004-5 reference period. During this time 2,044 mt of food were delivered to14,422 beneficiaries of HIV and AIDS activities with a value of USD 1,733,512 that year.

2. In Côte d'Ivoire WFP's HIV and AIDS activities were implemented through a Regional PRRO (10372.0)173 launched in 2004. According to the CO response to the pre-evaluation survey HIV and AIDS activities implemented focussed on the role of nutritional and dietary support of food aid through general distribution of rations to PLWHA with the objective of improving their nutritional status. WFP also used food assistance as an incentive to support training on HIV and AIDS, with the objective of raising awareness. At the time of the evaluation field visit the CO had recently launched a new PRRO (10672.0) Regional Protracted Relief and Recovery Operation: Assistance to Populations Affected by the Côte d'Ivoire Protracted Crisis. According to the PRRO document the current operation represents a significant reduction in resources allocated to relief and a shift towards supporting the recovery end development process.

3. Field work in country included visits to HIV and AIDS implementation sites in Abidjan, Man and Bouaké. Meetings were held with WFP CO and Sub-office staff as well as with government and non-government partners. Thus field work was extremely limited. The team also held a limited number of meetings with *Ministere de la Lutte Contre le SIDA*, and UN Agency staff. Unfortunately, meetings could not be scheduled with donors such as PEPFAR, partners such as ANADER at the central level (under the Ministry of Agriculture), and key staff of sister UN agencies such as the Nutritionist and HIV and AIDS officers of UNICEF. Consequently, there was insufficient opportunity in field to triangulate or include all pertinent information.

HIV and AIDS Specialist's Findings and Recommendations

Policy Implementation

4. The project documents of PRRO 10372.0 and 10672.0 indicate that the HIV and AIDS activities of the Côte d'Ivoire CO to have been planned and guided using the logical framework tool. However, IPs were not providing WFP with adequate data to enable the CO to determine whether its objectives were being met.

[173] Protracted Relief and Recovery Operation- Côte d'Ivoire 10372.0. Response to the Côte d'Ivoire Crisis and Its Regional Impact in Burkina Faso, Côte d'Ivoire and Mali.

Coherence

5. The national strategic plan[174] provides a good basis for the achievements of WFP's own strategic objectives in response to the AIDS epidemic. The *Plan Stratégique National de Lutte contre le VIH/SIDA 2006-2010* indicates an integrative approach of food and nutritional assistance to support people infected with HIV or affected by AIDS. Specifically it sets nutritional support as one of its six priority areas using the strategic approach of improving the nutrition and food security of PLHA and AIDS-affected (particularly orphans and vulnerable children) together with the promotion of fortified foods. These objectives are approached through the provision of food and nutrition "kits", food and seed distribution, food fortification and sensitisation and the operationalisation of pilot experiences. In terms of HIV and AIDS PRRO 10372.0 was in line with the national strategic plan in its approach to supporting micronutrient fortified food (CSB and oil) in its interventions to food insecure people infected with HIV or affected by AIDS. The longer term food security of approaches of the national strategy are also reflected in the current PRRO's (10672.0) objective of providing food support to enable to rehabilitation of productive assets. This complements the national strategic plan's objective of enhancing food security through seed distribution.

6. Evaluation of the degree of coherence of WFP's role in the UN Division of Labour for the AIDS Response in Côte d'Ivoire could not be evaluated in the course of fieldwork as it has not yet been established and a draft was not received by the team.

7. Interviews with a limited number of partners indicated a strong appreciation of the importance of food and nutritional support in response to the epidemic and particularly in enabling and optimising adherence and efficacy drug regimens among food insecure people infected with HIV and TB. This was clear in among sister UN agencies such as UNAIDS, the *Ministere de la Lutte Contre le SIDA* major partners such as CARE and IPs at the field level. While WFP's mandate and approaches may be well understood in Côte d'Ivoire as in many other evaluation county case studies, there is a general perception among partners that WFP does not have adequate resources to realise its HIV and AIDS policy in the field.

8. A lack of coherence between HAWP policy and practice was noted by the team at the CO-level. No condoms were available in the men or women's toilets, in line with current policy and there was a lack of HIV and AIDS information displayed.

[174] Plan Stratégique National de Lutte contre le VIH/SIDA 2006-2010. République de Côte d'Ivoire. Conseil National de Lutte Contre le SIDA. Secrétariat Technique. Juin 2006.

9. In the Man SO visited by the HIV and AIDS specialist there was evidence of both longer term and more recent adherence to WFP's HAWP policy. In the kitchen area a number of posters providing a wide variety of information on HIV and AIDS appeared by their age to have been on display for some time. More recent in appearance were high visibility and innovative condom dispensers accompanied by a variety of slogans and messages. A mix of public and private display of messages and access to free condoms was deemed to be appropriate in the SO setting. Dispensers and messages in public spaces of the SO provided strong messages concerning WFP's endorsement of their use in HIV prevention, while the private access in all wash rooms and vehicle first aid kits enabled discreet access by office-based and mobile staff.

Relevance

10. Given that Côte d'Ivoire was a state divided with a high level of insecurity and displacement as a consequence of the civil conflict following the attempted coup in 2002, the PRRO 10372.0 was appropriate in addressing both the national and cross-border impact of the crisis. The general food distribution and selective feeding components of this PRRO that targeted vulnerable people, refugees and returnees was in line with the food and nutritional support needed by people who had lost their production assets in the course and the conflict. The approach to providing food to support the rebuilding and protection of production assets through seed protection was relevant both to the need to establish sustainable food security and to support national approaches to the crisis. This was informed by the joint FAO and WFP food needs assessment that indicated both a depletion of food and seed stocks.

11. As teachers and trainers were among those fleeing conflict and control of the north of the country by the *Forces Nouvelles*, WFP's approach of proving emergency school feeding through PRRO 10372.0 was relevant to the need to assist the government in re-establishing the education system necessary to the future food security of the region's children who were out of school. Food for training and food for work were also relevant to sustained livelihood needs of OVCs both in terms of supporting their immediate food and nutritional needs, but also their future production options and livelihoods.

12. PRRO 10672.0 that had been launched just prior to the evaluation fieldwork in Côte d'Ivoire appears from the project document to be relevant to the needs to vulnerable people and food insecure people infected with HIV or affect by AIDS re-establishing their lives in the north of the country. The shift in activities from the previous PRRO from relief to recovery and development is relevant to the food security situation in the north among vulnerable groups and the need to re-establish livelihoods and sustainable food security. The protection of seed stocks approach appears to be a theme continued throughout the two PRROs, however, there was no evidence to the evaluation team that this was based on assessment of the impact of this strategy.

Efficiency and Effectiveness

13. Interviews conducted with government and UNAIDS indicated that the current CD with support from the Nutrition and HIV consultant is regarded to be a highly engaged chair of the HIV and AIDS UNTWG. The CD underscored the requirement for such expertise in taking the current lead in the UNTWG and in steering WFP activities in country according to WFP HIV and AIDS policy.

14. The WFP Nutrition and HIV consultant is regarded both by WFP colleagues and IPs to be a key actor in supporting the implementation integration of food and nutritional support to food insecure people infected with HIV or affected by AIDS in country. The consultant has been innovative in attempting to secure additional funding for this approach in Côte d'Ivoire by liaising with PEPFAR and preparing a grant application. Although certain administrative issues have been stumbling blocks, there are indications that the consultant's proposal might yield additional funding for WFP's HIV and AIDS approaches in Côte d'Ivoire.

15. In addition to the essential technical advice provided by the consultant to support WFP's HIV and AIDS activities and current leadership role in the UNTWG, according to SO staff the consultant has also made efforts to raise the skill base of colleagues in the field. This appears to have been a highly cost effective means of ensuring the mainstreaming of WFP's HIV and AIDS approaches and improving technical capacity.

16. The key role of the consultant to WFP's HIV and AIDS role in Côte d'Ivoire again highlights certain organisational issues related to mainstreaming of WFP's HIV and AIDS policy. By relying on a single source of temporarily contracted expertise there is no assurance, internally or externally, that the CO will have the long-term capacity to take a lead in food and nutritional support in response to the epidemic.

17. In terms of the effectiveness in achieving its HIV and AIDS objectives, according to the SPR in 2006 the Côte d'Ivoire CO supported significantly more beneficiaries who were infected or affected by the virus. According to the SPR in that year under PRRO 10372.0 181.4 % of beneficiaries "impacted by HIV/AIDS" were supported. In common with other CO's visited in the course of the evaluation, the effectiveness of the CO in achieving SP3 as set out in PRRO 10672.0 (Contribute to maintaining the nutritional status of vulnerable groups, women, children PLWA) could not be determined as data had not been reported on changes in nutritional status following WFP interventions. Indeed, the log frame of this PRRO sets out inadequate outcome indicators to determine effectiveness and guide subsequent programming. The current PRRO, however, sets out more appropriate performance indicators such as percentage weight gain among patients of TB and ART programmes.

18. The CO in Côte d'Ivoire clearly has to deal with capacity issues regarding certain national structures which hamper achievements of WFP's HIV and AIDS objectives and their further funding. Interviews with the CCM revealed a very poor understanding of national proposals to the GFATM. Interviews with WFP and partners indicated the process of proposal development to have been a somewhat closed government process in the past that minimised the potential for partners such as WFP to ensure that food and associated indirect food costs are included in proposals. Given that CARE is the current PR of the GFATM is anticipated that WFP will lobby to ensure that these items are included in future proposals as appropriate to the future national situation.

19. Although guidance on exit strategies for food and nutritional support to people infected with HIV or affect by AIDS was only provided by WFP in 2007, in Man it appeared that WPF had selected an IP with the capacity and vision to do so. IDE Afrique in Man offered a combined package of quality VCT, IGA training and support, FFT aimed at OVCs and FFW. In course of its complimentary activities, some of which were supported by WFP commodities, the IDE Afrique graduated recipients on to project activities aimed at asset and livelihood strengthening. While this process did not appear to have been led by WFP, the NGO offered its own, appropriate exit strategy from WFP food support that would enhance sustainability of WFP's investments.

20. Similarly, Caritas Man distributes WFP food support to 94 food insecure people undergoing ART and TB treatment have the capacity to graduate recipients on to a number of livelihood support programmes such as pig breeding, charcoal and palm products. By encouraging recipients to form locally-based associations, communities are able to strengthen their coping capacity through psycho-social support as well as practical IGA. Some have even developed community micro-credit and revolving savings and loans systems. B y providing support to community activities through training and funding Caritas has provided a sustainable exit strategy to WFP's initial food support to food insecure people infected with HIV or affected by AIDS.

Recommendations

- Given the current lack of data collection and reporting by IPs on changes in nutritional status with food support to TB and ARV programmes, it is crucial that WFP provide guidance and training on data collection, collection and analyses to enable efficient and effective reporting of performance (i.e. base line, when and how to measure, simple and appropriate statistical analyses)
- The WFP CO should ensure that WFP's HIV and AIDS in the Workplace principles are translated at all levels – particularly it ensure that condoms are freely and discretely available to all staff. Given that the CO purchases condoms and stocking is the main obstacle, the CO might make arrangements with the cleaning contract staff to replenish supplies in washrooms in the course of their regular activities.
- To enhance the sustainability and status of its HIV and AIDS approaches the CO requires organisational flexibility in order to ensure that at least one fixed-term position might be filled by a candidate with the HIV and AIDS expertise needed for the country context.
- The CO might further enhance in-house HIV and AIDS expertise by tapping into the 2003 UN Volunteer agreement as well as opportunities to second suitable staff from bilateral agencies.

Best Practice

- Selecting an IP that has the capacity to graduate HIV-affected recipients of food and nutritional assistance onto livelihoods support and skills development to enhance the sustainability of inputs and recovery of quality of life.
- Making condoms positive attitudes to their use visible both publicly and privately on SO premises and in WFP vehicles.
- Persistence in applying to PEPFAR in spite of obstructing administrative and contractual issues.

Nutrition Specialist's Findings

Internal Coherence

21. The current PRRO is more coherent with WFP's EB HIV policy, as planned; and initial implementation has followed this. From review of project documents and a field visit to the sub-office in Man, the following examples were found: provision of household rations to homes caring for OVCs has replaced the provision of food support to orphanages; and a log frame with improved nutrition and adherence indicators along with an M&E system has been developed for the HIV activities. Man, the sub-office visited and their implementing partners, recently had training in the data collection for the new M&E system. In addition, one of the partners visited in Man had started to use the vulnerability or food security screening form; and is planning to follow the new graduation criteria.

22. Several of the current PRRO activities demonstrate mainstreaming of HIV in other WFP programming. Where operational areas converge, MCHN sites have been planned in collaboration with UNICEF, so that the food assistance for eligible beneficiaries is provided in health centres with trained health staff so that ANC services are improved. Also VCT and PMTCT services are provided on site. A UNICEF/WFP MCHN/PMTCT pilot project is currently being implemented in 8 sites; if this is found to be effective, it should be scaled-up, particularly in areas of the county with a higher prevalence of HIV.

23. In addition, school feeding, the largest component of the PRRO, includes a minimum health package implemented with UNICEF; another example of mainstreaming HIV programming. Training in HIV, gender and conflict resolution education for teachers and peer educators along with the formation of student health/hygiene clubs is included. A recent review indicates that 200 of the planned 1200 teachers have been trained; in eighty schools, peer educators have been trained and clubs started. The number of teachers to be trained in the 2007/2008 school year is not specified, however NGOs have been identified to train peer educators in 200 schools over the same time period. To support this effort, a module for training teachers and others in HIV/AIDS has been developed by Ministry of Education and UNICEF.[175]

24. WFP's collaboration with UNICEF in school feeding, nutrition and HIV and AIDS programming has provided services which complement the food assistance and support a broader set of outcomes. However, increased roll-out and scaling up is needed to bring results. For example, more schools need to be reached for HIV awareness and prevention education. Further, a system which monitors the training of teachers, and in turn, their teaching on HIV and AIDS to their students is needed.

[175] République de Côte d'Ivoire, Ministère de l'Education Nationale, Fonds des Nations Unies pour l'Enfance, Module de Formation sur le VIH/SIDA en Milieu Scolaire, Août 2006.

25. One of Man's IPs, MSF-H, provides community or ambulatory therapeutic feeding in 7 sites provides another example of HIV mainstreaming. It also provides HIV testing to all mothers of children suffering from severe acute malnutrition and then tests the children of positive mothers. They are also able to provide treatment (OIs and ART) for HIV infected children and adults. MSF has started collecting data on the number of children with severe acute malnutrition that test positive for HIV. Integrating VCT services and adult/paediatric AIDS treatment at government and NGO TFCs, like MSF-H's new program in the Man area, represents another potential area of WFP/UNICEF collaboration.

26. Weak HIV and nutrition partners, particularly the government, but also NGO partners with limited monitoring and record keeping capacity have hindered policy implementation. Obviously the political situation is a constraint to policy implementation as is the lack of resources and trained staff.

Relevance

27. Although available in other African countries, to date, guidelines on HIV and nutrition have not been developed by the Ministry of Health in Côte d'Ivoire, thus it is not possible to compare WFP's HIV programming with such guidelines. HIV and nutrition guidelines establish the basis for integrating nutrition services[176] within HIV programming. A nutrition and HIV working group chaired by the PNN (the nutrition division within the Ministry of Health) was formed and met several times, but could not reach consensus on a ToR and, thus disbanded. This is unfortunate as nutrition and HIV working groups have often been the impetus for developing HIV and nutrition guidelines, as well as, for garnering the resources to support their implementation. This may soon be addressed as technical support for the development of a national policy on nutrition and HIV is part of PEPFAR's program planning for FY 08. WFP has well positioned itself with PEPFAR; and as a result will receive funding to support the development of guidelines as well as to train NGO partners in HIV and nutrition.

28. Overall, there is a lack of nutrition capacity in Côte d'Ivoire. Recently the Plan National Nutrition (PNN) was formed within the MoH, but it lacks resources; and with the years of conflict, the development of nutrition policy has fallen behind. However, at the same time, HIV and AIDS donors are beginning to drive the agenda for the development of nutrition (and HIV) policy and protocols. For example, currently no protocols exist for the treatment of moderate and severe acute malnutrition in children, nevertheless, the Clinton Foundation, as part of their paediatric AIDS support, is in discussion with the PNN to provide RUTF for the treatment for severe acute malnutrition in children. As the development of protocols to treat acute malnutrition begins, WFP should support this process given its child nutrition focus coupled with the HIV overlap.

[176] Nutrition services for PLWHA include food assistance, nutrition assessment, treatment for malnutrition, and nutrition counselling and education.

29. For a number of reasons, it is difficult to assess how well aligned WFP's HIV and AIDS activities are with the government's policy and plans. First, the GoCI HIV plan for the PEPFAR resources was developed several years ago and has not been updated. Although PEPFAR staff has recently become more interested in food assistance and nutrition support for the HIV infected and affected, the plan does not include nutrition services.[177] On the other hand, the national strategic plan to fight HIV/AIDS (2006-2010) includes food assistance, livelihood support and nutrition interventions, such as, the development and promotion of fortified foods and the distribution of micronutrients and nutrition kits.[178] However, the strategic plan's operational plan has not been developed. Further, it appears little, if any, of what has been specified regarding nutrition has begun to be implemented. In addition, a strategic plan to address tuberculosis has been developed; it mentions a partnership between the PNLT (the national program to fight TB), PNN and WFP to provide a nutrition supplement to all TB patients during the initial phase of treatment.[179] TB programming is included in the new PRRO, however, it has not been planned with the PNLT or PNN and the criteria for selection and graduation are not consistent with the tuberculosis plan.

30. Considering the political situation and weak government, which in turn, affects its ability to produce timely planning documents it may prove difficult for WFP to be consistently included in government HIV strategic planning documents. However, it appears that in principle that WFP is aligned with government HIV planning documents.

31. The draft joint UN HIV/AIDS planning document includes WFP's and their partners major HIV activities, which include more focus on gender and monitoring and evaluation.[180] This reflects WFP's involvement and engagement in this process, however, ongoing work will be needed to update the plan with, for example, the current planned activities recently funded by PEPFAR.

32. Given the absence of nutrition and HIV guidelines and overall lack of nutrition capacity in CDI among government and partners, it was not surprising that in one program area visited, Man, although nutrition information is provided to PLWHA, nutrition assessment and counselling have not been integrated into HIV treatment services.

Appropriateness

[177] République de Côte d'Ivoire, Plan d'Urgence du Président pour la lutte contre le SIDA, Stratégie quinquennale pour la lutte contre le VIH/SIDA en Côte d'Ivoire.

[178] République de Côte d'Ivoire, Plan Stratégique National de Lutte Contre le VIH/SIDA 2006-2010, Conseil National de Lutte Contre le SIDA, Secrétariat Technique, Juin 2006.

[179] République de Côte d'Ivoire/MSHP/PNLT, Plan Stratégique de la Lutte Contre la Tuberculose en Côte d'Ivoire, version 2006.

[180] Nations Unies, VIH/SIDA Plan Conjoint NU, 2007-2010, draft.

33. Regarding the food distribution modalities, one distribution was observed in the town of Man, conducted by the NGO, IDE Afrique. In this case, to distribute food from the FDP to their homes, most beneficiaries hire wheel barrows. Cost depends on the distance, but it wasn't identified as a problem for the beneficiaries queried during the distribution.

34. The distribution was carried out according to WFP guidelines, in that, beneficiaries were informed of the quantities of food to be provided. Further, it appeared to run quite smoothly with beneficiaries (13) waiting patiently for their turn. Food appeared to be distributed with minimal waste. At this distribution, sugar was not provided and the CSB stored was close to its expiration date of November of 2007. The oil provided was fortified with vitamin A and D and the salt was iodized as specified in WFP guidelines.

35. Although the warehouse staff had been trained, food was inappropriately stored in one of the IP's (IDE Afrique) warehouse; sacs of food were stored against walls and one of the commodities, lentils, were stored directly on the floor without pallets. The nutritionist was informed that this wasn't a problem as the food is seldom stored for longer than five days. Lastly, when beneficiaries were scooping their foods from basins, bare hands were used to fill and level the measuring tools.

36. According to beneficiaries interviewed (around 8) and a WFP conducted post food distribution monitoring report, foods are well accepted.[181] On the other hand, IPs involved in supplemental and therapeutic feeding in the Man area, identified the quality of CSB as a problem. They reported that the CSB sometimes arrives past its expiration date and that regularly the CSB is infested with insects. However, IDE Afrique warehouse manager related that the CSB problem occurred in the past and did not involve much of the food.

37. Considering the commodities available to WFP, the ration had been tailored based on the nutritional needs and the eating problems faced by PLWHA. A blended food high in protein and micronutrients was provided, which cooks quickly into an easily digested porridge. Sugar, as well was provided to increase the palatability of the CSB; this can be particularly important for the sick and weaker PLWHA often suffering from poor appetite. Also it has been WFP's experience that CSB is not well consumed without the inclusion of sugar. Iodized salt was provided to increase the palatability of the food and to address poor accessibility of iodized salt. In addition, lentils, a quicker cooking and easier to digest pulse is included in the food basket. Lastly, fortified maize meal provided was included.

[181] The food distribution monitoring report was from a seed protection food distribution, not an HIV distribution. No HIV post distribution monitoring reports were provided.

38. With the new PRRO, the HIV rations had been reduced from a full ration of 2100 calories to a two-thirds ration of 1380 calories. This was based on the food security assessment (September/October 2006), which indicates low levels of food insecurity in Côte d'Ivoire compared to other countries.[182] However, the level (and causes) of food insecurity along, eating habits, food intake and types of food usually consumed by HIV beneficiaries identified through vulnerability screening was not determined as part of the ration development exercise.

39. Further, the average household size (5.2) determined by the food security study was used to establish the number of members (5) living in HIV households. The nutrition and HIV focal point developed the ration based on typical family demographics, although HIV often changes the family constellation. The limited number of interviews with beneficiaries confirmed this; household sizes of 7, 6, 11, 11, 3, 5, 8 and 10 were reported. Several of the women headed households caring for their own children and orphans; one lived with her siblings.

40. The beneficiaries met in Man did not identify the smaller ration as a problem, although beneficiaries in Bouake did. In Man, beneficiaries mentioned that the three month disruption in food distributions during the shift from the past PRRO to the current PRRO was particularly difficult for them and their families.

41. Partners involved in therapeutic feeding in the Man area, identified the smaller caretaker ration for the TFCs as a problem, particularly on top of the cut of the 1-month family ration provided when the child graduates. They are concerned that the smaller caretaker ration with fewer foods (CSB, sugar and oil) will act as a disincentive for families to bring their children for treatment. The elimination of the graduation ration further acts as a disincentive and could lead to more recidivism among rehabilitated children. One NGO, MSF-H is continuing to provide a caretaker and graduation rations with their own funding.

Efficiency

42. Staff reported that the HIV "Getting Started" guidelines are not particularly helpful; and, as similarly described by staff in other countries, they are not practical or useful in guiding program design or implementation for either the technically trained staff or others with more general background. Staff also feel that PDPH provides some helpful technical reports and information on HIV and AIDS to the field, but they don't seem to have staff sufficiently experienced to provide more practical programming guidance—they need more field input. On the other hand, the Côte d'Ivoire WFP office benefited from a RB HIV consultation last December, which was particularly helpful in designing the HIV component of the PRRO. It is expected that the upcoming meeting in Dakar, October 12-19 with PDPH, PDPN and ODD on HIV ration and program design will also be instructive and helpful; the Nutrition/HIV focal person plans to attend.

[182] According to the Côte d'Ivoire: Évaluation approfondie de la sécurité alimentaire (September/October 2006), 9 percent of households are food insecure and 20 percent are at risk of food insecurity.

43. Contracting with a nutritionist with experience in HIV and AIDS programming has addressed some of the HIV staffing constraints. However, the nutritionist's contract is short-term, which is risky for the program and represents a lack of commitment to HIV and nutrition programming. On the other hand, within WFP's HR policy the problem of recruiting for established UN positions is also noted, that is, only the program officer description and grade are utilized. As a result, it is not possible to recruit based on the technical qualifications needed for an HIV and nutrition focal point. Fortunately, although this may be against WFP policy, the HIV/nutrition focal point attends regular WFP HIV trainings and is utilized as a professional staff position. At the sub-office level, field monitors have been identified as HIV and nutrition focal points.

Effectiveness

44. In the last PRRO HIV M&E data was not being collected. Further, the PRRO was not evaluated or reviewed at its midpoint. The new PRRO includes a log frame and the monitoring and evaluation tools have been developed and partners trained. For the most part, the indicators selected are appropriate and importantly, they are not too many. Some indicators, for example, the adherence one, which applies to TB, ART and PMTCT will need modifications as monitoring data is collected.

45. The food basket, for the most part, was rated as acceptable and the foods appropriate for most beneficiaries. Some noted that they preferred rice instead of maize meal; their more commonly consumed staple. WFP is aware of this; and has tried to procure rice, however, donations of maize meal far exceed those of rice. From the nutrition perspective, maize meal particularly since, in this case, it is fortified, it is more nutritious than rice. From discussions with beneficiaries of the IP, IDE Afrique, the food and nutrition information provided on home visits which covered how to prepare the food provided and eating healthily with HIV supports good utilization of the foods provided and was appreciated by beneficiaries.

46. The ration for HIV beneficiaries provides two-thirds of an adult's caloric need and is provided as a household ration for a family size of 5. It is important to note that adults with HIV when asymptomatic need 10 percent more calories and when symptomatic need 20 to 30 percent more calories.[183] Dietary fats should be at least 17 percent of calories. PLWHA do necessarily need more protein or micronutrients than a balanced increase in calories would provide unless their usual intake is below what is recommended. However, lower intakes of protein, fat and micronutrients may be expected given the results of the food security assessment. The ration provides two-thirds of an average adult's caloric need, along with 80 percent of protein and nearly 100 percent of the fat required. It is high in most micronutrients assessed: over 100 percent of vitamins A, C, niacin and thiamine, 77 percent of iron, 60 percent of iodine, calcium and riboflavin. Thus the ration has been designed taking into consideration available information on food consumption of the food insecure and provides relatively high nutrition value for the calories. However, a survey of HIV beneficiaries to assess their dietary habits and food consumption could better inform the development of the ration.

[183] WHO, Nutrient Requirements for people living with HIV/AIDS: Geneva, 2003.

47. The ration includes iodized salt to increase palatability. When WFP provides salt, adequately iodized salt is required. Recent Information on the use of adequately iodized salt in CDI is not available. The recent PRRO notes that 84 percent of household have access to iodized salt, a reference is not provided. It is reported that some of the iodized salt available comes from Liberia and Guinea and is falsely advertised as iodized. Continuing to offer adequately iodized salt in all rations, particularly the MCHN and PMTCT rations is warranted until more information regarding the use of adequately iodized salt is available.

Connectedness/ Sustainability

48. In the Man sub-office, WFP's partners including government have received training on the treatment of moderate malnutrition, participatory and innovative approaches to nutrition education, nutritional support for PLWHA and monitoring and evaluation. The training contributes to government and civil society capacity building. And the nutrition training, in particular, if appropriately implemented with beneficiaries, supports sustainability through improved utilization of food assistance and the other foods available to households.

49. One of WFP's in Man, MSF-H recently phased-over the management of the TFC in the hospital to the NNP/MSH. Indirectly WFP's food assistance continues to support this. On the other hand, another less positive example from Man was reported. WFP has phased-out food assistance to the hospital, however, the government was not prepared or able to provide foods for the patients, thus MSF-H has filled this gap by providing food for the patients.

50. Beneficiaries of IDE Afrique provided anecdotal evidence of the effectiveness of food and nutrition support. Consistently they reported improved strength and wellbeing since initiating food assistance and often ART. Some reported weight gains and several now feel strong enough to return to work.

Recommendations

- WFP should continue its participation in nutrition and HIV activities, particularly as this relates to policy and guidance on HIV and nutrition given their role in the UN Division of Labour coupled with the limited nutrition capacity within the government and UN agencies. The funding currently being sought through PEPFAR will enable this. It is recommended that WFP, at a minimum, provide input into the food security and food assistance sections of the HIV and nutrition guidelines to be developed over the next year and that they become involved when guidelines for the treatment of acute malnutrition in children are developed.
- It is recommended that when the training funded by PEPFAR is developed on HIV and nutrition that it is designed based on the HIV and nutrition guidelines (also to be developed) as part of a package that would later include training on nutrition assessment, counselling and treatment. In this way, WFP with the support of partners can work toward fulfilling its role in the UNAIDS Division of Labour.

- WFP should be commended for its efforts in mainstreaming HIV within School Feeding and MCHN programming. Their strong relationship with UNICEF and the MOU in Nutrition, HIV and School Feeding should be continued along with efforts to increase coverage, follow-up monitoring and results. Further mainstreaming opportunities, such as, with therapeutic feeding programming should be sought.
- As opportunities present, WFP should become more involved with the government HIV planning process. It would be helpful to coordinate the food assistance for TB patients which is currently starting with government planning and interventions.
- The HIV and nutritionist focal point position should be more formally established within the staff configuration. At a minimum the contract should be longer term. The field monitors serving as HIV focal points, should be upgraded given the additional technical knowledge and skill coupled with their added responsibilities.
- Given the variation in the household sizes of HIV beneficiaries, establishing several rations sizes, such as, in addition to a ration for 5 members, including one for 3, or 9 household members is recommended.
- A small study of HIV beneficiaries identified as food insecure to collect more information on their level of food insecurity, household sizes, eating habits, foods consumed and coping mechanisms is recommended to potentially tailor the ration, support nutrition education activities and to support the development of livelihood support.
- It is recommended that some of the HIV M&E indicators be adjusted. For example, adherence to PMTCT is much lower than adherence to ART or TB.

Best Practices

- Formalized collaboration between WFP and UNICEF's to create synergy through the integration of school health programming in schools with school feeding programs.
- Joint piloting of WFP MCHN with UNICEF supported VCT and PMTCT programming.

Food Security Specialist's Findings and Recommendations:

Coherence

51. With regard to targeting and food security aspects, the HIV and AIDS activities implemented in Côte d'Ivoire are only partly in coherence with the 2003 policy and the following EB notes. In particular, the first PRRO implemented 2004-2005 was not implemented in accordance with the 2003 Policy , for instance with regard to graduation/phasing out from food assistance and initiation of livelihood activities. The second PRRO (July 2007-December 2008) had started shortly before the Evaluation Mission and it is thus difficult to assess its implementation. The second PRRO is, however, expected to be more coherent with the policy, for instance with regard to targeting and graduation. Great effort has thus been put into streamlining the new PPRO to be more coherent with the policy; however, all elements are not yet implemented. Thus, for instance an eligibility form for selection has been developed, but is not yet in use by all partners, and not all partners have put into practice graduation from food assistance to livelihood.

52. It should be noted, however, that the WFP policy papers provide little if any strategic guidance on planning and implementation of HIV and AIDS programmes and that it was not until the 2007 EB Policy Issues paper: "Time to deliver – An Update on WFP's Response to HIV and AIDS" that exiting from food assistance and the duration of the assistance of food assistance was mentioned in a policy paper. Moreover, a HIV and AIDS focal point was not employed until 2006; the focal point is employed on short-term contracts (on monthly basis), which obviously seriously obstruct long-term planning.

53. HIV and AIDS issues have not been mainstreamed into food security and vulnerability assessments in Côte d'Ivoire. According to the EB policy on HIV (2003), WFP will adjust all programming tools such as for example needs assessments and vulnerability analysis to reflect what is termed the new reality presented by HIV and AIDS. CO Côte d'Ivoire has, however, not included any HIV and AIDS or proxy indicators in the food security and vulnerability assessments conducted by the VAM unit.

54. The fact that the HIV and AIDS (and Nutrition) focal point is relatively new in place hampers the analysis of the factors hindering the implementation of the policy. However, presumably the civil conflict, weak partner capacity and lack of guidance from CO were the main factors impeding the implementation of the previous PRRO (2004-2005). No livelihood activities as part of the exit from food assistance were implemented during the previous PPRO. It should, however, be taken into consideration that graduation from food assistance to livelihood was not mentioned in an EB paper until 2007 (cf. above). At the time of the Evaluation Mission, during the implementation of the PRRO 2007-2008 and with elements of policy guidance in place, the team found that implementation of livelihood activities as part of ART or PHA programmes (PRRO 2007-2008) was not done consistently. The partners in one SO (Bouake) visited during the Evaluation Mission were thus not implementing any livelihood activities, and it turned out that some households in this area had received food assistance in 5-6 years continuously without any attempts to introduce livelihood activities. Partners visited in another SO (Man) were, on the other hand, implementing livelihood activities.

Relevance

55. No national food security strategy is currently in place in Côte d' Ivoire. The only food security related policy is the "Global Plan for Agriculture 1995-2015" under the Ministry of Agriculture. Under the overall plan "The Special Programme for Food Security and Nutrition" (April 2000) has been developed with support from WFP and FAO. WFP's school feeding programme is part of this programme. "ANADER", which is a government structure under the Ministry of Agriculture, provides advice, training and monitoring in relation to agricultural activities. According to informants in the Ministry of Agriculture ANADER has been instructed to employ special measures to address HIV and AIDS affected and infected; and the informants declared that the Ministry of Agriculture was willing to assist HIV and AIDS affected and infected. Unfortunately, due to time constraints, it was not possible to meet with ANADER at national level.

56. On the whole, the overall objective for WFP HIV and AIDS activities seem to be in line with government policies and programmes. The WFP objectives for HIV and AIDS activities are not clearly set out in the 2003 Policy Paper and the following EB Notes. However, the Inception Report prepared prior to the Mission has extracted from the papers the following mitigation objectives: "preserve incomes on HIV and AIDS affected families" and "preserve living-standards of PLWHA" (through income-generating activities), which are overall coherent with the national programme.

57. WFP Côte d'Ivoire's food security monitoring and assessment system seem to be synergistic with FAO in the sense that each partner contribute according to its area of expertise. With regard to initiation of livelihood activities, there is a potential area for collaboration and synergy between WFP and FAO. Currently, FAO Côte d'Ivoire only has limited experience with livelihood activities for HIV and AIDS infected and affected. However, two projects are being implemented through the partners; i.e. IDE Afrique (community gardens) and Caritas (cooking and gardening sessions, distribution of seeds, demonstration gardens). Although not directly linked to HIV and AIDS programmes, FAO has great competence with regard to livelihood activities at household and community levels. During the discussion with an FAO officer, a number of relevant suggestions for livelihood activities for HIV and AIDS infected and affected came up such as for example: attica production, rice hulling, fish smoking, fermentation of milk, production of hibiscus juice, piggery (in non-muslim areas), poultry, and gardening.

58. WFP food assistance to HIV and AIDS infected/affected and OVCs was found to be a relevant tool for achieving the mitigation objectives (preserve income and living-standards) during a period of recovery. The food assistance was also very much appreciated by the beneficiaries met in Bouake and the composition of the food basket was found to be suitable. The food basket consisted of rice, beans, CSB, oil, salt and sugar. With the introduction of a new PRRO in July 2007 the ration was reduced (cf. Nutritionist's findings), which led to complaints from some beneficiaries.

59. During the implementation of the previous PRRO no criteria for graduation and no exit strategy for phasing out from food assistance were in place. Although a new PRRO currently is being implemented with specific norms for duration of time and graduation, the reality looks different. In the SO (Bouake) visited by the food security specialist, the phasing out from food assistance was done according to partners' assessment of the general situation of the beneficiaries and not according to a specific duration of time or specific criteria. This led to some beneficiaries receiving food assistance for long periods of time, for instance the two visited households, whom had received food assistance for 6½ and 5 years respectively as mentioned earlier.

60. None of the implementing partners visited in SO Bouake had consistently initiated livelihood or IGA during the period of provision of food assistance or immediately after although the food security specialists heard of a few attempts. However, some partners, for instance Akwaba, had implemented livelihood activities as part of other programmes, for instance for children soldiers and prostitutes. Some partners might hence have capacity with regard to livelihood/IGA. In the Man SO, one partner (IDE Afrique) visited by the Evaluation Team was implementing a commendable combined package of IGA training and support, FFW and FFT targeting OVC with the overall

objective of asset and livelihood strengthening. Another partner visited by the Evaluation Mission were graduating beneficiaries to a number of livelihood activities, for example pig breeding, charcoal and palm production. However, although both partners received some support from WFP, the livelihood component was supported by FAO and its success should hence be attributed to this organization. The two projects illustrate the strength of partnering with an organization with strong competence in livelihood, such as for example FAO.

Appropriateness

61. As WFP does not have a global policy and strategy for targeting and no targeting guidelines were prepared as part of the previous PRRO, it was rendered urgent by the current HIV and AIDS focal point to develop an eligibility form for selection of beneficiaries. A manual for the use of the form has been prepared and the SOs and IPs have been trained in how to use the form. Overall guidelines, comprising all steps from the geographical to household targeting have not been developed.

Efficiency

62. As noted above, no global targeting guidelines exist; neither has comprehensive guidelines for WFP Côte d'Ivoire been developed. The above-mentioned eligibility form was known by all the partners visited in Bourke; however, none of the partners had started to use the eligibility form for selection of beneficiaries as it had been distributed very recently. During the previous PRRO, the visited implementing partners in Bouake targeted beneficiaries in PHA programmes on basis of medical status (lists of HIV infected on ARV or prophylaxis treatment from health centres). Social workers from the health centres afterward assessed whether the person was eligible for food assistance. However, as observed in the assessment conducted by the social workers for the organization Akwaba, no objective criteria for assessing the food security situation were used; instead the social worker could write a general comment on the overall situation of the potential beneficiaries. With regard to the other partners visited in Bouake, they were not aware of the criteria used by the social workers for selection of beneficiaries for receiving food assistance. In the case of the SO in Man, one of the partners visited during the Evaluation Mission had started to use the eligibility form.

63. Two IPs implementing OVC activities (OVC in family) were met during the mission. The partners were using the following procedure for targeting: firstly, the partners received information on the OVC from social workers (employed at health clinic), secondly, the partners would assess the socio-economic status of the potential beneficiaries. Currently, the assessment of the socio-economic situation of the beneficiary take place according to each partners own procedures.

64. In the future, the eligibility form is going to be used for all HIV and AIDS programme types; including OVC programmes. In general, thus the preparation of an eligibility form for the selection of beneficiaries represent a huge step forward as well as the fact that the partners seem to have a good knowledge of how to use the form.

65. The WFP Ivory Coast VAM units seem to be adequately staffed and with well-qualified people. The CO is staffed with 2 persons, the head of the Unit and one assistant. The five sub-offices all have one VAM officer. All of the VAM personnel have relevant educational background such as degrees in rural development, sociology, agronomy, statistics and demography. However, the staff are all on 1 year service contracts to be renewed every year, which obviously constrain long-term planning.

66. Visiting the SO in Bouake a best practice for capacity building of staff was observed. Hence, it was a general practice that all staff members would participate in training conducted in the SO in order to optimise the possibilities for other staff members to accommodate replacement whenever the person in charge was not available. Moreover, all staff members participated in general meetings at SO level in order to develop ownership to the WFP programme.

Effectiveness

67. As no M&E data were collected during the implementation of the previous PRRO, it is not possible to assess whether the planned outputs and outcome have been achieved. Logically following, it is also not possible to assess whether HIV and AIDS activities implemented in Côte d'Ivoire have contributed to the overarching WFP corporate objectives. In the case of the new PRRO (2007-2008) a M&E system with a log frame has been developed; moreover, the partners have been trained in the M&E system.

68. The M&E system for the PRRO 2007-2008 has two outcome indicators under the Strategic Objective 2 ("Protect livelihoods, support rehabilitation of productive assets and enhance resilience to shocks"). Out of the two outcome indicators, one indicator is relevant for HIV and AIDS programmes: "Increased ability of targeted Ivorian households vulnerable to shocks to acquire and apply learned skills including households affected by HIV/AIDS". The performance indicator is: "Percentage of trained beneficiaries applying food transformation and/or conservation skills (should exceed 90 %)". The performance indicator is relevant as applying the skills taught indicate a higher ability to protect livelihoods; the performance indicator is moreover durable as data on the percentage of beneficiaries applying the skills taught can be collected. Thus, if collected in a systematic and regular manner, the data on livelihood can indicate whether Strategic Objective 2 is being achieved.

Connectedness and Impact

69. WFP is in a strategic partnership, i.e. The Food Security and Nutrition Group, with other UN bodies such as FAO, UNICEF, ORCHA, UNDP, the government (Ministry of Agriculture, Ministry of Health) and NGOs. WFP is co-chairing the group together with FAO. WFP for instance uses the Food Security and Nutrition Group for receiving comments on the Food Security Monitoring System, which includes bi-annual assessments in the four departments of the SOs. In general there seem to be good collaboration between WFP and the Ministry of Agriculture and the Ministry expressed great appreciation of the collaboration with WFP.

70. WFP supports and develops the capacity of the Ministry of Agriculture, for instance through the collaboration in the Food Security and Nutrition Group. According to the officials met in the Ministry of Agriculture, WFP generally function as an advisor to the Ministry and provides very important input to government action as WFP is present at field level.

71. Due to lack of impact data collected as part of a monitoring system for the implementation of the previous PRRO, it was not possible to assess the impact of WFP's HIV and AIDS activities at household level. The current PPRO had just started 2 months prior to the mission and hence had not produced any data.

Burkina Faso case study (1-6 October 2007)

Introduction

1. Burkina Faso was selected as a case study country for the thematic evaluation from the pre-evaluation survey. This indicated that during the 2004-5 reference period the CO had the third highest tonnage of food distributed and expenditure in the ODD/Y region under HIV and AIDS activities. During this time 1,155 mt of food were delivered to 7,688 beneficiaries of HIV and AIDS activities with a value of USD 516,950 that year. Additionally Burkina Faso provided an opportunity to evaluate the mainstreaming of WFP's HIV and AIDS policy in a Sub-Saharan country with a relatively low prevalence of the virus estimated by the 2006 UNAIDS Report to be between 1.5 and 2.5% of the population.

2. The team were able to observe the Burkina Faso CO's WFP's HIV and AIDS activities currently implemented through a Country Programme (10399.0) launched in January 2007

Limitations of the evaluation process in country

3. Only four and a half days of field work in Burkina Faso. The field work in country included visits to HIV and AIDS implementation sites in Ouagadougou and Bobo Dioulasso. Meetings were held with WFP CO staff as well as with government and non-government partners. The team held a limited number of meetings with the *Programme National Tuberulose* of the *Ministere de la Sante,* and the National AIDS Council the *Secretariat Permanent du Conseil National de Lutte Contre le SIDA* (SP/CNLS), the Global Fund and the Local Fund Agent. A small number of Implementing Partners (IPs) REVS+ (Responsibilité Espoir Vie Solidarité), VIVRE APED (*Association Pour la protection des Enfants en Danger*), ABSAFE, CANDAF were interviewed and project sites visited, however, some of the team only had limited opportunities to interview beneficiaries. Among the UN sister agencies met were: UNDP, UNICEF, FAO, and WHO. Unfortunately, meetings could not be scheduled with UNFPA, and the UNICEF School Feeding Programme Officer. HIV and AIDS Specialist's Findings and Recommendations:

HIV and AIDS Specialist's Findings and Recommendations:

Coherence

4. The Burkina Faso CO should be commended on taking forward the HAWP policy. Last year the CO organised an awareness raising event for staff and their families. Although agreed UNFPA supplies have not always been received in line with agreements for the provision of UN staff condom supplies, the CO has taken the initiative to purchase stocks for the office. However, during the period of the evaluation visit, not all washrooms were stocked with condoms.

5. The PRRO launched at the very beginning of the year, while clearly aimed at addressing undernutrition, fails to include aspects of HIV and AIDS. Given that the 2003 HIV and AIDS policy sets out that "…WFP will take HIV/AIDS into account in all of its programming categories…" the PRRO document appears to have missed the opportunity to do so. The activities of the PRRO include the provision of supplementary rations for malnourished children under three, pregnant and lactating women. These could have been linked with prevention and sensitization activities such that WFP's food and nutritional support provided through the PRRO might provide the added value of supporting national efforts to increase awareness and VCT.

6. The government's response to HIV and AIDS is coherent with the GIPA initiative in that it supports associations of sero-positive people and affected family members through a designated financial and technical support programme known as PAMAC (*Programme D'Appui au Monde Associatif et Communautaire*). PAMAC, attached to the SP/CNLS provides services including VCT, community based care and support, legal aid, prevention services and support to HIV/AIDS and TB institutions. This provides a sound basis for implementing WFP's HIV and AIDS policy.

Relevance and Appropriateness

7. Burkina Faso has a substantial number of street children and older orphans and vulnerable children in urban and peri-urban areas. Anecdotal information indicates that these children are at high risk of sexual abuse, reliance on commercial and transactional sex to meet basic needs and cross-border child trafficking to paramilitary groups. These factors combined with the associated risks of homelessness, lack of adult protection and likelihood of substance abuse, place this substantial group at high risk of HIV infection. Given the high level of illiteracy, poverty, malnutrition and the demographic profile of the population, consideration needs to be given to the role WFP might play in using food both to meet the nutritional needs of this substantial and vulnerable group, but also to support prevention activities of specialist NGOs and association. Following the examples of WFP activities in Burundi and Rwanda,[184] the CO should explore the advantages of WFP engaging in activities such as Food for Training to support skills development towards longer-term income generation and food security with a strong prevention element among this vulnerable group. This might contribute to and complement the national response to the epidemic, especially as street children are concentrated around Ouagadougou where HIV prevalence is higher than in rural areas.

[184] WFP/EB.1/2004/4-E Update on WFP'S Response to HIV/AIDS. WFP/EB.1/2004/4-E Update on WFP'S Response to HIV/AIDS.

8. During focus group discussions (FDG) and interviews with beneficiaries, weaknesses became apparent in delivery modalities. For example, in a REVS+ (Responsibilité Espoire Vie Solidarité) FGD held in Bobo Dioulasso with approximately 30[185] HIV infected adults and AIDS affected recipients (notably grandparents caring for orphans) a number of issues were raised. Discussion and polling of the group indicated that recipients had to walk considerable distances to food distribution sites each month. The majority had to walk between 2 and 10 km each way. Only two recipients had access to hand carts that they could borrow. The majority had to head-load the month's supply of food and rely on assistance from their personal networks to carry heavy loads.

9. Many of the recipients interviewed at REVS+ were in a poor to very poor nutritional and health state. Their lack of cash prevented them using motorised vehicles to transport food rations from the distribution centre to their homes. Many encountered difficulties regarding the care of children and sick relatives in the home due to the length of the journey time on foot. Others found it an extreme drain on their limited energy resources; a fact that was highlighted by the collapse of one of the recipients in the course of the FGD.

10. Apart from the negative health and nutritional implications of the distribution modality, recipients must contend with a pervasive threat of robbery while transporting rations to the home. Three of the beneficiaries present reported being robbed in the last year of food and drug supplies, and all members of the FGD indicated that they feared robbery and physical assault during transportation of their rations from the distribution site. Targeting of recipients for robbery seems to be aggravated by the local belief that beneficiaries also receive cash as part of their monthly benefits.

11. As has been noted in other case study countries visited in the course of the Thematic Evaluation, the inclusion of unmilled maize in the food baskets presents challenges for beneficiaries with limited energy resources. Approximately 90% of recipients in the REVS+ focus group reported dehusking maize to be a drain on their energy and health. Transportation to grinding machines placed an extra burden on their health and energy. The cost of milling at 500 CFA per box of grain[186] also presented difficulties for beneficiaries who had been targeted according to their food insecurity associated with poverty.

12. In common with certain other beneficiary interviews and FGDs in the course of this evaluation, reports were received of problems encountered with CSB. This is often found to be spoiled by worm infestation and to develop a bitter taste. Given the reliance of the most vulnerable recipients (AIDS patients and young children) on this component of the food basket it is essential that the cause of spoilage be determined and remedied immediately and appropriately.

[185] Numbers fluctuated in the course of the FGD period as beneficiaries arrived and others left.

[186] The local means of measuring grain. This was appeared to be equivalent to approximately 10 kg of grain but due to time limitations, was not verified by the evaluation team.

13. Focus group discussions with beneficiaries at CANDAF in Ouagadougou indicated less severe problems encountered by beneficiaries in transporting food from the distribution site and to and from grain mills. This appeared to be because communities had better access to ownership of non-motorised transport means such as carts and bicycles as well as mopeds, which they use for movement of rations. However, recipients undergoing ART were cycling up to 16km to grain mills with heavy loads, which is inappropriate given their health status.

Efficiency and Effectiveness

14. Following the recommendations of the Mid-Term Evaluation of the Country Programme 10000.0 (2000-2005)[187] the current CP (10399.0) provides performance indicators designed to measure the outcomes of HIV and AIDS and TB activities. This for example sets out the measurement of adherence to DOTS therapy in terms of the percentage of patients receiving WFP food support completing their treatment. Although the National TB Programme is the designated data source of verification of this adherence to treatment, in the course of the evaluation the team found no evidence to indicate that these indicators were being monitored centrally by WFP to inform on effectiveness and guide approaches.

15. The CO took advantage of the opportunities offered by the 2003 WFP initiative with United Nations Volunteers (UNVs), to the draw on UNVs to strengthen HIV and AIDS programming in the field. A UNV with a strong health background and experience of working in the field of HIV and AIDS was recruited in 2003. The CO should be commended for its efforts to sustain its HIV and AIDS expertise by recruiting the same UNV as a professional officer within two years.

16. The CO has also employed a programme assistant (PA), who like the PO has a portion of working time allotted to WFP's HIV and AIDS policy mainstreaming. The PA selected clearly has a strong motivation and personal capacity within this theme. As the PO has been enabled to attend international and regional WFP workshops on HIV and AIDS mainstreaming, this has enabled capacity building of the PA, while the PA's local knowledge of HIV and AIDS issues and mechanisms has strengthened the CO's capacity to respond to the national context.

[187] Summary Report of the Mid-Term Evaluation of Country Programme – Burkina Faso (2000-2004). EB.3/2003/6-A72.

17. Beneficiaries at project sites visited reported no knowledge of the duration of the food support they receive from WFP. Among the CANDAF recipients, the majority had received food aid for a year and at REVS+, beneficiaries had been in receipt of WFP food and nutritional support for between 7 months and 3 years – the majority being recipients for two years or more. Neither project had any linkage with micro-credit or other income generating or food production activities to enable WFP an exit strategy via graduation of beneficiaries onto livelihoods support projects. A number of beneficiaries reported that they had become food insecure as a consequence of stigma surrounding HIV infection. Some previously had small businesses producing and selling food (baking bread, butchery etc), however, local beliefs in transmission of disease brought about a marked fall in business once their sero status became known. Clearly linkage with micro-credit accompanied by training in adequately researched fields of craft, skills and enterprise is needed to support beneficiaries to sustain themselves once their health has been strengthened following ART/TB treatment supported by WFP food assistance.

18. Beneficiaries of activities implemented by WFP's IP APED reported support for livelihoods development in the form of training and linkage with microcredit to establish small enterprise such as soap-making and clothes selling. However, these same informants were also long-term recipients of WFP food. This indicates that the CO should review IP's criteria for beneficiaries exiting from WFP food support.

19. In common with other country case studies, HIV and AIDS policy documentation is regarded to be too cumbersome for rapid referral and digestion by non-specialist staff.

20. It was apparent that the annual programming meetings on HIV and AIDS provided by PDPH are highly valued by the HIV and AIDS focal point. Apart from the updates provided on themes determined by pre-meeting questionnaire, these meetings are of value in enabling focal points to develop networks that they can use for peer assistance and advice from HQ. The relationship with the RB is regarded to be satisfactory in terms of receiving technical support. The CO reported that the regional HIV and AIDS focal point visited Burkina Faso to assist in planning activities.

21. Interview with the CD raised the issue of a disconnect between policy and different national contexts. In response to this issue WFP has held a regional consultation of CDs in Dakar, where discussions highlighted the appropriateness of a single policy in different country settings and the degree to which it is realistic and appropriate for CO's activities to be in compliance with HQ on HIV and AIDS approaches and organisational mechanisms for applying for additional funding such as that of the GFATM. The team have requested the minutes of this meeting and will comment further once this is received and reviewed.

22. A constellation of issues surrounding the GFATM budget for food and nutritional support TB and HIV patients has obstructed signing of the 2006-7 agreement between WFP and the SP/CNLS the GFATM Principal Recipient (PR). Previously WFP signed an agreement with UNDP as the initial PR, for two of the five years of the award. During the last year, the role of RP has been phased over to the SP/CNLS and the main area of contention concerns the fact that the GFATM budget line does not distinguish between actual food and non-food costs that include movement, handling, transport and storage of commodities together with WFP overheads. The previous PR,

being a UN agency did not take issue with these costs. However, even though the CO has obtained a waiver from HQ in the requirement for 7% indirect support costs to a special agreement for only 4%, this remains a point of contention for SP/CNLS that has prevented the MOU being signed for the release of the subsequent three years funding for food support to HIV and TB patients.

Recommendations

- The CO should ensure that HIV and AIDS considerations are mainstreamed into all programming according to WFP HIV and AIDS policy – notably current PRRO activities.
- The CO should ensure that IPs are reporting baseline data together with regular analysis and reporting of performance indicator data to determine whether there have been improvements in therapy adherence among beneficiaries undergoing TB, HIV and PMTCT treatment.
- WFP should supervise its IPs to review distribution modalities in terms of the mode of transport to which HIV infected and AIDS affected beneficiaries have access and the distances over which they need to transport their rations from the distribution sites to their homes. It should enable and ensure that IPs devise appropriate and effective solutions to reduce the energy cost of food transportation as well as the security risks to recipients moving their rations.
- The cause of CSB spoilage should be immediately explored at various levels (i.e at warehouses and in recipients' homes as well as during manufacturing and transport if deemed necessary).
- WFP should encourage its IPs to link with training aimed at IGA to ensure that beneficiaries exit from food support and graduate onto support to livelihoods development to ensure sustained food security and independence.
- The CO should consider providing food and nutritional support to IPs working with the substantial number of street children and older orphans and vulnerable children in urban and peri-urban areas.
- WFP should make concerted efforts to solve the outstanding issues surrounding non-food costs that are hampering the release of funds from the GFATM Principle Recipient that compromise the pipeline to HIV/AIDS/TB recipients.

Best Practice

- Taking immediate advantage of the opportunities offered by the 2003 WFP initiative with United Nations Volunteers to strengthen HIV and AIDS programming at the country level.
- Responding to the need for HIV and AIDS expertise within the national context by combining the skills of a national PA and international PO. This approach has the added value of providing reciprocal capacity building within the time constraints of the multiple duties of the two officers.

Nutrition Specialist's Findings

Internal Coherence

23. As the executive board guidance on HIV programming was issued in 2003, as expected the former country program (2000-2004) proposal, formulated in 1998/99 did not include HIV and AIDS programming. An HIV pilot project, which included rations for PLWHA, OVCs and TB patients was initiated in January of 2004 covering 9,250 beneficiaries.[188] The country program (2000-2004) mid-term review[189] called for continued and strengthened support for HIV/AIDS programming, as it was both a government and WFP priority, however, due to resource limitations the current Country Program could only be increased to 14,000 HIV beneficiaries. Support to orphanages has been discontinued, which is more aligned with WFP's HIV policy of prioritizing the support to orphans cared for by families. The planned support for PMTCT programming has not been implemented, due to the difficultly reaching consensus with the government on program sites.

24. The West Africa (and Burkina Faso) context of low prevalence of HIV and AIDS, 1.8 percent among adults[190] and 4.4 among pregnant women compared with the high prevalence of child and woman malnutrition (children: acute malnutrition- 18.6 %, chronic malnutrition- 38.7 %, and underweight- 37.7 %; underweight women- 20.8 %[191)] needs consideration when designing and implementing HIV activities.[192] This issue was discussed at a West Africa Regional Country Director meeting in 2006. The particular West Africa context may call for a modified approach, such as, intensified HIV prevention activities mainstreamed through all program activities versus extensive food assistance to support HIV infected and affected households.

25. The largest component of the current Country Program, School Feeding, includes an HIV and AIDS awareness component. A module on HIV awareness for primary school students has been developed for training school directors. School directors are trained as trainers so that the teachers in their schools receive this information; and can, in turn, teach this to children. However, data on the inclusion of HIV awareness in the school health curriculum is not currently being tracked; nor is it included in the CP log frame. In addition, the CP refers to collaboration with UNICEF, so that the schools benefiting from WFP food assistance can also benefit from school health programming, including HIV awareness. Due to time constraints it was not possible to discuss this with UNICEF.

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[188] WFP Burkina Faso, Fiche Signalétique du Projet d'Appui Alimentaire aux Initiatives de Prise en Charge des personnes vivant avec le VIH au Burkina Faso. BLF 6129.

[189]WFP Executive Board, Rome, Summary Report of the Mid-Term Evaluation of Country Programme—Burkina Faso (2000-2004), 12 September, 2003.

[190] Burkina Faso Enquête Démographique et de Santé 2003, Institut National de la Statistique de la Démographie Ministère de l'Economie et du Développement, Ouagadougou, Burkina Faso, et ORC, Marcro Calverton, Maryland, USA, Septembre 2004.

[191] Ibid, 3.

[192] The prevalence of micronutrient deficiencies, such as, iron deficiency anaemia and vitamin A deficiency are also quite high in Burkina Faso. Poor access to adequately iodized salt is also a problem contributing to iodine deficiency.

26. The CP MCHN component and the PRRO MCHN program have not integrated HIV prevention and awareness. Although, the prevalence of HIV is low in Burkina Faso, this is a missed opportunity for prevention education, particularly considering the higher prevalence of HIV among reproductive women and the risk of HIV+ pregnant/lactating women transmitting the virus to their infants and given the large number of women reached by the program. Further, the third CP component, support for rural development, also has not integrated HIV awareness, although the role of literacy programs in promoting community health was pointed out in the prior country program's mid-term review. This lack of HIV mainstreaming in other programs may be part of a larger CO problem of not prioritizing HIV and AIDS.

27. Lack of resources has been an impediment in implementing the HIV policy, as mentioned the expansion in beneficiaries from the pilot to the country program was limited. Further, training of staff not directly involved in HIV programs has limited mainstreaming HIV within other country program components. Lastly, overall government nutrition capacity is weak; this has potentially limited delivering nutrition information and treatment of acute malnutrition for PLWHA.

28. WFP's successful role in drawing attention to the deteriorating maternal and child nutrition indicators has been noted by partners. WFP is not as widely recognized as an advocate for food and nutrition support for PLWHA as for MCHN, which is understandable given the critical need to address the chronic/acute malnutrition problem and the overall lack of nutrition capacity prior to more comprehensively addressing HIV nutrition issues. However, in the past, their partnership with the national TB program in piloting food assistance for TB patients lead to the provision of food assistance to all TB patients in 2006 through the GFATM.[193] This was recently again shown when several of the HIV Associations lobbied for increased food support; and as a result the most recent GFATM proposal includes food assistance for 5,000 PLWHA.

29. The recent advocacy of WFP and others to address the deteriorating maternal and child nutrition situation contributed to the approval of a national council to fight malnutrition similar to the one formed to fight HIV and AIDS in July of this year. As the council is established, the formation of a subcommittee on HIV and nutrition linked to the national council to fight HIV/AIDS could support integrating HIV nutritional care with overall treatment for acute malnutrition.

[193] The current CP provides assistance to 1,700 TB patients in 8 centres while the GFATM funds the remaining TB patients served by 73 TB centres.

Relevance

30. To date, guidelines on HIV and nutrition have not been developed by the Ministry of Health in Burkina Faso, thus it is not possible to assess if WFP's HIV programming complies with such guidelines. HIV and nutrition guidelines are critical as they provide the basis for integrating nutrition services[194] within HIV programming. Given the low prevalence of HIV and problems of stigma, an informational booklet on eating well for people with illnesses, such as HIV, TB and other diseases was developed instead of nutrition and HIV guidelines.[195] Such an informational pamphlet can not serve the same purpose as a policy document with specific guidelines.

31. In the last two years, a practical guide for feeding infants and young children and guidelines for the prevention of mother to child transmission of HIV were published by the MoH.[196,197] Although both documents include information on infant feeding for HIV-exposed infants, this information is no longer consistent with the more recently released WHO guidance (2006) on breastfeeding and HIV. Further, they both fail to cover the nutrition issues related to complementary feeding for HIV-exposed infants and the need for close medical and nutrition follow-up.

32. The DN released an updated national nutrition policy earlier this year. Under the objective of reducing morbidity and mortality related to malnutrition, nutrition surveillance for PLWHA and nutrition management for PLWHA who are sick is included.[198] However, how this will be realized is not specifically elaborated under the surveillance section or with the plans to improve the operation of the nutrition rehabilitation centres for children (CREN).

33. Recently due to the increased attention on the problem of severe acute malnutrition and with the support of UNICEF and WHO, the DN has developed and published protocols for the treatment of moderate and severe acute malnutrition in infants and young children, birth to age 5.[199] It includes guidance on the treatment of severe acute malnutrition in ambulatory settings as well as for in-patients, though no information on HIV screening or on the treatment of severe acute malnutrition in HIV-infected children is included.

34. WFP's HIV and AIDS programming is consistent with the CNLS and the UN planning documents. The CNLS strategy (2006-2010) calls for the development of a strategy to provide nutrition support and food assistance.[200] This is further supported

[194] Nutrition services for PLWHA include food assistance, nutrition assessment, treatment for malnutrition, and nutrition counselling and education.

[195] Ministère De La Santé, Direction De La Nutrition, Bien Manger Pour Rester en Bonne Santé et Combattre les Maladies, Burkina Faso, 2005/6.

[196] Ministère De La Santé, Direction De La Santé De La Famille, Directives Nationales pour la Mise en Oeuvre du Programme National de Prévention de la Transmission Mère Enfant du VIH, Novembre, 2006.

[197] Ministère De La Santé, Direction De La Nutrition, Guide Pratique pour une Alimentation Optimale du Nourrisson et du Jeune Enfant, Burkina Faso, Novembre, 2005.

[198] Ministère De La Santé, Direction De La Nutrition, Politique Nationale de Nutrition, Février, 2007.

[199] Ministère De La Santé, Direction De La Nutrition, Protocole National De Prise en Charge De La Malnutrition Aigue, Mars, 2007.

[200] Cadre Stratégique de Lutte Contre le VIH/SIDA et les IST 2006-2010, Burkina Faso.

in the CNLS Operational Plan (2006-2010) which includes nutritional care under the heading of strengthening the access to medical treatment and community care.[201] Under priority strategies and actions, training in nutritional care and the dissemination of nutrition guides are listed; and WFP is included in the operating budget. WFP staff and others, such as, UNICEF advocated for the inclusion of nutrition in the CNLS documents. As a result, WFP's current HIV activities, such as, food support, HIV and nutrition training for IP staff and dissemination of nutrition guides are reflected in the CNLS documents.

35. WFP's involvement in JUNTA was acknowledged in terms of coordination, however, follow-up meetings with UNICEF to discuss the OVC support provided by both agencies when operating in the same areas has not occurred. PAMAC staff acknowledged that they would prefer more information sharing with WFP coupled with joint field visits in order to monitor HIV Associations' nutrition activities.

36. Regarding the implementation of activities to complement food assistance, such as, the provision of nutrition education and counselling, WFP has in the past worked closely with one partner in particular, PAMAC, whose role is to strengthen HIV community based organizations.[202] Joint training in nutrition and HIV; and nutrition education and counselling for PLWHA were organized in 2005 and 2006. WFP has supported these trainings and also continued with training this year through continuing to access additional funding, such as "Canadian" grants.

37. WFP has also developed a guide to support staff in providing nutrition and health information to PLWHA. Although it has not been formally evaluated, the second printing incorporated suggestions from field use, such as, the inclusion of recipes using CSB. Association staff visited provided positive feedback; it appears that no other materials have been developed to support individual or group nutrition/health education for PLWHA and this guide is appreciated and widely used.

Appropriateness

38. Among CANDAF beneficiaries, the transportation of the food from the centre to their home and from their home to the mill was identified as a burden. The milling and transportation costs and carrying the food (from the FDP to their means of transportation, etc.) for some, particularly for the weaker beneficiaries was also problematic. Some beneficiaries used bicycles or borrowed motor bikes, but most reported needing to pay for taxis both to transport the food home and to the mill. The distance to the mill from their homes was reported to be far. Information on milling whole maize for improved nutritional value and higher bran content versus milling maize with the bran removed for easier digestion had not been provided.

[201] Présidence du Faso, Conseil National De Lutte Contre le VIH/SIDA et les IST, Plan D'opérationnalisation Du Cadre Stratégique de Lutte Contre Le VIH/SIDA et les Infections Sexuellement Transmissibles 2006-2010, Burkina Faso.

[202] PAMAC is an acronym for Programme d'Appui au Monde Associatif & Communautaire de Lutte Contre le VIH/SIDA.

39. Food is sent to IPs (HIV Association and TB Centres) every three months.[203] Given the shelf life of CSB, i.e. 6 months or 1 year[204], this could be problematic, particularly when stored during the rainy season. The CSB currently in country comes from Italy and expires a year after production; for example, the CSB stored in one warehouse visited expires this November. At two Associations visited (REV+ in Bobo Dioulasso, CANDAF in Ouagadougou), beneficiaries complained they were unable to eat the CSB given the smell and infestation with bugs. WFP staff felt these complaints were unusual, and perhaps caused by the recent rainy season and humid weather, as they consistently hear beneficiaries prefer CSB to the other commodities.

40. Although the warehouse staff had been trained, food was inappropriately stored in the Bobo-Dioulasso TB centre; sacs of food were stored on pallets, though stacked against walls. The staff mentioned that when the food arrives there is difficulty finding sufficient space to adequately store it. A food storage warehouse was requested.

41. One distribution was observed at CANDAF that appeared to be well organized with beneficiaries waiting patiently for their turn; and the food appeared to be distributed with minimal waste. The distribution was carried out according to WFP guidelines, in that, beneficiaries were informed of the quantities of food to be provided; this was reinforced with a laminated poster which depicted the quantities of food per person per month. At this distribution, the iodized salt was not provided; and had not been available for 3 months according to beneficiaries. The oil provided was fortified with vitamin A and D as specified in WFP guidelines.

42. The beneficiaries interviewed at the CANDAF program site reported high acceptability and quality of the foods provided, except for the CSB. Most of the food provided, such as, maize, iodized salt, oil, sugar and dried beans are used locally; and selected based on availability, acceptability and the nutritional needs and the eating problems faced by PLWHA. For example, CSB, a blended food high in protein and micronutrients, such as, iron was provided, which cooks quickly into an easily digested porridge. Sugar, as well was provided to increase the palatability of the CSB; this can be particularly important for the sick and weaker PLWHA often suffering from poor appetite. Iodized salt, to address the lack of availability and help prevent iodine deficiency is also included.

43. On the other hand, the provision of maize as whole versus ground presents an unnecessary burden for beneficiaries. It is also a missed opportunity to potentially improve the nutrition quality of the maize through fortification during the milling process. It has been difficult for the WFP to address this. As it is only recently that one company has started to produce fortified maize within WFP specifications. As it is now possible for WFP to purchase fortified maize meal this is planned.

[203] However, the REV+ program and TB program visited in Bobo Doulasso had received food in April and expected deliveries in October.

[204] Programme Alimentaire Mondial, Aliments Mélangés Fortifiés Recettes: Caractéristiques et utilisations pratiques, Rome, July, 2002.

44. Beneficiaries reported receiving nutrition information monthly, but did not receive practical instruction on how to prepare the foods received for improved nutrition, on small scale vegetable gardening, or how to stretch their limited food resources. They reported most of the nutrition suggestions provided were "out of their reach." Two members of the group received individual nutrition counselling when they were ill and hospitalized.

Efficiency

45. Staff reported that the PDPH HIV "Getting Started" guidelines are appreciated; the technical and programming information is helpful and that the length is appropriate. On the other hand, some of the HIV policy documents are not particularly useful. The yearly international HIV meetings have supported the development of the HIV focal point through providing updated information on HIV programming along with a network of colleagues in other countries to contact. The meeting also serves as a forum to connect the focal points to PDPH staff. However, it was felt that the technical level and experience of some of the PDPH staff was not sufficient to adequately support the field. The regional HIV workshops were also relevant in contextualizing what was learned at the international meetings to West Africa and to develop products, such as the regional HIV strategy.

46. Burkina Faso's HIV programming has benefited from the public health background of the current focal point, the yearly training she attended as well as her relatively long tenure. As a result, the recommended complementary nutrition education and counselling has been well integrated into HIV programming. Staff initiative has also increased the budget for training and materials to support the integration of nutrition information with food assistance. This is important as nutrition education when interactive, practical, skill-based and focused on behaviour change, can support program sustainability, in that, beneficiaries potentially learn how to improve their diets and to manage the side effects of HIV; this in turn, can improve their nutritional status, health, energy level and quality of life.

47. Regarding technical assistance from the RB, it was noted that the Burkina Faso CO has continued to postpone the HIV/AIDS technical advisor's visits, although he has been able to visit all the other countries in his region in the last year.

Effectiveness

48. Regarding the planned outputs as delineated in the CP results matrix which have been expanded in the CPAP, the indicators selected related to treatment and/or program adherence and weight gain are appropriate. However, they are not entirely consistent with the indicators included in the yearly work plans. Further, the approach selected to collect impact data through surveys instead of from Partners monitoring and evaluation system makes it difficult to assess the results of the program. The process of building IPs capacity to collect monitoring also increases staff awareness of program objectives and how to measure progress which is also useful. (See section on Connectedness and Impact for additional discussion on the available survey reports.)

49. The HIV ration provides just over 2100 calories or 100 percent of the average caloric value used as the basis to design individual rations, for non-HIV infected/affected

individuals.[205] HIV and AIDS increase caloric needs by 10 percent for the asymptomatic adults; and 20 to 30 percent for symptomatic adults.[206] In addition, the ration is low in some micronutrients, such as, riboflavin (40% of RDA) iron (60% of RDA) and calcium (30% of RDA). Thus the ration alone does not provide sufficient calories or nutrients to cover the daily energy and micronutrient needs for HIV adult beneficiaries. Although most beneficiaries probably have access to other sources of food, so this may be acceptable.

50. At the sites visited, most beneficiaries received an individual ration plus additional rations depending on the number of children and/or orphans in the household and if the other adult was registered at the same Association. Guidelines on number of rations per family have not been developed; and thus this is determined by the IPs. From limited discussions, household size varied significantly, i.e. from 3 to 12 and most reported significantly more family members than the number of rations received; beneficiaries reported the ration usually lasted 2 to 3 weeks. None of the beneficiaries interviewed reported sources of income--when the foods ran out they were dependent on relatives for help.

51. The ration does not appear to have been designed based on the findings of the VAM assessment in 2003 or a food intake assessment of TB Centre or HIV Association beneficiaries. The VAM assessment reports lower consumption of protein sources and fruits/vegetables among the vulnerable households. Lower protein intakes are typically noted in Sub-Saharan countries, particularly among poorer households; this has also been found among HIV infected and affected households. Given this, providing a ration relatively higher in protein compared to energy may be appropriate; performing an assessment of potential beneficiaries to confirm this is needed.

Connectedness and Impact

52. Regarding the sustainability of food assistance and a potential exit strategy for WFP, one partner, the DN recommended that a study be conducted to evaluate the need for food assistance among PLWHA and those affected. Further, involving the Ministry of Social Action (MoSA) was suggested as their programming includes free medical care and food for individuals/families identified as destitute. Through pursuing a partnership with MoSA, it may be possible to develop a safety net program through building the costs of food assistance or a cash transfer program into the government budget for some categories of HIV beneficiaries.

53. Beneficiaries of REV+ and CANDAF provided anecdotal evidence of the effectiveness of food and nutrition support. Several beneficiaries reported that they had gained weight and feel better since starting food assistance and ART. Other remarked that the food assistance was shared among many family members and thus they did not eat as much of the food as they needed. And some reported that they now feel strong enough to return to work since receiving and consuming the food assistance.

[205] The ration was analyzed using NutriVal. The foods analyzed include yellow maize (degermed) as beneficiaries reported having the maize degermed in the milling process. Cow peas were used for the beans, as they were observed in one site, along with CSB, sugar, fortified oil and iodized salt.

[206] WHO, Nutrient Requirements for people living with HIV/AIDS: Geneva, 2003.

54. The data from the MoH, TB program demonstrates that adherence to treatment has increased with food assistance, although only half a year of data is available and treatment adherence had been increasing prior to food support as well. (See table below.) TB program staff attributes increased adherence to the improved quality of treatment, of which food assistance is an important component along with home visits to trace defaulters and ongoing staff training. They feel food assistance has contributed to the increased treatment adherence and lower defaulter rates.

Burkina Faso National TB Program Data[207]

Year	number of TB cases	cured	percentage cured	defaulted	percentage defaulted
2000	1545	932	60.3%	253	17.4%
2001	1522	993	64.0%	191	12.4%
2002	1544	979	64.1%	203	13.4%
2003	1703	1127	65.6%	214	12.5%
2006 (1st half of the year)	2663	984	71.9%	140	6.1%

2004, 2005 data is not included as during these years food assistance was piloted in some clinics. In 2006 all patients received food assistance.

55. A retrospective study comparing treatment results and weights of TB patients who received food assistance to patients who did not was conducted last year. Patients' adherence rates were compared from 2003/2004 before food assistance was provided to patients' adherence rates in 2006 when food assistance was expanded to all TB patients. Since the food assistance expanded to all TB beneficiaries, at the same time, the opportunity to compare adherence results to a control group not receiving food assistance was not possible. The results, as expected given the TB program data, report a higher percentage of beneficiaries receiving food assistance completed treatment (96.7 %) compared to beneficiaries not receiving food assistance (92.0 %); the difference was statistically significant (p= 0.01).[208] Given the nature of the study, i.e. retrospective, it is not possible to determine if (and how much of) the increased adherence is attributable to the food assistance as others factors, such as, improved quality of services also influenced increased adherence.

[207] Data in the table was provided by Dr. Michael Sawadogo, Medical Specialist in Public Health, Programme National Tuberculose.

[208]Ministère de la Santé, Direction Générale De La Santé, Direction de la Lutte Contre La Maladie, Programme National de Lutte Antituberculeuse, Evaluation des Données Anthropométriques Chez les patients Tuberculeux Mis en traitement de 2004 a 2006 au Burkina Faso, Rapport d'enquête commandite part le PAM, représentation du Burkina Faso, Janvier 2007.

56. When comparing weight gains over the course of TB treatment, results indicate that food assistance did not contribute to increased weight gain.[209] However, when the data was stratified by urban and rural patients, those served by rural clinics receiving food assistance had significantly higher weights at the end of treatment when compared to rural patients not receiving food assistance.[210] Why the food assistance impacted weight gain among rural patients receiving food assistance and not those in urban areas is not known. This needs further investigation.

57. The overall lack of effect of the food assistance may partially be explained by the provision of individual rations and lack of nutrition education, thus, sharing of the food among family members was probably common.[211] In addition, the nature of the study, i.e. retrospective, may have introduced bias, such as, the accuracy of the weights measured. Further, without patient heights it was not possible to calculate body mass index (BMI), and in turn, classify patients according to nutritional status and identify the patients suffering from moderate and acute malnutrition. Thus the data analysis was not able to classify the patients according to nutritional status to determine if the food assistance contributed to improved nutritional status for some beneficiary groups, such as, those moderately or mildly malnourished.

58. A preliminary report from a study commissioned earlier this year comparing the weights of PLWHA on ART and OVC beneficiaries receiving food assistance to those not receiving assistance has recently been drafted.[212] However, not all the beneficiary records have been included in the data analysis; nor has the data been stratified by level of food security. Further for the children, the sample sizes are small and the age grouping wide, such as, birth to age 12 and 12 to 18 years. Thus, although some preliminary data was included, the final results are needed prior to drawing conclusions.

[209] Ibid, 23

[210] Ibid, 23.

[211]When the program was in its pilot phase, nutrition education was provided, though with scale-up this hasn't been expanded, rather it has been phased-out in the pilot sites.

[212]Evaluation de l'impact des appuis alimentaires du PAM faits aux orphelins du SIDA et adultes VIH+ de la ville de Ouagadougou, Rapport draft, Septembre, 2007.

Recommendations

- Given the low prevalence of HIV in Burkina Faso, within the context of high malnutrition indicators and low literacy, the CO's priorities as defined through their programming are reasonable. However, the size of the HIV program has limited its emphasis as larger program components receive priority, thus more emphasis on HIV programming is needed. To that end, the upcoming scheduled visit with the RB HIV/AIDS focal point could provide input in how best to do this.
- Increased mainstreaming of HIV prevention into all Country Program and PRRO components is advised. In particular, a closer collaboration with UNICEF may be needed to support the integration of HIV awareness into school health curriculum. At a minimum, more follow-up is needed to monitor schools provided training in HIV awareness by WFP. Developing an HIV prevention component to integrate with the CP and PRRO MCHN and rural development programs is also needed.
- The CO should be commended for their advocacy regarding the poor maternal and child nutrition indicators; as needed, this work should continue with participation in the Council to Fight Malnutrition once it is established. Supporting the formation of a nutrition and HIV committee linking the Council to fight HIV and AIDS with the Malnutrition Council is encouraged.
- The problem identified regarding the poor quality of the CSB should be more closely reviewed. Providing food stocks for 3 months most likely contributes to this problem. If this can't be resolved given logistical issues and transportation costs, potentially the ration could be revised to include more milled fortified maize meal and additional pulses with the CSB eliminated during the rainy season.
- It is understood that it has been difficult to negotiate a ration of higher nutritional quality and/or calories. Further, IPs "stretch" the WFP food to reach more families, as a result, it appears that full family rations are not provided and the effectiveness of the ration is compromised. For the TB program, only individual rations are provided; resources should be sought for a family ration for the TB program. In addition, for HIV IPs it may be necessary to provide more training and written guidance on how the family ration should be provided. However, implementing this should be accompanied by a specified period to receive food assistance, graduation criteria and livelihood support.
- Given the size of the HIV program, it is recommended that it be implemented more like a pilot/model with more monitoring and evaluation with the objective of demonstrating effectiveness of food assistance and sustainability. Partnering with the Ministry of Social Action to provide a safety net for particular groups of 'destitute' beneficiaries may also be helpful. This may form part of an effective exit strategy for WFP.

- Further, given the small number of women to support (1500), the technical background needed to assess and supervise PMTCT programming, as well as, the lack of a nutritionally adequate "weaning" food, initiating PMTCT programming is not advised. Rather continuing to utilize this food in other HIV programming is encouraged. If this recommendation is not adopted, WFP should conduct thorough assessments of potential PMTCT partners' programs; and in particular the existence of community-based components to provide any necessary treatment and support for infant feeding. Reviewing program outcome data, such as, mothers' adherence to treatment and percent of HIV exposed infants followed at 6 weeks and 18 months and their HIV status is also advised. In addition, clarifying the role of food assistance as it relates to program implementation is also recommended.
- Given the lack of practicality noted in the monthly nutrition education sessions, it may be prudent to provide more training in this area and then review this on supervisory visits to ensure that information is provided in an interactive format; and that skills are provided along with information that is targeted to beneficiaries needs. Additional counselling cards and flip charts may be needed to convey this information. Beneficiaries expressed interest in learning how to grow vegetables in small areas, which would be valuable to support improved diets.
- As conducting studies on the effectiveness of food assistance is expensive, and the expertise not readily available in country to conduct or supervise such studies, it is recommended that conducting such studies be discontinued. And rather the CO should focus on improving its M&E, particularly related to HIV outcome data. Specifically it is recommended that the CO focus on completing the outcome data required in the 2006 data base and collecting the 2007 data, which includes additional indicators. To accomplish this, IPs may need orientation and/or training to appropriately collect the additional data, as it requires taking heights and weights. If adequate training and supervision is not possible, deleting the indicators related to tracking weights and heights is suggested. Lastly, continuing to collaborate with the National TB program to provide data on TB program adherence among patients receiving food assistance is also needed.

Best Practices

- The ongoing commitment to securing funds and training HIV Associations (IPs) in nutrition education and counselling for PLWHA
- The pilot project with the national TB program, which supported the GFATM proposal to provide food assistance to all TB patients

Food Security Specialist's Findings and Recommendations:

Coherence

59. The HIV and AIDS activities implemented through the pilot project (January 2004-June 2005) and the Country Programme (2006-2010) are partly in coherence with the 2003 EB Policy Paper: "Programming in the Era of AIDS – WFP's Response to HIV/AIDS" and the following EB Notes as concerns targeting, graduation and food security aspects. It should be noted, however, that WFP policy papers provide little if any strategic guidance on planning and implementation of HIV and AIDS programmes. It was for example not until the 2007 EB Policy Issues paper: "Time to deliver – An update on WFP's Response to HIV and AIDS" that exiting from food assistance and the duration of food assistance was addressed at policy level.

60. With regard to targeting, the geographical targeting of the Burkina Faso programme differs from the strategy outlined in the 2003 Policy Paper. The 2003 Policy Paper stipulates focus on highly food insecure areas (with high prevalence of HIV and AIDS), whereas the Burkina Faso Programme focuses on peri- and urban areas (with high prevalence of HIV and AIDS). The geographical targeting of Burkina Faso is, however, regarded to be a rational strategy due to the low prevalence of HV and AIDS in the highly food insecure areas (cf. below).

61. In terms of graduation from food assistance, Burkina Faso CO has developed norms for the duration of food assistance for different project types. According to the Action Plan for Country Programme (CPAP)[213], the duration of food assistance for both PHA and OVC programmes should be 12 months, for PMTCT programmes the duration should be 9 months and for TB patients the duration should be 8 months. However, these norms for duration of food assistance did not seem to be known by the seven associations visited by the Evaluation Team although according to the HIV and AIDS focal point the topics of duration of food assistance has been part of the training given to the associations. Furthermore, the duration of food assistance is well specified in the protocols signed between the associations and WFP. In practice, the associations visited were providing food assistance over extended periods (number of years) although some beneficiaries were discharged when recovering (cf. the below section on relevance). Since the visited partners did not seem to be aware of the duration of time for food assistance an assessment of whether the beneficiary could graduate from food assistance after for example 12 months (for PHA programmes) did not take place.

62. With regard to training and initiation of livelihood activities/IGA, the Burkina Faso HIV and AIDS programme is coherent with the 2003 Policy as the majority of the implementing partners are initiating IGA activities/providing training.

63. Several factors may have hampered or promoted the implementation of the 2003 policy (and following EB notes) in Burkina Faso. WFP's general focus on providing food assistance to highly food insecure areas (which are most often rural areas) versus HIV and AID programme approaches focusing on targeting individuals (through vulnerability screening) in areas of higher HIV prevalence, usually urban areas, may have hampered programme implementation. On the other hand, the high number of associations implementing IGA and vocational training in Burkina Faso may be seen as one of the factors promoting the implementation of the policy. Thus, although capacity with regard to livelihood/IGA is one of the criteria for selection of partners, the existence of such partners cannot be taken for granted.

[213] CPAP, November 2005. Action Plan 2006-2010 (signed by government).p. 17.

64. HIV and AIDS appear only to a limited extent to be mainstreamed into other programmes and activities of WFP Burkina Faso. The most recent VAM report dates back to 2003, the year of the first 2003 Policy, and it is therefore not surprising that HIV and AIDS aspects are not included in the report. A Comprehensive Vulnerability Assessment is planned to take place in 2008. The details of the survey are yet to be planned, however, there seems to be no indication of HIV and AIDS indicators being applied; neither has the VAM units at headquarters and RB requested this. HIV and AIDS indicators might still be included in the coming assessment; however, the general impression from the Mission is that the area of HIV and AIDS has a low priority in the VAM unit and in the office in general.

Relevance

65. The HIV and AIDS component of the Country Programme of Burkina Faso CO responds to WFP's Strategic Objective: "Support the improved nutrition and health status of children, mothers and other vulnerable groups"[214].

66. A national strategy and programme for food security in Burkina Faso was prepared in 2003[215]. According to various sources in the CO, the strategy is, however, not in actuality guiding food security planning and action at various levels, one reason being the lack of government ownership to the strategy, which apparently was prepared with donor support. The national strategy and programme for food security does not include any HIV and AIDS activities and hence the WFP HIV and AIDS programme can hardly be said to be in line with national food security strategies and programmes.

67. In general, food security activities in Burkina Faso are implemented in the Northern and Eastern parts of the country, which are the most food insecure areas. On the other hand, WFP has selected urban and peri-urban areas, primarily in the West for the implementation of HIV and AIDS activities due to the higher prevalence of HIV and AIDS in these areas. WFP's geographical targeting strategy is, however, rational due to the low prevalence of HIV and AIDS in the highly food insecure areas. Moreover, the government has agreed with the selection of urban areas and has also participated in the selection of the IPs through ad hoc committees.

68. The collaboration between FAO and WFP seems generally weak in Burkina Faso. FAO is not implementing specific HIV and AIDS programmes and is not implementing/experimenting with labour-saving activities and methods (which could have been relevant for HIV and AIDS affected). According to the CO, one reason for the lack of collaboration with FAO is the lack of resources of the latter.

69. Food assistance is regarded a highly relevant tool for HIV and AIDS infected and affected to achieve the mitigation objective, primarily in PHA and OVC programmes. The food assistance in general as well as the specific food basket was also highly appreciated by the beneficiaries.

[214] The objective is, however, not clearly set out in the Result Matrix of the Country Programme.

[215] "Strategic Operatioelle et Programme de Securite Alimentaire Durable Dans une Perspective de Lutte Contre la Pauvrete". Ministere de L'Agriculture de L'Hydraulique et des Ressoruces Halieutiques". Burkina Faso. Unite-Progress-Justice. Avril 2003.

70. Due to the limitation of resources in the Country Programme, individual rather than family rations are provided. This is unfortunate as the individual ration in many cases will be shared with other household members thereby decreasing the effectiveness of the food assistance, in particular when it is given as nutritional support to HIV and AIDS infected. According to the guidance from the CO to the IPs more than one individual ration can be given to a household, i.e. if more than one person in the household is eligible for the individual ration. Even if this slightly improves the utilization of the food by the beneficiaries, there is a risk that the food will be divided among all members of the household, including the household members, who are not eligible for food assistance. The IPs visited were to some extent applying different practices with regard to number of individual rations allocated. Some would apply the principles given by the CO (although the selection criteria differed from the ones of the CO, cf. below); in other cases the IP would make a general assessment of the vulnerability of the household and then allocate a given number of rations, in some cases a maximum of four rations, in other cases a maximum of two rations.

71. During the visit to one of the partners in Bobo-Dioulasso (VIVRE APED) a serious problem in relation to food distribution was observed. The association was due to receive the food assistance October 1, but on the visit of the food security specialist on October 4 no food had arrived, and the association had received no information about the reason for the delay or when the food was likely to arrive. A number of women had walked from far and were waiting for the food assistance at the premises as they had heard that a WFP person was visiting.

72. No exit strategy for phasing out or graduation criteria for PHA or OVC programmes have been developed at headquarters[216]. Neither have guidelines for phasing out/graduation been developed at CO level. However, as earlier mentioned, the CO has developed norms for duration of food assistance for the different programme types (cf. above section on coherence). During the training of IPs, the CO moreover emphasises that food assistance must not make beneficiaries dependent of the support and should only be given when the beneficiaries are in dire need and should not be given continuously for several years[217].

[216] A new handbook: ”Food Assistance Programming in the Context of HIV” prepared by Food and Nutrition Technical Assistance (FANTA) and WFP has, however, come out very recently (September 2007). According to PDPH, Rome, the new handbook is going to serve as guidelines for targeting in the future.

[217] Power Point Presentation used for training in HIV and AIDS and nutrition for implementing partners, prepared by the HIV and AIDS focal point and her assistant.

73. None of the visited implementing partners seemed to be aware of the duration of time for giving food assistance and food assistance had been provided continuously for several years for many beneficiaries (PHA/ART and OVC programmes). All of the partners visited implementing PHA/ART programmes were applying the discharge criteria that when people had recovered and could return to their job, the food assistance was discontinued. In case the beneficiary had recovered, but did not have a job, the association would attempt to assist with initiation of IGA. Three of the associations visited (ABASF, ADS, AAS) reported that respectively 120, 100 and 100 persons had recovered and were discharged from the food assistance (and were replaced by new beneficiaries). With regard to OVC programmes, the discharge criteria applied by the associations was an improvement of the economic situation of the household of the OVC.

74. Five out of the seven associations visited by the Evaluation Team were initiating/providing training in different IGAs such as for example soap production, sewing and weaving, drying mangoes, production of neem oil, production of bags/purses (made out of re-cycled plastic bags), batik, gardening, rabbit breeding, and soymilk production. It was not possible to assess the feasibility of the different IGAs during the short visits to the associations; however, the associations should be commended for being innovative with regard to initiation of IGAs.

75. The OVC programme visited, (VIVRE APED) included support to OVC in families as well as vocational training and had a total of 200 children attached to the centre of which 102 received food assistance from WFP. The centre offered training in the trades: mechanics, sewing and carpentry. The first batch of 15 students had just finished their four years of training; the leadership of the centre was trying to find partners for employing the students; at the time of the mission they had not yet been successful in identifying jobs and partners for the students. The centre appeared to be relatively poorly equipped, which was also true with regard to working tools and materials for the training. There was no support for non-food items (working tools and materials).

Appropriateness

76. Targeting in HIV and AIDS programmes is only dealt with sporadically at policy level. According to the 2003 Policy [218] WFP should focus on areas with high levels of food insecurity and high HIV and AIDS prevalence (geographical targeting) and within these areas, WFP should focus on households, whose food security is threatened by HIV and AIDS (beneficiary targeting). However, although targeting is mentioned in the 2003 Policy, it is not among the four recommendations approved by the Executive Board and can hence not be regarded as part of the policy. Due to the limited policy guidance from headquarters, the responsibility for developing guiding principles for targeting to a large extent rests with the COs. In the case of Burkina Faso, no guidelines have been developed for targeting; however, the CO is in the process of developing a form for selection of beneficiaries to be used by the IPs. CO has received assistance the RB regarding preparation of the form.

[218] WFP EB Policy Issues: "Programming in the Era of AIDS – WFP's response to HIV/AIDS". Rome, 5-7 February 2003.

77. Training has been conducted for the IPs in which the basic targeting criteria were presented (cf. the power point presentation). According to the training material and to the CPAP, the medical criterion for selection of people living with HIV and AIDS is that the person should have reached the AIDS symptoms stage, whether on treatment or not. According to the training material/CPAP, the selection of the beneficiaries should moreover be based on economic vulnerability as assessed by the associations. Being economic vulnerable is not further defined except that it is stated that only widowers and widows, who have lost their spouse, can only be supported if the latter was significantly contributing to the financial resources of the family.

78. With regard to OVCs, according to the targeting criteria set out in the training material and the CPAP, only double orphans can be targeted. The reason for applying these very severe criteria is according to the HIV and AIDS focal point the shortage of food stock. Hence, only the extreme vulnerable can be targeted. In exceptional cases, families hosting a child, who has lost his/her parents due to AIDS and OVCs, whose parents are in the final stage of AIDS (and who are contributing significantly to the household income), can be targeted according to the training material.

79. The criteria given for the targeting of food assistance for HIV and AIDS affected in Burkina Faso seem very strict, i.e. primarily targeting beneficiaries in the final stage of AIDS and double orphans. The criteria for targeting in Burkina Faso are far stricter than the criteria applied in the other three countries visited as part of the HIV and AIDS Thematic Evaluation. According to the HIV and AIDS focal point, the reason for applying very strict targeting criteria in the case of Burkina Faso is the problem of resource allocation for the Country Programme allowing targeting of only the extreme vulnerable.

Efficiency

80. In terms of geographical targeting, the Country programme targets the whole country, but in particular the urban and semi-urban areas having a high prevalence of HIV and AIDS. This is only partly in line with the 2003 Policy[219], which stipulates focusing on food insecure geographical zones particularly affected by the pandemic. However, in the case of Burkina Faso high levels of food insecurity and high levels of HIV and AIDS do not overlap: the main food insecure areas of Burkina Faso are to be found in the North and East, whereas the highest prevalence of HIV and AIDS is in the Ouagadougou and the Western part of the country. Due to the general poor economic status of the country as well as the fact that the prevalence of HIV and AIDS in the highly food insecure areas is quite low, it is regarded as a rational strategy to focus on areas with higher prevalence, for instance the urban areas of Ouagadougou and Bobo-Dioulasso.

81. Five IPs (associations) were visited by the food security specialist as part of the Evaluation Mission; three associations around Ouagadougou (ABASFE, ADS, AAS) and two in Bobo-Dioulasso (AED, VIVRE APED). With regard to PHA programmes, all of the partners visited were applying medical targeting criteria, which were less strict than the medical targeting criteria set out by the CO. According to the medical criteria set out by the CO primarily people who have reached the AIDS symptoms

[219] "Programming in the Era of AIDS: WFP's Response to HIV/AIDS". EB. Rome 5-6- February 2003. Policy Issues.

phase should be targeted for food assistance. The overall targeting criterion for PHA programmes applied by all visited associations was being infected (whether on ARV or not; symptomatic or asymptomatic). With regard to targeting criteria in OVC programmes, a divergence between the criteria set out in the training material/CPAP and how they were applied by the associations was likewise observed. According to the CO only double orphans should be targeted; however, the associations visited were targeting both single and double orphans plus other vulnerable children.

82. According to the HIV and AIDS focal point, the majority of the associations are, however, applying the targeting criteria set out by the CO (persons in the last phase of the disease and double orphans). Although the IPs are expected to apply the targeting criteria set out by the CO, it can on the other hand be seen as positive that at least some of the IPs are able to apply less strict targeting criteria with the given food resources. Hence, there might be room for revising the current targeting criteria.

83. None of the visited partners were applying objective economic vulnerability (food security) criteria for the selection of beneficiaries. One association, ADS, was using a questionnaire for selection of beneficiaries (and follow-up); however, the questionnaire only included personal data (marital status, profession, etc.) as well as a subjective indication of reason for seeking assistance.

84. The partners visited applied different strategies for selection of beneficiaries; either they would collaborate with the Ministry of Social Action to identify vulnerable households or the association would use their own social worker to do the assessment. In most cases the assessment would include interviews and household visits to verify the information given with regard to the vulnerability of the household. Although all the partners visited seemed to be highly committed and sincere, also in terms of targeting the most vulnerable, objective selection criteria can reduce the risk of not targeting the most vulnerable as well as nepotism/favouritism in the selection process.

85. One association (AED) supporting OVC in families was visited during the Evaluation Mission. The association used the targeting criteria: single/double orphans; children of poor families; HIV infected children (at least one of the criteria should apply). The children were referred for example from the hospital or through people visiting the partner. Other selection criteria used by IPs were: vulnerable for other reasons, child headed households, and HIV infected parent.

86. Until the new handbook “Food Security Assistance in the Context of HIV” came out at the time of the Evaluation Mission, no global or regional guidelines existed for targeting, graduation and IGA/livelihood activities for HIV and AIDS programmes. The HIV and AIDS focal point emphasized that there is a need for support with regard to graduation from food assistance and initiation of IGA/livelihood activities. The need for graduation and IGA guidelines has become more imperative after ARV has become available and many beneficiaries recover and no longer need food assistance. The need for support with regard to initiation of IGA is also pressing as most associations are placed in urban areas where the HIV prevalence is highest; unfortunately WFP mainly has technical expertise with regard to IGA/livelihood activities in rural areas.

Effectiveness

87. The Country Programme document (2006-2010) sets out a result matrix with outcome and performance indicators. As noted earlier, the objectives result matrix does not clearly indicate the objectives. The Country Programme document (p.9), however, refers to Strategic Objective 3: "Support the improved nutrition and health status of children, mothers and other vulnerable groups" as the objective for HIV and AIDS activities in Burkina Faso. Two corporate indicators are used to measure the outcome of the programme: "Protocol adherence of patients under TB treatment and mothers enrolled in PMTCT programmes is improved" and "The effects of HIV/AIDS on food security of the infected and affected people targeted by WFP is reduced". Only the latter indicator is relevant in relation to food security. Five sub-indicators are specified in the CPAP. According to information from the CO, surveys to assess the outcome of the programme activities will be conducted twice during the period of implementation of the Country Programme, first time in 2007 and then presumably toward the end of the programme. At the time of the Mission, the 2007 survey had been conducted, however, the report had not been finalised and hence it was not possible to assess the outcome. No baseline survey has been conducted in the first year of implementation; this is unfortunate as this would have allowed an assessment of the outcome of the HIV and AIDS programme activities during the programme implementation 2006 to 2010. Moreover, conducting surveys on outcome a couple of times during the implementation of the programme cannot be compared to a genuine monitoring system collecting ongoing data.

Connectedness/Sustainability

88. Burkina Faso CO is actively involved in the national work for food security at various levels. The overall body for food security in Burkina Faso is the National Council for Food Security, which, however, has met only once since it was established in 2006. Under the Council a Technical Committee exists of which the Country Director of WFP is an active member together with Ministry of Agriculture, Ministry of Health, EU, France, and the Danish Embassy, among others. The objective of the work of the Technical Committee is management of the national food reserves as well as the Food Security Information System. The work of the Technical Committee is (despite its name) mainly political and strategic, whereas the actual technical work takes place in the Working Group under the Council and the Technical Committee. The VAM Unit Programme Officer is an active member of the Working Group, which has the overall objective of enhancing the national system of data collection, assessments and surveys for food security and nutrition aspects. In sum, Burkina Faso CO seems to be contributing much to enhancing and developing the national work on food security from the strategic to the technical level. It should, however, be noted that there seem to limited, if any focus on HIV and AIDS in the national work on food security and that WFP Burkina Faso does not appear to attempt to strengthen this aspect.

89. Burkina Faso CO seems to work hard to build capacities at governmental levels, for instance through participation in the above-mentioned Food Security Technical Committee and Working Group, but also more generally. The CO has for example provided training of government technical staff in emergency assessments (4-5 days in 2005/2006). The CO moreover has a strategy of trying to involve government counterparts as much as possible, for example in the development of a data base, in conducting surveys, etc. Most of WFP's food security activities are hence implemented through national counterparts.

90. The VAM unit's initial ideas about the planning of Comprehensive Vulnerability Assessment to take place in 2008 also witness about a very good understanding of how to build capacity and local ownership. The plan is that the government should take the lead in conducting the assessment, for instance by establishing a governmental-led technical committee to monitor the planning and implementation of the assessment. The general principle is that the role of WFP is not to conduct assessments, but to do capacity building of the government in this regard and that if the government does not take the lead in this process, there will be no national ownership to the assessment.

Impact

91. There has been no impact assessment of the pilot project (January 2004 to June 2005); moreover, the Country Programme (2006-2010) has only started recently and hence it is not possible to assess the impact of the HIV and AIDS programmes at household level. The HIV and AIDS component of the Country Programme includes an M&E system with outcome indicators. As mentioned above, surveys to assess the outcome of the programme activities will be conducted twice during the period of implementation of the Country Programme, first time in 2007 and then presumably toward the end of the programme. However, the 2007 report had not been finalised; moreover no baseline survey has been conducted in the first year of implementation, and thus it will not be possible to assess the impact of the programme from its beginning.

Recommendations

- WFP HQ should develop more elaborated geographical targeting criteria applying to different situations, for example high versus lower prevalence of HIV and AIDS and different levels and patterns of food insecurity.
- Burkina FASO VAM Unit should ensure that HIV and AIDS indicators are integrated in the Comprehensive Vulnerability Assessment to be conducted in 2008 as well as in other national assessments.
- Burkina Faso CO should develop overall targeting guidelines, including a manual for applying the eligibility form, which is already under preparation. SO staff and IPs should be trained in applying the new targeting guidelines.
- Burkina Faso CO should develop guidelines for graduation from food assistance to IGA/livelihood activities with clear graduation criteria. The eligibility assessment (form used for selection of beneficiaries) should be repeated after the duration of time for food assistance indicated in the CPAP in order to assess whether the beneficiary could move from food assistance to IGA/livelihood support. SO staff and IPs should be trained in applying the new graduation guidelines.

- Burkina CO should explore possibilities to further strengthen the IGA/livelihood activities implemented by the implementing partners (associations). Due to the limited capacity of WFP in this regard, it is important to explore opportunities for WFP to partner with other organizations/institutions with technical expertise. It is recommended contracting a consultant for the task with the more specific objectives of:
    - assessing the feasibility of the most commonly implemented IGA/livelihood activities as well as exploring alternative feasible activities
    - assessing the capacity of current partners in this regard and develop plans for training
    - identifying, if possible, organizations/institution with technical expertise in IGA/livelihood activities with whom WFP can partner
    - preparing guidelines for the IGA and livelihood activities to be initiated by the implementing partners

- Burkina Faso CO should explore the possibilities for providing non-food item support to the associations in order to enhance the IGAs as in some other countries, for instance Uganda.

Annex F: WFP's planned activities and outputs according to the four HAWP strategies set out in the Agents of Change Conceptual Framework 2004

STRATEGIES	PLANNED OUTPUTS/ACTIVITIES
Strategy #1Information, Education and Communication (IEC)	Training for All - Training Curriculum - Training Roll-out
	Other Approaches to Learning0 - Specialized Training for Management and Human Resource Personnel
	Country-specific Communications Strategies
	Peer Educators
	Print and other Informational Materials
Strategy #2 Facilitating Access to Care and Treatment	Insurance Coverage
	Care and Treatment Inventories
	Access to Condoms
Strategy #3 Policy Harmonization	Insurance
	Formal Complaint
	Post-Exposure Preventive (PEP) Treatment
	Policy Reform
Strategy #4 Bottom-up Approaches	Country-specific Workplace Initiatives
	Tangible Privileges
	Orientations for New Staff Members
	Small Grants

Annex G ***Profile of evaluation team members***

Kate Molesworth, MSc, PhD: HIV and AIDS Consultant/Team Leader is the Reproductive Health and Social Development Adviser of the Swiss Centre for International Health at the Swiss Tropical Institute. She has worked as technical advisor and evaluator of health projects and programmes in development, humanitarian and conflict settings with organisations such as the World Bank, WHO, UNDP, UNICEF, DFID, Save the Children Fund, the Tajik-Swiss Health Sector Reform and Family Medicine Support Project; and the European Commission. She is Technical Editor of the Eldis/DFID Health Resource Guides on Maternal and Neonatal Health and Sexual and Reproductive Health. Dr. Molesworth is a member of the steering group of the SDC/Sida Programme of Networked Research developing research on mobility and health in 30 sites in Asia, Africa and Latin America. As a technical advisor to the Swiss Agency for Development and Co-operation (SDC) on reproductive health and health, HIV and AIDS and mobility, she was seconded to provide technical support to the Thematic Evaluation of WFP's approaches in response to HIV and AIDS.

Pernille Nagel Sørensen: Food Security Specialist holds a BA, MA and PhD in Anthropology and has worked and carried out research in Africa and South Asia for the past 15 years. She currently works as an independent consultant, specialising in food security, food aid, linking relief and development, rural development, sustainable livelihood systems, sustainable agriculture, intra-household relations and gender for clients such as WFP, Norad, Danida, and various NGOs. From 2002 – 2005, Dr. Sørensen worked as a food security advisor (external and internal) to DanChurchAid. Prior to this position, she was a coordinator and researcher on the Impact Study of the Joint Ethio-Danish Development Programme in North Wollo, Ethiopia from 1997-2008. Dr. Sørensen has several publications in the fields of rural development, food security and livelihoods, development economics and gender.

Alison Gardner: Nutrition Consultant holds a MS in Human Nutrition, MPH in International Health and is a Registered Dietitian. She has over 20 years of public health experience with over 7 years of consulting in Africa and Asia. During this time she has worked as a nutrition/health technical advisor and program evaluator for organizations such as, the World Bank, WFP and various NGOs in complex emergencies as well as in relief and development contexts. One of her areas of specialization is food assistance, HIV and nutrition programming. She is a nutrition and health technical advisor for USAID/OFDA and a partner in Nzinga International.

Laura Lo Cicero: Data Analyst and Information Officer is a consultant with four years experience in a number of WFP departments including PDPF. She designed, piloted, conducted and analysed a survey of CO-level HIV and AIDS activities within the reference period of 2004-5. Ms. Lo Cicero is a qualified lawyer specialising in Human Rights who works as a data analyst and report writer in the fields of Food for Education and HIV and AIDS.

Annex H: List of Persons Met by Evaluation Mission Team

WFP Rome Headquarters			
Date	**Division/service**	**Name**	**Title**
30.08.07	PDPS	Adame Faye	Programme Advisor
	PDPN	Martin Bloem	Chief
	ODAN	Wolfgang Herbinger	Chief
31.08.07	PDPT	Nick Crawford	Chief
	PDPT	Sarah Laughton	Programme Advisor
	PDPT	Sheila Grudem	Programme Officer
	PDPH	Mary Njoroge	Programme Advisor, OVC
	PDPG	Istau Jallow	Chief
	PDPT	Nick Crawford	Chief
02.11.07	PPDH	Katrin von der Mosel Alain Cordeil	Sr Evaluation Officer OEDE
	PPDH	Robin Landis	Programme Advisor HIV/AIDS Service
	PPDH	Imadeldin Osman-Salih	Deputy Chief HIV/AIDS Service
	PPDH	Ann Strauss	Senior Technical Advisor HIV/AIDS Unit
	PPDH	Faria Zaman	Consultant
	PPDH	Willy Mpoyi Wa Mpoyi	Programme Officer
06.11.07	PDE	Allan Jury	Director
	PDPH	Gaurab Tewari	Focal Point for Evaluation
07.11.07	PDPH	Robin Jackson	Chief
08.11.07	PDPT	Nick Crawford	Chief
	PDPN	Martin Bloem	Chief
	SDC	Denise Lüthi	
09.11.07	OEDE	Julian Lefevre	Senior Evaluation Officer
	PDPG - Gender and MCH Service	Isatou Jallow	
12.11.07	PDPF	Salha Hamdani	Programme Officer
	ODO	Hildegard Tübbi-Groff	Programme Adviser, M&E
	PDPN	Tina van den Briel	Chief, Nutrition, MCH & HIV/AIDS
	PDPH	Francesca Duffy	Consultant
	PDPH	Robin Landis	Policy Officer, HIV/AIDS
	PDPH	Willy Mpoyi Wa Mpoyi	Programme Officer
	PDPH	Mary Njoroge	Programme Officer HIV/AIDS
	ODAN	Valérie Ceylan	Programme Advisor
	PDPH	Laurence Bequet	Consultant
	OEDE	Laura Lo Cicero	Consultant
	OEDE	Caroline Heider	Director
	PDPH	Tomoko Hayashi	JPO
	ODO	Ram Saravanamittu	Senior Programme Advisor
	OEDE	Julien Lefevre	Senior Evaluation Officer
	ODAU (VAM)	Chiara Brunelli	Food Security Officer

14.11.07	FDD	Hakan Fakall	Senior Donor Relations Officer
15.11.07	Staff Relations Branch (ADHS)	Ahmareen Karim	Staff Relations Officer
	Staff Relations Branch (ADHS)	Charlotte Nana Yaa Nikoi	Senior Staff Relations Adviser
	ADHS	Sergio Arena	WFP Medical Officer
	FDD	Terri Toyota	Director
	ODAN – Emergency Needs Assessment Branch	Wolfang Herbinger	Chief
	PDP – Policy, Strategy and Programme Support Division	Stanlake Samkange	Director
14.11.07	PDPH (HIV/AIDS Service)	Robin Jackson	Chief
“		Imad Osman-Salih	Deputy Chief
“		Robin Landis	Programme Adviser
“		Willy Mpoyi Wa Mpoyi	Programme Officer
“		Anne Strauss	Senior Technical Adviser
“		Faria Zaman	Programme Adviser
“		Thobias Bergmann	Programme Officer
“		Valerie Ceylon	Consultant
16.11.07	PDPN – Nutrition Service	Martin Bloem	Chief
16.11.07		Andrew Thorne-Lyman	Programme Adviser
“	PDPF – School Feeding Service	Francisco Espejo	Chief
“		Pamela Shao	Consultant
“	PDPG – Gender and MCH Service	Isatou Jallow	Chief
“		Vera Kremb	Programme Adviser
“	PDPT – Emergency and Transition	Nick Crawford	Chief
16.11.07	PDE – External Relations Division	Allan Jury	Director
16.11.07		Gernot Ritthaler	Consultant, Partnership Adviser
“	VAM Unit	Joyce Luma	Chief
“	ADHC – Human Resources Staff Development Branch	Geneviève Merceur	Coordinator, HIV/AIDS in the Workplace Programme

Uganda			
Date	**Organization**	**Name**	**Title**
03.09.07	WFP-CO	Alix Loriston	Country Director
	WFP-CO	Els Kocken	Deputy Country Director
	WFP-CO	Yvonne Diallo	Programme Officer, HIV/AIDS
	WFP-CO	John Sseemakalu	Programme Officer, HIV/AIDS
	WFP-CO	Esther Akunno-Owor	SPA
	WFP- CO	Odette Kweli	Sr. Programme Assistant
	WFP – CO	Edward	Report Officer M&E
	WFP-ODK	Susana Rico	Regional Director
	WFP-ODK	Sana M. Ceesay	HIV/AIDS Regional Advisor
	WFP –ODK	Marina Kalisky	Regional Nutritionist
	WFP – ODK	Annet Birungi	Senior Program Assistant , MoH, HIV/AIDS
	TASO – Kampala	Frances Babirye	Programme Officer, Livelihood and Sustainable Livelihoods
	MUJHU	Deo Waswire	Coordinator, MTCT+
	MUJHU	Phillippa Musoke	Site Director, MTCT+
	MUJHU	Murro Francis	Professor
	MUJHU	Betty Mirembe	Doctor
	UNAIDS – Uganda	Brian Wall	M&E Advisor
	UNAIDS – Uganda	Jane Wilson	Country Coordinator
	WHO	Beatrice Crunay	Medical Office HIV Unit
	WHO	Frank Lule	National HIV Officer
04.09.07	Ministry of Health	Namukose Samalie Bananuka	STD/AIDS Control Programme, Nutritionist
	Ministry of Gender, Labour and Social Development	Michael Alula	
	Ministry of Gender, Labour and Social Development	Otim	Commisioner
	Feeding the Children	Loy Nampala	(liste fra Debriefing)
	RYDA –Buloba	Geoffrey Steven Kyeyune	Director
	AVSI –Kampala	Nambi Ritah	
	Meeting Point –Kampala	Owere Silver	
	Meeting Point –Kampala	Ayebabe Simon	
	NACWOLA –Kampala	Ivan Kintu	
	NACWOLA –Kampala	Jacinta Magero	
	UNICEF	Dr. Richard Oketch	PMTCT and Pediatric AIDS Officer
05.09.07	WFP –SO Arua	Martin Malinga	Head of WFP SO Arua
	WFP-SO Arua	Harriet Laker	HIV/AIDS Focal Person
	NACWOLA Training Centre	Dona Aseru Abiniku	Officer
	NACWOLA –Arua	Helen Chandrew	Member
	NACWOLA –Arua	Loyce Aikoni	Member
	NACWOLA –Arua	Omali Sally	

	UNHCR	Abdoulaye Barry	Head of Sub-Office Arua
	WFP – Soroti	Geoffrey Ebong	Head of Sub Office
	WFP – Soroti	Mary Namanda	Field Monitor (Food for Health)
	MoH District Health Office, Soroti		
	TASO – Soroti	Isiko Samuel	Centre Manager
	TASO – Soroti	Beatrice Okwara	Programme Officer
	Soroti Referral Hospital	Dr. Florence Alaroker	Pediatrician PIDC, TFC and PMTCT Programs
06.09.07	WFP Uganda	John Ssemakalu	Program Officer HIV/AIDS
	Ministry of Health	Samalie Namukose	STD/AIDS Control Program, Nutritionist
	Ministry of Agriculture, Animal Industry and Fisheries	Charles Mulcama	Senior Economist
	Ministry of Agriculture, Animal Industry and Fisheries	Deus Muhwezi	Assistant Commisioner
07.09.07	WFP –CO	Andrew Malinga	Senior Programme Assistant, VAM Unit
	WFP-CO	Hassan Abdelrazig	Programme Officer, Food-for Asset Programme
	WFP –ODK	Scott Ronchini	Regional VAM Advisor
	WFP – ODK	Dr. Sana Ceesay	Regional Programme Coordinator for HIV/AIDS
	John Hopkins – MU-JHU Care Ltd	Mary Glenn Fowler	Onsite Investigator
	Office of the Prime Minister	Jeno Toma	Asst. Settlement Commandant
	Reach Out Mbuya HIV/AIDS Initiative	Peter Paul Igu	Food Support Supervisor
	Uganda AIDS Commission	David Kihumuro Apuuli	Director General
08.09.07	WFP	Paul Howe	Em. Coordinator
	WFP	Yvonne Diallo	Programme Officer
	WFP	John Sseemakalu	Programme Officer, HIV/AIDS
	WFP	Els Kocken	Deputy Country Director
	Mulago Hospital Complex	Elizabeth Kiboneka	Pediatric Service, Nutrition Rehabilitation
	Mulago Hospital Complex	Otim Katherine	Public Health Nurse (SFC)
	NAEWDLA	Banage Grace	Program Assistant
	Feed the Children Uganda	Loy Nampala	Project Officer
	WFP – CO	Odette Kweli	Sr. Program Assistant
	WFP – CO	Martin Ahimbisibwe	Sr. Program Assistant – Nutrition

Tanzania			
Date	**Organization**	**Name**	**Title**
10.09.07	WFP	Juvenal Kisanga	Programme Officer
	WFP	Cindy Serre	Consultant
	WFP	Hae-Won Park	Head of Programme and Procurement Unit
	WFP	Estifanos Tekle	Nutrition Consultant
	WFP	Patrick Buckley	Representative and Country Director
	Ministry of Health and Social Welfare (National Office)	Dr. Fred Lwilloa	TB Program Senior Program Officer
	UNAIDS - Geneva	Luc Barrière-Constantin	Programme Adviser, Country Performance and Analysis, Country and Regional Support Department
11.09.07	Ministry of Health and Social Welfare (National Office)	D. M. Charwe	Assistant Commissioner Dept. of Social Welfare
	UNICEF	Felicite Tchibindat	Nutrition Program Officer
	Tanzania Food and Nutrition Centre	Dr. Joyce Kaganda	Nutritionist
	DSM Archdiocese Mlandizi Parish HBC/OVC Program	Paschal Lucas	Community Health Educator
	DSM Archdiocese Mlandizi Parish HBC/OVC Program	Costa G. Kauki	Food Committee Member
	DSM Archdiocese Mlandizi Parish HBC/OVC Program	Verdaula D. Machumu	Food Committee Member
	DSM Archdiocese Mlandizi Parish HBC/OVC Program	Charles Mungelle	Food Committee Member
	DSM Archdiocese Mlandizi Parish HBC/OVC Program	Epmarh Mjema	Program Coordinator
	DSM Archdiocese Mlandizi Parish HBC/OVC Program	Dr. Mwita Lumumba	
	Tanzanie Commission for AIDS	J.M.V. Temba	GFATM Coordinator
	WFP	Domina Kambaringwe	National Program Officer
12.09.07	WFP Arusha Sub-Office	Kitururu Mbwanbo	Programme Officer, Head of Arusha Sub-Office
	Arusha Municipal Council	Job Laiser	Municipal Director
	UHAI Center	Sister Mosha Agreda	UHAI Center Director
	UHAI Center	Leons Mumburi	UHAI Center Physician
	UHAI Center	Joseph Valerian	UHAI Center Project Coordinator
	Selian Lutheran Hospital AIDS Control Program	John Laizer	Selian Hospital HIV/AIDS Coordinator

	WFP Dodoma Sub-Office	Neema Nima Sitta	Head of Sub-office
	WFP Dodoma Sub-Office	Steyne Roggers	Senior Programme Assistant
	Food Committee, Mvuli Makulu village	Jeniva Chamhene	Member of Food Committee
	Food Committee, Mvuli Makulu village	Roy Masangaa	Member of Food Committee
	Village Council, Mvuli Makuku	Kenneth Mtube	Chair, Village Council
	Mvuli Makulu village	Francis Kambona	Food Committee
	Dodoma District Council	Mohammed S.. Ngwalima	District Executive Director Chamwino
	Dodoma District Council	Benedici R. Temba	District Aids-Coordinator
	Dodoma District Council	Arnede Amani	Council HIV/AIDS Coordinator (Bahi
	Dodoma District Council	Culhbert J. Korgila	District Health Officer
	Makete District	Godfrey Mwaktwa	District Coordinator
	Makete District	Enock Henjewele	OVC Project Officer
	Makete District	Phabior Msafiri	MFI project Officer
	Makete District	Jassal Mwamwala	District Committee Chairman
	IDYDC	Johnnie L. Nkoma	Accountant
	CSMR Office Dodoma	Lauden Mwamwala	Administrator
	CSMR Office Dodoma	Francis G. Manghundi	Deputy Country Representative
	CSMR Office Dodoma	Paul Damasam	Project Officer
	CSMR Office Dodoma	Gondwe Stanley	D&D's Office
13.09.07	TANGA AIDS Working Group (TB)	Harold Metier	Project Coordinator
	Ministry of Health- Korogwe	Dr. Bunu	Kororgwe District TB and Leprosy Program Coordinator
	IDYDC	Martin Haule	Micro-finance Coordinator
14.09.07	Shukrani Vocational Centre, Makete	Barikikatindasa	Principal
	Shukrani Vocational Centre, Makete	Jamila Masamba	
	Shukrani Vocational Centre, Makete	Rebeca Duma	
	Shukrani Vocational Centre, Makete	Ibrahim LeLeu-Paron	

Cote D'Ivoire			
Date	**Organization**	**Name**	**Title**
21.09.07	SDC Humanitarian Office	Hansjürg Ambühl	Head Africa Division
	SDC Africa Division	Nathalie Vesco	Officer
	SDC Africa Division	Denise Lüthi	Programme Officer
24.09.07	WFP	Abdou Dieng	Country Director
	WFP	Annarita Marcantonio	Programme Officer
	WFP	Deiva Baskarane	Security Officer
	UNAIDS	Aoua Paul Diallo-Diawara	Country Coordinator
	Rep. of Côte d'Ivoire – Ministry of the Fight against AIDS	Christine Nebout-Adjobi	Minister
25.09.07	Plan National Nutrition	Diby Clement	Nutritionist
	Plan National Nutrition	Kamara Diaken	Nutritionist
	WFP Man Sub-office	Patrick Teixeira	Programme Officer/Head of the Sub-Office
	GFATM	Christian W. Kla	Financial Service Manager, Permanent Secretary of CCM
26.09.07	MSF-H Danane	Dink Devolche	Project Coordinator
	MSF-B Branzolo	Boure Honori	Project Coordinator
	CNT/CHR Man	Dirhou Daniel	Project Coordinator
	FocolARI Man	Kakou Estelle	Project Manager
	WFP Man Sub-Office	Dion Guen Alphomine	Field Monitor
	Caritas Man	Sokou Lou Joelle	Project Coordinator
	Caritas (CNS Danane)	Loua Bogbe Prosper	Project Coordinator
	IDE Afrique	Guem Simpilice	Coordinator for PLWHA
	IDE Afrique	Gle Bernadette	Coordinator VCT
	IDE Afrique	Lion Frederic	Program Director
	UNICEF Man Sub-Office	Dr. Berthe	HIV Focal Point
	IDE Afrique	Marcellin Aye	Technical Advisor
	IDE Afrique	Marguerite Thari	Advisor
	IDE Afrique	Raymond Bleou	Advisor
	CARE International	Jennifer Walsh	Health Sector Coordinator
	CARE	Kpangui Emmanuel Bentuni	M&E
	CARE – MAN	N'Dui Yao	Officer
	CARE – MAN	Norbert Saouré	Officer
	WFP – MAN	Alphonsine Diou	
	WFP – MAN	Jean Yao	
28.09.07	UNICEF Abidjan	Dr. Maka Coulibaly	PMTCT Coordinator
29.09.07	WFP	Nicolas Joannic	Programme Officer Nutrition HIV

Burkina Faso			
Date	**Organization**	**Name**	**Title**
01.10.07	Ministry of Health/National TB Program	Dr. Michel Sawadogo	Medical Specialist in Public Health
	MoH/Nutrition Division	Farma Royhail	Assistant to the Program Chief
	MoH/Nutrition Division	RlboubsoEmmaneul	Nutritionist
	MoH	Dr. Jean- Gabriel G. Ouango	Secretary General of the Ministry of Health
	UNDP	Rubby Rojon Sandhu	Country Director
	Presidency of FASO – Permanent Secretariat of the National Council for the Fight Against Aids and STDs	Joseph André Tiendrebeogo	Permanent Secretary
	Presidency of FASO – Permanent Secretariat of the National Council for the Fight Against Aids and STDs	Pascal Ouedraogo	Inspector of Youth and Sports, Head of the Dept. in Charge of Customary and Religious Communities, NGOs and Associations
	Presidency of FASO – Permanent Secretariat of the National Council for the Fight Against Aids and STDs	Dr. Wamarou Traore	GFATM Team Leader
	WHO – Ouagadougou	Ghislaine Conombo	Chargée de Programme VIH
	UNDP	Ruby Sandhu-Rojon	Country Director
02.10.07	UNICEF	Dr. Ndeye Toure	Program Officer HIV/AIDS
	St. Camille	Dr. Jacques Simpore	Research Director St. Camile/University of Ouagadougou
	UNICEF	Dr. Constance Nana	Nutrition Program Officer
	Royal Embassy of Denmark	Mogens Pedersen	Ambassador
	Royal Embassy of Denmark	Abdoulaye Ouedraogo	Chargé de Programme
	CANDAF – Centre d'acceuil	Gilbert Sawadogo	in charge of food allocation
03.10.07	MoH/Nutrition Division	Dr. Tapsoba	Director of the Nutrition Division of the MoH
	PAMAC	Dr. Fode	Nutrition Specialist
		Georges Clément Bouyin	Nutritionist
04.10.07	REVS+	Bernadette Pare	Trésorière générale
	REVS+	Kirotimi Salouka	Vice Présidente
	REVS+	Cécile Sanon	Secrétaire générale adjointe
	REVS+	Mireille Dabire	Secrétaire de direction
	REVS+	Alexandre S. Some	Chargé de suivi et évaluation (M&E)
	REVS+	Aboubacan Siribie	Médecin
	REVS+	Fanta Basselet	Pharmacien
	REVS+	Hawa Sieba	Responsable vivres

	REVS+	Dr. Fao Paulin	Epidemiologist
	REVS+	Ayssou Kossinwavi Ida	Nutritionist
	Regional TB Center	Dr. Daa Florentin	Medical Officer
	Regional TB Center	Dakuyo	Nurse
	University of Ouagadougou, Department of Epidemiology and Public Health , Centre Murraz	Dr. Nicolas Meda	Lecturer and researcher
	Vivre – Association pour la Protection des Enfants en Danger	A. Alpha. Yago	Executive Director
	Government of Luxemburg – Regional CooP, Ouagadougou	Alexandra Pesch	Chargée de Programme
	Government of Luxemburg – Regional CooP, Ouagadougou	Rol Reiland	Chef du Bureau
05.10.07	Ministry of Health/National TB Program	Dr. Dembele Mathurin	Director of the TB Program MoH
	WFP	Paola Dos Santos	Program Officer, VAM
	WFP	Fanny Yago Wienne	Program Officer, HIV/AIDS and Nutrition
	PNUD	Mrs Vansplulunter	HIV/AIDS M&E team
	WHO	Dr Konombo Ghislain	Family Health Programme, Nutrition Child + add. Health Injury, SIDA, Nutrition for PLWHA
		Dr. Traoré Etienne	Communicable diseases, humanitarian assistance
	WFP Representative	Annalisa Conte	Country Director
	UNAIDS	Mamadou Sakho Lamine	Country Coordinator

Teleconference ODD/Y

6.11.07	WFP ODD/Y	Olivier Nkakudulu	HIV/AIDS Regional Advisor

Teleconference UN Agencies

29.11.07	UNICEF NYHQ	Anirban Chatterjee	Advisor Nutrition & HIV,
3.12.07	UNFPA NYHQ	Steven Kraus	Chief, HIV/AIDS Branch, TSD
	GFATM (London)	Peter Godfrey-Faussett	Chair Technical Review Panel
4.12.07	WHO, Geneva	Micheline Diepart	Medical Officer, HIV/AIDS Department
6.12.07	WHO, Geneva	André BRIEND	Medical Officer Department of Child & Adolescent Health and Development
	UNICEF NYHQ	Arjan de Wagt	HIV/AIDS Section

Annex I: Survey Results For HIV/AIDS Thematic Evaluation

Laura Lo Cicero, Data Analyst

April 2007

Acronyms

ART – Anti Retroviral Therapy

RB – Regional Bureaux

CO – Country Office

CP – Country Programme

DEV – Development Programme

DOTS –

EB – Executive Board

EMOP – Emergency Operation

FFT – Food for Training

FFW – Food for Work

HBC – Home Based Care

IGA – Income Generating Activities

NGO – Non Governmental Organization

OVC – Orphans and Other Vulnerable Children

PLWHA – People Living With HIV & AIDS

PMTCT – Prevention of Mother-to-Child transmission

PRRO – Protracted Relief and Recovery Operation

SF – School Feeding

SO – Special Operation

Basic definitions

HIV/AIDS Beneficiaries: All those included in WFP HIV/AIDS activities[220].

All WFP activities: All activities undertaken by the countries who participated in the survey.

All ODB/ODC/ODD/ODJ/ODK/ODP/ODS activities: All activities undertaken by countries who participated in the survey in each RB.

Executive Summary

The WFP Office of Evaluation conducted a desk study and a survey to learn more about WFP HIV & AIDS activities as a preparatory phase of its HIV & AIDS thematic evaluation.

Within the whole WFP country portfolio, 74 countries have been selected for the survey as they were the ones assisted by WFP on a regular basis.

The survey exercise covers the period of 2004-2005

The Survey was conducted in collaboration with PDPH Unit and with the support of RBs, COs and HIV & AIDS Focal Points over a period of two months.

The Survey found, inter alias, that:

- WFP HIV & AIDS activities have been implemented in 54% of surveyed countries; they represent 4% of the yearly WFP food deliveries and 2% of the yearly assisted beneficiaries.

- The major WFP HIV & AIDS objective-category of intervention is Mitigation, which represents 77% in food and 74% in beneficiaries.

- WFP HIV & AIDS activities are mostly implemented through:
  - PRROs.
  - In Africa.

In Africa, where the HIV & AIDS prevalence rate is higher, WFP HIV & AIDS activities were not totally matching the UNAIDS prevalence rate – world mapping:

  - In Cameroon the HIV & AIDS prevalence rate was above 5%, but WFP was not implementing any HIV & AIDS activity.
  - In Namibia the HIV & AIDS prevalence rate was above 19%, but WFP was not implementing any HIV & AIDS activity.
  - In Swaziland the HIV & AIDS prevalence rate was above 30%, but WFP distributed less than 2000 tons of food (yearly). However, it is also to be taken into consideration the limited size of the country.

- WFP top 10 countries in terms of food delivered for HIV & AIDS activities were Zambia, Malawi, Mozambique, Lesotho, Zimbabwe, Burundi, Uganda, Tanzania, Eritrea and Ethiopia.

[220] This is not the standard definition of HIV & AIDS beneficiary according to the Program Guidance Manual. For further explanation, please refer to Annex A "Analysis Report", Para 3 "Criteria and Definitions"

- The major WFP co-operating Partners' category was NGOs (internationals and locals).

- The major hurdle encountered by COs in implementing HIV & AIDS activities was related to "Funding".

Part I: Background information

Background

WFP has worked in the area of HIV/AIDS for many years and under the framework of an approved policy since February 2003.
The overall scope of the evaluation will be policies, activities, mechanisms and project operations undertaken by WFP at corporate as well as country/local level in the period of 2003 – 2006, starting from the time when the strategy was approved.
The objectives are four-fold:

- assess the extent to which the objectives outlined in the Policy Paper "Programming in the Era of AIDS: WFP's Response to HIV/AIDS", WFP 2003, as well as those outlined in the EB information Notes circulated to the WFP EB (2004, 2005 & 2006) have been achieved,
- assess the effectiveness, efficiency, outcomes/impact and connectedness of objectives laid out in the strategy,
- produce recommendations which will help to shape WFP's future HIV/AIDS programming, and
- provide accountability to the Executive Board and other stakeholders.

The evaluation will be conducted according to the following underlying principles:

- Independency and impartiality: in this respect, the evaluation will be conducted by external consultants
- Transparency (Involving stakeholders – at global and country levels) refers to openness about findings and methodology, dialogue, consultation with stakeholders and debriefing.
- **Using multiple approaches/triangulation (document reviews, participatory assessments, surveys, focus groups, workshops)**
- Applying the evaluation norms and standards established by the United Nations Evaluation Group more especially for evaluation criteria, principles and quality control (available from the UNEG website: http://www.uneval.org/).

Survey Purpose

The WFP Office of Evaluation conducted a survey and a desk review to learn more about WFP HIV & AIDS activities as a preparatory phase of its HIV & AIDS Thematic Evaluation.
A desk study of primary and secondary data and literature has been required to collect data and specific information on HIV & AIDS activities.
In particular, this survey was to undertake the following:

- To assist in the design of the HIV & AIDS Thematic Evaluation

- To create the basis for the selection of cases study.

Information Requirement

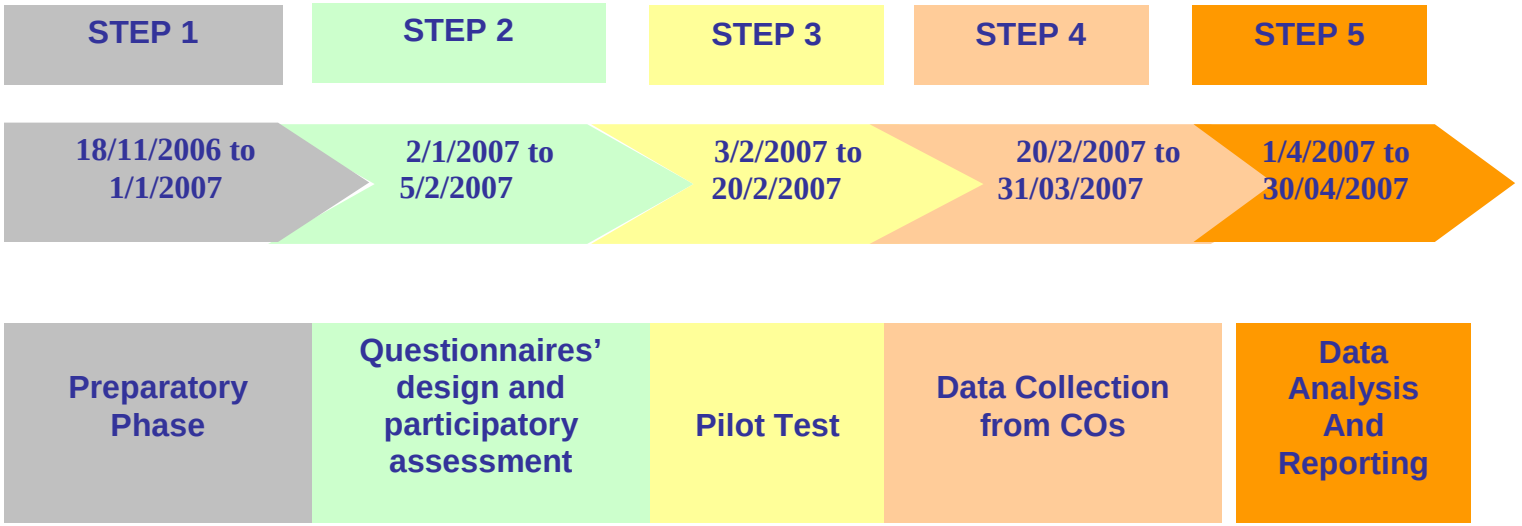
The basic information required from the Survey was to:

- Define WFP HIV & AIDS objectives, activities, role(s) of food aid and how they are linked to each other
- Measure the weight of HIV & AIDS activities in terms of food delivered, number of beneficiaries and expenditure (yearly)
- Locate HIV & AIDS activities in terms of food delivered, number of beneficiaries and expenditure (yearly)
- Identify WFP categories of Partners and their roles in implementing HIV & AIDS activities
- Address the main issues noted by COs during the implementation of HIV & AIDS activities

Survey Methodology

The method used is summarised in the following diagram and explained more fully below.

Diagram 1. Summary of the Survey Method



Step 1 Preparatory Phase

1.1 Selection of the Survey Sample

Within the WFP country portfolio, 74 countries have been selected for the Survey. They are the ones assisted by WFP on a regular basis. Some countries have been consequently excluded from the survey exercise, such as Maldives and Togo because they have not been assisted by WFP on a regular basis or like Philippines and China because they are no longer assisted by WFP[221].

1.2 Selection of the Survey Reference Period

Although the Evaluation will be on HIV & AIDS activities undertaken by WFP in the period of 2003-2006, the Survey exercise covers the period of **2004-2005**.
This choice was made for two reasons:

- As the most important WFP policy paper[222] on this topic was published in 2003, it was worth to investigate the status of the policy implementation two years after its release date.
- The selection of countries for the cases study needs to be done on those having implemented HIV & AIDS activities for a sufficient duration. Therefore, COs which have started implementing HIV & AIDS activities in 2006 were not taken into consideration.

Desk Study of WFP literature and data collection

Prior to implementing the survey, a desk study and data collection was undertaken. The purpose was two-fold:

- To ensure the efficiency of the survey. To this extent, all WFP literature[223] has been consulted and examined to assess the information requirement.

- To minimize COs work, it has been decided to supply pre-filled questionnaires.

[221] Refer to Annex A for the complete list of surveyed countries

[222] Programming the Era of AIDS: WFP's Response to HIV/AIDS

[223] EB Papers on HIV & AIDS from 2001 to 2005 and PDPH Reports

The following table provides a detailed list of needed information and sources.

Table 1

Data	Blue Book	Project Documents	SPRs	HIV/AIDS Country Profile	Survey	WFP in Statistics and Dacota
General Info (Region, Country, Programming Category, Project number, duration of operation)	**X**	**X**	**X**			
Objective(s) of HIV/AIDS activity	**X**	**X**		**X**		
Role(s) of food aid for the objective(s) of HIV/AIDS activity	**X**	**X**				
Total Food Tonnage (yearly)						**X**
Food Tonnage for HIV/AIDS activities (yearly)					**X**	
Total Number of Beneficiaries (yearly)						**X**
Number of Beneficiaries for HIV/AIDS activity (yearly)					**X**	
Total Operational Cost (yearly)						**X**
Operation Cost of HIV/AIDS activity (yearly)					**X**	
List of Partners for HIV/AIDS activity				**X**	**X**	
Role of Partners in HIV/AIDS activity					**X**	
Reasons					**X**	

Step 2 Questionnaires' design and participatory assessment

2.1 Questionnaires' design

Two questionnaires[224] were designed to elicit information from the responsible HIV & AIDS Focal Points on the implementation of HIV & AIDS activities:

- Excel questionnaire regarding HIV/AIDS activities.

The purpose of this questionnaire was to have a comprehensive picture of what were the HIV & AIDS activities implemented in the surveyed countries in 2004 – 2005 and, for each given activity actually implemented, the related objective(s), the role(s) of food aid, the actual number of beneficiaries, food tonnage, cost of operation, as well as the food basket composition and implementation issues.
Basically, the information gathered from Blue Books, Project Documents, SPRs and PDPH Country Profiles, have been used to facilitate the work of COs in filling in the excel questionnaire which has been partially filled in with information on the Operations implementing HIV & AIDS activities in 2004 - 2005 (q. 1 to 7). In this respect, COs have been requested to check whether the information already reported were valid and eventually correct them, to delete the activities which have not been actually implemented and to fill in the empty cells (q. 8 to 13).

- Word questionnaire on Partnership within HIV & AIDS activities

The purpose of this questionnaire was to gather information on WFP Partners' category (NGOs, UN agencies etc.), as well as their role(s) in achieving HIV & AIDS objectives.

2.2 Participatory assessment

The questionnaires have been discussed with PDPH Unit and the rest of the evaluation team, in order to incorporate comments and suggestions.
PDPH team supported the survey methodology and addressed the need of an additional questionnaire in order to gather some important information on gender issues, advocacy at national level and other governmental issues[225] .

Step 3 Pilot Test

A pilot test of the Survey was conducted on 3 COs: Mali, Cambodia and Central African Republic.
Following this pilot phase, minor changes were made on the survey methodology and on the questionnaires.

Step 4 Data Collection from COs

The Survey has been circulated on 20 February, 2007. RBs have been fully involved in the survey implementation as well as CDs and HIV & AIDS focal points.
COs have been provided with a continuous support and technical assistance on the requested data and provided with further details on the evaluation, upon request.

[224] Refer to Annex B for questionnaires' sample

[225] Refer to Annex B for further details

The questionnaires received were compiled and analysed. They have been incorporated in this full report and presented to the OEDE team and the so-called “Reference Group” through a Power Point Presentation.

Major Hurdles

Questionnaires have been circulated on the 20th of February 2007 and the deadline for COs responses was on the 31st of March 2007. Despite this large amount of time, 70% of COs sent back the questionnaires only 3-4 days before the deadline.

One of the main concerns of this survey has been the difficulty to obtain figures broken down by HIV & AIDS activity. It seems that lack of institutional memory and recorded data was the main constraint for COs.

Because of the above difficulties, COs tended to aggregate all activities.

It has been noted that some COs have been confused by other surveys conducted by other Units. This has caused a delay in responses.

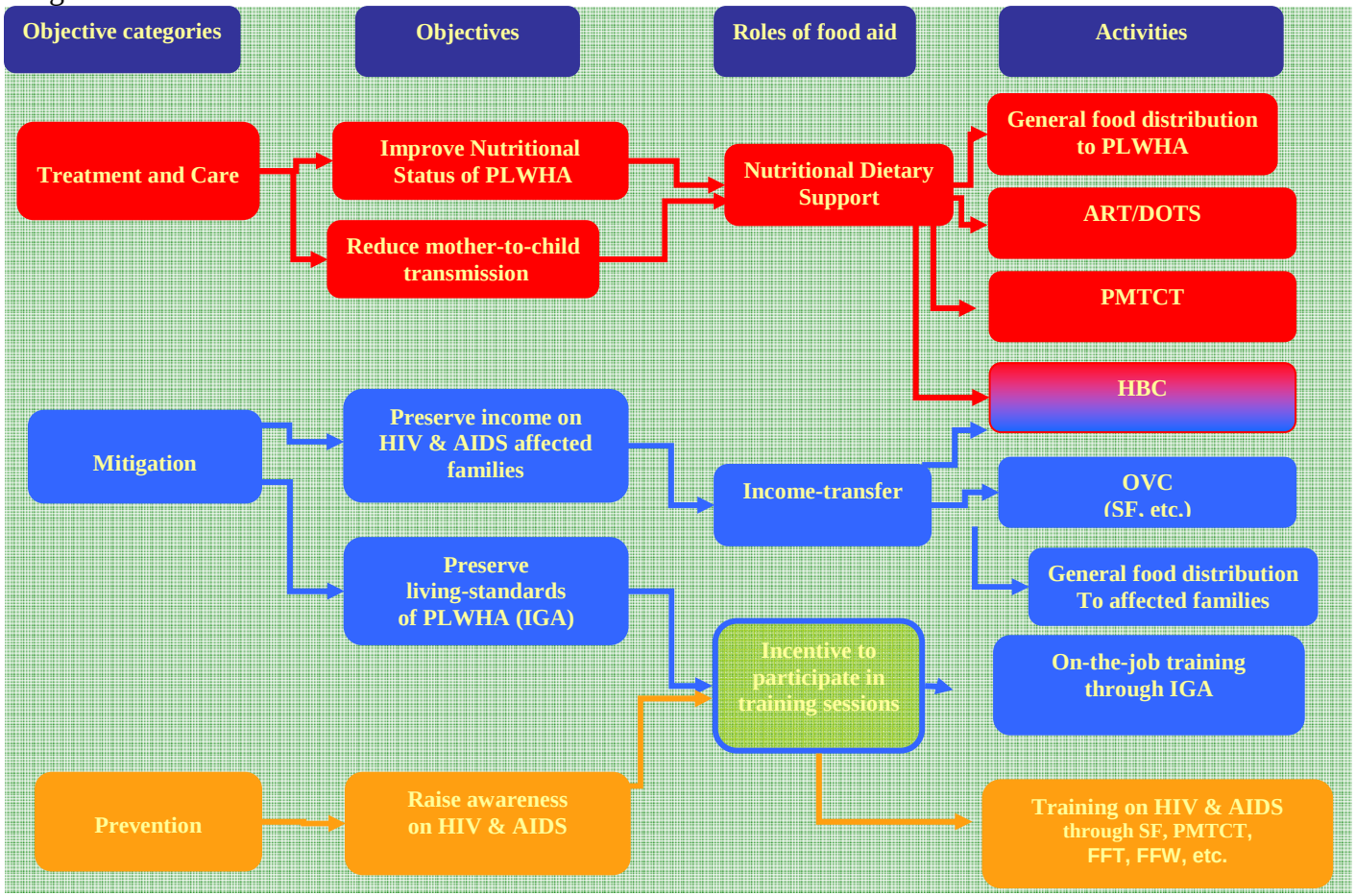
Response Rate

Despite COs encountered constraints 73 out of 74 surveyed countries provided appropriate responses, i.e. a response rate of 99%.

Part II: Findings Summary

WFP HIV & AIDS objectives, activities and roles of food aid

Diagram 2



The above diagram displays the links between HIV & AIDS objectives with the correspondent roles of food aid and activities.
This diagram has been set using COs responses on HIV & AIDS activities implemented in 2004-2005, where it has been provided, for each given activity, the related objective and role of food aid.
While most HIV & AIDS activities are clearly linked to define objective categories, it looks as if the HBC category belongs both to Nutrition and Mitigation. A possible conclusion from the analysis results could be that HBC is a "mixed activity" which comprises different aspects. However, within all HBC activities implemented during the reference period, 35% were related to the nutritional aspects of PLWHA, while 65% were more focused on providing assistance to preserve families' income from the impact of HIV & AIDS.

Share of WFP HIV & AIDS activities

Countries with WFP HIV & AIDS activities

40 countries out of 74 implemented HIV & AIDS activities during the reference period, 2004-2005, the result being 54% of the country portfolio.

HIV & AIDS activities versus total WFP activities

HIV & AIDS activities represent 4%, 2% and 3% of all WFP activities, respectively in terms of food tonnage, number of beneficiaries and expenditure.

HIV & AIDS activities versus WFP activities by Regional Bureau

In ODB, ODC and ODS the presence of HIV & AIDS activities appears not to be a priority.

In ODD/ODDY HIV & AIDS activities represent 2% of the total food tonnage and expenditure and 1% of the total number of beneficiaries.

In ODJ HIV & AIDS activities represent 21%, 13% and 29% of all WFP activities, respectively in terms of food tonnage, number of beneficiaries and expenditure.

In ODK HIV & AIDS activities represent 3%, 2% and 3% of all WFP activities, respectively in terms of food tonnage, number of beneficiaries and expenditure.

In ODP HIV & AIDS activities represent 3%, 1% and 4% of all WFP activities, respectively in terms of food tonnage, number of beneficiaries and expenditure.

Across all RBs, HIV & AIDS activities are mostly represented in ODJ, with a share of 68%, 70% and 65%, respectively in terms of food tonnage, number of beneficiaries and expenditure. ODK covers 23% of food tonnage, 21% of the number of beneficiaries and 23% of expenditure.

Share of WFP HIV & AIDS categories of activities

Within all WFP HIV & AIDS activities, the most implemented activity is HBC with a share of 41%, 54% and 35% respectively in terms of food tonnage, number of beneficiaries and expenditure.

"General Food distribution to affected families" covers 22% of food tonnage, 14% of beneficiaries and 19% of expenditure.

Assistance to OVC affected by HIV & AIDS represents 16% of food tonnage, 8% of beneficiaries and 15% of expenditure.

ART/DOTS represent 11% of food tonnage and beneficiaries, 17% of expenditure.

The remaining activities ("General Food Distribution to PLWHA", "IGA for PLWHA", "PMTCT" and "Training on HIV & AIDS") represent a slight share of all HIV & AIDS activities.

Share of WFP HIV & AIDS categories of activities by Regional Bureau

In ODB, ODC and ODS, the share of HIV & AIDS activities was very low and, therefore, this type of analysis has no value.

In ODD/ODDY, the most implemented activity was "General Food Distribution to PLWHA", with a share of 45%, 29% and 57%, respectively in terms of food tonnage, number of beneficiaries and expenditure.

In ODJ, the most implemented activity was HBC, with a share of 38%, 63% and 39%, respectively in terms of food tonnage, number of beneficiaries and expenditure.

In ODK, the most implemented activity was HBC, with a share of 43%, 40% and 30%, respectively in terms of food tonnage, number of beneficiaries and expenditure.
ART/DOTS it is also largely implemented with a share of 24%, 25% and 27%, respectively in terms of food tonnage, number of beneficiaries and expenditure

In ODP, the most implemented activity was "General Food distribution to affected families", with a share of 88%, 79% and 83%, respectively in terms of food tonnage, number of beneficiaries and expenditure (Tab. 15, Chart 30, 31 and 32.

Share of WFP HIV & AIDS objectives

Within all surveyed countries, the most relevant WFP HIV & AIDS objective was to "Preserve the income of HIV & AIDS affected families", with a share of 73%%, 69% and 65%, respectively in terms of food tonnage, number of beneficiaries and expenditure.
WFP HIV & AIDS objective of "Improving Nutritional Status of PLWHA" had a share of 19%, in terms of food tonnage and beneficiaries, and 25%, in terms of expenditure.

Share of WFP HIV & AIDS roles of food aid

Within all surveyed countries, the most relevant WFP HIV & AIDS role of food aid was "Income-transfer", with a share of 73%%, 67% and 65%, respectively in terms of food tonnage, number of beneficiaries and expenditure.
The share occupied by "Nutritional Dietary Support" was 23 % of food tonnage and number of beneficiaries, 29% of expenditure.

Mapping of WFP HIV & AIDS activities

WFP HIV & AIDS activities by Programme Category

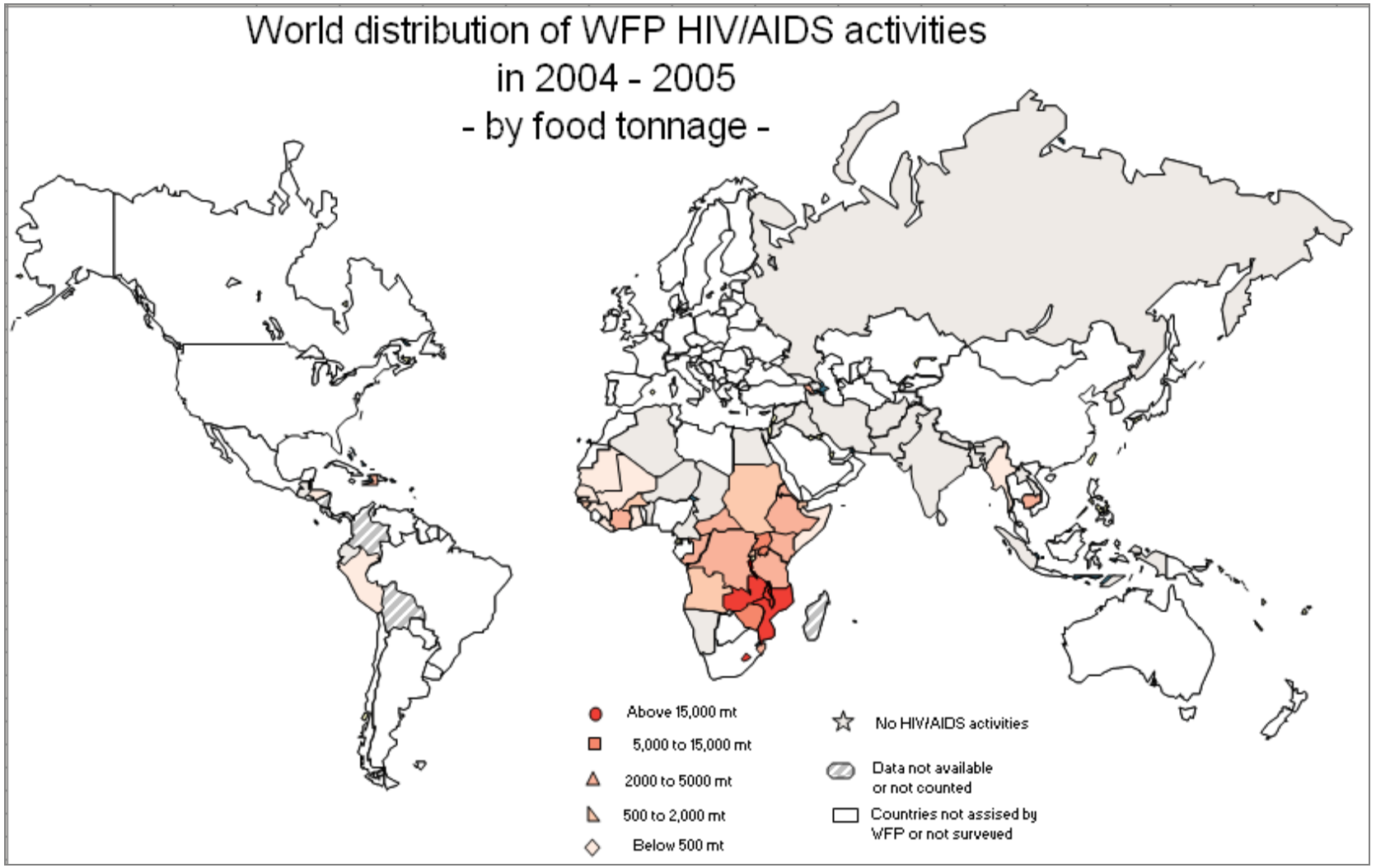
Within all surveyed countries, HIV & AIDS activities were mostly implemented through PRROs, with a share of 73 %, 78% and 69%, respectively in terms of food tonnage, number of beneficiaries and expenditure.

HIV & AIDS activities were also implemented through CP/DEV projects, with a share of 27%, 22% and 29%, respectively in terms of food tonnage, number of beneficiaries and expenditure.

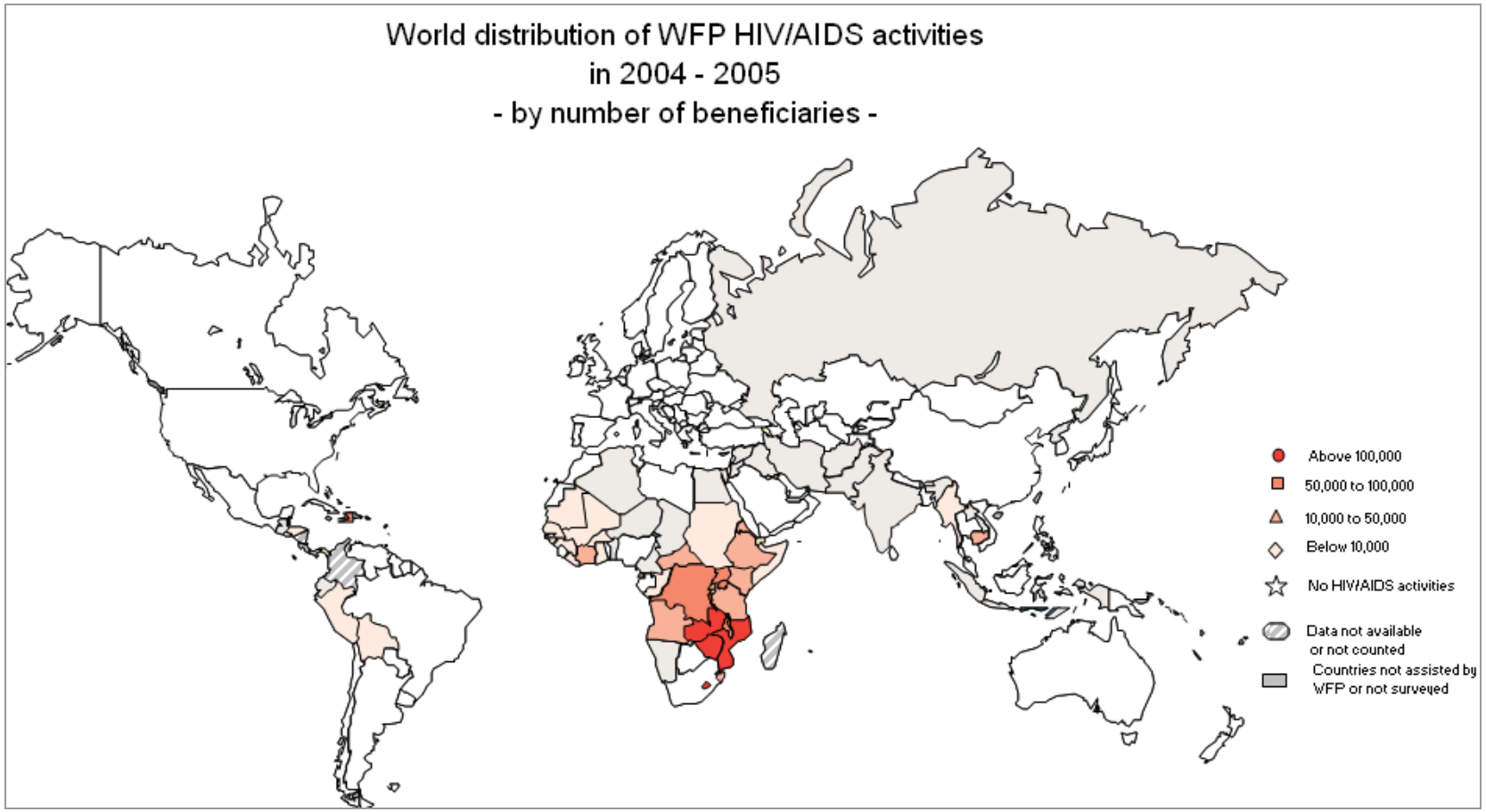
World distribution of WFP HIV & AIDS activities

The world maps in the next pages (Picture 1, 2 and 3) show where WFP HIV & AIDS activities were distributed during the reference period in terms of food tonnage, number of beneficiaries and expenditure.

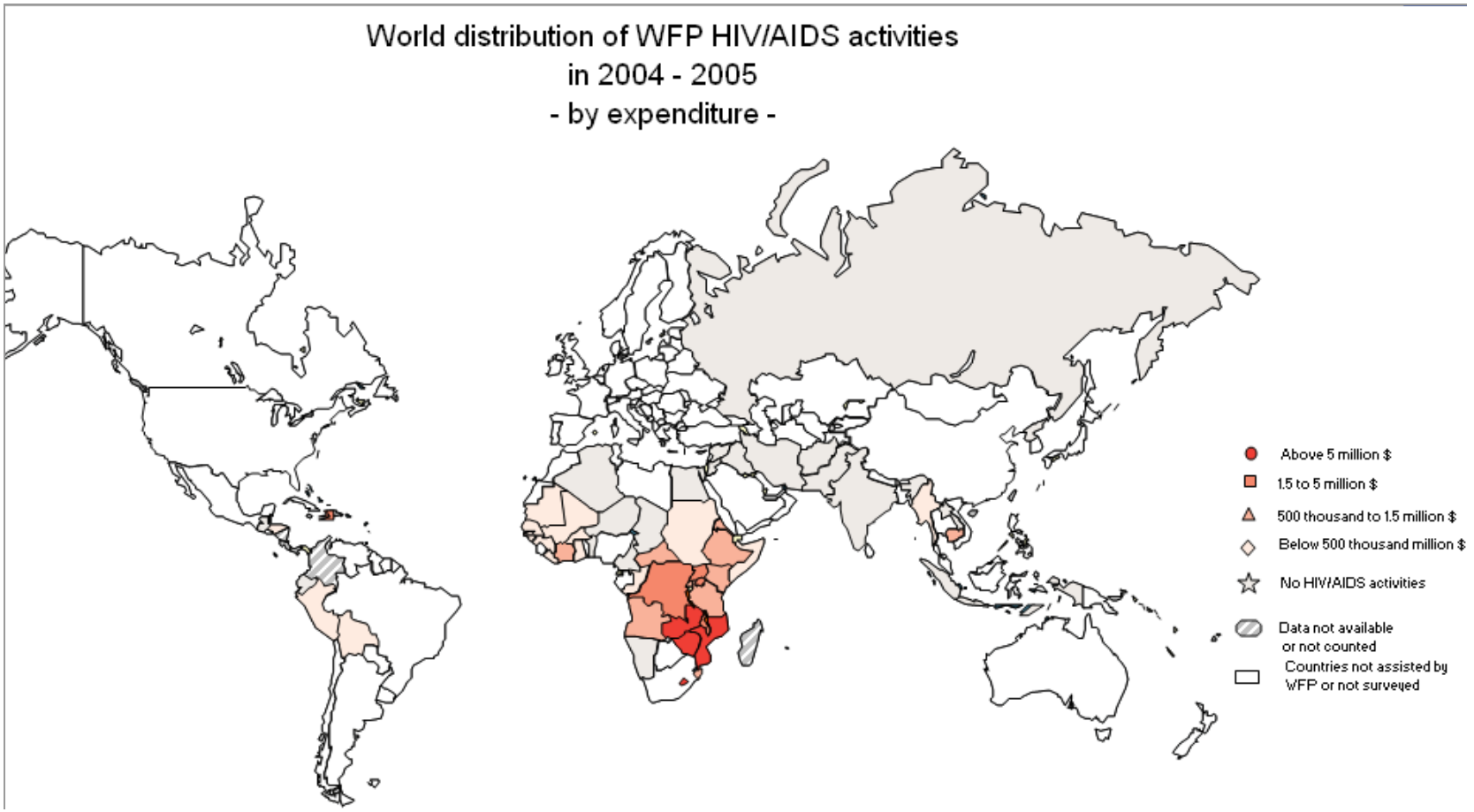
Picture 1


World distribution of WFP HIV/AIDS activities
in 2004 - 2005
- by food tonnage -
Above 15,000 mt
5,000 to 15,000 mt
2000 to 5000 mt
500 to 2,000 mt
Below 500 mt
No HIV/AIDS activities
Data not available
or not counted
Countries not assised by
WFP or not surveued

Picture 2


World distribution of WFP HIV/AIDS activities
in 2004 - 2005
- by number of beneficiaries -
Above 100,000
50,000 to 100,000
10,000 to 50,000
Below 10,000
No HIV/AIDS activities
Data not available
or not counted
Countries not assisted by
WFP or not surveyed

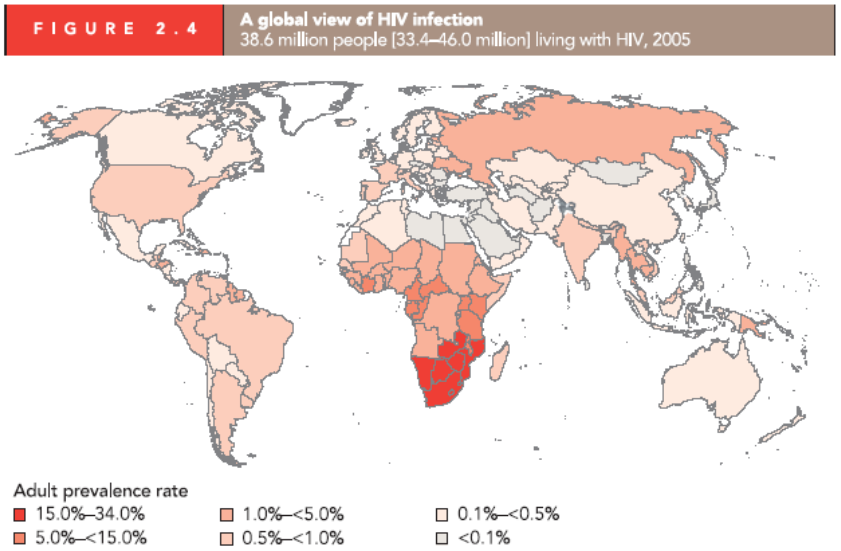
Picture 3



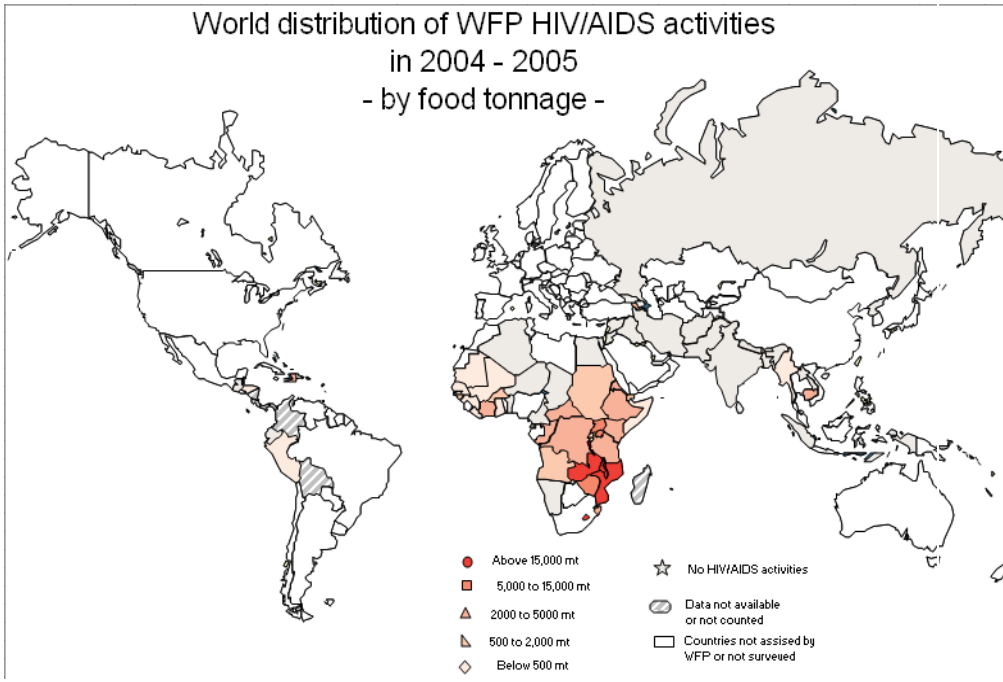
UNAIDS Prevalence Rate versus WFP HIV & AIDS activities

The UNAIDS world map (Picture 4) shows where the HIV & AIDS prevalence rate is higher (orange/red). Comparing this map with the one representing WFP food distribution for HIV & AIDS activities, it is possible to have a visual impact of whether WFP was intervening. This comparison is not meant to have any statistical value, but only an attempt to identify where WFP should have concentrated more its intervention.

Picture 4

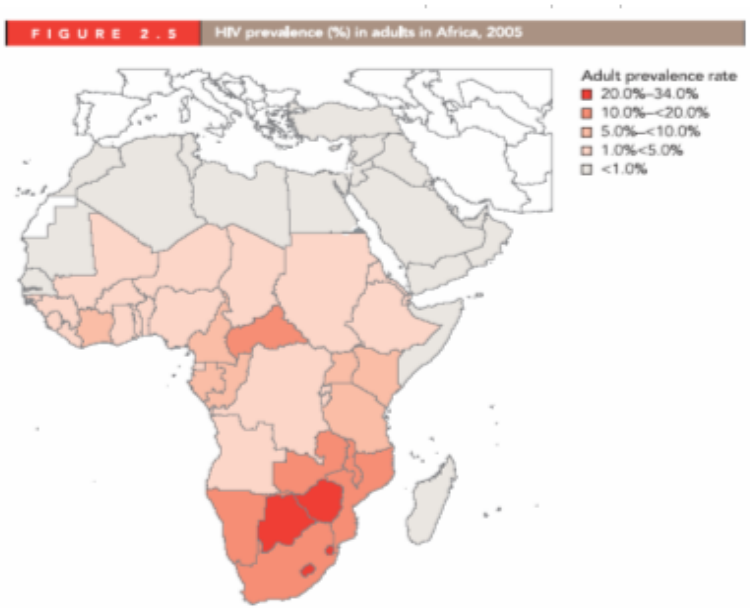


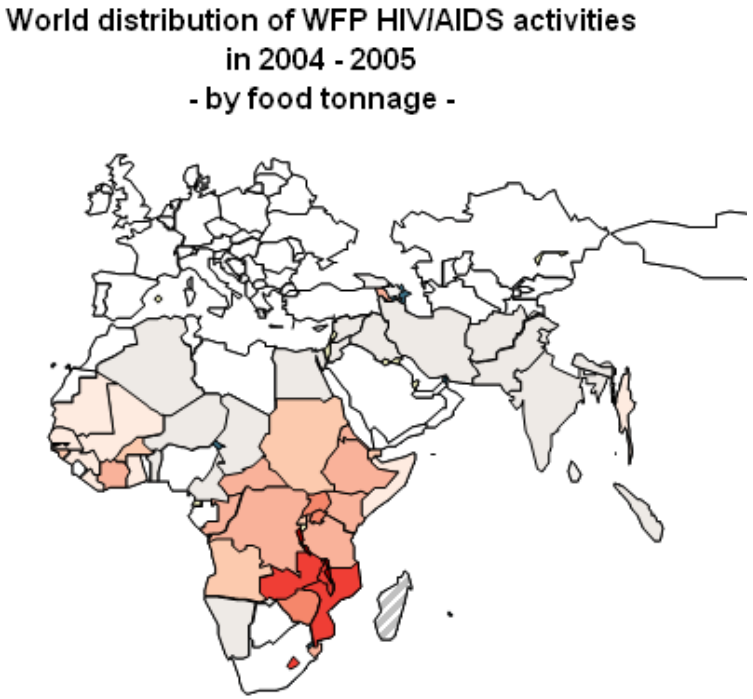
Picture 5



In Africa, where the HIV & AIDS prevalence rate is higher, WFP HIV & AIDS activities were not totally matching the UNAIDS prevalence rate – world mapping. In fact,

- In **Cameroon** the HIV & AIDS prevalence rate was above 5%, but WFP was not implementing any HIV & AIDS activity.
- In **Namibia** the HIV & AIDS prevalence rate was above 19%, but WFP was not implementing any HIV & AIDS activity.
- In **Swaziland** the HIV & AIDS prevalence rate was above 30%, but WFP distributed less than 2000 tons of food (yearly). However, the limited size of the country it is also to be taken into consideration.





Distribution of WFP HIV & AIDS activities by Regional Bureau

Top WFP countries with HIV & AIDS activities

In terms of food distribution, the following were the top 5 WFP countries implementing HIV & AIDS activities.
1 - Zambia
2 - Malawi
3 - Mozambique
4 - Lesotho
5 - Zimbabwe

In terms of number of beneficiaries and expenditure, the following were the top 5 WFP countries implementing HIV & AIDS activities.
1 - Zambia
2 - Zimbabwe
3 - Malawi
4 - Mozambique
5 - Lesotho

Top WFP countries with HIV & AIDS activities by Regional Bureau

In **ODB**, only Cambodia and Myanmar implemented HIV & AIDS activities.

In **ODC**, only Armenia implemented HIV & AIDS activities.

In **ODD/ODDY**, the following were the top 3 countries implementing HIV & AIDS activities:
In terms of food distribution,
1-CAR
2- Cote d'Ivoire
3- Burkina Faso

In terms of number of beneficiaries, the following were the top 3 WFP countries implementing HIV & AIDS activities:
1 - Cote d'Ivoire,
2 - Central African Republic,
3 - Senegal

In terms of expenditure, the following were the top 3 WFP countries implementing HIV & AIDS activities:
1 - Cote d'Ivoire,
2 - Central African Republic,
3 - Burkina Faso

In **ODK:**
In terms of food distribution, the following were the top 3 countries implementing HIV & AIDS activities:
1- Burundi
2- Uganda
3- Tanzania

In terms of number of beneficiaries, the following were the top 3 countries implementing HIV & AIDS activities:
1 - Uganda
2 - Congo DR
3 - Burundi

In terms of expenditure, the following were the top 3 countries implementing HIV & AIDS activities:
1 - Burundi
2 - Congo DR
3 - Rwanda

In **ODJ**
In terms of food distribution and expenditure, the following were the top 3 countries implementing HIV & AIDS activities:
1- Zambia
2- Malawi
3- Mozambique

In terms of number of beneficiaries, the following were the top 3 countries implementing HIV & AIDS activities:
1 - Zambia
2 - Zimbabwe
3 - Malawi

In ODP Haiti, Honduras, Peru and Bolivia implemented HIV & AIDS activities, but Haiti is the top country for this Region.

WFP Co-operating Partners in achieving HIV & AIDS objectives

Co-operating Partners' categories according to WFP objectives

The WFP co-operating Partners' categories to "Raise awareness on HIV & AIDS" are: 51% Local NGOs, 27% International NGOs, 9% Religious Organizations, 7% Individual/others, 6% UN Agencies.

The WFP co-operating Partners' categories to "Improve Nutritional Status of PLWHA" are: 50% Local NGOs, 22% International NGOs, 18% Religious Organizations, 10%Individual/others, 0% UN Agencies.

The WFP co-operating Partners' categories to "Preserve living-standards of PLWHA" are: 51% Local NGOs, 27% International NGOs, 9% Religious Organizations, 7%Individual/others, 6% UN Agencies.

The WFP co-operating Partners' categories to "Mitigate the impact of HIV & AIDS on affected families' income" are:
37% Local NGOs, 44% International NGOs, 12% Religious Organizations, 3%Individual/others, 4% UN Agencies.

Co-operating Partners' roles according to WFP objectives

The WFP co-operating Partners' roles to "Raise awareness on HIV & AIDS" are:
60% "provision of training sessions, 36% "advocacy on HIV & AIDS", 4% "general coordination".

The WFP co-operating Partners' roles to "Improve Nutritional Status of PLWHA" are:
52% "Food distribution", 10% "provision of drugs for ART/DOTS", 9% "food cooking training" and "targeting", 7% "counselling to PLWHA", 5% "monitor adherence to treatment" and "general coordination", 3% "provision of non-food items".

The WFP co-operating Partners' roles to "Preserve living-standards of PLWHA" are:
39% "provision of training sessions, 27% "IGA implementation", 18% "food distribution", 9% "gardening implementation", 7% "provision of small grants to families".

The WFP co-operating Partners' roles to "Mitigate the impact of HIV & AIDS on affected families' income" are:
54% "Food distribution", 19% "targeting", 8% "provision of school fees", 6% "provision of non-food items", 5% "counselling to PLWHA" and "provision of small grants to families", 3% "general coordination".

Implementation Constraints

66% of HIV & AIDS activities encountered problems during the implementation of HIV & AIDS activities.

The most frequent constraints encountered by COs during the implementation of HIV & AIDS activities were related to:
Resourcing - 50%
Limited capacity of Partners - 28%

Others

78% of surveyed countries have been incorporating gender issues to address HIV/AIDS through existing programmes
65% of surveyed countries provided technical support, regarding linkages in the areas of food security/nutrition and HIV/AIDS

95% of surveyed countries advocated at local, national or international levels to promote the importance of food and nutrition?

87% of surveyed countries which advocate at national level collaborated with national governments, donors, and NGOs to make sure food and nutritional support (technical information and/or actual food) is included in the National HIV/AIDS Strategic Plan.

Annex A: Analysis report

1 - Structure and sources of variability

The first step of the analysis includes an assessment of the initial data matrix. It contains a relatively large amount of information expressed by the number of variables considered: The first block of variables, represented by the questionnaire on HIV & AIDS activities is composed by n. 13 variables; The second block of variables, represented by the questionnaire

on partnership, is composed by n. 2 variables; The third block of variables, represented by the additional questionnaire, is composed by n. 4 variables.
The relative limited amount of available cases is represented, for the first block of variables by the number of activities = 135, for the second and third block of variables by the number of countries surveyed = 74.

Few missing answers have been noted on the data matrix. However, some countries (Burundi, Central African Republic and, only partially, Senegal and Uganda) were not able to provide with broken down figures, but only with totals for the whole operation. For technical reasons, this caused the need of making an assumption. In fact, in these cases total figures have been simply divided by the number of activities implemented, in order to create disaggregated figures. However, because of the very limited number of these cases, this did not affect the analysis of the findings.

2 - Statistical Method

Descriptive quantitative analysis is the statistical method used. This analysis is an appropriate technique for the analysis of categorical data. It is a very versatile procedure that can be applied to frequency data, percentages and heterogeneous data sets.

3 - Criteria and definitions

The counting of beneficiaries, food tonnage and expenditure was an important issue in this type of data matrix, in order to avoid biases in the analysis results.
The starting points for this analysis are the following definitions226:

- Beneficiaries impacted by HIV/AIDS: beneficiaries (targeted persons who are provided with WFP food) infected or affected by HIV & AIDS and who are assisted through an HIV & AIDS-related food assistance programme.
- HIV & AIDS affected person: a person whose life or livelihood has been adversely changed due to the HIV & AIDS pandemic.
- HIV & AIDS-related food assistance programme: this can be a specific food component of an HIV & AIDS or TB health/care programme or any food-assisted programme in the area of care, treatment, prevention or mitigation of HIV and AIDS.

According to the nature of the objective, the role of food aid and the type of beneficiary receiving WFP food support, the HIV & AIDS activity named “Trainings on HIV/AIDS disease” (i.e. HIV/AIDS awareness) through FFT/FFW, School Feeding etc. do not match the above definitions/criteria:

- HIV/AIDS awareness through School Feeding: in this case, the core activity is School Feeding and the role of food aid is to attract children to school in order to ensure pupils’ enrolment/attendance. Moreover, pupils attending HIV/AIDS trainings through School Feeding are not HIV/AIDS affected people, quite on the contrary they are “assumed” non-affected by HIV/AIDS. The specific food component is not HIV/AIDS-related, it is, instead, a School Feeding-related specific food component. We can inappropriately say that WFP “take advantage” of School Feeding programmes to increase pupils’ knowledge of HIV/AIDS.

[226] Source: WFP Programme Design Manual – Project Planning Information Guide

- HIV/AIDS awareness through FFT/FFW: as in the previous case, the core activity is Food For Training/Food for Work and the role of food aid is to attract people to the training sessions in order to increase their ability to meet food needs. Again, people attending FFT/FFW activities are not HIV/AIDS affected, they are instead "assumed" non-affected by HIV/AIDS. As in the previous example, the specific food component is not HIV/AIDS-related, it is, instead, a FFT-related specific food component and we can once again inappropriately say that WFP "take advantage" of FFT programmes to increase people awareness on HIV/AIDS.

One of the basic rules of counting beneficiaries is to avoid double-counting where there is an overlap in beneficiary numbers.
Counting the mentioned activities related to HIV/AIDS awareness as specific HIV/AIDS activities in terms of food distributed and cost of operation would have caused an overlap of numbers with other activities such as School Feeding and FFT/FFW and consequently it would have affected the analysis results.
On the other hand, the importance of HIV/AIDS awareness especially in terms of number of participants into the training sessions was not to be neglected and excluded from the analysis.

Conclusion:
In order to ensure a comprehensive analysis of WFP HIV/AIDS intervention, it has been decided to consider as "HIV/AIDS Beneficiaries" those who benefited from HIV/AIDS activities; not only those who are "impacted" by HIV/AIDS (infected and/or affected), but also those who are "assumed" non affected (participants to awareness trainings). In other words, this means that participants into training session on HIV/AIDS disease have been counted in the Number of HIV/AIDS beneficiaries. However, for the reasons explained above, the food and the cost related to the same type of activities have not been counted in the Food Tonnage and Operational Cost for HIV/AIDS activities.

Annex B: List of surveyed countries

Region	Country	Region	Country
ODB	Afghanistan	ODC	Iraq
ODC	Algeria	ODC	Jordan
ODJ	Angola	ODK	Kenya
ODC	Armenia	ODB	Korea DPR
ODC	Azerbaijan	ODB	Laos
ODB	Bangladesh	ODJ	Lesotho
ODDY	Benin	ODD	Liberia
ODB	Bhutan	ODJ	Madagascar
ODP	Bolivia	ODJ	Malawi
ODD	Burkina Faso	ODD	Mali
ODK	Burundi	ODD	Mauritania
ODB	Cambodia	ODJ	Mozambique
ODDY	Cameroon	ODB	Myanmar
ODDY	CAR	ODJ	Namibia
ODDY	Chad	ODB	Nepal
ODP	Colombia	ODP	Nicaragua
ODK	Congo	ODD	Niger
ODK	Congo DR	ODC	Occupied Palestinian Territories
ODD	Cote d'Ivoire	ODB	Pakistan
ODP	Cuba	ODP	Peru
ODK	Djibouti	ODC	Russia
ODP	Ecuador	ODK	Rwanda
ODC	Egypt	ODD	Sao Tome and Principe
ODP	El Salvador	ODD	Senegal
ODK	Eritrea	ODD	Sierra Leone
ODK	Ethiopia	ODK	Somalia
ODD	Gambia	ODB	Sri Lanka
ODC	Georgia	ODS	Sudan
ODDY	Ghana	ODJ	Swaziland
ODP	Guatemala	ODC	Syria
ODD	Guinea	ODC	Tajikistan
ODD	Guinea Bissau	ODK	Tanzania
ODP	Haiti	ODB	Timor Leste
ODP	Honduras	ODK	Uganda
ODB	India	ODC	Yemen
ODB	Indonesia	ODJ	Zambia
ODC	Iran	ODJ	Zimbabwe

Annex C: Detailed Findings

WFP HIV & AIDS objectives, activities and roles of food aid

Country	HIV/AIDS Standardised Objectives	Standardised activities	Standardised Role of Food Aid
Angola	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Angola	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Angola	Raise awareness on HIV/AIDS	Training on HIV/AIDS through FFA	Incentive to participate in training sessions
Armenia	Raise awareness on HIV/AIDS	Training on HIV/AIDS through FFT	Incentive to participate in training sessions
Bolivia	Raise awareness on HIV/AIDS	Training on HIV/AIDS	Incentive to participate in training sessions
Burkina Faso	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Burkina Faso	Preserve income of HIV/AIDS affected households	HBC	Income-transfer
Burundi	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Burundi	Reduce mother-to-child transmission	PMTCT	Nutritional Dietary Support
Burundi	Preserve income of HIV/AIDS affected households	HBC	Income-transfer
Cambodia	Preserve income of HIV/AIDS affected households	HBC	Income-transfer
Central African Republic	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Central African Republic	Improve Nutritional Status of PLWHA	General Food Distribution to PLWHA	Nutritional Dietary Support

Country	HIV/AIDS Standardised Objectives	Standardised activities	Standardised Role of Food Aid
Central African Republic	Reduce mother to child transmission	PMTCT	Nutritional Dietary Support
Colombia	Raise awareness on HIV/AIDS	Training on HIV/AIDS through FFT and MCH	Incentive to participate in training sessions
Congo	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Congo	Preserve living-standards of PLWHA	On-the-job training through Income Generating Activities (IGA)	Incentive to participate in training sessions
Congo	Reduce mother-to-child transmission	PMTCT	Nutritional Dietary Support
Congo DR	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Congo DR	Preserve living-standards of PLWHA	On-the-job training through Income Generating Activities (IGA)	Incentive to participate in training sessions
Cote d'Ivoire	Improve Nutritional Status of PLWHA	General Food Distribution to PLWHA	Nutritional Dietary Support
Cote d'Ivoire	Raise awareness on HIV/AIDS	Training on HIV/AIDS through School Feeding	Incentive to participate in training sessions
Djibouti	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Djibouti	Preserve income of HIV/AIDS affected families	General Food Distribution to HIV/AIDS affected families	Income-transfer
Djibouti	Improve Nutritional Status of PLWHA	General Food Distribution to PLWHA	Nutritional Dietary Support
Eritrea	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Eritrea	Preserve income of HIV/AIDS affected families	HBC	Income-transfer

Country	HIV/AIDS Standardised Objectives	Standardised activities	Standardised Role of Food Aid
Eritrea	Preserve income of HIV/AIDS affected families	HBC	Income-transfer
Ethiopia	Improve Nutritional Status of PLWHA	HBC	Nutritional Dietary Support
Ethiopia	Preserve income of HIV/AIDS affected families	OVC/School Feeding	Income-transfer
Ethiopia	Reduce mother-to-child transmission	PMTCT	Nutritional Dietary Support
Gambia	Raise awareness on HIV/AIDS	Training on HIV/AIDS through School Feeding	Incentive to participate in training sessions
Ghana	Improve Nutritional Status of PLWHA	General Food Distribution to PLWHA	Nutritional Dietary Support
Guinea	Improve Nutritional Status of PLWHA	General Food Distribution to PLWHA	Nutritional Dietary Support
Guinea Bissau	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Guinea Bissau	Reduce mother-to-child transmission	PMTCT	Nutritional Dietary Support
Haiti	Preserve income of HIV/AIDS affected families	General Food Distribution to HIV/AIDS affected families	Income-transfer
Haiti	Preserve income of HIV/AIDS affected families	General Food Distribution to HIV/AIDS affected families	Income-transfer
Haiti	Preserve income of HIV/AIDS affected families	General Food Distribution to HIV/AIDS affected families	Income-transfer
Honduras	Preserve income of HIV/AIDS affected families	General Food Distribution to HIV/AIDS affected families	Income-transfer
Kenya	Improve Nutritional Status of PLWHA	General Food Distribution to PLWHA	Nutritional Dietary Support
Kenya	Preserve income of HIV/AIDS affected families	HBC	Income-transfer

Country	HIV/AIDS Standardised Objectives	Standardised activities	Standardised Role of Food Aid
Kenya	Raise awareness on HIV/AIDS	Training on HIV/AIDS through FFT	Incentive to participate in training sessions
Lesotho	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Lesotho	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Lesotho	Preserve income of HIV/AIDS affected households	General Food Distribution to HIV/AIDS affected families	Income-transfer
Lesotho	Preserve income of HIV/AIDS affected families	OVC/School Feeding	Income-transfer
Liberia	Improve Nutritional Status of PLWHA	HBC	Nutritional Dietary Support
Malawi	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Malawi	Preserve income of HIV/AIDS affected families	General Food Distribution to HIV/AIDS affected families	Income-transfer
Malawi	Preserve income of HIV/AIDS affected households	General Food Distribution to HIV/AIDS affected families	Income-transfer
Malawi	Improve Nutritional Status of PLWHA	HBC	Nutritional Dietary Support
Malawi	Preserve income of HIV/AIDS affected households	HBC	Income-transfer
Malawi	Preserve living-standards of PLWHA	On-the-job training through Income Generating Activities (IGA)	Incentive to participate in training sessions
Mali	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support

Country	HIV/AIDS Standardised Objectives	Standardised activities	Standardised Role of Food Aid
Mali	Raise awareness on HIV/AIDS	ART/DOTS	Nutritional Dietary Support
Mali	Improve Nutritional Status of PLWHA	General Food Distribution to PLWHA	Nutritional Dietary Support
Mauritania	Improve Nutritional Status of PLWHA	General Food Distribution to PLWHA	Nutritional Dietary Support
Myanmar	Preserve income of HIV/AIDS affected families	HBC	Income-transfer
Nicaragua	Raise awareness on HIV/AIDS	Training on HIV/AIDS through Vulnerable Group Programme	Incentive to participate in training sessions
Peru	Improve Nutritional Status of PLWHA	General Food Distribution to PLWHA	Nutritional Dietary Support
Peru	Raise awareness on HIV/AIDS	Training on HIV/AIDS through FFT	Incentive to participate in training sessions
Rwanda	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Rwanda	Preserve living-standards of PLWHA	On-the-job training through Income Generating Activities (IGA)	Incentive to participate in training sessions
Rwanda	Reduce mother-to-child transmission	PMTCT	Nutritional Dietary Support
Senegal	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Senegal	Improve Nutritional Status of PLWHA	General Food Distribution to PLWHA	Nutritional Dietary Support
Somalia	Preserve income of HIV/AIDS affected families	General Food Distribution to HIV/AIDS affected families	Income-transfer
Sudan	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support

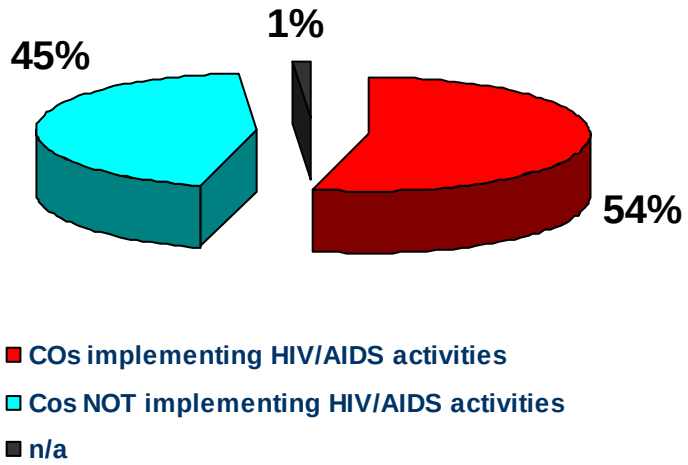
Country	HIV/AIDS Standardised Objectives	Standardised activities	Standardised Role of Food Aid
Sudan	Preserve income of HIV/AIDS affected families	HBC	Income-transfer
Sudan	Raise awareness on HIV/AIDS	Training on HIV/AIDS through FFT	Incentive to participate in training sessions
Sudan	Raise awareness on HIV/AIDS	Training on HIV/AIDS through FFT	Incentive to participate in training sessions
Swaziland	Preserve income of HIV/AIDS affected households	General Food Distribution to HIV/AIDS affected families	Income-transfer
Swaziland	Preserve income of HIV/AIDS affected families	OVC/School Feeding	Income-transfer
Swaziland	Raise awareness on HIV/AIDS	Training on HIV/AIDS through FFT	Incentive to participate in training sessions
Tanzania	Preserve income of HIV/AIDS affected families	HBC	Income-transfer
Tanzania	Improve Nutritional Status of PLWHA	HBC	Nutritional Dietary Support
Tanzania	Preserve income of HIV/AIDS affected families	OVC/School Feeding	Income-transfer
Uganda	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Uganda	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Uganda	Improve Nutritional Status of PLWHA	HBC	Nutritional Dietary Support
Uganda	Improve Nutritional Status of PLWHA	HBC	Nutritional Dietary Support
Uganda	Reduce mother-to-child transmission	PMTCT	Nutritional Dietary Support

Country	HIV/AIDS Standardised Objectives	Standardised activities	Standardised Role of Food Aid
Zambia	Improve Nutritional Status of PLWHA	ART/DOTS	Nutritional Dietary Support
Zambia	Improve Nutritional Status of PLWHA	HBC	Nutritional Dietary Support
Zambia	Preserve income of HIV/AIDS affected families	HBC	Income-transfer
Zambia	Preserve living-standards of PLWHA	On-the-job training through Income Generating Activities (IGA)	Incentive to participate in training sessions
Zambia	Preserve income of HIV/AIDS affected households	OVC/School Feeding	Income-transfer
Zambia	Raise awareness on HIV/AIDS	Training on HIV/AIDS through FFT	Incentive to participate in training sessions
Zambia	Raise awareness on HIV/AIDS	Training on HIV/AIDS through PMTCT	Incentive to participate in training sessions
Zimbabwe	Preserve income of HIV/AIDS affected households	HBC	Income-transfer
Zimbabwe	Reduce mother-to-child transmission	PMTCT	Nutritional Dietary Support

Share of WFP HIV & AIDS activities

Countries with WFP HIV & AIDS activities

Chart 1



HIV & AIDS activities versus total WFP activities

Table 2

	Food Tonnage (mt)	Food Tonnage %	Beneficiaries (number)	Beneficiaries %	Cost ($)	Cost %
HIV/AIDS activities	169,488	**4%**	2,019,483	**2%**	88,389,198	**3%**
All WFP activities[227]	3,921,092	100%	89,068,847	100%	2,737,186,518	100%

Chart 3

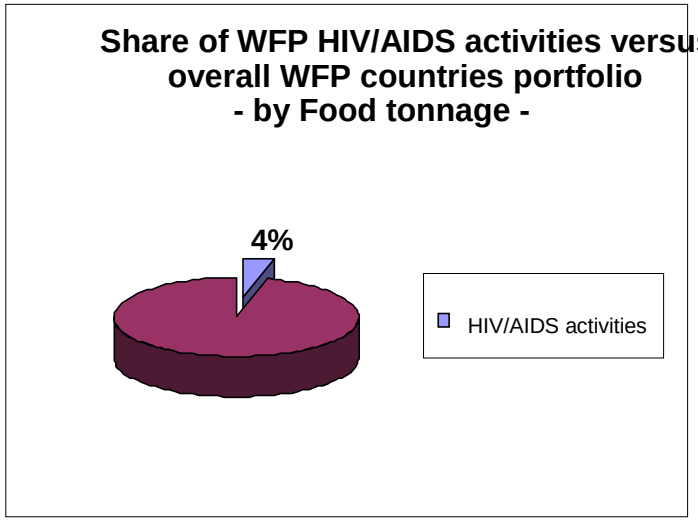
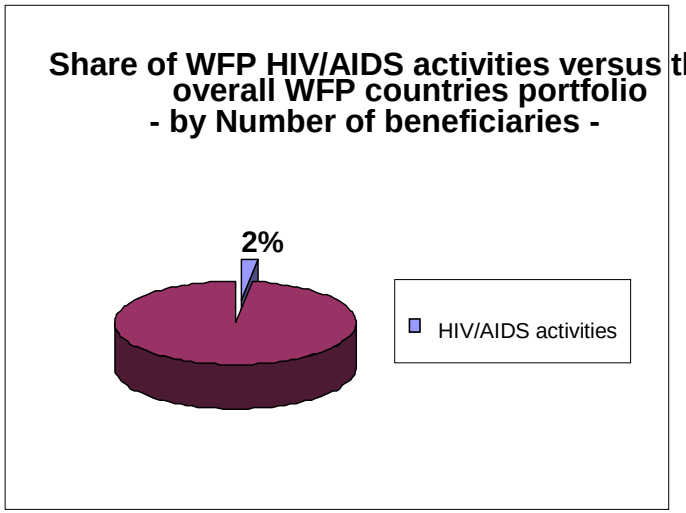
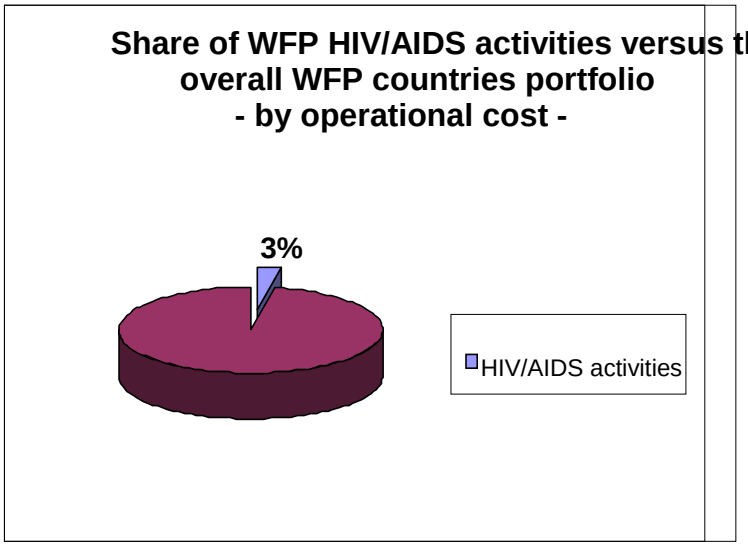


Chart 4



[227] By "All WFP activities" we intend all activities implemented by the 74 surveyed countries. Refer to Annex C for all definitions. Source of information for global figures on food tonnage and costs: WFP in Statistics. Source of information for global figures on beneficiaries: DACOTA database.

Chart 5



HIV & AIDS activities versus WFP activities by Regional Bureau

Tab. 3

	ODB					
	Food Tonnage (mt)	**Food Tonnage %**	**Beneficiaries (number)**	**Beneficiaries %**	**Cost $**	**Cost %**
HIV/AIDS activities	2,536	**0%**	48,699	**0%**	1,355,817	**0%**
All ODB activities	942,980	100%	32,867,415	100%	446,851,000	100%

Tab. 4

	ODC					
	Food Tonnage (mt)	Food Tonnage %	Beneficiaries (number)	Beneficiaries %	Cost $	Cost %
HIV/AIDS activities	0	**0%**	300	**0%**	0	**0%**
All ODC activities	272,032	100%	6,235,795	100%	499,597,018	100%

Tab. 5

	ODD/ODDY					
	Food Tonnage (mt)	Food Tonnage %	Beneficiaries (number)	Beneficiaries %	Cost $	Cost %
HIV/AIDS activities	7,268	**2%**	63,779	**1%**	4,444,977	**2%**
All ODD/ODDY activities	307,509	100%	9,101,934	100%	239,073,000	100%

Tab. 6

	ODJ					
	Food Tonnage (mt)	Food Tonnage %	Beneficiaries (number)	Beneficiaries %	Cost $	Cost %
HIV/AIDS activities	116,604	**21%**	1,385,666	**13%**	57,660,845	**29%**
All ODJ activities	551,446	100%	10,325,155	100%	202,249,000	100%

Chart 6

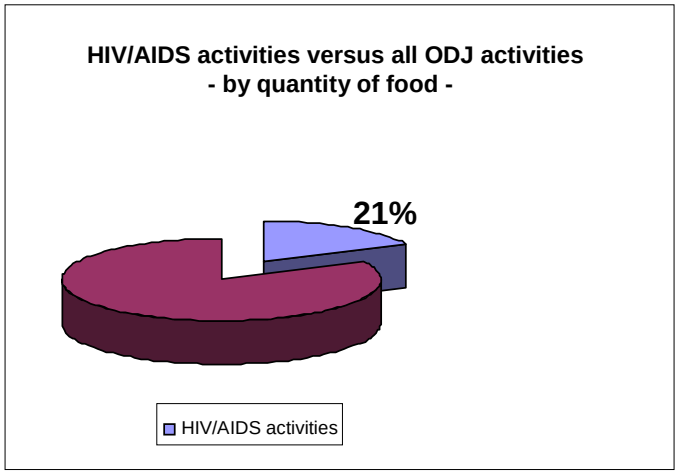


Chart 7

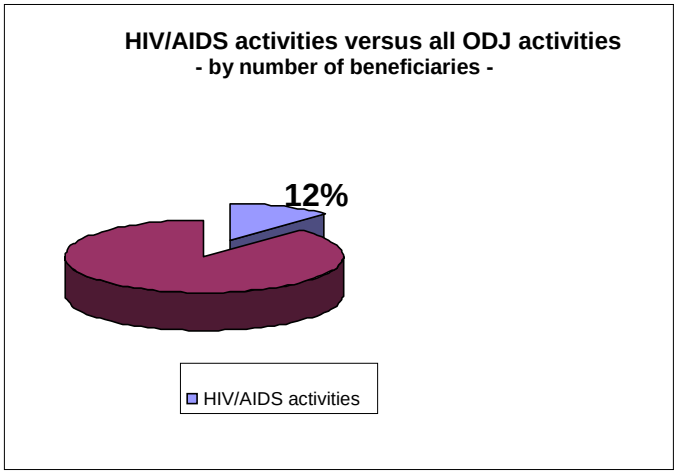
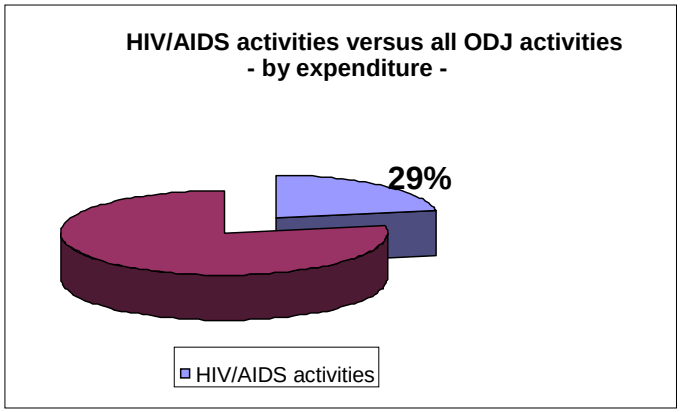


Chart 8



Tab. 7

	ODK					
	Food Tonnage (mt)	Food Tonnage %	Beneficiaries (number)	Beneficiaries %	Cost $	Cost %
HIV/AIDS activities	38,631	**3%**	418,857	**2%**	20,203,891	**3%**
All ODK activities	1,297,747	100%	19,127,914	100%	657,568,000	100%

Chart 9

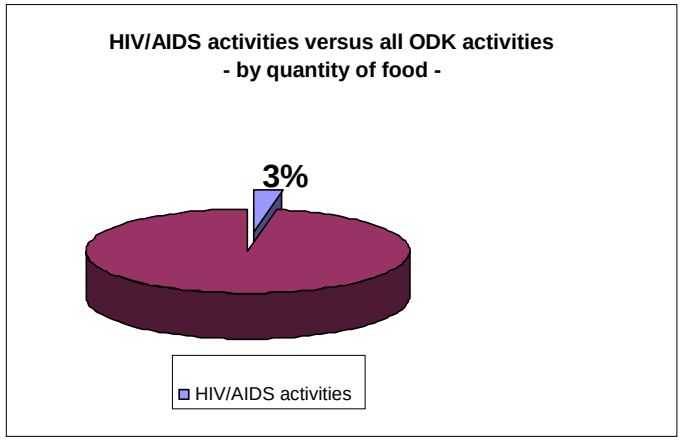


Chart 10

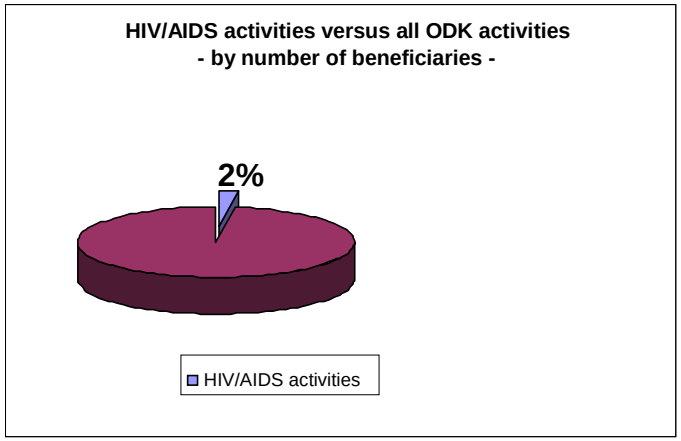
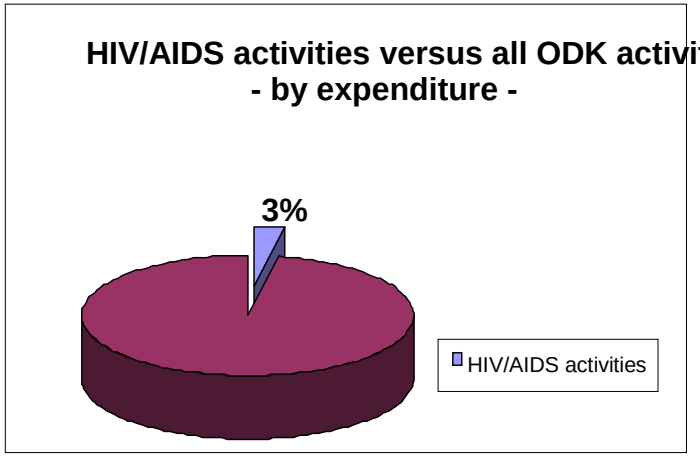


Chart 11



Tab. 8

	ODP					
	Food Tonnage (mt)	**Food Tonnage %**	**Beneficiaries (number)**	**Beneficiaries %**	**Cost $**	**Cost %**
HIV/AIDS activities	2,673	**3%**	75,884	**1%**	2,935,970	**4%**
All ODP activities	100,313	100%	5,996,852	100%	65,910,000	100%

Chart 12

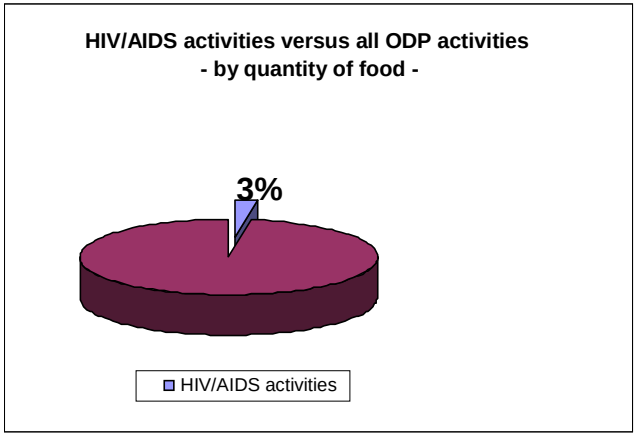
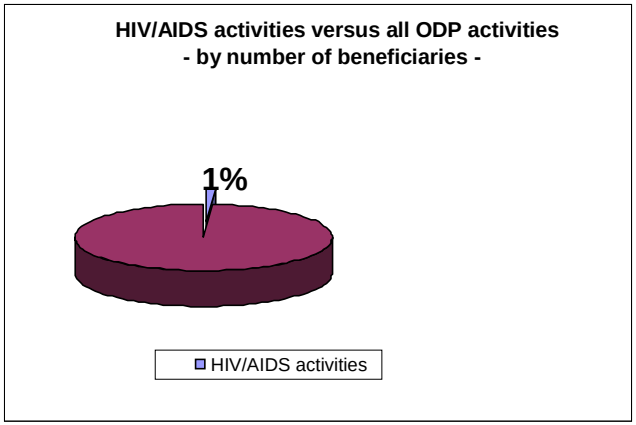
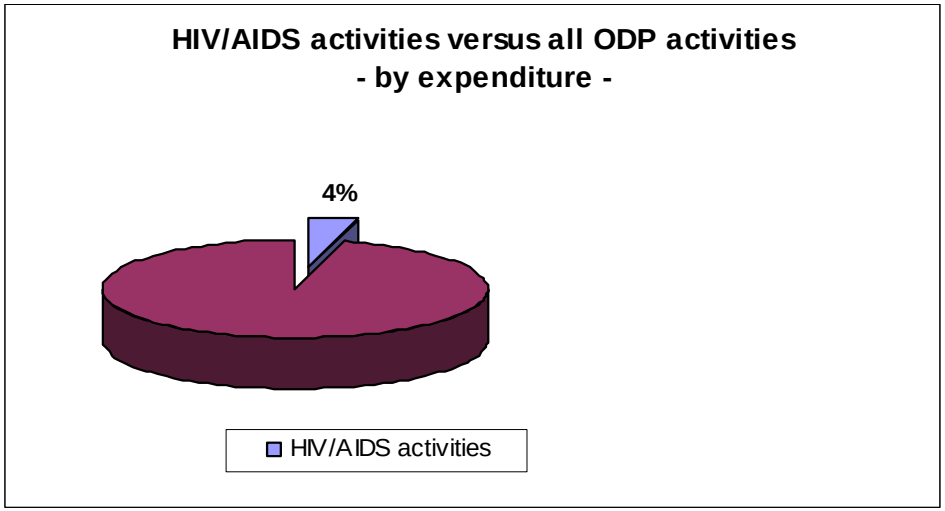


Chart 13





Tab. 9

	ODS: Sudan - Stand Alone Country					
	Food Tonnage (mt)	Food Tonnage %	Beneficiaries (number)	Beneficiaries %	Cost $	Cost %
HIV/AIDS activities	1,160	**0%**	3,198	**0%**	1,374,400	**0%**
All ODS activities	449,066	100%	5,413,784	100%	537,130,000	100%

Tab. 10

HIV/AIDS activities across Regional Bureaux			
Regional Bureaux	Food Tonnage (mt)	Beneficiaries (number)	Cost ($)
ODB	2,536	48,699	1,355,817
ODC	0	300	0
ODD/ODDY	7,268	63,779	4,444,977
ODJ	116,604	1,385,666	57,660,845
ODK	38,631	418,857	20,203,891
ODP	2,673	75,884	2,935,970
ODS	1,160	3,198	1,374,400

Chart 15

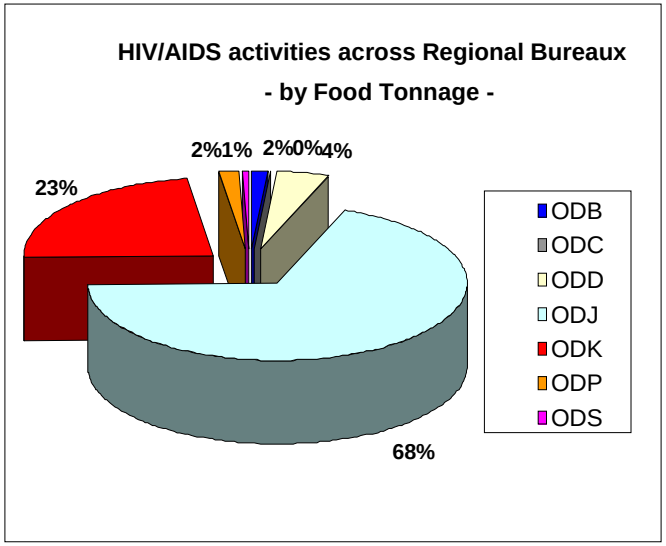


Chart 16

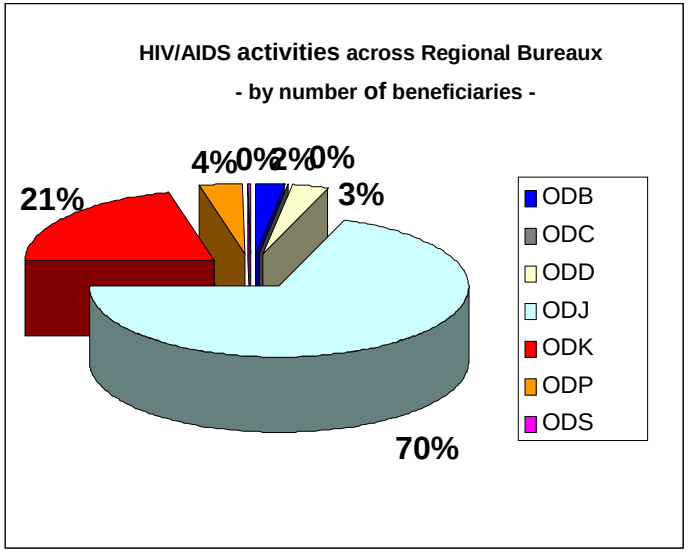
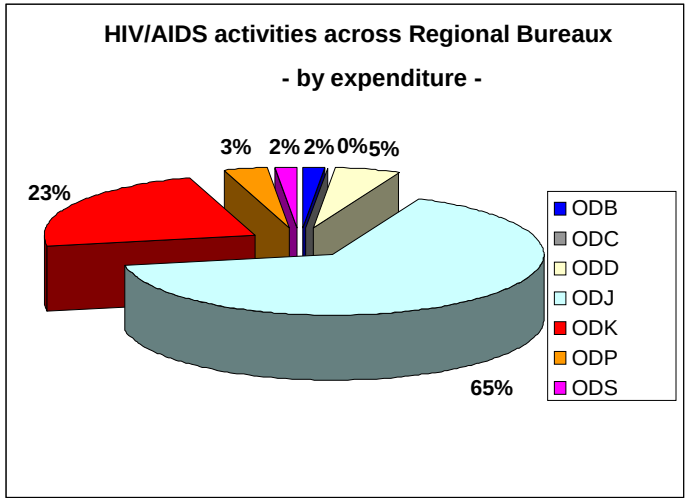


Chart 17



Share of WFP HIV & AIDS categories of activities

Tab. 11

HIV/AIDS Activity	Food Tonnage (mt)	Food Tonnage %	Beneficiaries (number)	Beneficiaries (%)	Cost (million $)	Cost (%)
HBC	70,211	**41%**	1,100,171	**54%**	31,293,470	**35%**
ART/DOTS	17,924	**11%**	220,574	**11%**	15,400,413	**17%**
PMTCT	6,044	**4%**	45,491	**2%**	3,168,565	**4%**
OVC (School Feeding)	26,941	**16%**	154,683	**8%**	13,594,814	**15%**
IGA (FFT, FFW)	6,208	**4%**	106,894	**5%**	4,947,396	**6%**
General Food Distribution to PLWHA	4,279	**3%**	28,350	**1%**	3,343,688	**4%**
General Food Distribution to HIV/AIDS affected families	37,881	**22%**	280,199	**14%**	16,640,852	**19%**
Training on HIV/AIDS (School Feeding, FFT, FFW)[228]			83,123	**4%**		
Totals	**169,488**	100%	**2,019,484**	100%	**88,389,198**	100%

[228] Food Tonnage and Expenditure have not included in analyses of "Awareness (School Feeding, FFT, FFW)"; for further explanation refer to Annex A.

Chart 18

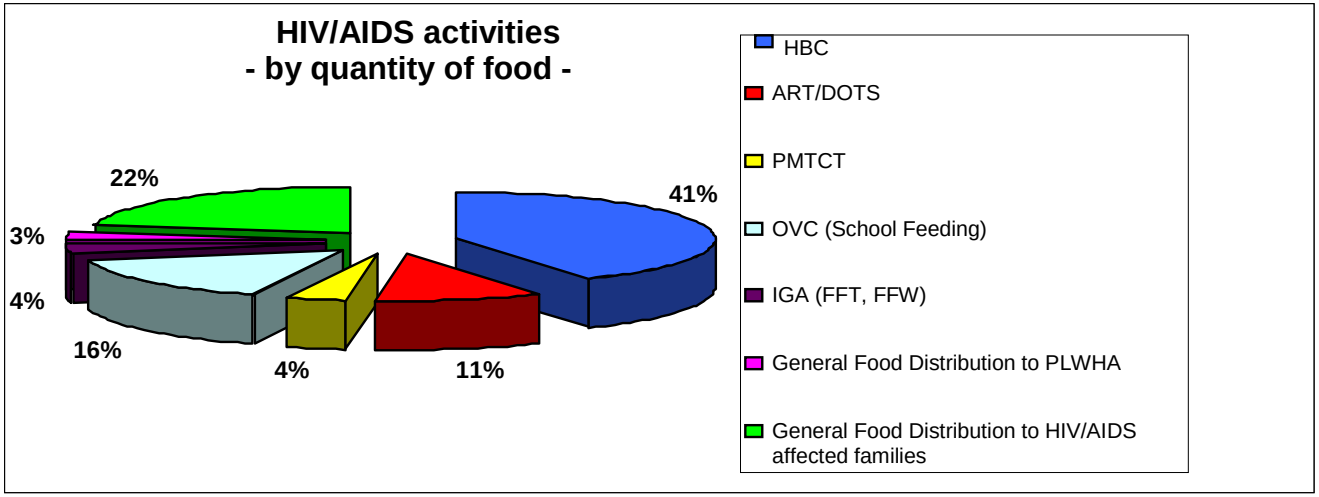

HIV/AIDS activities
- by quantity of food -
22%
3%
4%
16%
4%
11%
41%
HBC
ART/DOTS
PMTCT
OVC (School Feeding)
IGA (FFT, FFW)
General Food Distribution to PLWHA
General Food Distribution to HIV/AIDS affected families

Chart 19

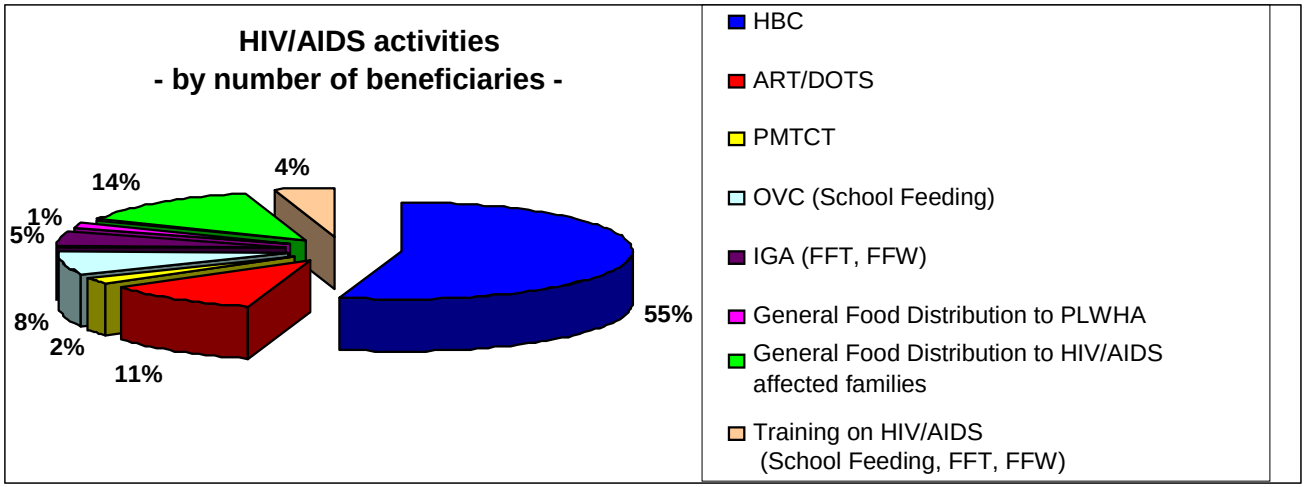
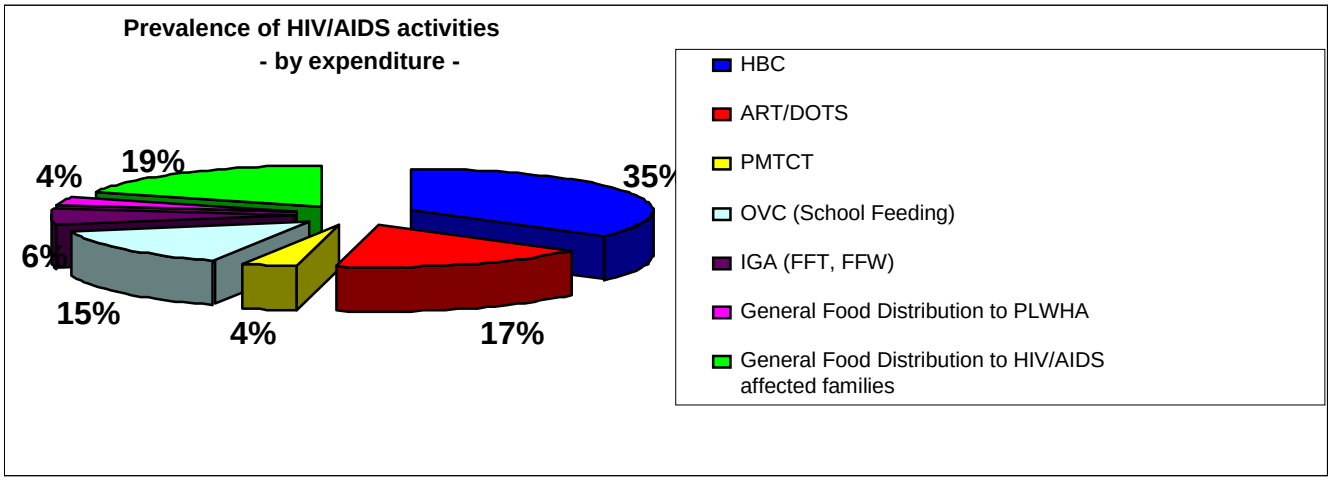


Chart 20



Share of WFP HIV & AIDS categories of activities by Regional Bureau

Tab. 12

ODD/ODDY						
HIV/AIDS Activity	**Food Tonnage (mt)**	**Food Tonnage %**	**Beneficiaries (number)**	**Beneficiaries (%)**	**Cost ($)**	**Cost (%)**
HBC	1,156	**16%**	8,235	**13%**	505,102	**11%**
ART/DOTS	1,411	**19%**	22,048	**35%**	650,445	**15%**
PMTCT	1,412	**19%**	4,872	**8%**	769,496	**17%**
OVC (School Feeding)	0	**0%**	0	**0%**	0	**0%**
IGA (FFT, FFW)	0	**0%**	0	**0%**	0	**0%**
General Food Distribution to PLWHA	3,290	**45%**	18,240	**29%**	2,520,027	**57%**
General Food Distribution to HIV/AIDS affected families	0	**0%**	0	**0%**	0	**0%**
Training on HIV/AIDS (School Feeding, FFT, FFW)*			10,384	**16%**		
Totals	**7,269**	100%	**63,779**	100%	**4,445,070**	100%

Chart 21

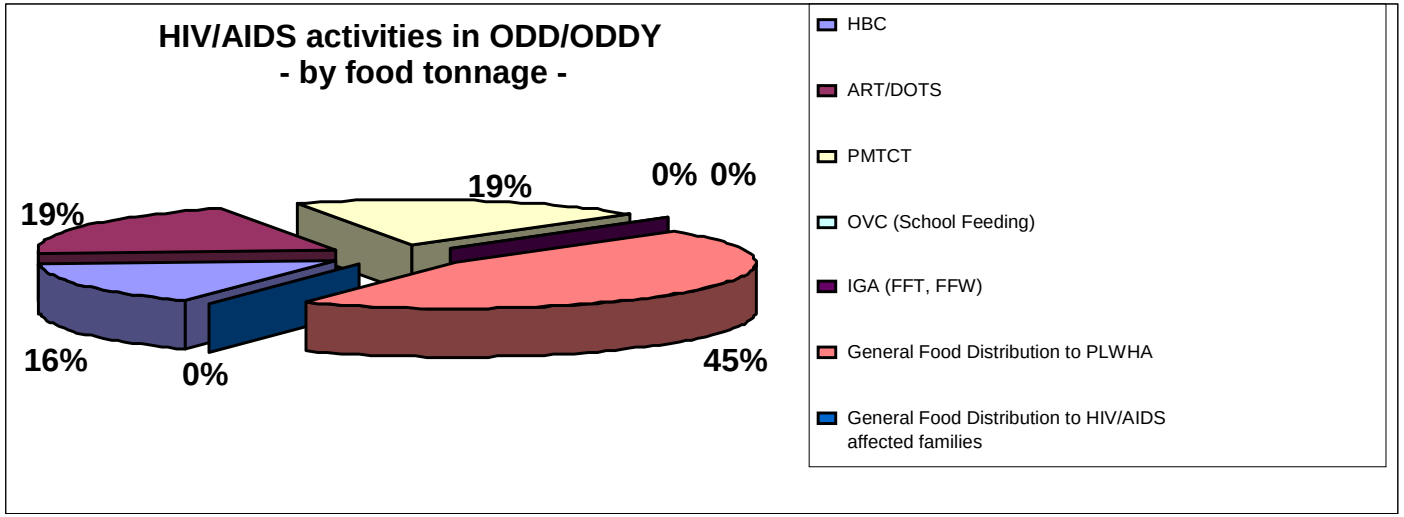


Chart 22

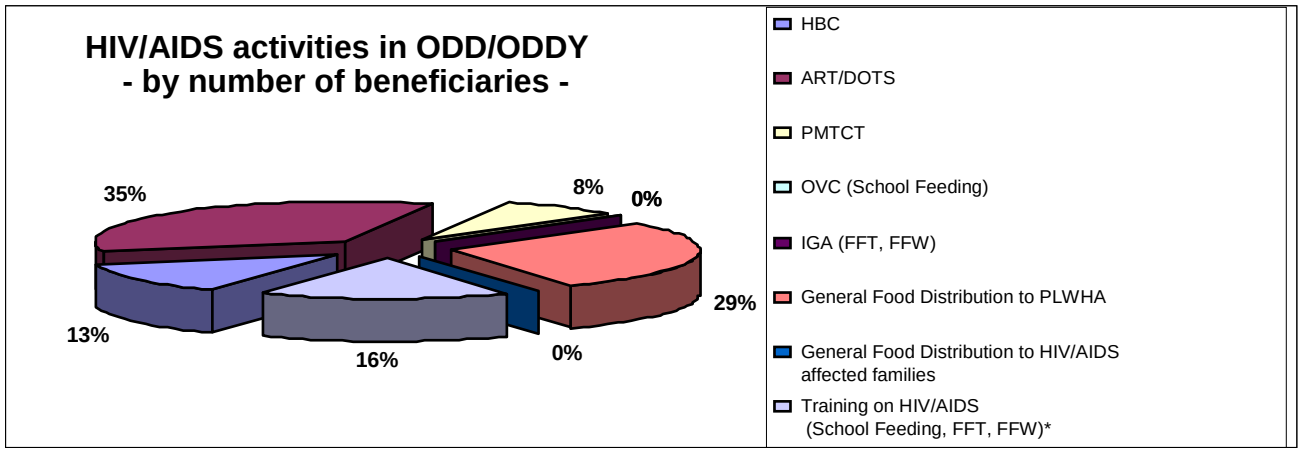
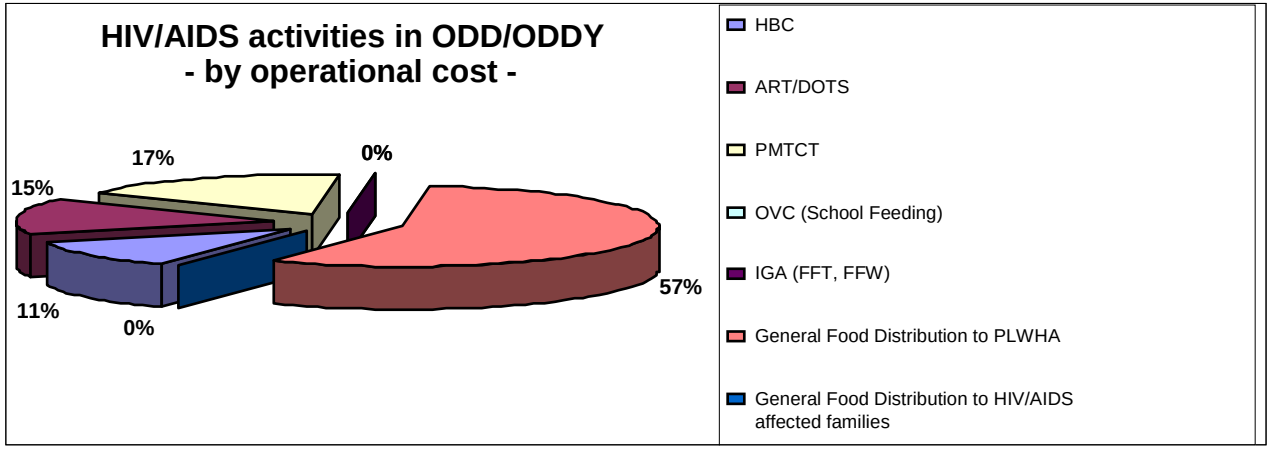


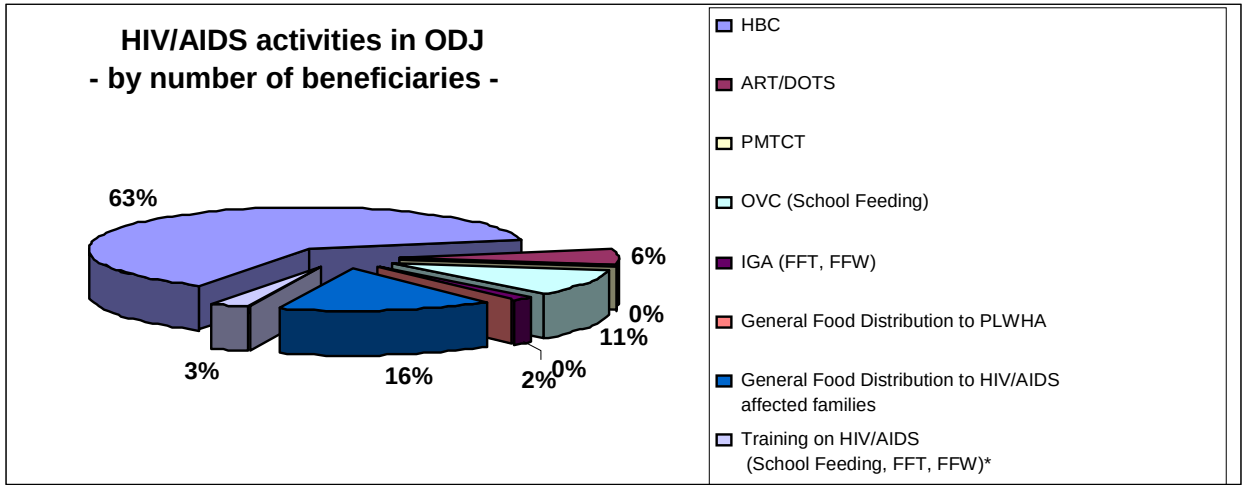
Chart 23



Tab. 13

ODJ						
HIV/AIDS Activity	**Food Tonnage (mt)**	**Food Tonnage %**	**Beneficiaries (value)**	**Beneficiaries (%)**	**Cost (million $)**	**Cost (%)**
HBC	49,066	**38%**	865,099	**63%**	22,445,480	**39%**
ART/DOTS	6,600	**5%**	83,344	**6%**	8,747,978	**15%**
PMTCT	11,977	**9%**	801	**0%**	486,592	**1%**
OVC (School Feeding)	23,666	**19%**	144,432	**11%**	11,767,175	**20%**
IGA (FFT, FFW)	1,279	**1%**	22,020	**2%**	1,279,022	**2%**
General Food Distribution to PLWHA	0	**0%**	0	**0%**	0	**0%**
General Food Distribution to HIV/AIDS affected families	35,194	**28%**	218,615	**16%**	12,934,598	**22%**
Training on HIV/AIDS (School Feeding, FFT, FFW)			40,179	**3%**		
Totals	**127,780**	100%	**1,374,490**	100%	**57,660,845**	100%

Chart 24



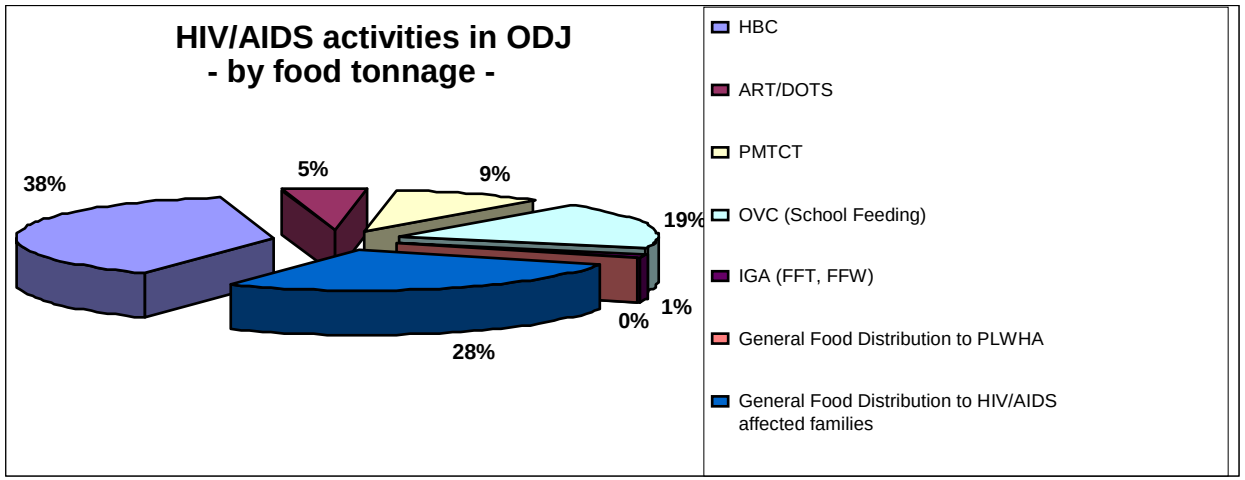
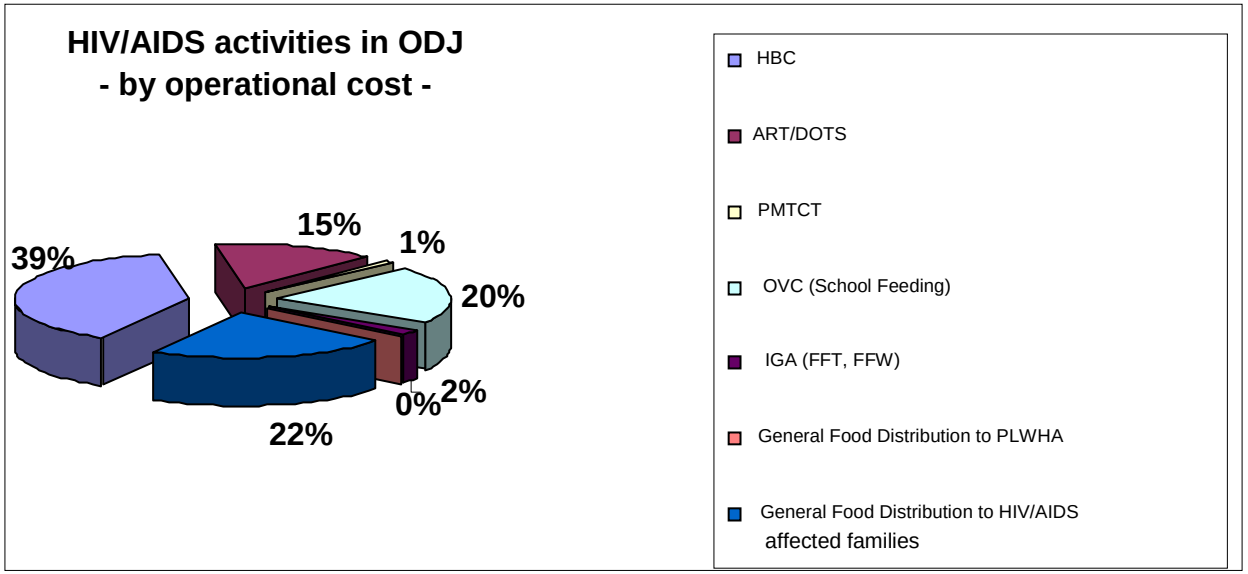


Chart 25

Chart 26



Tab. 14

	ODK					
HIV/AIDS Activity	**Food Tonnage (mt)**	**Food Tonnage %**	**Beneficiaries (value)**	**Beneficiaries (%)**	**Cost (million $)**	**Cost (%)**
HBC	16,896	**43%**	177,639	**40%**	6,094,271	**30%**
ART/DOTS	9,311	**24%**	112,484	**25%**	5,520,390	**27%**
PMTCT	3,831	**10%**	28,642	**6%**	1,912,477	**9%**
OVC (School Feeding)	3,276	**8%**	10,251	**2%**	1,827,639	**9%**
IGA (FFT, FFW)	4,929	**13%**	84,874	**19%**	3,668,374	**18%**
General Food Distribution to PLWHA	666	**2%**	5,610	**1%**	315,661	**2%**
General Food Distribution to HIV/AIDS affected families	338	**1%**	1,700	**0%**	1,278,284	**6%**
Training on HIV/AIDS (School Feeding, FFT, FFW)*			20,760	**5%**		
Totals	**39,246**	100%	**441,959**	100%	**20,617,095**	100%

Chart 27

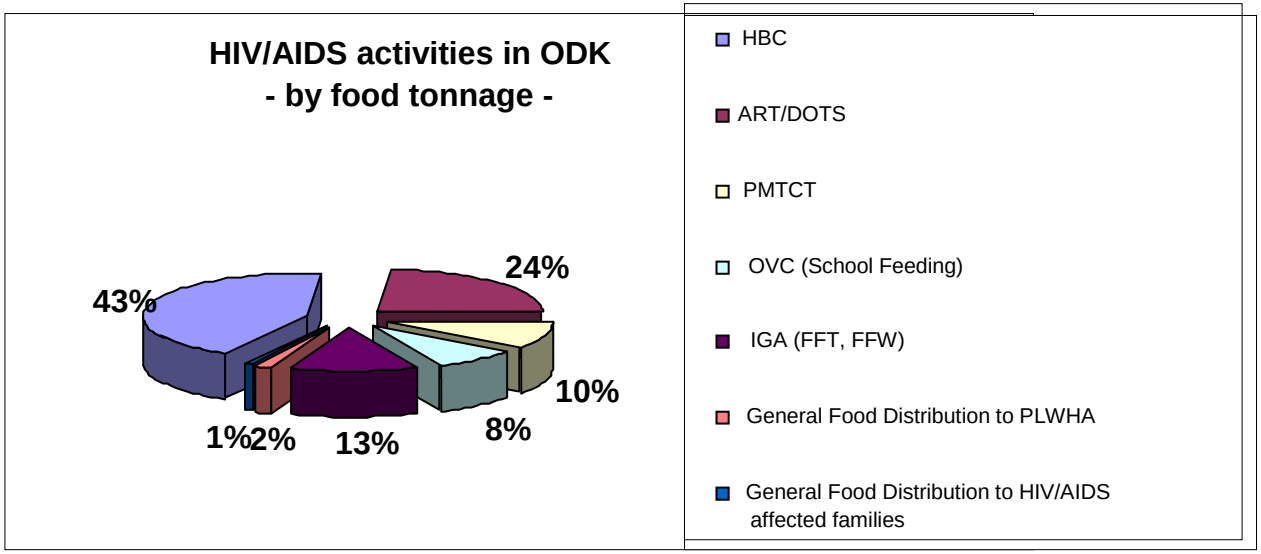


Chart 28

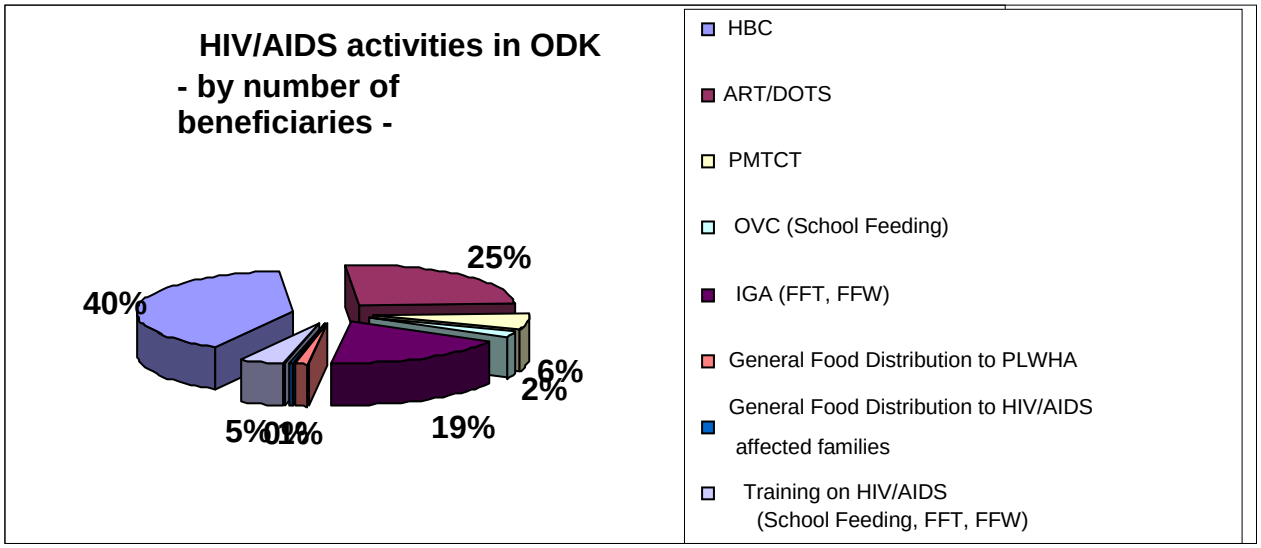
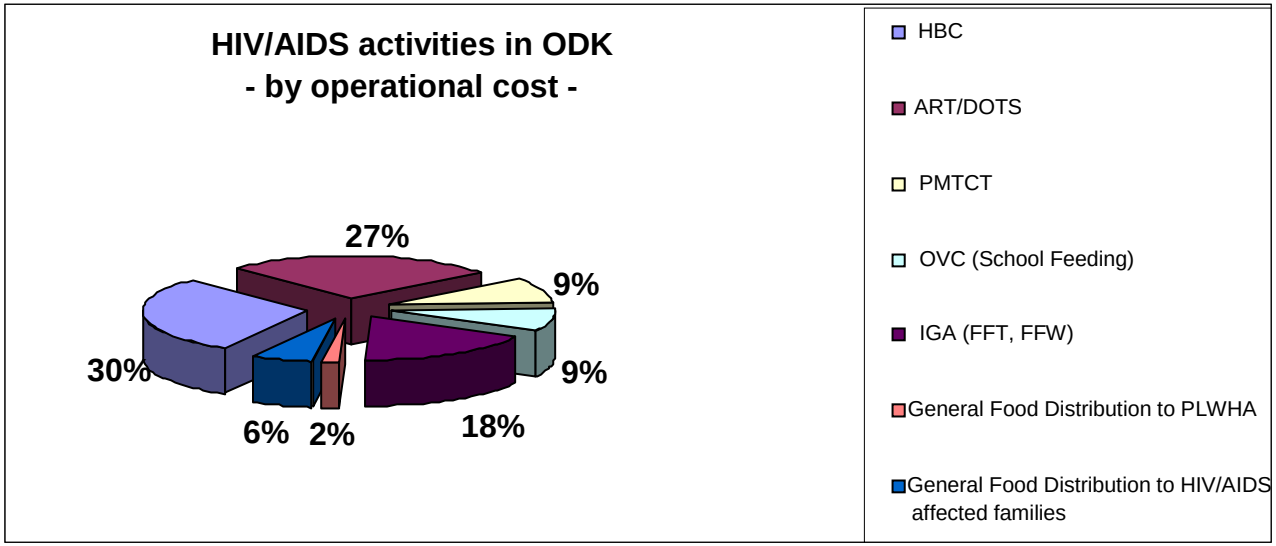


Chart 29



Tab. 15

	ODP					
HIV/AIDS Activity	**Food Tonnage (mt)**	**Food Tonnage %**	**Beneficiaries (value)**	**Beneficiaries (%)**	**Cost (million $)**	**Cost (%)**
HBC	0	**0%**	0	**0%**	0	**0%**
ART/DOTS	0	**0%**	0	**0%**	0	**0%**
PMTCT	0	**0%**	0	**0%**	0	**0%**
OVC (School Feeding)	0	**0%**	0	**0%**	0	**0%**
IGA (FFT, FFW)	0	**0%**	0	**0%**	0	**0%**
General Food Distribution to PLWHA	324	**12%**	4,501	**6%**	508,000	**17%**
General Food Distribution to HIV/AIDS affected families	2,349	**88%**	59,884	**79%**	2,427,970	**83%**
Training on HIV/AIDS (School Feeding, FFT, FFW)*			11,500	**15%**		
Totals	**2,673**	100%	**75,885**	100%	**2,935,970**	100%

Chart 30

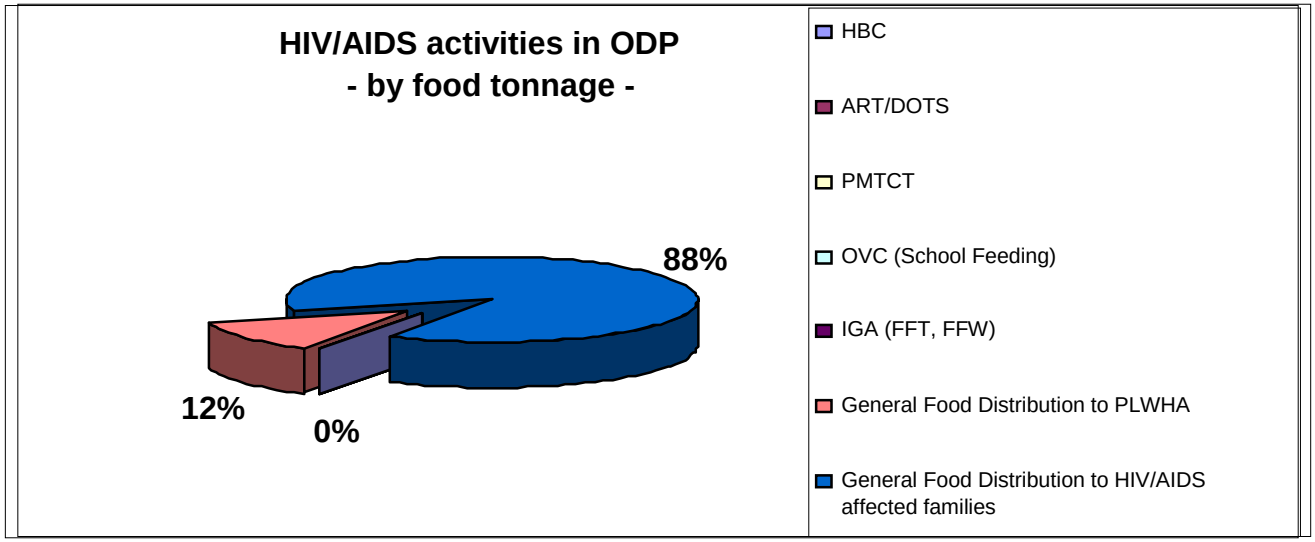


Chart 31

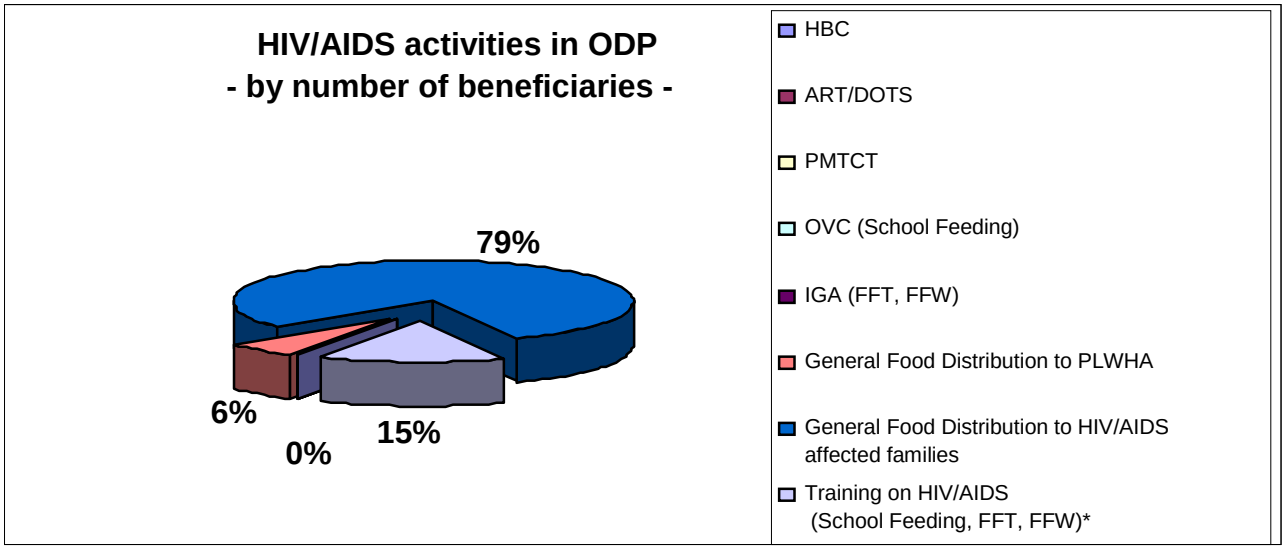
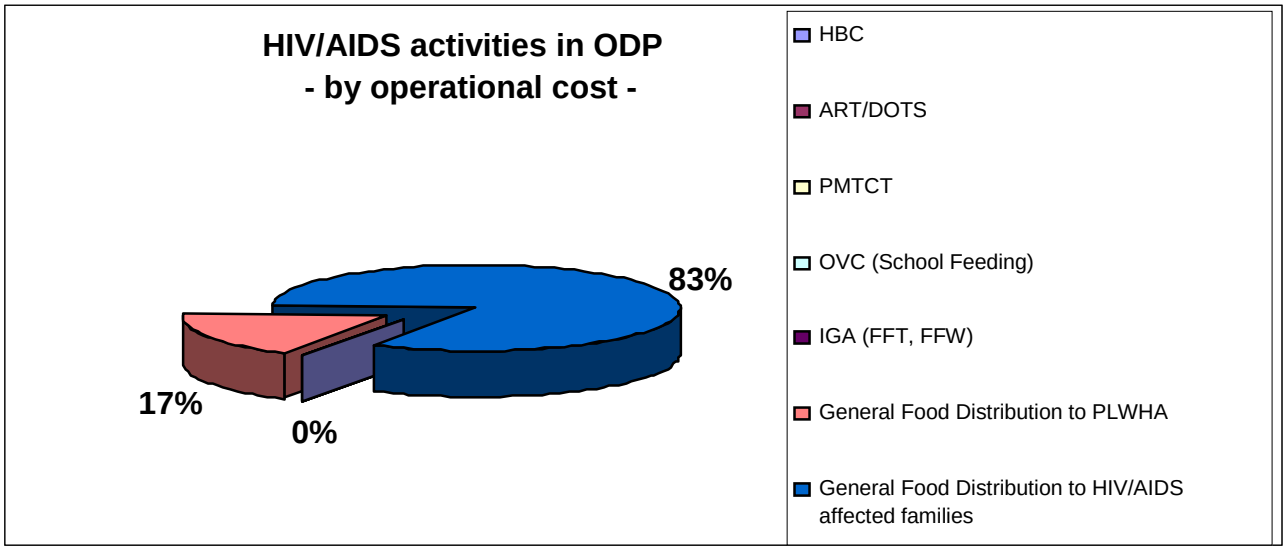


Chart 32



Share of WFP HIV & AIDS objectives

Tab. 16

HIV & AIDS Categories of Objectives	HIV/AIDS Objectives	Food Tonnage (mt)	Food Tonnage %	Beneficiaries (number)	Beneficiaries (%)	Cost ($)	Cost (%)
Treatment and Care	Improve Nutritional Status of PLWHA	32,738	**19%**	386,668	**19%**	22,474,100	**25%**
	Reduce mother-to-child transmission	6,044	**4%**	45,491	**2%**	3,168,565	**4%**
Mitigation	Preserve income of HIV & AIDS affected families	124,495	**73%**	1,397,057	**69%**	57,798,195	**65%**
	Preserve living-standards of PLWHA	6,208	**4%**	106,894	**5%**	4,947,396	**6%**
Prevention	Raise awareness on HIV & AIDS			83,373	**4%**		
	Totals	**169,484**	100%	**2,019,483**	100%	**88,388,256**	100%

Chart 33

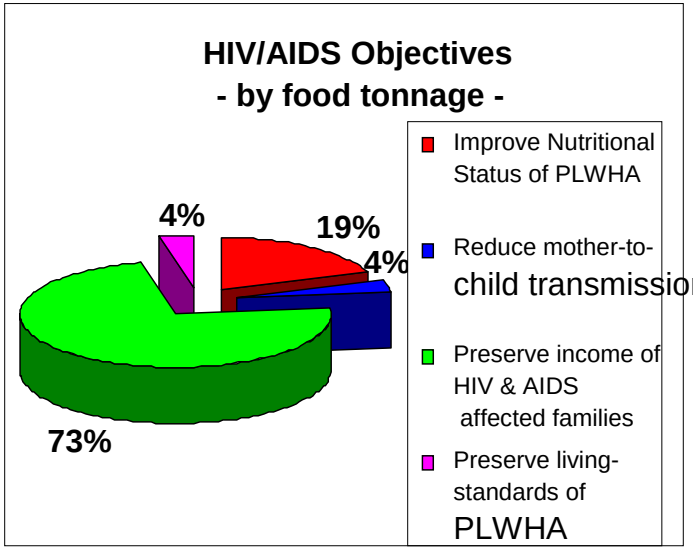


Chart 34

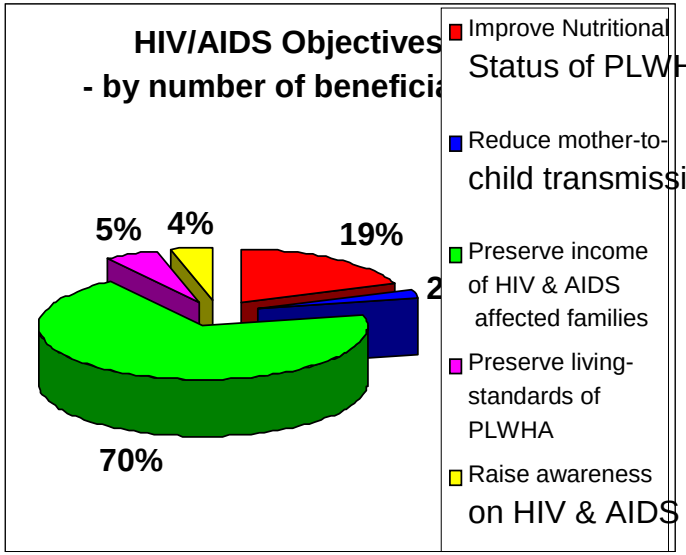
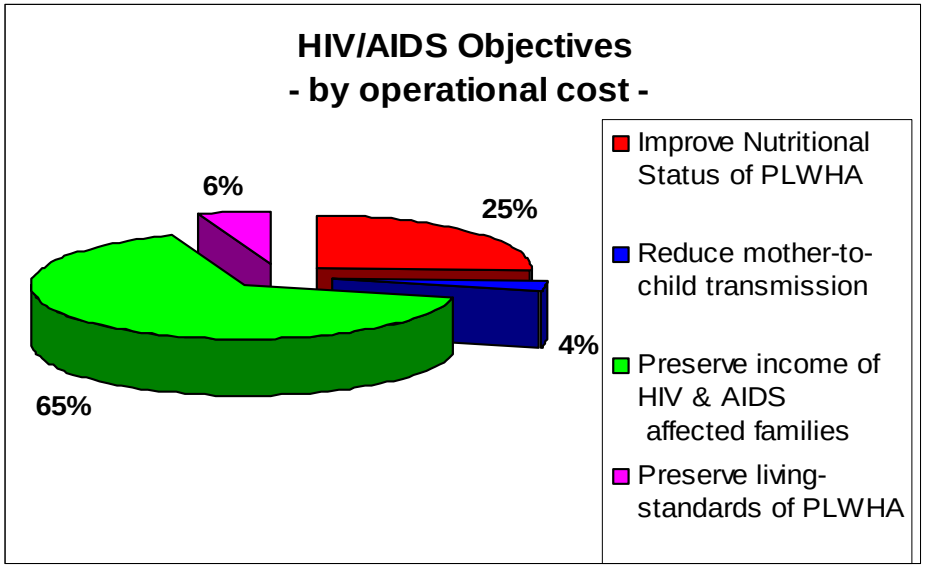


Chart 35



Share of WFP HIV & AIDS roles of food aid

Tab. 17

HIV/AIDS Roles of Food Aid	Food Tonnage (mt)	Food Tonnage %	Beneficiaries (number)	Beneficiaries (%)	Cost ($)	Cost (%)
Nutritional Dietary Support	38,786	**23%**	432,409	**23%**	25,643,607	**29%**
Income transfer	124,495	**73%**	1,273,509	**67%**	57,798,195	**65%**
Incentive to participate into training sessions*	6,208	**4%**	190,017	**10%**	4,947,396	**6%**
Totals	**169,488**	100%	**1,895,935**	100%	**88,389,198**	100%

Chart 36

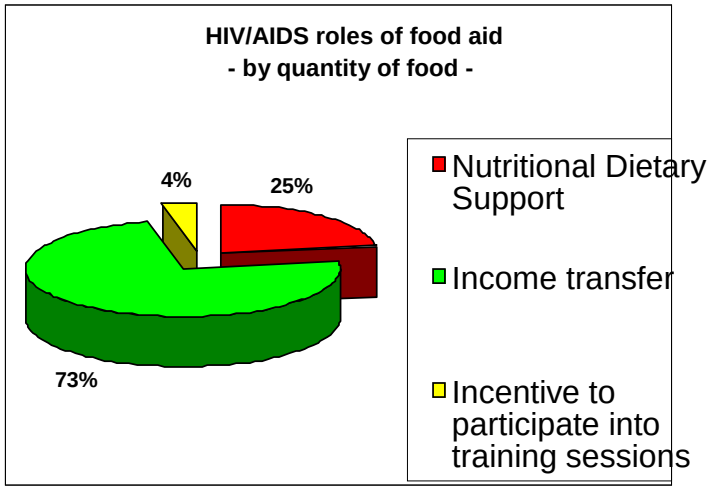


Chart 37

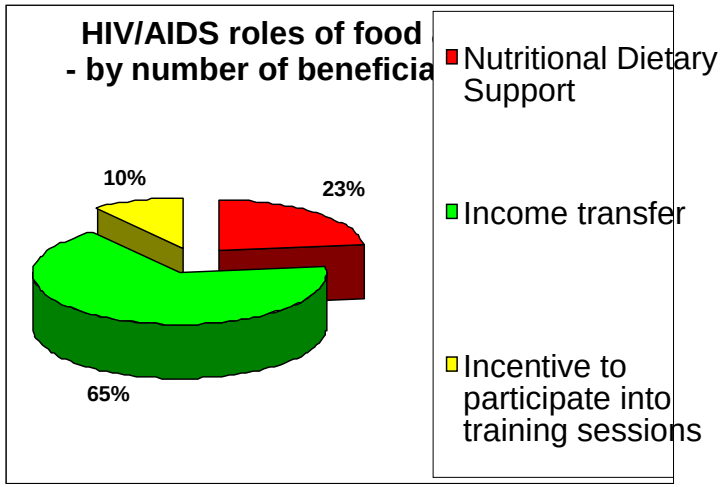
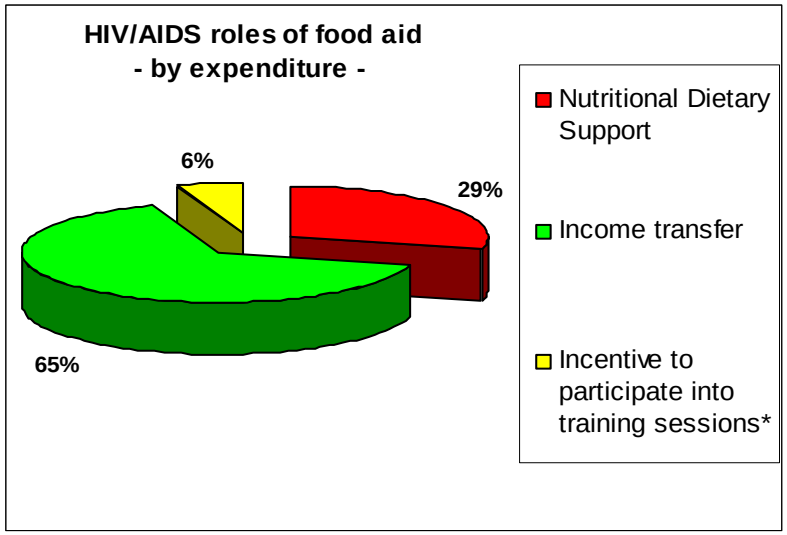


Chart 38



Mapping of WFP HIV & AIDS activities

WFP HIV & AIDS activities by Programme Category

Tab. 18

	Food Tonnage (mt)	%	Beneficiaries (value)	%	Cost (million $)	%
PRRO	**123,129**	**73%**	**1,572,666**	**78%**	**60,998,551**	**69%**
CP/DEV	**45,199**	**27%**	**443,620**	**22%**	**26,016,247**	**29%**
EMOP	**1,160**	**1%**	**3,198**	**0%**	**1,374,400**	**2%**
SO	0	**0%**	0	**0%**	0	**0%**
Totals	**169,488**	100%	**2,019,484**	100%	**88,389,198**	100%

Chart 39

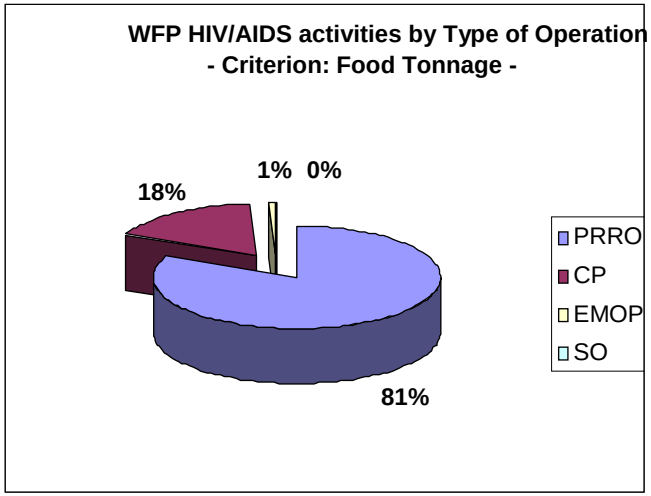


Chart 40

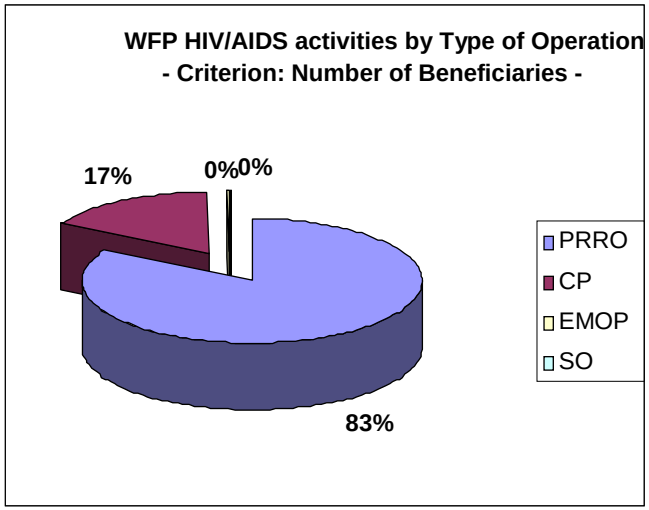
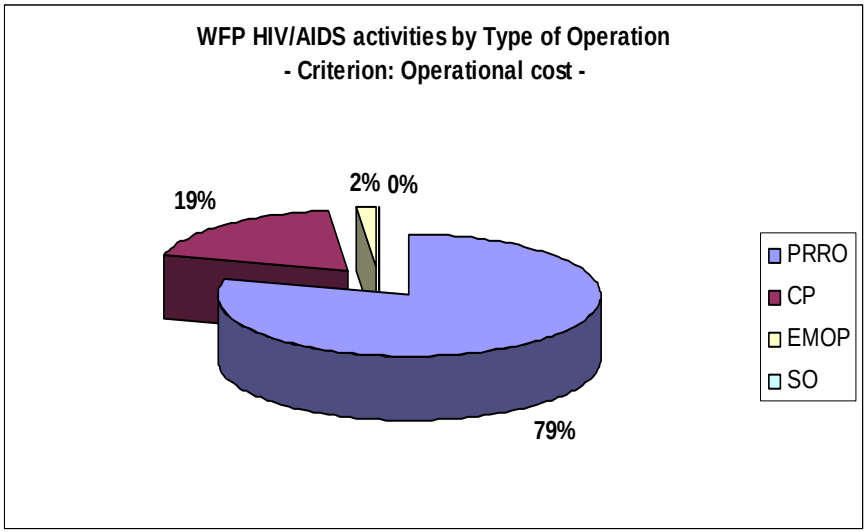


Chart 41



World distribution of WFP HIV & AIDS activities

Region	Country	ACTUAL Food Tonnage for HIV/AIDS activities (YEARLY)	ACTUAL Number of HIV/AIDS beneficiaries (YEARLY)	ACTUAL WFP Operational Cost for HIV/AIDS activities (YEARLY)
ODB	Afghanistan	no activity	no activity	no activity
ODC	Algeria	no activity	no activity	no activity
ODJ	Angola	624	23,152	392,493
ODC	Armenia	not counted	300	not counted
ODC	Azerbaijan	no activity	no activity	no activity
ODB	Bangladesh	no activity	no activity	no activity
ODDY	Benin	no activity	no activity	no activity
ODB	Bhutan	no activity	no activity	no activity
ODP	Bolivia	not counted	7,000	not counted
ODD	Burkina Faso	1,155	7,688	516,950
ODK	Burundi	7,511	61,015	4,078,283
ODB	Cambodia	2,496	46,013	1,343,335
ODDY	Cameroon	no activity	no activity	no activity
ODDY	Central African Republic	2,288	13,333	1,261,125
ODDY	Chad	no activity	no activity	no activity
ODP	Colombia	not counted	n/a	not counted
ODK	Congo	2,492	3,965	1,735,607
ODK	Congo DR	3,283	97,107	2,934,555
ODD	Cote d'Ivoire	2,044	14,422	1,733,512
ODP	Cuba	no activity	no activity	no activity
ODK	Djibouti	973	4,600	1,497,733
ODP	Ecuador	no activity	no activity	no activity
ODC	Egypt	no activity	no activity	no activity
ODP	El Salvador	no activity	no activity	no activity
ODK	Eritrea	3,656	18,090	1,681,760
ODK	Ethiopia	3,646	30,932	1,443,618
ODD	Gambia	not counted	6,100	not counted
ODC	Georgia	no activity	no activity	no activity
ODDY	Ghana	118	255	74,088
ODP	Guatemala	no activity	no activity	no activity
ODD	Guinea	86	1,763	48,370
ODD	Guinea Bissau	778	1,825	418,144
ODP	Haiti	1,916	58,099	2,275,594

Region	Country	ACTUAL Food Tonnage for HIV/AIDS activities (YEARLY)	ACTUAL Number of HIV/AIDS beneficiaries (YEARLY)	ACTUAL WFP Operational Cost for HIV/AIDS activities (YEARLY)
ODP	Honduras	434	1,785	152,376
ODB	India	no activity	no activity	no activity
ODB	Indonesia	no activity	no activity	no activity
ODC	Iran	no activity	no activity	no activity
ODC	Iraq	no activity	no activity	no activity
ODC	Jordan	no activity	no activity	no activity
ODK	Kenya	2,036	39,769	757,736
ODB	Korea DPR	no activity	no activity	no activity
ODB	Laos	no activity	no activity	no activity
ODJ	Lesotho	17,726	100,000	6,440,820
ODD	Liberia	286	2,197	115,652
ODJ	Madagascar	NO ANSWER	NO ANSWER	NO ANSWER
ODJ	Malawi	28,086	182,905	17,290,000
ODD	Mali	199	4,383	90,587
ODD	Mauritania	196	474	186,549
ODJ	Mozambique	18,666	149,969	11,255,660
ODB	Myanmar	40	2,687	12,482
ODJ	Namibia	no activity	no activity	no activity
ODB	Nepal	no activity	no activity	no activity
ODP	Nicaragua	not counted	n/a	not counted
ODD	Niger	no activity	no activity	no activity
ODC	Occupied Palestinian Territories	no activity	no activity	no activity
ODB	Pakistan	no activity	no activity	no activity
ODP	Peru	324	9,000	508,000
ODC	Russia	no activity	no activity	no activity
ODK	Rwanda	3,612	49,623	2,401,748
ODDY	Sao Tome and Principe	no activity	no activity	no activity
ODD	Senegal	121	11,340	93,396
ODD	Sierra Leone	no activity	no activity	no activity
ODK	Somalia	63	350	47,250
ODB	Sri Lanka	no activity	no activity	no activity
ODS	Sudan	1,160	3,198	1,374,400
ODJ	Swaziland	1,681	43,250	137,918

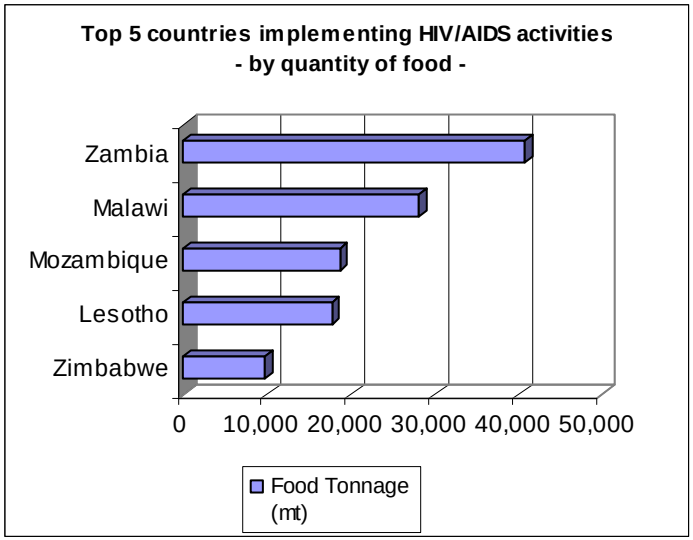
Region	Country	ACTUAL Food Tonnage for HIV/AIDS activities (YEARLY)	ACTUAL Number of HIV/AIDS beneficiaries (YEARLY)	ACTUAL WFP Operational Cost for HIV/AIDS activities (YEARLY)
ODC	Syria	no activity	no activity	no activity
ODC	Tajikistan	no activity	no activity	no activity
ODK	Tanzania	3,999	13,480	2,313,778
ODB	Timor Leste	no activity	no activity	no activity
ODK	Uganda	7,363	99,929	1,311,825
ODC	Yemen	no activity	no activity	no activity
ODJ	Zambia	40,743	610,231	22,506,844
ODJ	Zimbabwe	9,692	299,261	4,962,304

Distribution of WFP HIV & AIDS activities by Regional Bureau
Top WFP countries with HIV & AIDS activities

Tab. 19
- By Food Tonnage -

Region	Top 5 countries	Food Tonnage (mt)
ODJ	Zambia	**40,743**
ODJ	Malawi	**28,086**
ODJ	Mozambique	**18,666**
ODJ	Lesotho	**17,726**
ODJ	Zimbabwe	**9,692**

Chart 42

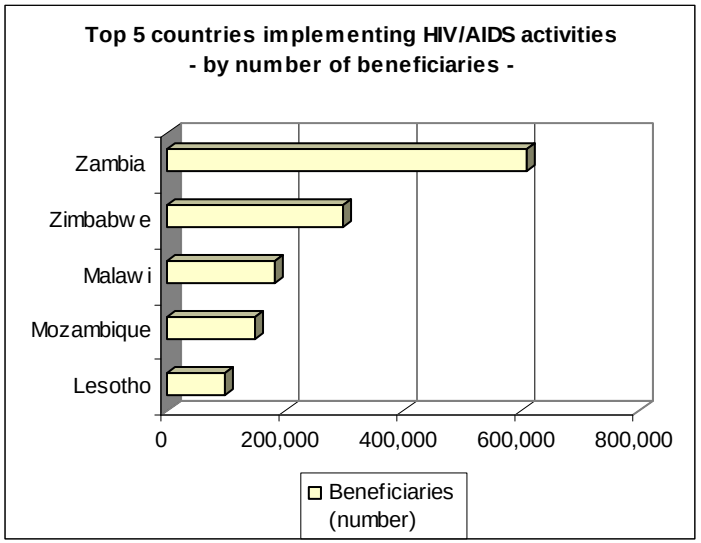


Tab. 20

- By Number of Beneficiaries -

Region	Top 5 countries	Beneficiaries (number)
ODJ	Zambia	**610,231**
ODJ	Zimbabwe	**299,261**
ODJ	Malawi	**182,905**
ODJ	Mozambique	**149,969**
ODJ	Lesotho	**100,000**

Chart 43

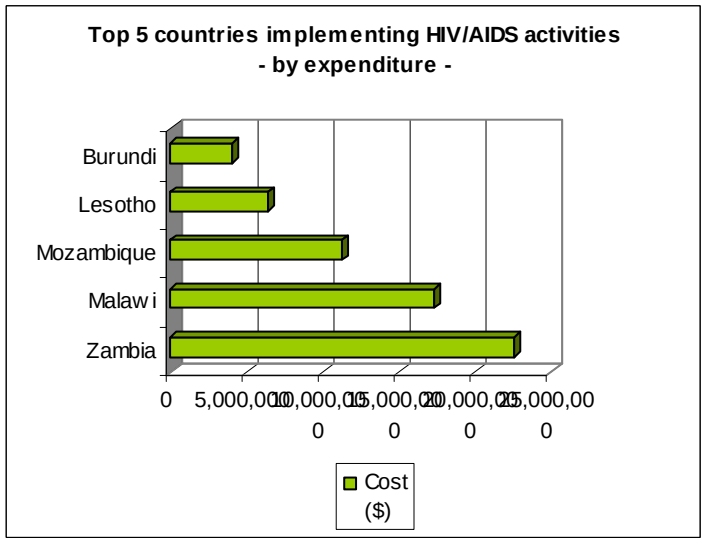


Tab. 21

- By Expenditure -

Region	Top 5 countries	Beneficiaries (number)
ODJ	Zambia	**610,231**
ODJ	Zimbabwe	**299,261**
ODJ	Malawi	**182,905**
ODJ	Mozambique	**149,969**
ODJ	Lesotho	**100,000**

Chart 44



Top WFP countries with HIV & AIDS activities by Regional Bureau

In ODB

Tab. 22

ODB			
Top 3 countries*	Food Tonnage (mt)	Beneficiaries (value)	Cost (million $)
Cambodia	**2,496**	**46,013**	**1,343,335**
Myanmar	**40**	**2,687**	**12,482**

In ODC

Tab. 23

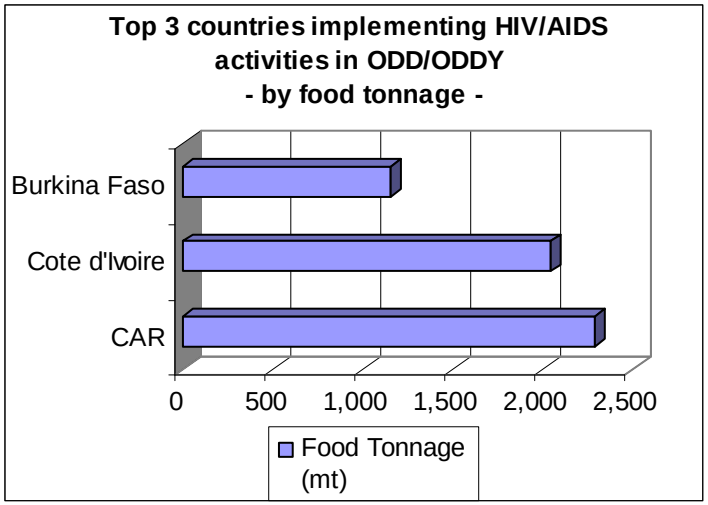
ODC			
Top countries*	Food Tonnage (mt)	Beneficiaries (number)	Cost ($)
ARMENIA	**0**	**300**	**0**

In ODD

Tab. 24

ODD/ODDY	
Top 3 countries	Food Tonnage (mt)
CAR	**2,288**
Cote d'Ivoire	**2,044**
Burkina Faso	**1,155**

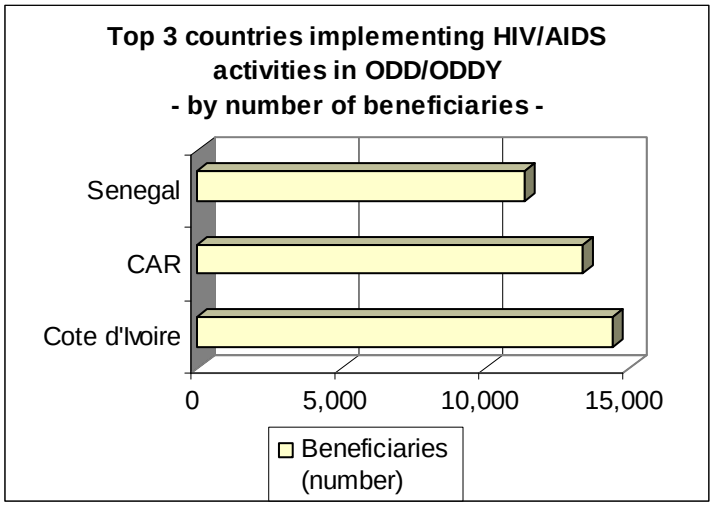
Chart 45



Tab. 25

ODD/ODDY	
Top 3 countries	**Beneficiaries (number)**
Cote d'Ivoire	**14,422**
CAR	**13,333**
Senegal	**11,340**

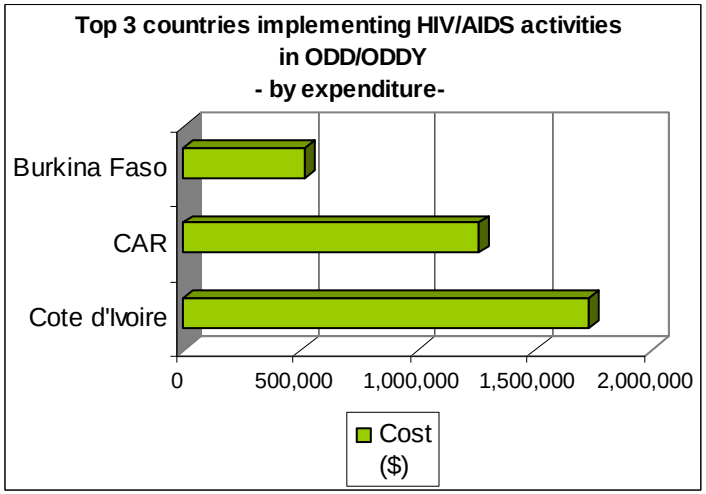
Chart 46



Tab. 26

ODD/ODDY	
Top 3 countries	**Cost ($)**
Cote d'Ivoire	**1,733,512**
CAR	**1,261,125**
Burkina Faso	**516,950**

Chart 47

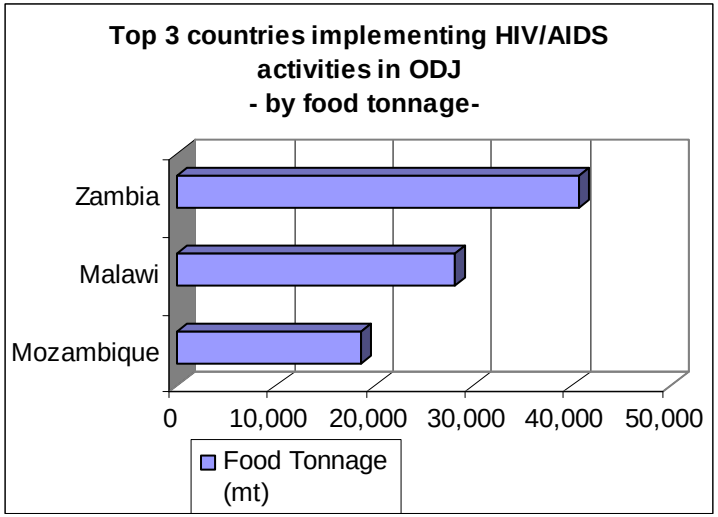


In ODJ

Tab. 27

ODJ	
Top 3 countries	**Food Tonnage (mt)**
Zambia	**40,743**
Malawi	**28,086**
Mozambique	**18,666**

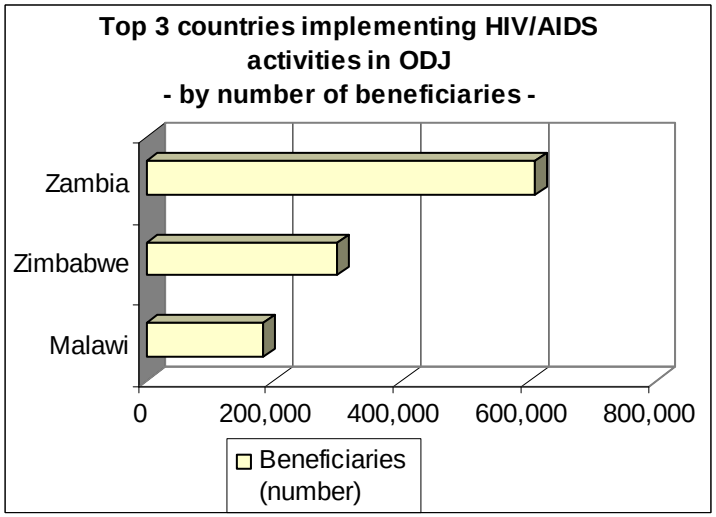
Chart 48



Tab. 28

ODJ	
Top 3 countries	**Beneficiaries (number)**
Zambia	**610,231**
Zimbabwe	**299,261**
Malawi	**182,905**

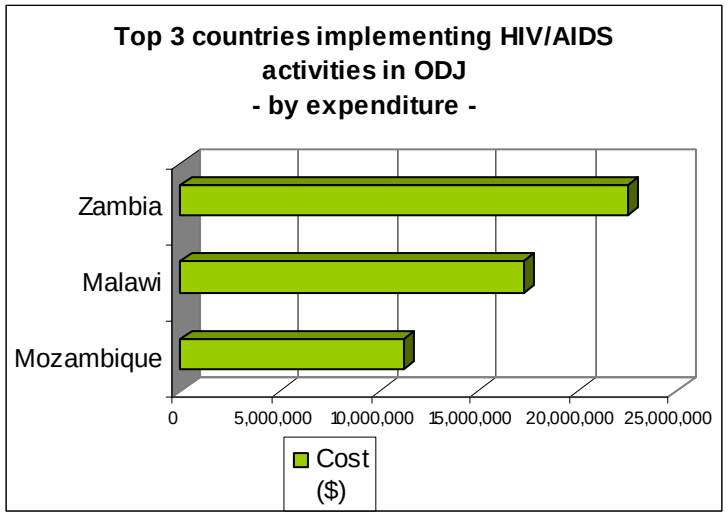
Chart 49



Tab. 29

ODJ	
Top 3 countries	**Cost ($)**
Zambia	**22,506,844**
Malawi	**17,290,000**
Mozambique	**11,255,660**

Chart 50

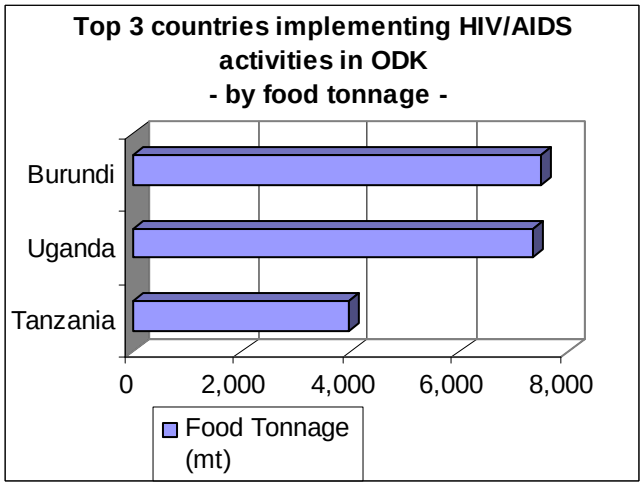


In ODK

Tab. 30

ODK	
Top 3 countries	**Food Tonnage (mt)**
Burundi	**7,511**
Uganda	**7,363**
Tanzania	**3,999**

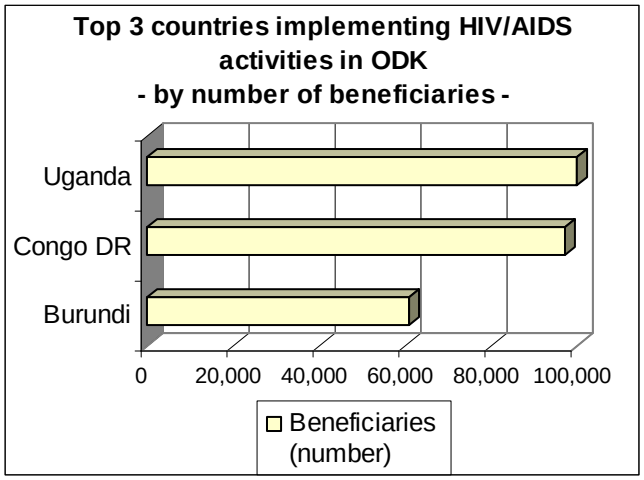
Chart 51



Tab. 31

ODK	
Top 3 countries	**Beneficiaries (number)**
Uganda	**99,929**
Congo DR	**97,107**
Burundi	**61,015**

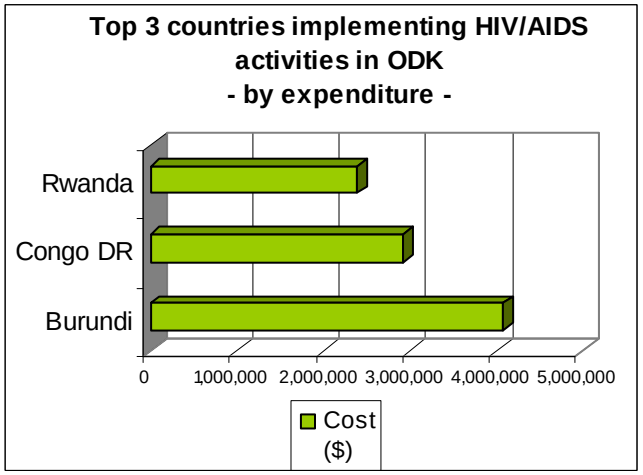
Chart 52



Tab. 32

ODK	
Top 3 countries	**Cost ($)**
Burundi	**4,078,283**
Congo DR	**2,934,555**
Rwanda	**2,401,748**

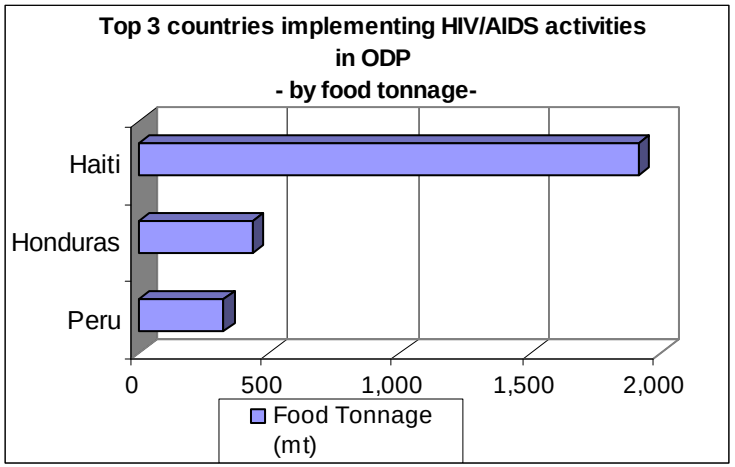
Chart 53



Tab. 33

ODP	
Top 3 countries	**Food Tonnage (mt)**
Haiti	**1,916**
Honduras	**434**
Peru	**324**

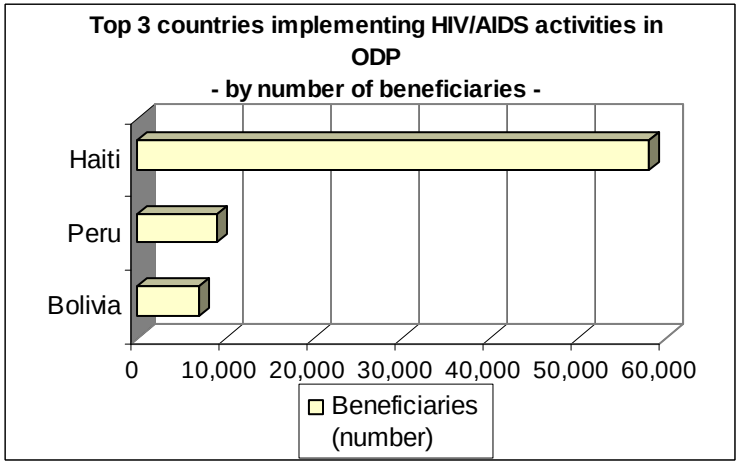
Chart 54



Tab. 34

ODP	
Top 3 countries	**Beneficiaries (number)**
Haiti	**58,099**
Peru	**9,000**
Bolivia	**7,000**

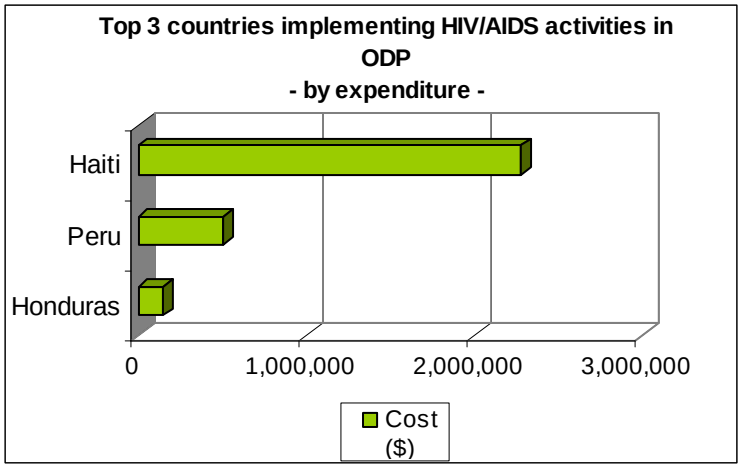
Chart 55



Tab. 35

ODP	
Top 3 countries	**Cost ($)**
Haiti	**2,275,594**
Peru	**508,000**
Honduras	**152,376**

Chart 56



Tab. 36

ODS: Sudan - Stand Alone Country -			
	Food Tonnage (mt)	**Beneficiaries (value)**	**Cost ($)**
Sudan	**1,160**	**3,198**	**1,374,400**

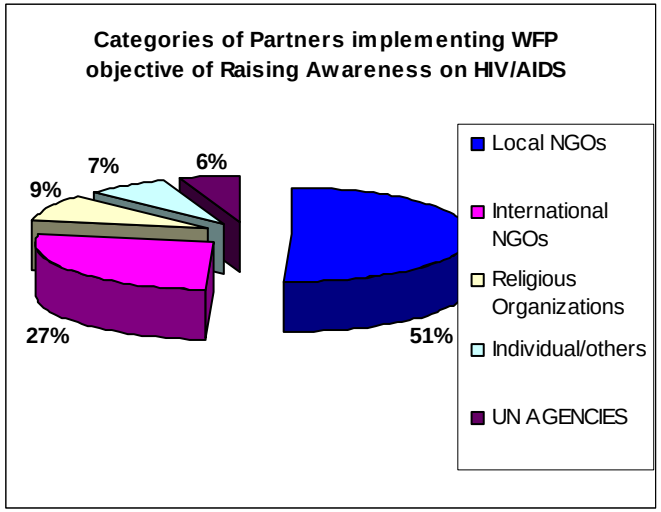
WFP Partners in implementing HIV & AIDS activities

Co-operating Partners according to WFP objectives

Tab. 37

objective: Raise HIV/AIDS awareness Partnership Category	frequency
Local NGOs	55
International NGOs	29
Religious Organizations	10
Individual/others	8
UN AGENCIES	6

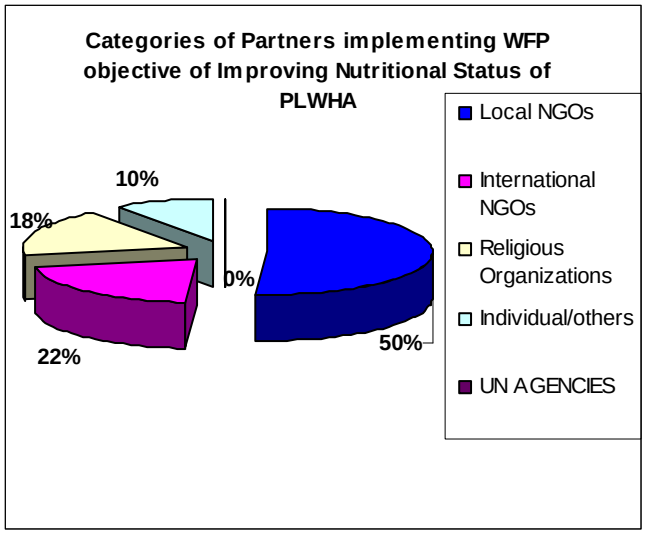
Chart 57



Tab. 38

objective: Improve Nutritional Status	
Partnership Category	**frequency**
Local NGOs	52
International NGOs	22
Religious Organizations	18
Individual/others	10
UN AGENCIES	0

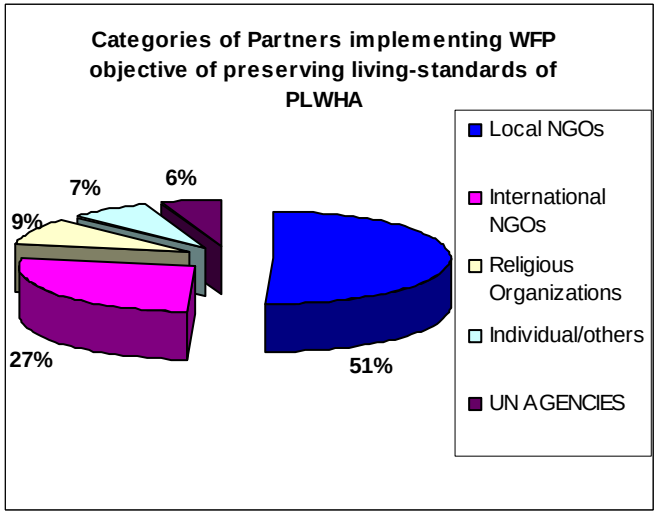
Chart 58



Tab. 39

objective: Preserving living-standards	
Partnership Category	**frequency**
Local NGOs	29
International NGOs	23
Religious Organizations	6
Individual/others	3
UN AGENCIES	2

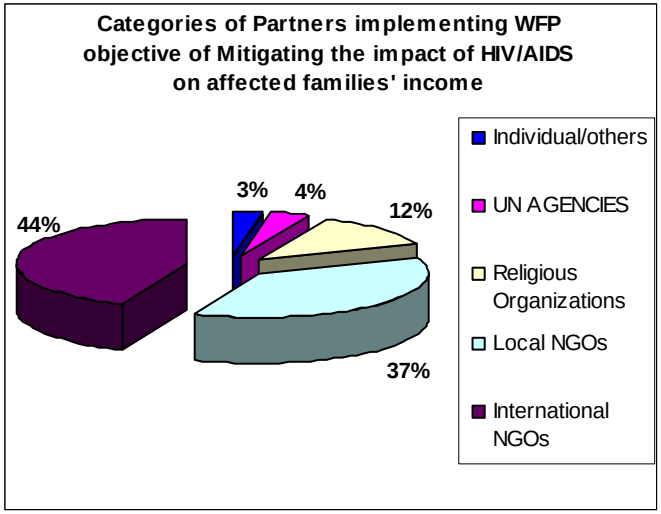
Chart 59



Tab. 40

objective: Mitigate the impact on income	
Partnership Category	**frequency**
Individual/others	3
UN AGENCIES	4
Religious Organizations	13
Local NGOs	39
International NGOs	46

Chart 60

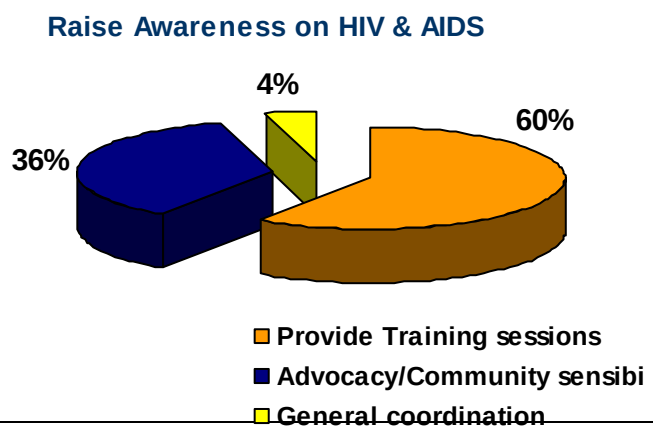


Co-operating Partners' roles according to WFP objectives

Tab. 41

Raise awareness	
Partners' Role**	**FREQ.**
Provide Training sessions	57
Advocacy/Community sensibilization	35
General coordination	4

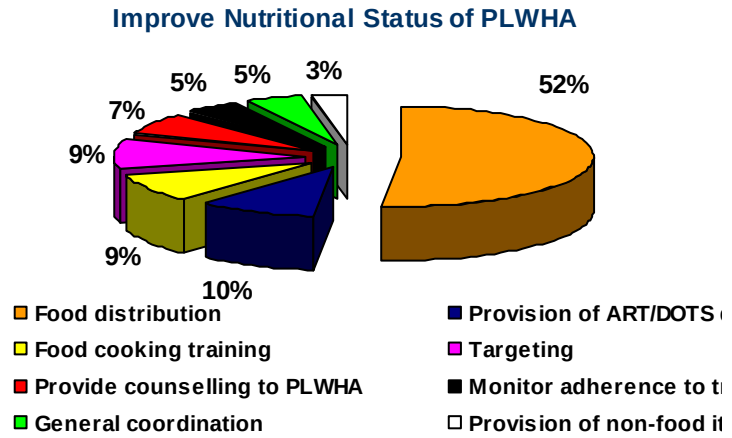
Chart 61



Tab. 42

Improve Nutritional Status	
Partners' Role**	**FREQ.**
Food distribution	66
Provision of ART/DOTS drugs	13
Food cooking training	12
Targeting	12
Provide counselling to PLWHA	9
Monitor adherence to treatment	6
General coordination	6
Provision of non-food items	4
…	

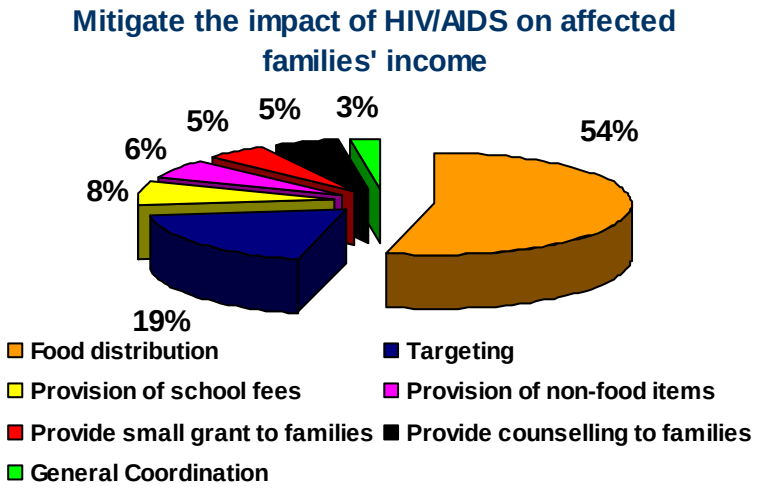
Chart 62



Tab. 43

Mitigate the Impact of HIV/AIDS on income	
Partners' Role**	**FREQ.**
Food distribution	42
Targeting	15
Provision of school fees	6
Provision of non-food items	5
Provide small grant to families	4
Provide counselling to families	4
General coordination	2
…	

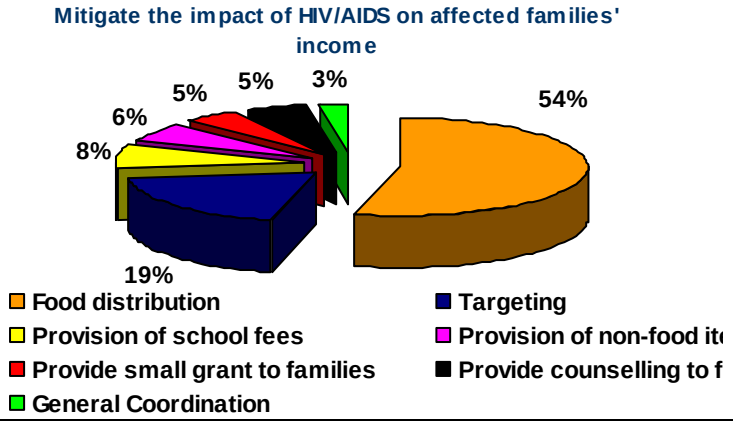
Chart 63



Tab. 44

Preserving living-standards	
Partners' Role**	**FREQ.**
Provide Training sessions	17
IGA implementation	12
Food distribution	8
Gardening implementation	4
Provide small grant to families	3
…	

Chart 64

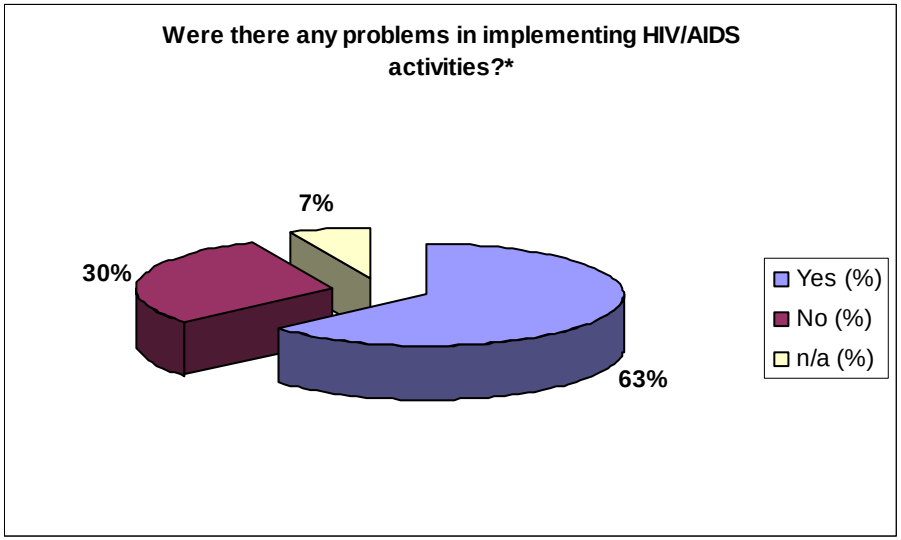


Implementation Constraints

Tab. 47

	Yes (n)	Yes (%)	No (n)	No (%)	n/a (n)	n/a (%)	Total (N)
Were there any problems in implementing HIV/AIDS activities?*	63	**66%**	27	**28%**	6	**6%**	96

Chart 66



Tab. 48

Problems during implementation**	Freq.	%
Resource	**30**	**50%**
Limited capacity of partners	**17**	**28%**
Lack of national guidelines	**4**	**7%**
Food basket not nutritionally optimised	**3**	**5%**
Difficulty in reaching the targeted beneficiaries	**2**	**3%**
High cost of transport	**2**	**3%**
Beneficiaries' stigmatization	**2**	**3%**
Totals	**60**	**100%**

Others

Tab. 46

** Other questions	Yes (%)	No (%)	Yes (n)	No (n)	Total (N)
Are gender issues incorporated to address HIV/AIDS through existing programmes?	**78%**	**23%**	31	9	40
Does your Office provide technical support, regarding linkages in the areas of food security/nutrition and HIV/AIDS?	**65%**	**35%**	26	14	40
Do you advocate at local, national or international levels to promote the importance of food and nutrition?	**95%**	**5%**	38	2	40
In the case of national level, do you advocate with national governments, donors, and NGOs to make sure food and nutritional support (technical information and/or actual food) is included in the National HIV/AIDS Strategic Plan?	**87%**	**13%**	33	5	38

Annex D: Questionnaires: Example of questionnaire on HIV & AIDS activities for ODB Region.

1) Country	2) Project Number	3) Title	4) HIV/AIDS Objectives/outcomes extracted from Blue Books and Project Documents	5) HIV/AIDS Standardised Objectives	6) HIV/AIDS Activities	7) Role of Food Aid	8) ACTUAL Number of HIV/AIDS beneficiaries (estimated YEARLY figure)		9) ACTUAL Food Tonnage for HIV/AIDS activities (estimated YEARLY figure)		10) ACTUAL WFP Operational Cost for HIV/AIDS activities (estimated YEARLY figures)		11) What does the food basket consist of?	12) Were there any problems in implementing HIV/AIDS activities? (Yes/No)	13) If yes, briefly explain
							2004	2005	2004	2005	2004	2005			
India	10107.0	WFP/NACO Technical Assistance & Capacity Building Project	This capacity building project aims to contribute to improve nutritional status and quality of life of Persons Living with HIV/AIDS leading to increase productivity and household food security Objectives Specifically, this technical assistance project aims to .Strengthen the state level capacity to target, manage, coordinate, and demonstrate outcomes of food and nutrition-supported HIV/AIDS programmes;	Mitigate the impact of HVI/AIDS on PLWHA's income	**This activity should be better specified by CO (e.g. ART, PMTCT, HBC, etc.)**	**The role of food aid should be better specified by CO**									
Nepal	10093.0	Country Programme based on 3 Activities	All participants (expectant and nursing mothers or caretakers of young children) are to receive information through the MCHC services on nutrition and health, safe motherhood, hygiene and HIV/AIDS.	Raise awareness on HIV/AIDS (HIV/AIDS affected and non affected people)	Training on HIV/AIDS disease through PMTCT activities	Incentive to participate into training sessions									
Totals															

Annex B: Questionnaire on Partnership

OEDE – OFFICE OF EVALUATION
SURVEY ON IMPLEMENTED HIV/AIDS ACTIVITIES
QUESTIONNAIRE ON PARTNERSHIP

Country: _____

1) WFP HIV/AIDS Objectives	2) Please provide the name(s) of co-operating partner(s), other than governmental for each objective (if there are no Partners, leave it blank)	3) Please provide the role/activities played by each partner
Raise awareness on HIV/AIDS (HIV/AIDS affected and NON-affected people)	1.	
	2.	
	3.	
	4.	
	5.	
	6.	
Improve Nutritional Status (PLWHA, patients in drug therapy etc.)	1.	
	2.	
	3.	
	4.	
	5.	
	6.	
Mitigate the impact of HIV/AIDS on income (affected households and OVCs foster families, etc.)	1.	
	2.	

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