HAARP OUTCOMES AND DFAT LESSONS ASSESSMENT

Final Report

PSI/Vietnam

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Authorship Note

This report was developed with input from the following individuals who were involved in providing M&E Support to the HAARP project through PSI/Vietnam: Gary Mundy, Hoang Tran, Josselyn Neukom and Jennifer Rowley.

Contents

Acronyms

ADB	Asian Development Bank
ANPUD	Asian Network for People who Use Drugs
ARHP	Asia Regional HIV/AIDS Program
CP	Country Programs
CSU	Country Support Units
DP	Development Partners
DFAT	Department of Foreign Affairs and Trade
DQA	Data Quality Assessment
FHI360	Family Health International
FI	Friends International
FSW	Female Sex Workers
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMS	Greater Mekong Sub-Region
HAARP	HIV/AIDS Asia Regional Program
HCCF	HAARP Consultation and Coordination Forum
IDPC	International Drug Policy Consortium
IMTR	Independent Mid-Term Review
KHANA	Khmer HIV/AIDS NGO Alliance
Korsang	Cambodian Implementing Partner (NGO)
M&E	Monitoring & Evaluation
MMT	Methadone Maintenance Treatment
MSM	Men who have Sex with Men
NACD	National Authority for Combating Drugs
NSP	Needle & Syringe Programs
OST	Opioid Substitution Therapy
PAF	Performance Assessment Framework
PCPI	Police Community Initiative Program
PWID	People Who Inject Drugs
QAI	Quality at Implementation
RGoC	Royal Government of Cambodia
RQA	Rapid Qualitative Assessments
RTCU	Regional Technical & Coordination Unit
SEARH	South East Asia Regional Hub (DFAT)
STI	Sexually Transmitted Infection
TSU	Technical Support Unit
UIC	Unique Identifier Codes
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
VAAC	Vietnam Administration of HIV/AIDS Control
WHO	World Health Organization
YUNDI	China/Myanmar Implementing Partner (NGO)
3MDG Fund	Three Millennium Development Goal Fund

Executive Summary

This report explores the highest-level outcomes and lessons associated with the HIV/AIDS Asia Regional Program (HAARP). It assesses the progression of HAARP through design, implementation, and completion, and has identified key program successes and missed opportunities. Particular emphasis has been placed on identifying underlying program challenges, with the intention that these will serve as constructive learning points for future policy makers and program managers. The HAARP Outcomes & DFAT Lessons Assessment has sought to specifically assess and document: implicit qualitative achievements; program strengths and challenges; impact of HAARP's accelerated closure; and key program lessons.

HAARP was funded by the Australia Department of Foreign Affairs and Trade (DFAT) over the course of seven years and implemented in Cambodia, Vietnam, Lao PDR, China, and Myanmar. The program had a unique and progressive focus on harm reduction and a highly targeted approach towards people who inject drugs (PWID). This was complemented by impressive efforts to balance programmatic and policy change results. Harm reduction service provision was further supported in tandem with appropriate capacity building efforts. Critically, HAARP established some of the very first needle exchanges, drop-in centers, and methadone treatment programs across countries in the Greater Mekong Sub-region (GMS). The project had a unique and progressive focus on harm reduction and a highly targeted approach towards injecting drug users.

HAARP was designed to create and sustain links with national and local actors, including government ministries, HIV/AIDS agencies, drug control bodies, and local organizations, among others. Though the program ultimately intended to improve enabling environments and service provision on a regional scale, country-specific design and implementation formed HAARP's backbone. The program experienced several major obstacles during implementation, including observed underperformance against annual and project-wide targets, relatively late development of more effective country-specific yet regionally consistent monitoring and evaluation frameworks, and challenging country specific operating contexts. In response, HAARP underwent several program adjustments. Alongside shifts in program emphasis and strategies implemented, the program management structure evolved to include greater decentralization of day-to-day oversight and technical support from regional to in-country levels.

In response to Government of Australia budget cuts and aid effectiveness mandate HAARP halted operations through an accelerated exit strategy, and formally ended all program activities six months ahead of schedule on December 31, 2014. Although HAARP transition and exit strategy planning had begun relatively early in the project implementation cycle, this accelerated close-out timeline and reduced budget levels had significant implications for service provision, capacity building, advocacy and monitoring and evaluation (M&E) activities and related results.

Ultimately, HAARP launched and transitioned service provision programs in all five target countries, positive examples of sustained activities include the transfer of Methadone Maintenance Treatment (MMT) in Vietnam and Cambodia and the transition of Needle & Syringe Programs (NSP) in Lao PDR. Substantial and promising changes to government acceptance of harm reduction have also been identified in Cambodia, Vietnam, and China.

Key Findings

Visionary Focus: Interviewees widely regarded HAARP as a progressive, worthwhile program for several reasons: it paved the road to harm reduction policy formation, it looked to tailor programs specifically around the needs of a vulnerable population, and it addressed the HIV epidemic through a regional lens. In short, HAARP made important steps forward for health policies in numerous and significant ways.

Challenging Regional-National Balance: The design and early implementation period of HAARP was far more protracted than anticipated, in part because of its highly collaborative approach which was intended to promote stakeholder buy-in from the program's outset while maintaining regional priorities. Throughout its life course, the program underwent numerous adjustments in structure and implementation strategy, in part because of the challenges faced in maintaining a productive regional-national balance.

Weak M&E: The program suffered from an initially weak monitoring and evaluation framework, which hindered proper collection and analysis of data. This limited country program managers' ability to respond to operational challenges and regional program managers' ability to recognize inaccuracies in coverage and service distribution, which made gauging country program progress difficult.

Receptive Beneficiaries: Qualitative data collected from PWID (Lao PDR and Cambodia) indicated a largely positive perception of HAARP's activities. Respondents claimed that programs opened up a quality of service that had not been available previously, in addition to creating positive and safe spaces for receiving healthcare.

Key Lessons

Realizing HAARP's ambitious and visionary objectives has provided important insights into the challenges facing harm reduction policy development, thoughtful service provision to marginalized populations, as well as regionally minded programming. The following key lessons have been extracted from qualitative data collection and formal assessment of program documentation:

- The combination of service delivery and advocacy objectives was both realistic and appropriate.
- Opportunities were missed to address regional harm reduction issues related to global best practice.
- Regional support works best when it is focused on select leadership and coordination roles, and balanced with complementary in-country project management and technical assistance.
- Securing high-level, consistent in-country championship within DFAT teams early on and throughout the project period can significantly enhance regional program results.
- Unclear measures of success hampered program results.
- External organizations selected specifically to fill program competencies, can add value to a regional program.
- Work remains to be done to serve the needs of communities most at risk of HIV/AIDS in the region.

Background

The HIV/AIDS Asia Regional Program (HAARP) is a seven-year regional program funded by the Australia Department of Foreign Affairs and Trade (DFAT). The program was initiated in 2007 and ran until December 2014 with a final total budget of $38 million. HAARP spanned across five Country Programs (CPs) in the GMS: Cambodia, Vietnam, China, Myanmar and Lao PDR. The overall initiative budget has been readjusted from an initial $59 million submitted request approved in 2007, to $47 million in 2013, to an estimated final obligation of $38 million.

HAARP sought to continue the Australian Aid Program's HIV reduction program the Asia Regional HIV/AIDS Program (ARHP), which ran from 2002-2007 and implemented activities in Vietnam, Myanmar, and southern China. HAARP was "welcomed by stakeholders as an innovative and far-sighted initiative" that had the potential to build off the progress made by its predecessor ARHP, according to the 2009 Quality at Implementation report.

The overall objective of HAARP was to strengthen the capacity and will of governments, at all levels, and communities in the Greater Mekong Sub-Region (GMS) to adopt effective harm reduction approaches for HIV among people who inject drugs (PWID) and their partners. This specific population has been long identified as a marginalized group with limited access to HIV harm reduction services and thus stood to benefit greatly from HAARP's aims. HAARP sought to achieve this goal by improving the quality and effectiveness of harm reduction approaches in the region and scaling up harm reduction responses in its focus countries.

In addition to promoting the efficacy of harm reduction policies in host governments, HAARP aimed to achieve the intermediate objective of increasing direct delivery of HIV/AIDS harm reduction services to PWID and their partners. Plans for service provision initially spanned needle and syringe program (NSP), condom programming, opioid substitution therapy, peer outreach, and referrals. Over its lifetime, HAARP rolled out NSP in Cambodia, Myanmar, Vietnam, Lao PDR, and China, as well as methadone maintenance treatment (MMT) in Cambodia and Vietnam.

HAARP has sought to engage other key regional stakeholders in all five countries. In Vietnam, HAARP has partnered government health ministries, HIV/AIDS agencies, and drug control boards; in Lao PDR activities have been implemented through the United Nations Office on Drugs and Crime (UNODC); in Cambodia through NGOs: FHI360, Khmer HIV/AIDS NGO Alliance (KHANA), Korsang, Friends International and the World Health Organization (WHO); and YUNDI in China under coordination of the United Nations Joint Program on HIV and AIDS (UNAIDS). HAARP mainland China was successfully transferred to government systems in 2012 and in Myanmar, funding has been channeled (since 2012) through the Three Millennium Development Goal Fund (3MDG Fund). Between 2008 and 2012 the program was implemented by UNODC. Regionalized partnerships were also established with the International Drug Policy Consortium (IDPC), the Asian Network for People who Use Drugs (ANPUD) and PSI Vietnam.

Several issues confronted the HAARP program on both regional and country levels, which will be discussed at length in the outcomes and key findings section. Difficulties in the design and implementation related to the multi-country modality of HAARP characterized its early years. An overly complex M&E system also hindered appropriate program assessment for five of its seven years of operation. Issues in engaging governments and reaching PWID were also faced.

Key tactical pivots were made in the latter years of HAARP's operations in light of a mid-term review in February 2011. The original multi-country framework saw a great degree of decentralization that produced increased levels of efficiency according to annual reports.

Additionally, a gap analysis and M&E overhaul headed by PSI Vietnam in 2012 and 2013 paved new methods for reliably assessing program performance and reach. These events will also be discussed in the outcomes section.

In December 2013, DFAT Bangkok, in consultation with bilateral Posts, developed an accelerated HAARP exit strategy, building on an earlier exit strategy developed in 2012. The former detailed a responsible way for DFAT to rationalize and conclude HAARP, while mitigating reputational and developmental risks. The latest exit strategy was specifically designed in anticipation of DFAT aid program budget cuts and was approved in December 2013. The aid program budget reduction was later confirmed in January 2014. HAARP concluded all activities by 31 December 2014.

According to HAARP's minimum data set records, over the course of the program more than 120,000 PWID were reached, through more than 3 million service contacts across all five HAARP countries. Additionally, more than 45,000 referrals to HAARP related health services were made. Materials distributed totaled at over 5.5 million condoms, 8 million sterile water vials, and 22.3 million needles and syringes. HAARP's most implicit achievements identified and assessed through this evaluation exercise help provide richer understanding of HAARP's quantitative accomplishments.

Purpose

The overall purpose of the HAARP Outcomes & DFAT Lessons Assessment is to articulate the program's implicit qualitative achievements, key organizational strengths and challenges and lessons learned. Assessment of these aspects would represent a constructive program legacy document, from which program managers can operationalize lessons and inform DFAT's wider regional program strategy. Specific analysis has been undertaken of how HAARP contributed to changes (outcomes) at the country level, related to PWID service delivery, behavior and access to care, in addition to any policy advancement related to harm reduction goals.

Objectives

To assess HAARP's outcome level achievements and DFAT's programmatic lessons learned since the program's inception in 2007 through to its closure on 31 December 2014, the following key objectives were identified in consultation with DFAT South East Asia Regional Hub (SEARH) and in consultation with all HAARP CPs:

- Assess and document HAARP's implicit qualitative achievements, as well as progress against overall program and country specific outcomes.
- Identify and document program strengths and challenges arising from HAARP's design, DFAT management of program implementation, and country contexts (political, social and cultural) throughout the program's life cycle.
- Assess and document how HAARP's accelerated closure has impacted outcomes and management. Specifically, through the prioritization of service delivery over capacity building and advocacy, and transfer of management/technical oversight back to Posts.
- Develop and document key lessons learned for DFAT from evidenced program achievements and challenges; in order to inform future DFAT initiative design, implementation and strategic approaches in the GMS.

Methodology

The methodology utilized to achieve the objectives outlined above followed the pre-determined evaluation plan (attached as Annex IV) included:

i) A desk review of project related documents, of which a full list of those reviewed is attached as Annex I, related to HAARP's design, logical framework, monitoring and evaluation (M&E), and various key country reports.

ii) In-depth primary data collection interviews with key program stakeholders at global, regional and country levels, to supplement information available through project documentation and solicit qualitative insights related to HAARP's implicit achievements and lessons. Interviews were conducted in person or by telephone from October to December 2014. A full list of individuals interviewed is included as Annex II. Interview guides were developed in consultation with DFAT SEARH to assess overall perceptions of HAARP achievements, challenges and lessons.

Relevant information from the reports listed above were reviewed and synthesized with qualitative inputs from stakeholder interviews to gather and summarize key regional and country-level program outcomes. Cross-cutting qualitative themes were identified by reviewing in-depth interview notes around key themes including perceptions of HAARP's achievements, challenges, lessons and recommendations related to project design and management.

Outcomes were assessed through a comparison of formal reports against HAARP's overall goals and country-level objectives articulated from the outset of the project. Qualitative perceptions regarding the project's most significant achievements were also integrated into the report. Bias was limited through the use of a standard questionnaire across interviews with each stakeholder group, and through a purposeful effort to interview a range of stakeholders representing different perspectives. Findings related to project lessons are based on qualitative insights from a subset of key stakeholders involved in the project design, implementation and management.

Three HAARP countries (Cambodia, Vietnam, and Lao PDR) were still active at the time of this assessment and this presented greater opportunity for more detailed qualitative analysis in these countries. HAARP China's key outcomes and lessons were addressed in a previous independent review at the program's conclusion in 2012. HAARP Myanmar also completed its formal contract in the same year and associated reporting has been used to contribute to this assessment's objectives. While both country-level challenges, outcomes, and lessons have been reviewed in both the outcomes and key lessons sections, however, Cambodia, Vietnam, and Lao PDR are more prominent in this assessment.

Challenges

The review was largely completed consistent with the Scope of Work approved by DFAT, with the exception of additional interviews with service users. Due to limited time and resources, it was not feasible to conduct additional interviews with project beneficiaries. Fortunately, in-depth feedback from project beneficiaries was collected by PSI earlier in the HAARP project implementation period through Rapid Qualitative Assessments (RQA) conducted in Cambodia and Laos PDR. Results from the RQA exercises conducted in two countries during 2014 were used to complement other findings summarized in this report with the important perspective of PWID regarding some of HAARPs achievements and lessons.

The assessment became constrained in its scope as a result of available resources and time to comprehensively review of project Outcomes and Lessons in all CPs. This report summarizes high-level findings gleaned from a review exercise conducted by three individuals over a period of approximately four months. DFAT provided productive guidance throughout the review design and data collection process, to ensure that resources were used in an effective manner. In addition, DFAT facilitated critical contract extensions to ensure sufficient time for review and reflection of key findings, including the incorporation of reviewer feedback in February 2015.

Several of the stakeholder interviews and reviewer comments highlighted an interest in analysis of higher level—i.e. behavioral or outcome—results achieved by HAARP, as well as of cost-efficiency. Unfortunately, due to the limited available data regarding behavioral or higher level impact as well as costs associated with HAARP activities, this fell beyond the scope of the Outcomes & Lessons review exercise. This report aims to summarize the main project achievements and lessons based on the review of available quantitative and qualitative data during a fourth month data collection and analysis period at the end of the HAARP project.

PSI's experience providing M&E support to HAARP during the last two years of the implementation period was particularly beneficial given PSI's understanding of the program's overall objectives and related indicators as outlined in the project M&E framework. In addition, PSI's in-country experience working with HAARP partners in Cambodia, Lao PDR and Vietnam, also facilitated the review and analysis of key Outcomes and Lessons due to previous engagement with key partners.

Program Analysis & Timeline

2007-2009: Design & Early Implementation

HAARP's initial design was comprised of three program elements, with two functioning at the regional level and one at the country level. The first major component of HAARP's design was a Technical Support Unit (TSU) implemented through a managing contractor model based in the DFAT Bangkok office, which managed HAARP's regional operations. This entity was intended to coordinate regional efforts internally, primarily by directing regional advocacy efforts and providing technical and policy support.

The second program element emphasized collaboration with multilateral agencies and other donors, which was managed by DFAT Bangkok. These regional partnerships were formed early on as HAARP engaged with donors in Lao PDR, Cambodia, Vietnam, Myanmar, UN agencies, and key international and local NGOs involved in HIV/AIDS and harm reduction in the region. The envisioned benefits of this mechanism included joint efforts in coordinated regional research, information sharing, and activity harmonization.

The third component worked at the national level by delivering activities via Country Programs (CPs) in each of the five HAARP countries. National level activities included creating an enabling environment (e.g. reform of policy and legal frameworks); building partner government and NGO capacity in harm reduction; and delivering harm reduction services through needle and syringe programs (NSP), condom programming, opioid substitution therapy, peer outreach, and referrals into HAARP healthcare services, among others. CPs' design plans were to be developed and approved in collaboration with DFAT Bangkok.

The first two years of the program (2007-2009) saw a protracted CP design phase according to corresponding Quality at Implementation (QAI) reports. The length of the design period was not anticipated in initial design plans, as approval of country-specific program designs from DFAT Bangkok was unexpectedly delayed for some countries. Design, approval, implementation and scaling up of services all struggled with the unanticipated complexity of aligning with national plans and systems, according to early program reports.

Limited human resources were also identified by Australian Aid Program Posts as a concern in managing the complex country-specific negotiations demanded by the program design. An emphasis on effective two-way communication between managers (TSU, DFAT Bangkok, and DFAT Posts) in this early phase of design and implementation was cited in annual reports as a vital step in ensuring the launch of these programs, the last of which were Lao PDR and Vietnam in mid-2009.

2010-2011: Continuation of Initiatives & Services, Mid-Term Review

HAARP underperformed in its first four years according to assessments in several reports. Design confusion persisted, particularly as to the split of regional and country-level focus, and as to the roles of TSU, program directors, regional (Bangkok) and country Posts. Unclear program logic and objectives remained issues.

During the formation of CPs, the TSU played a role in directing efforts and providing support through technical advice. However, as HAARP CPs became increasingly established, TSU support became less consistent and reliable as identified in an independent mid-term review (IMTR) conducted in 2011, particularly because CPs increasingly required permanent responsive and strategic in-country programming and in-country support. High-level managers

remarked in annual reports that this was indicative of regional structures quickly becoming an artifact of initial—now less relevant—visions for HAARP.

According to annual reports during this time, the TSU found it relatively difficult to address program M&E, effective inclusion of PWID in activities, and in incorporating a broader development focus in implementation. The role of the TSU evolved over time from addressing technical needs to meeting more programmatic requirements from CPs, including contract management of service delivery and quality assurance. This collectively warranted a tactical shift away from HAARP's initial regional delivery approach.

Another significant obstacle was an overcomplicated and unused M&E framework that hindered the program in terms of monitoring progress, particularly because it was often incompatible with existing in-country M&E infrastructure. The HAARP Performance Assessment Framework (PAF) was endorsed by HAARP's Advisory Board in mid-2008, and was developed prior to the completion of most CP designs. The PAF served as a high-level guide for program assessment, but therefore could not be used for detailed monitoring purposes. Compounding this, no supplementary M&E systems existed at the country-level in the first two years.

Despite these difficulties, HAARP made important gains in its first five years towards political environment improvements and in building capacity to deliver harm reduction services, according to program reviews. One of the major achievements of HAARP has been the establishment of condom distribution, HIV testing and methadone maintenance treatment (MMT) clinics in countries and locations where this was previously not possible. In 2011, Vietnam made a major breakthrough by implementing a condom program in detention centers and prisons for the first time. Additionally, several NSP in Myanmar, China, and Cambodia were launched, while HIV-related service provision started in Lao PDR in 2011.

Additionally, TSU managed nine cross border sites during this time, which reached over 4,400 PWIDs a year. It is important to note that government collaboration enabled HAARP to target activities at locations using an evidence base. While progress remained inconsistent across countries due to variations in policy climate, program launch dates, and staff capacity, a qualitative assessment of contemporary documents reveals that project managers saw potential in HAARP in this phase of implementation, particularly at the country-level.

2012-2014: Structural Adjustments & M&E Overhaul

In 2012, substantial rearrangements of HAARP were made with an emphasis on improving the quality of the program and ensuring that the objectives of HAARP were clearly defined. HAARP's regional operational framework underwent major adjustments between 2012 and 2013 in response to the 2011 IMTR, which identified structural limitations imposed by top-down focused support systems in a multi-country modality. In May 2012, the TSU model was ended with the expiration of the current managing contract. Dedicated technical resources were therefore unavailable, although DFAT Bangkok continued to oversee the regional component of HAARP through knowledge management, M&E, community engagement, and gauging current harm reduction political environments across CPs.

In 2013, HAARP fully adopted the country support unit (CSU) multi-country delivery model to decentralize technical and program management support. Within this new framework, DFAT Bangkok continued to provided regional support to CPs through knowledge management, M&E, community engagement, and scoping on regional harm reduction policy environment. At the national level, DFAT Posts and CSUs managed contracts and stakeholder relationships with a greater deal of autonomy to improve the efficiency of day-to-day decision-making. However,

CSUs were only partially established in 2013 and, despite efficiency gains, the CSU model was abandoned in 2014 owing to reductions in the Australian aid budget.

HAARP also ended its investments in mainland China and Myanmar in 2012 and early 2013 respectively. Encouragingly, the conclusion of HAARP China allowed the Chinese government to take over HAARP activities and implement their own harm reduction program. However, all remaining funds allocated to HAARP Myanmar were coursed through the 3MDG multi-donor trust fund from January 2013 onwards due to tightened policies on harm reduction implementation. HAARP, as a brand, no longer existed after that point (this will be discussed further in Myanmar's country assessment).

Large-scale changes in the remaining three countries' (Cambodia, Vietnam, and Lao PDR) M&E frameworks occurred in 2013. Until this overhaul, HAARP continued to lack a functional regional M&E framework and the integrity of country-level M&E data varied greatly. In 2012-2013, PSI Vietnam was contracted to perform a gap analysis of the remaining HAARP countries.

In addition to preserving HAARP's overarching goal of strengthening the will and capacity of governments, at all levels, and communities to reduce HIV-related harm among PWID, an intermediate program outcome to increase delivery of HIV/AIDS harm reduction services for PWID and their partners was also incorporated at the regional level in 2013. Measurable indicators and realistic targets were established for key program aspects at the outcome level, As the IMTR noted, to restrict M&E to service delivery limits its ability to demonstrate country leadership, enabling environment creation, long term sustainability, and effectiveness of harm reduction to CP stakeholders.

Thus, the following indicators were integrated into the M&E framework:

1. Evidence of policy development and implementation that creates an enabling environment for HIV harm reduction services *(target: implementation progress proceeding satisfactorily)*;
2. The number of times HIV/AIDS harm reduction services are accessed by PWIDs and their partners *(2013/14 annual target: 340,000)*;
3. The number of men and women on MMT/Opioid Substitution Therapy (OST) *(2013 annual target: 1,200, 2014 cumulative target: 1370)*; and
4. Number of police and other law and order officials trained *(annual target 1,250)*.

Regional M&E workshops as well as training sessions for partners were used to operationalize this new system at the country level. However, knowledge of M&E among partners was cited as persistently weak in program reports. Newly instituted CSUs served a crucial role in incorporating M&E into country work plans, except for Myanmar due to its prohibitive political climate. Work also began in 2013 on improving CP monitoring approaches using unique identifier codes in outreach work in Vietnam, Lao PDR, and Cambodia.

Performance in the last two years of HAARP was measured against these performance indicators to assess countries' progress towards improved enabling environments, increased capacity and increased service delivery. Qualitative data from the document review and stakeholder interviews has been compared in following sections against performance indicators to elucidate final outcomes.

According to minimum data sets, over the course of the program more than 120,000 PWID were reached through more than 3 million service contacts, across all five HAARP countries. Additionally, more than 45,000 referrals to HAARP related health services were made. The number of harm reduction commodities distributed totaled over 5.5 million condoms, 8 million sterile water vials, and 22.3 million needles and syringes. It is important to note that PSI's gap analysis indicated significant inaccuracies in data collection and methods used across Cambodia, Vietnam, and Lao PDR (in some instances involving double or triple counting). However, despite the question of the precise measurements reported in early data sets, the scale and magnitude of HAARP's outcomes indicates significant accomplishments across the region, which is corroborated by qualitative findings reported below.

In 2014, PSI Vietnam conducted RQA in Cambodia and Laos PDR to collect insights related to the perceived quality of HAARP service provision among the project's beneficiaries. RQA exercises were designed and organized in consultation with key HAARP implementing partners and DFAT teams in both countries. As indicated previously, these assessments provided useful data to inform beneficiary perceptions and implicit achievements of the program.

2014: Program Conclusion & Exit Strategy

In response to the Government of Australia's aid effectiveness mandate and budget cuts announced in early 2014, DFAT Bangkok, in consultation with bilateral Posts, developed an accelerated HAARP exit strategy that built on an earlier exit strategy developed in 2012. HAARP concluded all activities by 31 December 2014.

The original and subsequent exit strategies emphasized 3 key focal areas. The first was leaving responsibly to ensure activities under HAARP would continue beyond its lifetime. The main component of this was a sustainability plan for each country. The second area was mitigating risks, primarily by understanding the risks for partner countries and DFAT when programs concluded in 2014. Finally, ensuring legacy through ongoing stocktaking of the achievements made by the project, its impact on HIV prevention in each country, and the positive changes it has created.

The accelerated exit strategy maintained focus on achieving a responsible conclusion of programming across its regional, and remaining three country programs. The strategy recognized the program's responsibility to its direct beneficiaries and prioritized support to lifesaving service delivery—particularly NSP and MMT programs in Vietnam and Cambodia—over capacity building and advocacy. Where possible it also emphasized opportunities to transfer and sustain HAARP operations through government systems or partners supported by alternative means to ensure continuity of services. Consolidation of services and impact, sustainability, and legacy remained key guiding principles. However, a number of exit strategy recommendations included in the original 2012 exit strategy roadmap could not be included in the 2014 revised plan due planning and resource constraints given the accelerated closure.

The accelerated pace at which the program was brought to a close left country teams and stakeholders with little time to identify and plan for the longer-term funding of NSP and MMT programs. Future government funding of these services in Cambodia, Vietnam and Lao PDR was uncertain at the time this assessment was conducted. While both Cambodia and Vietnam showed promise of securing alternative funding through other external organizations, government funding has not been committed officially in either platform. However, government enthusiasm for maintaining programing is apparent—though to varying degrees—across all three sites. Whilst it is by no means guaranteed that a longer lead out time would have resulted

in greater certainty about future funding, there is no doubt that the accelerated pace at which HAARP came to completion posed a major challenge to implementing countries.

In terms of improving harm reduction policy environments HAARP has helped carve a space for harm reduction as a component of governments' HIV strategies, but there is significant risk of policy reversal undoing the considerable progress made during the program. Where possible, HAARP platforms have made the ever-important effort to identify alternative funding sources for HAARP activities beyond its closure.

Program Outcomes: Successes and Missed Opportunities

The majority of outcomes described in this section are country specific. There are relatively few outcomes that are truly regional in nature, but rather these are an aggregation of achievements from the country level. This, in itself, represents something of a missed opportunity and was echoed in the views of country level implementing teams, who struggled to articulate the regional nature of the project, or the benefits of it being a regional program. Information sharing across countries was seen as positive, but this in itself, is not a regional outcome, nor something that necessitates a regional program management structure.

Regional Outcomes

Regional performance indicators have been indicated below to contextualize and contrast quantitative assessment and implicit achievements identified under these outcomes.

Improved Enabling Environments

Program review documents together with in-depth interviews suggest HAARP contributed significantly to creating improved enabling environments for harm reduction programming within individual countries as well as at a regional level. While achievements in this area varied by country, overall the HAARP project was the first, multi-country initiative targeted at addressing harm reduction barriers among PWID. As such, in-country and regional discussions facilitated by HAARP—such as through the HCCF forum—played an important role in advocating for a more conducive and supportive operating context relative to harm reduction priorities.

As stated in an annual program review, HIV harm reduction was supported by national strategic plans in all HAARP countries on some level. However, evidence of enabling policy development and implementation of harm reduction services varied greatly from country to country. Cambodia, Vietnam, and China's governments all showed some level of commitment to the programs aims, however less government buy-in was seen in Myanmar. Lao PDR's government commitment to HAARP was minimal.

Stakeholder interviews and document reviews elucidated the status of HIV harm reduction in HAARP countries. Cambodia has demonstrated a high level of support for institutional acceptance of harm reduction, such as through its implementation of the Police Community Initiative Program (PCPI), which has trained over 3,500 officials in harm reduction. In addition, allowing the first MMT program to open its doors under HAARP is indicative of larger, deeper shifts in the government climate around MMT. Cambodia's service provision progression suggests positive change in policy and law enforcement environments around harm reduction. This has been corroborated by annual reports.

Similarly, Vietnam has made policy level shifts regarding PWID, particularly by reaffirming a commitment to voluntary rather than compulsory involvement of PWID in treatment programs. According to program reports, notable strides in service provision through government collaboration indicates that a space for harm reduction has been created that was not there before, both in an advocacy, capacity, and service provision sense. Vietnam's 2013 commitment to incorporate HIV harm reduction service delivery into government policies underscores this analysis.

Government buy-in levels in China have been extremely encouraging. The Yunnan and Guangxi provinces of China have made clear and directed efforts to adopt harm reduction as their own cause by formally taking over operations for NSP, supported by provincial government funding. The sustainability outlook of China's enabling environment is positive, according to HAARP Program Managers.

However, Lao PDR's government struggled to take ownership of HAARP's aims. Apparent difficulties existed in translating program objectives (will & capacity building as well as service provision) into practice. Interviews highlighted government suspicions around HIV harm reduction approaches as a key obstacle. Political sensitivities in Lao PDR surrounding this general topic restricted program progress according to annual reviews. Additionally, strained implementing partner relationships with UNODC compounded existing barriers to enabling environment creation. However, as discussed further in the country assessment, Lao PDR saw progress through the establishment of the country's first and only NSP.

In Myanmar, the potential for enabling environment creation increased greatly since the nation's political climate has stabilized. Under the direction of 3MDG, policy and legal frameworks underwent review to analyze where feasible harm reduction inclusions could be made, according to the 2014 QAI.

Increased Harm Reduction Capacity

Sufficient progress has also been made towards institutionalizing harm reduction within government systems. HAARP sought to raise awareness about harm reduction harm reduction and drug use for both government officials as well as on-the-ground officers, thus building cohesion between the policy and enforcement levels. Over 9,500 police and other law and order officials were trained over the life of HAARP through in-country capacity building activities. Training programs have taken place in Myanmar, Cambodia, Vietnam, and China between 2009 and 2014 according to annual project reviews.

Institutionalizing harm reduction perspectives into law enforcement, such as those in Cambodia, can serve as a powerful reinforcement to policy level enabling environment creation. This method of capacity building has exemplified a holistic, country-specific solution to barriers to care for marginalized populations, particularly among those involved in illicit activities. Cambodia, Vietnam, China's commitments to HAARP through human capital investment shows promise for government buy-in across the region. Similar investments in capacity building, though on a much smaller scale, were also made by Myanmar.

Additionally, HAARP sought to increase harm reduction capacity by fostering partnerships with community and other stakeholders relevant to HAARP's target population and program goals as part of its community engagement strategy. In 2013, DFAT Bangkok contracted ANPUD and IDPC as part of the programs community engagement strategy, designed to enhance the capacity of networks of PWID and identify organizations involved in HIV harm reduction and drug policy activities respectively.

DFAT Bangkok partnered with ANPUD to develop a community initiative to build capacity of country level PWID networks through completing a stock take analysis, developing a set of training manuals, and delivering training and ongoing mentoring to PWID networks. According to annual program reviews, ANPUD has indeed delivered a strengthened national network of PWIDs, as well as capacitate local civil society to be able to represent national and regional PWID issues.

Increased Service Delivery

HAARP has been effective in progressing towards its intermediate outcome of increased delivery of HIV/AIDS harm reduction services for PWID and their partners. This is evidenced by HAARP's end of program quantitative headline data, as well the presence of established HIV harm reduction activities. HAARP has funded NSP in Myanmar, Cambodia, Vietnam, Lao PDR, and China (2008 - 2012 and through a cross border project in Yunnan province 2013 - 2014).

MMT programs were made available in Cambodia and Vietnam, with both seeing substantial growth over their life courses. By the end of 2014, these MMT programs had enrolled over 430 men and women in Cambodia and over 1,100 in Vietnam.

A gender-conscious approach was built into the design of HAARP to ensure these services reached both men and women, however, more rigorous data collection and analysis in the last phases of the program suggests these services could have been more equally distributed, as indicated by disaggregated gender data from countries' minimum data sets. Varying coverage levels of female PWID may indicate differences in PWID population gender composition as well as multifaceted issues faced by female drug users in different country contexts.

Importantly, HAARP also reached drug users' partners, though to varying degrees. For example, a significant portion of individuals reached (69% in 2013) by HAARP Vietnam were partners and were primarily female. However, in Cambodia and Lao PDR, disaggregated data shows that no such levels of service provision were achieved amongst female partners.

While these achievements are very promising, arguably the most notable victories of HAARP can be found in the process of making these services available to all. Before HAARP, harm reduction services were either not available or very few and far between, particularly for marginalized populations such as PWID as indicated by an assessment conducted across the GMS region. Building the political and infrastructural capacity to achieve and sustain service provision within seven years is an important accomplishment in itself and underscores the logic behind the dual mandate of this program.

Missed Opportunity of Regional Advocacy

HAARP was largely unable to advocate for harm reduction on a regional level. While the program was successful in instilling receptiveness of policy changes in some countries such as Vietnam, Cambodia, and China, a broad regional shift was not achieved. Establishing national advocacy plans proved difficult. In 2011, all partner governments still enforced drug policies prohibitive to HAARP's goal of sustainable HIV prevention and care policies around harm reduction. One major takeaway from the independent mid-term review in 2011 was the need to deepen strategic engagement with governments, with the hopes that sustainable policy & law impacts could be made.

In 2012, HAARP enlisted IDPC to conduct a regional drug policy exercise to map organizations involved in harm reduction as well as assess pertinent laws across Southeast Asia. This exercise ultimately found that despite significant achievements in improving access to HIV-related services for PWID, very little change is apparent in their drug policies.

> *"Governments across the region disproportionally invest their resources on interdiction, incarceration, coercive abstinence-based treatment and forced crop eradication programmes." (Drug policy advocacy in Asia, IDPC)*

While HAARP has compelled promising shifts in drug policies, these shifts have been highly focused on specific protocols or procedures. The creation of health-focused programs, such as MMT and NSP, is an important achievement, and signifies the emergence of a new prevention paradigm. However, the persistent trend across the region, as reported by IDPC, is that these programs receive only marginal government support and are seen as emergency responses to deep-seated HIV epidemics. It was also found that harm reduction is almost exclusively implemented in the interest of HIV reduction, which often led to advocates engaging with health

ministries. This often proved ineffective, as health ministries do not hold the same level of decision-making power about drug laws as other government bodies.

IDPC's outputs created a platform for future advocacy to enhance program sustainability and contribute to enabling environments. However, this did not take place under HAARP. Reduced resources during the program's exit, as well as limited time, compromised HAARP's ability to give momentum to regional advocacy efforts after its completion. It is important to underscore the time and resources required to change long-term entrenched policy formulation processes, which would have ultimately created the most broadly applied drug policies according to the IDPC report. This missed opportunity for regional advocacy was fundamentally one of intended reach versus realized successes: the scale of enabling environment creation proposed by HAARP was not achievable in full with the given timeframe and funding. However, progress was made in smaller increments, such as law enforcement education and treatment protocol changes. Despite a missed opportunity to further exploit advocacy avenues in HAARP's later years, Australia's advocacy for HIV harm reduction has still proved influential in the region.

Country-Level Assessments

In addition to the collective successes and challenges encountered at a regional level, HAARP CPs' experienced context-specific factors that enhanced or inhibited their efforts. Each country varied in its initial political climate, degree of sensitivity to HIV and the PWID population, existing implementation and research infrastructure, and staff skill level. These issues were important to investigate from an HIV harm reduction perspective, but also brought to light more specific barriers that programs with similar aims and aspirations as HAARP could face in the future.

The following assessments outline each of the five HAARP countries' quantitative outcomes as indicated by collated minimum data sets, service provision achievements, and enabling environment facilitation milestones. Specific achievements and missed opportunities within these country settings have also been discussed.

Cambodia

Over the course of HAARP Cambodia, more than 11,000 referrals to HAARP related health services and almost 300,000 service contacts were made, resulting in over 7,600 PWID reached. Gender disaggregated data of PWID and partners reached in Cambodia show that about a quarter of individuals reached were female since 2011. Additionally, 1.3 million condoms were dispensed from 2009-2014. Through the country's NSP program, almost 1.5 million needle and syringes were distributed as well. HAARP also supported the first MMT clinic in Phnom Penh, which had 430 PWID enrolled as of the end of 2014, up from 61 at the program's initiation in late 2010. As evidenced by these figures, Cambodia's program saw significant success in providing services and resources to PWID, and achieved beyond the scale initially intended. This platform benefited from enthusiastic government support, meaningful external organization relationships, as well as well-targeted service delivery programs.

A key achievement reported by the CP has been the integration of the MMT program under the Ministry of Health (MoH)'s Health Equity Fund on January 1st, 2015. The MMT program will be financially sustained through user fees subsidized by co-funding from the Royal Government of Cambodia (RGoC) and other Development Partners (DPs). HAARP-funded methadone procurement has also been taken over by the MoH's procurement system starting from January 1st, 2015. This is a positive and sustainable achievement of HAARP in Cambodia in terms of both service provision and advocacy.

It has also been reported that WHO and NGO harm reduction service delivery under HAARP has been handed to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). This is a further commitment by stakeholders of the long-term need for NSP services. The establishment of the first MMT and subsequent policy support of MMT represents a noteworthy acknowledgment by government of the value that a wider package of interventions can offer public health aims by reducing harm among PWID.

The program catalyzed discussions between government departments on the development of a national harm reduction strategy, the need to align this within the broader HIV prevention strategy, and the need for principal ownership to be outside of law enforcement. These have been key implicit achievements of the HAARP program in Cambodia.

> *"The Mental Health and Substance Abuse Team became a full 'Department', with responsibility for implementation of harm reduction activities. The Ministry of Health now sits at the same table as the National Authority for Combating Drugs (NACD), on issues of drug use. It is now seen as being an issue of HIV prevention issue, and much less about law enforcement." (Implementing Partner)*

HAARP Cambodia has trained almost 4,500 police, law and order officials over its lifetime, which acknowledges the need for law enforcement authorities to be sensitized and engaged on the wider context of drug use and the needs of PWID. The incorporation of harm reduction into the national government endorsed training curriculum for police officers in Cambodia represents a progressive step forward and has been a key achievement of HAARP. This program was handed over to the Cambodian Police Academy School in 2014.

The majority of Government, DFAT, and in-country partners confirmed through qualitative interviews that this represents a significant achievement with potentially wide and long-term impact (see quotes below in the lessons section). In conjunction with the transition of HIV harm reduction service delivery under GFATM, the potential for sustainable harm reduction efforts in Cambodia is positive.

Vietnam

Over the course of HAARP Vietnam, nearly 15,000 referrals to HAARP related health services and over 1 million service contacts were made, resulting in over 22,600 PWID reached. Additionally, 1.6 million condoms were dispensed from 2009-2014. Through the country's first NSP, over 3.3 million sterile water vials, 1.6 million needle and syringes were distributed. HAARP also supported MMT programs that had over 1,100 PWID enrolled as of the end of 2014, and only after two and a half years of operation. Vietnam's stakeholders widely regarded HAARP's efforts as fruitful, achieving coverage levels that were consistently high and establishing previously inaccessible services.

Vietnam benefited from early public support of harm reduction from high-level officials according to early annual HAARP reports. Local championing was cited as a very positive sign for HAARP's engagement with Vietnam. However, delays in approval of the CP resulted in no service provision until 2010. In 2011, the HAARP CP made a significant breakthrough by implementing a condom program in detention centers and prisons for the first time. Although perceived as an achievement, addressing HIV related harm reduction in closed settings raised several human rights concerns. HAARP provided support to people in the centers, and not the centers themselves, and the program consistently advocated for a move away from compulsory to voluntary/community based support models. Support to harm reduction activities in closed settings ended through HAARP's accelerated exit strategy.

In 2012, HAARP collaborated with the Vietnam government to develop its own MMT program with two initial clinics planned, which in itself is an enormous accomplishment and indicates progress towards HAARP's goal of creating a supportive environment for harm reduction programming. Following these initial clinics, five more were established under HAARP. The Ministry of Health committed to MMT by ensuring that all methadone clinics established under HAARP will be maintained at a reduced operational cost following the program's closure.

> *"In Vietnam, the Government has committed to providing methadone to 80,000 PWID by end 2015… HAARP played a critical role in facilitating this commitment and the project's support has been leveraged for sustainable methadone scale up*." (DFAT Management)

Additionally, according to the qualitative review, the Vietnam government has shifted away from compulsory treatment for PWID, which is in line with international best practice for HIV harm reduction, as it eliminates punitive action against PWID. Reduced penalties for drug use amongst PWID have also been incorporated. These government-level actions together comprise a positive signal for credible and sustainable change in Vietnam for recovery care.

Lao PDR

Over the course of HAARP Lao PDR, a total of 450 PWID were reached between 2011 and2014. Over 16,000 condoms, 21,000 sterile water vials, and over 74,000 needles and syringes were distributed through the program. The referral system did not take hold in Lao PDR, with only 4 referrals recorded in the program's lifetime. Since 2011, PWID and their partners accessed HIV/AIDS harm reduction services over 14,000 times. HAARP Lao PDR also launched the first and only NSP program in the country. However, HAARP Lao PDR suffered from poorly-targeted programming as well as implementing partner challenges (outlined below), thus it never reached the scale HAARP initially intended. After facing these difficulties in designing and implementing its structure, projects, and goals, the project was terminated early in April 2014.

Overall, final evaluation documents reveal that HAARP Lao PDR has made a positive contribution to the prevention of HIV amongst injecting drug user populations and has succeeded in achieving acceptance of and political commitment to harm reduction approaches. The implementation of a pilot NSP in selected districts of Houaphanh and Phongsaly provinces is a clear accomplishment.

However, beyond these important milestones, this project faced numerous challenges. The start-up phase of Lao PDR's CP saw delays occurring in implementation which led to difficulties in scaling up services as originally planned. Standard operating procedures were not in place for service delivery, nor were there M&E systems to sufficiently measure outcomes. Confusion about appropriate decision-making channels between implementing partner organizations for management and technical support was an additional obstacle. Finally, limited HIV transmission between PWID in Lao PDR also placed constraints on HAARP's potential for impact.

During HAARP's transition to the CSU model in 2012-2013, synergies were hard to create within the CSU and with government counterparts. The CSU consisted of both a UNODC officer and a DFAT Technical Advisor. While the CSU arrangement was stated as an improvement for the project in evaluation documents, it lacked detailed allocation of decision-making power between each DFAT, UNODC and government official counterpart. In light of the sensitivities to HIV/AIDS and harm reduction within the country, this was an important balance to strike within the CSU model.

However, steps forward were made during this time, thus opening the door for a longer term positive legacy for HAARP Laos PDR. Improved collaboration for harm reduction policy services was seen through multi-agency participation in the country's Steering Committee and Technical Working Group on HIV. Through concerted CSU efforts, M&E systems were improved within HAARP and nationally, particularly through trainings on UIC and its utility for HIV harm reduction. HAARP Lao PDR reported increased awareness and understanding of NSP among senior drug control and health officials at the district level in an annual report, which indicates the potential for a future enabling environment, though it was not achieved in the course of HAARP.

Encouragingly, HAARP service delivery components were transitioned to Asian Development Bank (ADB) funding in the last quarter of 2014. Following significant effort from the HAARP Lao PDR harm reduction specialist, as well as country and regional program teams the ADB committed to sustain select HAARP activities including NSP and Point of Care programs. This reiterates the potential for HAARP's longer-term impact in Lao PDR, though government ownership will be an essential component moving forward.

China

Over the course of HAARP's investment in China (including a cross border component in Yunnan Province) between 2008 and 2014, saw over 67,000 PWIDs reached, 15,000 referrals made, and over 1,100,000 service contacts reported across the two provinces covered (Guangxi and Yunnan). Over 1 million condoms and 8.3 million needles and syringes were dispensed since 2009. HAARP China represents a major success, as evidenced through its large scale of services. This platform was supported by a positive climate, and thus wide reaching coverage was achieved.

HAARP China provided NSP and sexual transmitted infection (STI) testing and treatment in 31 project sites in Guangxi and Yunnan provinces and 45 NSP centers. The program's final evaluation after the conclusion of HAARP China in Guangxi and Yunnan in 2012 showed that the program had been highly effective at providing services to PWID. MMT had been previously established in China through provincial government funding and therefore was not included under HAARP, however, effective service transfer was promoted between NSP and MMT services.

The HAARP China CP ended in 2012 to allow the government to take over HIV harm reduction in mainland China. According to annual reports, HAARP China worked closely with provincial governments to build stronger policy and political commitment for harm reduction throughout its time in Guangxi and Yunnan. With HAARP's targeted advocacy, as well as practical field-based experience, the government of China has successfully taken on existing NSP programs.

The successful transition of these services to provincial health systems is a major milestone. It reiterates the relevance of sustainable HIV harm reduction efforts to China's health outcome goals for PWID, and also indicates the potential for a positive sustainable policy outcome. Program documents have cited the embedded policy support, local championing, and multi-sectorial engagement in Yunnan as particularly encouraging for sustainability. Furthermore, HAARP established NSP in both Guangxi and Yunnan provinces provide valuable precedent and strong evidence to inform future national harm reduction policy.

HAARP China continued its engagement until June 2014 through a cross border program implemented by a local NGO Yundi in Yunnan province. The program served Myanmar and Vietnamese nationals in China and was continued under a new collaboration with Yunnan AIDS

Bureau with oversight and management by UNAIDS China office. This cross border component demonstrated significant program achievements during its short timeframe and HAARP program teams have supported partners to secure alternative funding sources to maintain HAARP services following the programs conclusion.

Myanmar

Over the course of HAARP's data collection in Myanmar from 2009 to 2014, over 24,000 PWIDs were reached, 4,500 referrals made, and over 600,000 service contacts. Over 1.4 million condoms, over 4.6 million sterile water vials, and 8.8 million needles & syringes were dispensed. HAARP funded NSP in Myanmar and supported health service and MMT referrals under the program. Significantly, annual reports underscored the importance of HAARP Myanmar's efforts in the national public health landscape, as it provided an estimated one third of all harm reduction services in the country, signifying the success of HAARP Myanmar's service coverage.

HAARP Myanmar's CP differed from others in a number of ways (reflecting HAARP's multi country modality). HAARP Myanmar was initially channeled through UNODC to provide services and improve enabling harm reduction practices instead of the Myanmar government. Additionally, the country post was managed by the Bangkok office instead of a country Post and its government was not engaged in design negotiations, though informal input was sought at some points. Given the difficult political climate of Myanmar at the time of design and implementation, this was an appropriate shift in partner strategy.

Myanmar's policy and law enforcement climate posed many obstacles for both HAARP's advocacy and service provision goals, according to annual reports. HAARP's efforts coincided with political conflict, which inhibited direct government engagement. Additionally, policies made reaching PWID through other avenues difficult. Myanmar law required mandatory registration and treatment of PWID; non-compliance was punishable by a 3-5 year prison term. These laws created specific difficulties in reaching PWID who had not divulged their drug user status to the government.

In addition, delays in service delivery, government restrictions on NSP, closures of service delivery sites, and poor stakeholder coordination were all cited by HAARP managers as problematic. These issues spanned both partnerships with UNODC and 3MDG between 2009 and 2012. Despite this challenging environment, client numbers and service delivery sites continued to rise through HAARP's direct involvement until 2012. Myanmar's M&E systems remained weak throughout programming, with minimum data sets consistently having questionable reliability. In response, unique identifiers for clients at all HAARP sets were implemented in 2012.

UNODC ended its contract in Myanmar in December 2012, and thus HAARP Myanmar ceased official operations. In 2013, HAARP funding was allocated to harm reduction efforts via the Three Millennium Development Goal Fund (3MDG) in collaboration with the Global Fund. HAARP remained indirectly involved to ensure that harm reduction remained a focal point for 3MDG. After this transition, HIV-related output indicators measured by the larger 3MDG measurement frame showed that Myanmar increased access to HIV interventions for populations not readily covered.

The current climate in Myanmar has shifted, according to a recent 3MDG report from January to June 2014. Encouragingly, the report described progressing service provision, lessening legal barriers, and improving coordination and harmonization between stakeholders. Coverage

became consolidated in two states of Shan and Kanchin with relatively receptive environments. While HAARP's formal involvement ended years prior, it has left a legacy of increased integration of harm reduction into PWID policies as well as key improvements in service provision.

Key Findings

Scope & Objectives

HAARP was a very forward thinking program for its time, designed to break down traditional approaches to HIV, and address typical disconnects between host governments and marginalized communities. HAARP's unique emphasis on ameliorating the risk of HIV in a particularly vulnerable population, as well as its promotion of high impact harm reduction interventions, is widely regarded as one of its attributes and distinctive qualities.

The HIV epidemic has embedded itself in the public health landscape of the GMS, and thus poses real and relevant concern. Moreover, it is ever evolving, and programs have required increasingly innovative approaches like that of HAARP. Assessments of the GMS context and past Australian Government experience in HIV harm reduction supported the targeting of marginalized populations like PWID. HAARP's attentiveness to the needs and priorities of PWID in relatively conservative operating contexts helped governments adopt initiatives, which served this sensitive target group. Its programmatic focus received praise from many actors and stakeholders.

> *"HAARP was revolutionary in its focus on groups most at risk of HIV/AIDS. Targeting of HIV/AIDS interventions is relatively common today, but HAARP led the way with its clear focus on PWID and other most at risk groups." (DFAT Management)*

However, the primary focus on PWID as the *most* at risk population was possibly inappropriate for some HAARP countries, given the emergence of other groups as key epidemic catalysts, and the relatively sparse PWID population in some countries. Female sex workers (FSW) and men who have sex with men (MSM) have emerged in some countries as drivers of the spread of HIV.

Weak estimates of drug user population sizes and other preliminary demographic characteristics possibly overstated the potential impact through HIV harm reduction in some countries (such as Lao PDR). The relative low prevalence of HIV in some settings was cited as a contributing factor to lacking government buy-in on HAARP's aims. In addition, effective cost analysis remained elusive without a stronger population evidence base. Regardless, each country's PWID populations saw important changes in services available to them.

A limited field of donors combined with Australia's track record on harm reduction provided compelling reasons for Australia's continued involvement in the field of HIV harm reduction. Harm reduction methods before HAARP were described as lacking or entirely absent, thus this further underscored the programs relevance. More broadly, HAARP has demonstrated how large, multi-country programs can be applied and adapted to focus on marginalized, underserved, and stigmatized populations. It has set a precedent that will hopefully inspire future national and regional efforts in the GMS and beyond.

Design & Implementation

Evidence from annual reports indicates that these early years of HAARP placed more emphasis on regionalized objectives than later phases. Reports covering the first few years of operations highlighted regional components (such as the TSU) as key mechanisms for knowledge exchange and activity harmonization. Cited intentions for the program during this nascent period included; cross-border opportunities, establishing stronger links with other regional partners

such as the UN and multilateral organizations, and supporting increased communication through HCCFs. These regional components were exploited to varying degrees.

While the design of HAARP sought to achieve broad regional aims across its five participating countries, numerous difficulties were experienced in implementing such a complex, multi-country program without permanent in-country support. Country-centered, regionally-executed program design reduced program efficiency. In line with HAARP's goal of creating functionality of harm reduction policies within governments, the design phase focused on gaining traction for government support. However, staffing resources required at Posts to manage government engagement during the design phase were underestimated according to early Quality at Implementation reports. All partner governments, with the exception of Myanmar, were to be in agreement with HAARP teams on the CP design before implementation could proceed. While engaging with governments in this way built national ownership and buy-in in some cases, the capacity to implement services quickly was impeded, as identified in annual reports. However, early government buy-in proved important for the success of some country platforms, such as Cambodia and China, thus indicating that hampering efficiency was justified by the longer term impact this engagement had on HAARP's success. The multi-country modality was also constrained M&E development because of a need for country-specific frameworks and difficulty in capturing all-encompassing outcomes at the regional level, which is discussed at length below.

The transition period from TSU to CSU approaches proved challenging, and this increase in country level support was not swiftly adopted, which further delayed optimal management of CPs. Despite this, the CSU model largely improved HAARP's efficiency in remaining countries. In-country support facilitated timely decision-making regarding service delivery, operational risk management, and freed the regional post to provider greater program oversight rather than technically intense and country-specific management. Should it have had the chance to mature, this design strategy showed great promise for improving HAARP's multi-country modality as it married technical support with increased levels of in-country management and regional program oversight. However, as a result of aid program budget cuts, this model was abandoned in early 2014 consistent with HAARP's accelerated exit strategy and technical program oversight thus returned to Posts.

Country contexts differed and changed throughout the lifespan of HAARP, which is one factor that supported the need for a multi-country modality, to address country specific approaches to HIV harm reduction. Social, political and cultural dimensions in tackling HIV harm reduction have meant CPs have faced many obstacles, including prohibitive laws and particularly challenging policy environments. While improvements to countries' legal environments have been seen - in Vietnam, punitive responses to PWID have softened and in Cambodia HIV harm reduction approaches have started to be institutionalized - broader issues of stigma and discrimination remain. Furthermore, CPs have often had to deal with young civil societies, suspicion towards HIV harm reduction approaches, competing institutional partners and unfavorable personal attitudes throughout implementation.

The multi-country delivery model was arguably not the most appropriate in terms of achieving efficient and effective program performance. Future efforts will likely be more influential if executed through bi-lateral programs due to the country specific nature of interventions. In addition, the long timeframe over which necessary changes are realized further hampered the impact of HAARP, as most country-specific modalities would have ideally been developed from the outset.

Monitoring & Evaluation

HAARP's initial M&E framework suffered from undefined and overly complex guidelines, which often hindered the collection and analysis of data. Often, HAARP was confronted by incompatible existing data collection infrastructures at the country level, which compounded existing difficulties in accruing accurate M&E data to assess program performance at the regional level. Additionally, regional outcomes were difficult to measure and often unclear to country teams. Limited M&E systems often made program outcomes difficult to discern and learn from, thus interrupting an important feedback loop in a program of this complexity and duration.

HAARP's M&E framework was reviewed and updated in 2013 by PSI Vietnam after conducting a gap analysis, whereby intermediate goals with measurable indicators were developed. In addition, collection tools such as unique identifier codes (UIC) and data quality assessment (DQA) tools were introduced. These tools contributed to significant improvements in the quality of data collected by HAARP—for example UIC enabled HAARP programs to measure actual coverage of individual PWID vs. contacts (which typically included multiple points of contact with the same individual); whereas the DQA exercises facilitated participatory, in-depth analysis of the extent to which data being collected was relevant to program priorities and consistent with M&E plans/targets. RQA exercises provided the first opportunity during the project period, to collect meaningful feedback from project beneficiaries regarding perceived project benefits and suggested areas for improvements.

Updated M&E frameworks put remaining HAARP countries (Vietnam, Cambodia and Lao PDR) on track to operationalize improved M&E systems through to the end of the program. As a result of decisions to close HAARP six months ahead of its original end date (and even earlier in Lao PDR) the timeframe became too tight for these systems to be fully incorporated and tested, as most were only finalized in 2014. However, country programs showed receptiveness to incorporating new M&E frameworks into their projects, indicating the perceived value of such information for project managers.

Furthermore, an earlier review and resolution of the M&E framework's gaps would have provided more representative data and measures of impact for HAARP across all country settings. However, DFAT took necessary steps to improve the program's M&E and was able to realize quality data collection through the end of the program. This will prove useful for DFAT in future endeavors.

Beneficiary Perceptions and Experiences

Through HAARP's 2014 RQA exercises in Lao PDR and Cambodia, a relative sample of PWID's perceptions of program benefits and challenges were ascertained. PWID participants perceived improved services, specifically related to access to convenient, quality and affordable needles/syringes, sterile water, alcohol swabs and condoms. Distribution of harm reduction products through trained peer educators was also identified by PWID as both an appropriate and comfortable mechanism for them to access life-saving products in a non-discriminatory environment.

> *"Someone who also injects drugs confirmed that it [the NSP] was actually happening, and we could get free needles without any consequence. We felt very comfortable to meet and get syringes from friends who work for the project, because they also use drugs and know what we need…"*
> *(Program beneficiary [PWID] in Laos PDR)*

"Before the program he had to use the needle for two days and faced difficulty buying at the pharmacy. He's afraid of meeting his friend and the police will see him buying needles. After the outreach came near his home it makes it much easier for him to get needles and he feels safe from the police."
(Peer Educator in Cambodia)

Improved community acceptance of PWID, due to improved education and awareness generated through HAARP was cited as another notable program

"In the past he [the village chief] was very aggressive to us. He blamed us for anything happening in our house and in the village. Now he is quite open to listen to us… he is not really on our side, but just had fairly thought about us."
(Program beneficiary [PWID] in Laos PDR)

New, safer injecting behavioral norms were also encouraged by HAARP activities, and became increasingly practiced amongst PWID.

"Before there was such a program [NSP program] me and my friends used the same syringe with many people and they get stuck and the needle is broken and can cause transmission of disease."(Program beneficiary [PWID] in Cambodia)

MMT sites proved to be important settings for positive change in PWID's lives. Peer support received at MMT sites and related community events were often credited as motivating sustained commitments for safer behaviors and therefore reduced risk of HIV transmission. Methadone services provided by HAARP were acknowledged as very beneficial, as PWID were able to devote more time to their work and to their family, thus producing a dramatic shift in their day-to-day lives.

"When they come to get MMT they also meet others getting methadone. They communicate about how they were addicted to heroin, how long they have been using MMT, and how they benefit. They talk to each other about not using heroin anymore."(Program beneficiary [PWID Peer Educator] in Cambodia)

"[My peers] mention many benefits about methadone: save money, save time, keep jobs, improved image with family and society, and stay free from drugs.
(Program beneficiary [PWID] in Cambodia)

Despite this largely positive perception of HAARP's services held by those PWID interviewed, a number of challenges were also mentioned. One major theme that arose across both countries' interviewees was the need for improvement for quality and coverage of peer education. PWID suggested that additional trainings could address peer educators' knowledge of the program in addition to strengthening their communication skills. Another observation was that HAARP peer coverage was relatively limited, with hidden and newer PWID often being unreached by services. This was mentioned in by beneficiaries in Cambodia and Lao PDR.

Logistical barriers were also cited as a difficulty for PWID in accessing care. Harm reduction services (NSP & MMT) were primarily offered during working hours, despite the need for their availability at other, more convenient times of day. Frustration related to access barriers was

particularly strong in discussions about MMT services, which was a key finding from the RQA exercise in Cambodia. MMT clinic hours were perceived as incompatible with client work schedules. Additionally, these clinics were described as being overcrowded and having inconsistent staff. These factors combined with long travel distances limited access to MMT sites amongst PWID interviewed in Cambodia. Due to the limited remaining life span of HAARP, improvements based on these results were difficult to implement.

Discriminatory practices enacted by police and MMT service providers were also perceived by PWID. Whereas HAARP organized sensitivity trainings for both groups, PWID described ongoing stigmatization. Fear of police continued to be a significant barrier to accessing NSP. Future programs should go beyond police training to emphasize the legality of NSP distribution, and focus on fostering supportive relationships with local authorities. Training and mentoring must be ongoing and participatory for both police and service providers, and support is required for service providers and others interacting with clients (e.g. security staff) to effectively work with PWID.

Key Lessons

The combination of service delivery and advocacy objectives was both realistic and appropriate.

HAARP's dual mandate was challenging—particularly given the sensitivities involved in providing services to and advocating on the behalf of highly stigmatized groups—but it was necessary given the stage of the epidemic and the broader social and political operating contexts in the participating countries.

> *"HAARP propelled host country governments to 'know your epidemic and target your response' and simultaneously held partners accountable to serving groups most at risk with interventions that minimized risk."*
> *(DFAT Management)*

Progress against service delivery and advocacy targets required distinct approaches and skill sets within the implementing and technical teams supporting the project. Successes would have been difficult to achieve without a complementary focus on these areas. The magnitude of HAARP service delivery results alone is a poor measure of the program's true success, given that harm reduction service provision also serves as a lasting advocacy tool and given the context of nascent harm reduction policies and programming. Initiating needle/syringe distribution in a context, such as Lao PDR for example, played a critical role in developing more progressive mindsets among key stakeholders at national and local levels.

Opportunities were missed to address regional harm reduction issues related to global best practice.

This included fully capitalizing on cross-border program opportunities, negotiating for global price reductions for harm reduction products and services, and testing cutting edge interventions. Whereas the implementation of harm reduction service provision programs and advocacy efforts was—in and of itself—revolutionary in the HAARP countries, several stakeholders felt greater efforts could have been made to integrate emerging global best practices into HAARP programming earlier in the program period. Stakeholders gave specific examples of naloxone provision, low dead space syringe distribution and promotion, home HIV testing and unique identifier code (UIC) monitoring, as examples of areas in which HAARP could have pushed the envelope further.

> *"We should have drawn thicker lines, to ensure country partners were required to show more commitment and to support critical interventions which otherwise may not have been pursued." (DFAT Management)*

> *"HAARP could have done more to drive global advocacy for affordable methadone pricing." (DFAT Management)*

Although global best practice was regularly incorporated into regional forums—including HCCF meetings, some stakeholders felt regional presentations and/or discussions could have been more effectively followed-up through targeted local advocacy.

> *"There was no regionally developed cross-border strategy under HAARP. But, the project did encourage cross-border discussions across countries, which were productive and contributed to the design of harm reduction activities still ongoing in this country." (Implementing Partner)*

Several stakeholders interpreted these missed opportunities as signs that HAARP operated more as a multi-country initiative, and did not fulfill its full potential as a regional project.

Regional support works best when it is focused on select leadership and coordination roles, and balanced with complementary in-country project management and technical assistance.

Stakeholders expressed many different views about HAARP's management and technical support, but collectively the interviews highlighted an appreciation of the potential for both regional oversight and local management to add value to a program such as HAARP. Regional leadership and support was viewed as critical to promote global best practices in facilitating sound project design, M&E, cross-country communication and collaboration—to complement country level oversight and daily management of program deliverables and activities.

> *"The fact is taking on harm reduction as a regional issue was a great thing to do, particularly given the need to nudge progressive implementation and policies forward. Learning across countries was also a useful aspect of the project. HCCF meetings succeeded in organizing practical and open discussions about harm reduction in sensitive contexts, this was a good use of regional resources." (Implementing Partner)*

Regional leadership was described by some as critical to ensure appropriate balance between global and local priorities. This was touched on by several stakeholders:

> *"After DFAT ended the centralized management contractor in 2011, the oversight of project results, activities and budget expenditure seemed ad hoc. This was a mistake and it should have been maintained in addition to decentralized technical support." (DFAT Management)*

> *"The power in HAARP lied in its focus. There were times when this focus was challenged—even by some within our management and/or technical teams who advocated for an expanded mandate—and in cases where local decisions were made to sway from the two primary project goals, results were less clear." (DFAT Management)*

> *"The vision of the project was massive, but unfortunately in some cases implementing partners broke the vision into a set of tiny, disconnected pieces, which limited country-level results. It was essential for regional support to reinforce project parameters." (DFAT Management)*

Another stakeholder re-emphasized the importance of a regional voice, one step detached from country implementation and management teams, as being useful to drive advocacy agendas to facilitate an enabling environment and program results:

> *"Some say HAARP is a bilateral issue, that's true, but we need more than in-country support to drive this agenda forward given the sensitivities and complexities surrounding harm reduction." (Implementing Partner)*

Regional oversight, when implemented well, has helped address key challenges faced by HAARP. The pull from national stakeholders for broader, more generalized HIV/AIDS programing is one example where regional oversight ensured program activities and expenditures remained focused on high impact areas and desired outcomes.

On the other hand and with the benefit of hindsight, stakeholders strongly felt the evolution of HAARP management and technical support from the regional hub to posts (DFAT offices and TSU's respectively in each of the HAARP countries) should have happened sooner than the second half of the project implementation period. One of the key lessons from HAARP, according to stakeholders interviewed, is that it is very difficult to provide quality, timely, consistent and appropriate technical and program management support—including real-time identification and management of risks-- to multiple countries reporting to a regional hub. The decentralization of both technical and program management support was viewed as a positive step toward improving the utility and efficiency of day-to-day operations and reinforced efforts to achieve program goals. Within this general lesson, however, it was also acknowledged that in-country support teams worked better in some contexts compared to others as a result of variations in technical capacities, acceptance of external support, staff turnover and personalities.

In addition, regional support could have been better concentrated from the beginning, given that as many as five different individuals were involved from the regional office during the initial half of the project, a fact together with staff turnover, which challenged efforts to provide clear and consistent regional leadership during the program.

Securing high-level, consistent in-country championship within DFAT teams early on and throughout the project period can significantly enhance regional program results.

Stakeholders described HAARP design efforts as highly consultative and appropriately tailored to the distinct local contexts, including flexibility in selection of implementation partners in each of the participating countries. It was designed upon careful reflection of previous projects, specifically the previous Asia Regional HIV Program, and in consultation with a variety of international and national stakeholders including host governments, other funders and UNAIDS. Some stakeholders suggested that a stronger evidence base at the outset of the program design phase would have been beneficial, particularly if better evidence had been available regarding the size estimates of the injecting drug communities in each of the countries—particularly Lao PDR. Others highlighted the potential for more comprehensive analysis of political economies to assess interests, incentives and institutions relevant to harm reduction advocacy agendas.

Despite several things done 'right' during the program design, stakeholders expressed concern that high-level support for and commitment to HAARP within DFAT Posts was not adequately secured early on, and was also challenged by evolving leadership as a result of rotations of overseas posted officers. In cases where DFAT bi-lateral support did not include health or harm reduction as a priority, the program was particularly challenged to identify an in-country champion. One of the lessons from HAARP is that even in these cases; more could and should have been done to ensure DFAT Posts advocated for and facilitated the achievement of regional program goals, even in cases where these did not overlap with bi-lateral goals. In cases of disconnect between regional priorities and country level priorities, stakeholders felt these should have been more openly acknowledged and addressed to ensure sufficient local support for regional program goals.

Stakeholders within DFAT post teams faced challenges balancing the reality that HAARP required a relatively high level of operational oversight, even before program management responsibilities were decentralized during the second half of the project, with their other ongoing bilateral responsibilities. There was confusion regarding the roles and responsibilities of

regional vs. bi-lateral DFAT teams. As discussed elsewhere in this document, even in cases where adequate and appropriate regional resources (human and financial) are allocated for leadership and coordination, additional in-country support will be needed to assist regular program oversight and to provide timely, quality technical assistance.

> *"HAARP was not well integrated into our broader health strategy, [because it was initially led by the regional team, and we were brought into project oversight and support only later in the project period.]" (DFAT Management)*

Unclear measures of success hampered program results.

Several stakeholders identified the program's lack of clarity regarding critical success measures as the predominant program flaw. Initial efforts to articulate high level goals were problematic for a number of reasons outlined in the HAARP M&E Gap Analysis Review conducted in 2013. The lack of a clear results framework or practical M&E support to enable country teams to collect and analyze relevant data, has led to inefficient and in some cases ineffective programming. As discussed in the outcomes section, there were no high-level, i.e. behavioral outcomes measured by HAARP in its earlier stages.

The absence of a logical framework with clear, measurable indicators at outcome and lower levels made it very difficult during the first half of the project for country teams to make implementation decisions consistent with overall program priorities, and made it difficult for the regional team to assess program results. As outlined, the initial M&E approach (during the first half of the project) was viewed as overly complicated, highly centralized and inconsistent with national data collection systems and capacities. As a result, the overall program goal to prevent new HIV infections and build capacity and commitment to harm reduction among Government and community counterparts, were clear, the lower level objectives and measurable indicators of success to contribute to this were not. Consequently, there was an over reliance on short-term measures of success, defined through annual work plans for each participating country. Country teams were too focused on short-term, annual targets, but with little long-term vision of success, or strategy for contributing to the programs higher level goal.

The M&E support provided during the second phase of the project provided an invaluable opportunity to clarify objectives below this high level goal, and to outline measurable indicators of success at multiple levels of the logical framework. This was a key program achievement and one which future programs should ensure is built into the initial design phase. However, given that a practical results framework and M&E plan were not put in place until the penultimate year of the project, there was not sufficient time or resources to ensure measurement of key success indicators beyond minimum monitoring data requirements. Several stakeholders raised concerns regarding the lack of data collected/analyzed related to HAARP's cost-effectiveness and/or efficiency, to inform further analysis of the best way to utilize scarce and declining public health resources. Others focused on the absence of behavior change results as the clearest indication of a missed opportunity to evaluate HAARP outcomes.

> *"For a project of this scale, approximately AUD 38 million over close to 7 years, global stakeholders expected higher-level outcomes than what were included in HAARP reports." (DFAT Management)*

Future regional programs should have a clearly articulated results framework, aligned between the region and country-specific M&E plans. These ought to be in place from the outset of program implementation and be flexible enough to respond to changing contexts and program implementation stages.

External organizations selected specifically to fill program competencies, can add value to a regional program.

DFAT's regional leadership was able to enhance program performance through collaboration with respected external organizations such as ANPUD, IDPC and PSI—selected for their specific expertise in areas relevant to HAARP priorities, including network capacity building, advocacy and M&E. HAARP demonstrated the importance of ensuring external support was flexible, timely and responsive to in-country needs. In-depth interviews identified perceived value added through DFAT's regional leadership assisted by this targeted support from key external organizations. In this way, regional support can be used to bring additional expertise to the country level, and address a variety of complex challenges, which multi-country programs like HAARP must confront.

Work remains to be done to serve the needs of communities most at risk of HIV/AIDS in the region.

HAARP's long-term, significant commitment, including an initial budget allocation of $59 million across 5 countries over 8 years, facilitated local ownership of meaningful harm reduction interventions. The scope of HAARP's budgetary and implementation timeframe commitments were critical to securing local buy-in to program objectives and commitments to program oversight. Planning to sustain HAARP activities and impact beyond the end of DFAT funding began several years before the end of the project. Several stakeholders referenced the clear communication from DFAT beginning as early as late 2012, concerning the need to plan to secure alternative resources to sustain HAARP results beyond 2014. As outlined earlier in this report, there are several examples of successful planning to sustain HAARP activities beyond the program implementation period. Despite substantial results achieved during HAARP implementation as well as success in transitioning some activities initiated under HAARP to non-DFAT resources, much work remains to be done to meet the needs of communities most at risk in the region. High risk behaviors among PWID, as well as other key at risk communities namely MSM, remain high.

> *"Projects may come and go in 5-year blocks, but behavior change requires long-term commitment. We have not yet finished the work of slowing the spread of HIV/AIDS." (DFAT Management)*

There is great potential to further leverage HAARP tools and lessons to support greater harm reduction results in the future.

Annex I – Documents Reviewed

1. AusAID Gender Policy, March 2007
2. HAARP Advocacy Strategy, December 2007
3. HAARP Gender Integration Strategy, June 2008
4. AusAID HIV Strategy, February 2009
5. HAARP Communications Strategy, April 2009
6. HAARP Gender Research Report, January 2011
7. HAARP Community Engagement Strategy, May 2013
8. HAARP Key Points Exit Strategy, 2013
9. HAARP Final Exit Strategy, August 2013
10. HAARP Lao PDR UNODC Evaluation Report, April 2014
11. HAARP Human Rights Framework
12. HAARP SE Asia Human Rights Framework Annex

13. HAARP Regional Minimum Data Set Report 2009-2011
14. HAARP Myanmar Minimum Data Set Report 2009-2011
15. HAARP Cambodia Minimum Data Set Report 2009-2011
16. HAARP Guangxi Minimum Data Set Report 2009-2011
17. HAARP Vietnam Minimum Data Set Report 2009-2011
18. HAARP Yunnan Minimum Data Set Report 2009-2011
19. HAARP Cambodia MDS Qualitative Report 2013
20. HAARP Lao PDR MDS Qualitative Report 2013
21. HAARP Regional Minimum Data Sets, Updated August 2014
22. HAARP Consolidated Minimum Data Sets, Updated January 2015

23. HAARP Quality at Implementation Report 2009
24. HAARP Quality at Implementation Report 2010
25. HAARP Quality at Implementation Report 2011
26. HAARP Quality at Implementation Report 2012
27. HAARP Quality at Implementation Report 2013
28. HAARP Quality at Implementation Report 2014

29. HAARP Law and Policy Review, June 2009
30. HAARP Case Study Harm Reduction for Sale, 2011
31. ANPUD Organizational Capacity Building Module, 2013
32. IDPC Drug Policy in Southeast Asia, 2013
33. PSI M&E Gap Analysis Report, August 2013
34. PSI RQA Cambodia Report, 2014
35. PSI RQA Lao PDR Report, 2014

Annex II - Interviewee List

Regional

- Mr. Michael Wilson, Minister Counsellor, DFAT SEARH
- Ms. Eleanor Cupit, First Secretary - Development Cooperation, DFAT SEARH
- Mr. Royce Escolar, Senior Regional Program Manager, DFAT SEARH
- Mr. Richard Lee, Regional Program Manager, DFAT SEARH
- Mr. Michael O'Dwyer, Regional Health Specialist, DFAT SEARH

China (including Yunnan component)

- Ms. Linna Cai, Development Cooperation Manager, DFAT Beijing

Cambodia

- General Phorn Boramy, Director of Law Enforcement Department
- His Excellency, Dr. Chhum Vannaraith, Under Secretary of State
- His Excellency, Dr. Ly Kimlong, Deputy Secretary General
- His Excellency, Dr. Thia Phalla, Vice Chairman of NAA and NAA Team
- Dr. Thong Sokunthea, Director of Legislation, Prevention and Treatment Department
- Dr. Chhit Sophal, Director of Mental Health and Substance Abuse Department
- Dr. Hy Someth, PCPI Coordinator

- Ms. Marie-Odile Emond, Country Director, UNAIDS
- Mr. Ung Polin, Community Mobilization and Networking Advisor, UNAIDS
- Dr. Fujita Masami, Technical Officer, HIV/AIDS Team Leader, WHO
- Ms. Eng Dany, National Officer, WHO

- Ms. Margot Morris, First Secretary - Development Cooperation, DFAT Phnom Penh
- Dr. Premprey Sous, Senior Program Manager, DFAT Phnom Penh
- Mr. Bunmeng Chhun, Program Manager, DFAT Phnom Penh

Vietnam

- Dr. Nguyen Hoang Long, Central Project Management Unit
- Dr. Pham Duc Mang, Vietnam Administration of HIV/AIDS Control

- Ms. Van Duong, Senior Program Manager, DFAT Hanoi

Myanmar

- Ms. Sanda Aung, Senior Program Officer, DFAT Yangon

Lao PDR

- Ms. Rachel Jolly, First Secretary, DFAT Vientiane
- Ms. Irene Lorete, Harm Reduction Specialist, HAARP Lao PDR

Annex III - Terms of Reference

Terms of Reference for HAARP Outcomes and DFAT Lessons Assessment

1. Overview

These terms of reference provide guidance to PSI Vietnam in conducting an assessment of the HIV/AIDS Asia Regional Program (HAARP) outcome level achievements and Department for Foreign Affairs and Trade (DFAT) programmatic/operational lessons learned. HAARP's outcome assessment will focus on the final years of the program's implementation phase (2007–2014), while DFAT's lessons assessment will also incorporate HAARP's design and planning phase (2005-2007).

2. Background

The goal of HAARP is:

- Strengthen the will and capacity of governments, at all levels, and communities in the GMS to reduce HIV related harm associated with injecting drug use.

HAARP's intermediate outcome is:

- Increased delivery of HIV/AIDS harm reduction services for people who inject drugs (PWID) and their partners.

HAARP specifically targets PWID and their partners, a particularly marginalised group with limited access to life-saving HIV harm reduction services. The program is a seven year (2007-2014) $38 million multi-country HIV harm reduction initiative across five Country Programs (CPs) in the Greater Mekong Sub-region (GMS): Cambodia, Vietnam, China, Myanmar and Lao PDR. Overall initiative amounts have been recalculated from an initial $59 million ministerial submission approved figure in 2007, to $47 million in 2013, and a current estimate of $38 million. The latter amount represents the most realistic assessment of HAARP's absorptive capacity and suggests initial initiative values were overly ambitious and misleading.

HAARP is managed at a regional level by DFAT Bangkok, providing CP oversight and management of regional program [1] components through the International Drug Policy Consortium (IDPC), the Asian Network for People who Use Drugs (ANPUD) and PSI Vietnam. Due to the program's multi-country structure DFAT Posts, and Country Support Units (CSUs), have maintained operational management of CP stakeholders and implementing partners. In Vietnam, HAARP has partnered government health ministries, HIV/AIDS agencies, and drug control boards; in Lao PDR activities have been implemented through the United Nations Office on Drugs and Crime (UNODC); in Cambodia through NGOs: FHI360, KHANA, Korsang, and Friends International; and YUNDI in China under coordination of UNAIDS. HAARP mainland China was successfully transferred to government systems in 2012 and in Myanmar, funding has been channeled through the Three Millennium Development Goal Fund (3MDG Fund).

[1] DFAT Bangkok's definition of a "regional program" comprises of; 1) a development challenge relevant to multiple countries (three or more); 2) requires regional cooperation and coordination; 3) coordinated through a single mechanism; 4) is well-defined and has a clear focal point with the policy authority in each national jurisdiction; 5) has clear country ownership with mutual interest across countries.

In December 2013, DFAT Bangkok, in consultation with bilateral Posts, developed an accelerated HAARP exit strategy, building on an earlier exit strategy developed in 2012. The former detailed a responsible way for DFAT to rationalise and conclude HAARP while mitigating reputational and developmental risks. The latest exit strategy was specifically designed in anticipation of DFAT aid program budget cuts and approved in December 2013. The aid program budget reduction was later confirmed in January 2014. HAARP will conclude all activities six months earlier by 31 December 2014.

In 2014, HAARP will focus on life-saving HIV harm reduction service delivery, including needle and syringe programs (NSP) and methadone maintenance treatment (MMT) in Cambodia and Vietnam. NSP delivery operates through drop in centres and outreach modalities, while MMT is undertaken through dedicated clinics. In 2013, capacity building, training and advocacy activities ran parallel to service delivery and were important components in consolidating the program's impact, sustainability and legacy. The majority of capacity building and advocacy will end in 2014 owing to limited budgets and additional savings re-allocated to support service delivery activities.

3. Rationale

HAARP has achieved a great deal since its inception and was a visionary program for its time, however, many of its successes have been difficult to capture and weakened through challenges posed in the program's design and management. Multiple program changes have been implemented in an attempt to improve program efficiency and effectiveness. Some have arguably been introduced too late, but most have been appropriate responses constrained by the program's multi-country delivery modality. An overly complicated monitoring and evaluation (M&E) framework at design stage, appropriateness of Technical Support Unit (TSU) and CSU models, as well as raised levels of expectation against associated initiative figures, further indicate the need for comprehensive program reflection. In addition to complexities related to its design, HAARP was always going to be an extremely challenging program to implement, due to the context and attitudes surrounding HIV harm reduction in the GMS. As HAARP enters its final program phase in 2014, and with the benefit of hindsight, it is paramount that implicit qualitative program achievements, key organisational strengths and challenges, in addition to lessons are documented. These would represent a constructive legacy document from which initiative managers can operationalise, and will inform future DFAT regional program strategy in the GMS through a wider DFAT Bangkok review of lessons learned.

4. Objective

The overall objective of this activity is to assess HAARP's outcome level achievements and DFAT's programmatic lessons learned since the program's inception in July 2005 through to its closure on 31 December 2014. Within this objective the activity should:

- Assess and document HAARP's implicit qualitative achievements, as well as progress against overall program and country specific outcomes. Make value judgements based on indicators, targets, and evidenced based observations.

- Identify and document program strengths and challenges arising from HAARP's design, DFAT management of program implementation, and country contexts (political, social and cultural) throughout the program's life cycle.

- Assess and document how HAARP's accelerated closure has impacted outcomes and management. Specifically, through the prioritisation of service delivery over capacity

building and advocacy, as well as the transfer of management and technical oversight back to Posts.

- Develop and document key lessons learned for DFAT from evidenced program achievements and challenges; in order to inform future DFAT initiative design, implementation and strategic approaches in the GMS.

5. Key achievements, strengths and challenges

Exposition of rationale

HAARP was a visionary program for its time, given it focused on PWID and not more broadly on the general population. Targeting a most at risk population (MARP) was deemed appropriate through assessment of the GMS context and strong links to the Australian Government's experience in HIV harm reduction. However, with hindsight the primary focus on PWID may not have been suitable for all HAARP CPs given the emergence of other MARPs as key epidemic drivers. HAARP CP's have supported the implementation of life-saving service delivery through MMT and NSP, and significant numbers of PWID have been reached through these services. Positive contributions to enabling environments have been seen and encouraging sustainability and gender inclusive stories have been observed. Since 2007, HAARP CPs have reached over 117,000 PWID; dispensed 4.8 million condoms, over 7 million sterile water vials and 21 million needles and syringes. More than 44,000 referrals to HAARP related health care services have taken place and the program has contributed to partner governments' acceptance of HIV harm reduction in the GMS.

A number of challenges stemming from HAARP's design phase have constrained its efficiency and effectiveness. Over complicated and unused M&E frameworks hindered the program in terms of guiding implementation and monitoring progress (revised country level M&E frameworks were introduced in 2013/14). Particularly high program expectations, associated with arbitrary initiative values of $59 million and $47 million (not developed against defined and costed activities), as well as HAARP's true absorptive capacity have impacted how the program has been perceived internally and externally. Crucially, HAARP's multi-country delivery modality led to substantial opportunity costs for DFAT and has been a significant reason why financial and human resources have been diverted towards attempts to improve efficiency.

The HAARP multi-country delivery model has not been appropriate in terms of delivering efficiency and effectiveness, however, this model was adopted at design stage and DFAT has attempted to improve it through program changes. HAARP's original regional Technical Support Unit (TSU) model focused on providing Bangkok-based technical inputs to HAARP CPs. This model was arguably relevant during the initial stage of setting up HAARP CPs. However, as HAARP CP's were established, it became increasingly impractical and inefficient for an external TSU to provide fly-in support, on an adhoc basis. Particularly for a program like HAARP which requires permanent, responsive and strategic in-county program and technical support. The TSU model ended in May 2012 to coincide with the contract expiry date of the managing contractor. Dedicated technical resources were therefore unavailable, but were partially assumed from April 2012 when DFAT Bangkok hired a Strategic Transition Advisor to oversee the transfer of technical and daily program management functions to CSUs.

In 2013, HAARP de-centralised technical and program management support to CSUs. DFAT considered this model to be a more appropriate arrangement in managing a multi-country program. In this structure DFAT Bangkok provided regional support to CPs through knowledge management, monitoring & evaluation, community engagement, and scoping on regional harm

reduction policy environment. At the national level, DFAT Posts and CSUs managed contracts and stakeholder relationships. In practice CSUs were only partially established in 2013 and, despite efficiency gains, the CSU model has been abandoned in 2014 owing to reductions in the aid budget. With hindsight this model may have been better incorporated at the design stage.

Country contexts differ and have also changed throughout the lifespan of HAARP. This is one factor which has supported the need for a multi-country modality, as specific approaches to HIV harm reduction have been required to varying extents in each country. Social, political and cultural dimensions in tackling HIV harm reduction have meant CPs have faced many obstacles, including prohibitive laws and particularly challenging policy environments. While improvements to countries' legal environments have been seen - in Vietnam, punitive responses to PWID have softened and in Cambodia HIV harm reduction approaches have started to be institutionalised - broader issues of stigma and discrimination remain. Furthermore, CPs have often had to deal with young civil societies, suspicion towards HIV harm reduction approaches, competing institutional partners and unfavourable personal attitudes throughout implementation.

An assessment of the above, in addition to how HAARP's accelerated closure has impacted outcomes and management, (through the prioritisation of life-saving service delivery over capacity building and advocacy, as well as the transfer of management and technical oversight back to Posts), will form the basis of a comprehensive program reflection in the required reporting output.

6. Scope

The focus of this assessment will be primarily at the operational level to crystalize HAARP's outcome level achievements and challenges, provide initiative managers with program lessons that can be operationalised and which will indirectly feed into DFAT Bangkok regional program strategy. This assessment will specifically provide added value to end-of-program reporting and outcome data by analysing HAARP's contribution to changes at country level, in each country (i.e. contributions to policy change and behaviour change), identifying the uncaptured implicit outcomes due to initially weak M&E frameworks.

- Qualitative inputs will be incorporated from HAARP CPs inclusive of DFAT Posts and implementing partners where feasible in; China, Cambodia, Vietnam, Myanmar, and Lao PDR.
- DFAT Bangkok, the Mekong and Regional Hub and DFAT Canberra will also provide contributions. These inputs will be defined by the availability of personnel with knowledge of HAARP at the time of the assessments implementation.
- The assessment will cover HAARP's program design/planning period July 2005 – June 2007; and program implementation period July 2007 – December 2014. HAARP's outcome assessment will focus on the final years of the programs implementation phase, while DFAT's lessons assessment will also incorporate HAARP's design and planning phase.
- This activity is costed under Milestone 6 of this contract (66144) amounting to USD 18,696.80 and supported by associated Advisor Support and Project Operational Costs.

7. Output

- Assessment plan (concise): detailing assessment activities to be completed in line with this TOR and submitted to DFAT Bangkok by 30 May 2014.

- HAARP Outcome and DFAT Lessons Report (structure detailed in reporting section below).

8. Duration

The assessment will be conducted according to the submitted assessment plan, accounting for inputs from key individuals and stakeholders only available before July 2014. The majority of work will be undertaken between March and December 2014, as agreed in PSI Vietnam's 2014 workplan.

9. Methodology

- Desk review of documentation (inclusive but not limited to); design documents, CP and regional evaluations, Quality at Investment (QAI) reports, minimum data sets (MDS), qualitative assessments and partner reports;
- In-country interviews:
  - Thailand: DFAT Bangkok Program Management Team, Mekong and Regional Hub Specialist Health Advisor;
  - Cambodia: DFAT Phnom Penh and HAARP partners (FHI360, KHANA, Korsang and Friends International), National Authority for Combating Drugs (NACD), Ministry of Health (MoH), Ministry of Interior (MoI), the National AIDS Authority, UNAIDS and WHO;
  - Vietnam: Mekong and Regional Hub (interviews with Minister Counsellor prior to July 2014 and Counsellor); DFAT Hanoi, Central Project Management Unit and Ministry of Health).
- Telecon interviews with DFAT Canberra, Bangkok, Posts and partners where feasible; DFAT Beijing, Yangon, and Vientiane. NGO Yundi (China), 3MDG Fund (Myanmar) and UNODC (Laos PDR PDR).
- Key assessment questions:
  1) To what extent did HAARP communicate its specific objectives to partner governments and implementing agencies?
  2) To what extent did these objectives contribute to partner governments' development objectives?
  3) To what extent did the program operate with a clearly articulated theory of change (TOC) framework that linked proposed activities to outcomes and objectives?
  4) To what extent was this framework communicated to HAARP country teams?
  5) Describe and assess the M&E arrangements in place for each HAARP CP.
  6) To what extent were annual work plans operationalised?
  7) What have been the major and enduring outcomes at the program level? Has HAARP changed the enabling environment for harm reduction, either intentionally or unintentionally, and how?
  8) To what extent have project management and technical support arrangements for HAARP CPs been appropriate for realising program objectives?

9) What are the key lessons learned for DFAT around the design and implementation of the HAARP program?

10. Specification of team

As defined in Annex 1, Table 1 (Short Term Personnel) of Amendment 3, in this Contract (66144).

11. Reporting

A draft report will be submitted to DFAT Bangkok in electronic format by 16 January 2015 and a final revised report submitted by 30 January 2015, following comment and feedback from DFAT Bangkok. The report should be divided into four (4) sections; reflecting the main assessment objectives and not exceed 20 pages in length (including a two (2) page executive summary). The report should comprehensively address this TOR while recognising the need for clarity, brevity and usefulness.

Annex IV - Assessment Plan

HAARP Outcome and DFAT Lessons Assessment
---Implementation Plan---

I. Background and Rationale

The HIV/AIDS Asia Regional Program (HAARP) is a multi-country program funded by the Australian Department of Foreign Affairs and Trade (DFAT). The goal of HAARP is to strengthen the will and capacity of governments, at all levels, and communities in the Greater Mekong Sub-region (GMS) to reduce HIV related harm associated with injecting drug use. A key outcome of HAARP is to increase delivery of HIV/AIDS harm reduction services for people who inject drugs (PWID) and their partners.

HAARP specifically targets PWID and their partners, a particularly marginalized group with limited access to life-saving HIV harm reduction services. The program is a seven year (2007-2014) $38 million HIV harm reduction initiative across five Country Programs (CPs) in the GMS: Cambodia, Vietnam, China, Myanmar and Lao PDR. Overall initiative amounts have been re-calculated from an initial $59 million ministerial submission approved figure in 2007, to $47 million in 2013, and a final $38 million.

In December 2013, DFAT Bangkok, in consultation with bilateral Posts, developed an accelerated HAARP exit strategy, building on an earlier exit strategy developed in 2012. The former detailed a responsible way for DFAT to rationalise and conclude HAARP while mitigating reputational and developmental risks. The latest exit strategy was specifically designed in anticipation of DFAT aid program budget cuts and approved in December 2013. HAARP will conclude all activities six months earlier by 31 December 2014.

In HAARP's final program phase, and with the benefit of hindsight, it is paramount that implicit qualitative program achievements, key organizational strengths and challenges, in addition to lessons are documented. These would represent a constructive legacy document from which initiative managers can operationalise, and inform future DFAT regional program strategy in the GMS through a wider DFAT Bangkok review of lessons learned.

II. Objectives

To assess HAARP's outcome level achievements and DFAT's programmatic lessons learned since the program's inception in July 2005 through to its closure on 31 December 2014, including:

- Assess and document HAARP's implicit qualitative achievements, as well as progress against overall program and country specific outcomes. Also, make value judgments based on indicators and targets through evidenced based observations.

- Identify and document program strengths and challenges arising from HAARP's design, DFAT management of program implementation, and country contexts (political, social and cultural) throughout the program's life cycle.
- Assess and document how HAARP's accelerated closure has impacted outcomes and management. Specifically, through the prioritisation of service delivery over capacity building and advocacy, as well as the transfer of management and technical oversight back to Posts.
- Develop and document key lessons learned for DFAT from evidenced program achievements and challenges; in order to inform future DFAT initiative design, implementation and strategic approaches in the GMS.

III. Key assessment questions

- To what extent did HAARP communicate its specific objectives to partner governments and implementing agencies?
- To what extent did these objectives contribute to partner governments' development objectives?
- To what extent did the program operate with a clearly articulated theory of change (TOC) framework that linked proposed activities to outcomes and objectives?
- To what extent was this framework communicated to HAARP country teams?
- Describe and assess the M&E arrangements in place for each HAARP CP.
- To what extent were annual work plans operationalised?
- What have been the major and enduring outcomes at the program level? Has HAARP changed the enabling environment for harm reduction work, either intentionally or unintentionally, and how?
- To what extent have project management and technical support arrangements for HAARP CPs been appropriate for realising program objectives?
- What are the key lessons learned for DFAT around the design and implementation of the HAARP program?

These key assessment questions will be translated into 4 interview guides to be used with i) regional DFAT teams; ii) implementing partners in HAARP countries; iii) in-country DFAT teams; and iv) beneficiaries. These 4 interview guides will be designed to be consistent with the principles outlined in both the key assessment questions and the TOR.

IV. Methodology

1. Research on HAARP related data and information

The assessment team will:

- Collaborate with DFAT/BKK to collect project related documents through DFAT Bangkok and all CP offices for HAARP activities in 5 countries (Laos PDR, Cambodia, Vietnam, China and Myanmar) including, but not limited to:
    - Approved HAARP project documents, and their amendments if any, including HAARP design and key re-design documents;
    - Approved Regional and CP level work plans;
    - Minimum data sets from each CP for each year of the program;
    - Annual reports submitted to DFAT by each CP;
    - HIV/AIDS rapid situation assessments (when and where these have been conducted);
    - Reports of independent mid-term evaluations, if any;
    - Quality at Implementation (QAI) reports;
    - Reports from specific area analysis (for example: M&E GAP analysis), consultancy visits to project sites;
    - Surveys or other data collected from target populations, if any.
- Review the management and technical support mechanisms for each country and regional programs.
- Evidence the extent to which interventions were developed with reference to theory of change frameworks.
- Summarize documented outcomes, specifically:
    - Comparing quantitative outcome achievements against objectives, using target indicators stated in work plans/CP frameworks. This includes both highlighting achievements and the reasons why targets may have been unmet or not captured.
    - Map how changes in program management and funding arrangements may have shaped key outcomes over the duration of the program.

2. Primary data collection

Interviews with key informants: The assessment team will arrange individual interviews with the following key persons including those with strategic responsibility; program

managers and persons implementing HAARP activities. Given that HAARP activities have already ended in Myanmar, China, and Lao, a number of interviews will be conducted via telephone, and where possible in- person interviews for active CPs. Tentatively, the following teams/persons will be contacted for interviews and finalized in country specific plans:

- DFAT, implementation agencies and partners:
    - Thailand: DFAT Bangkok (Program Management Team), Mekong and Regional Hub (Specialist Health Advisor);
    - Cambodia: DFAT Phnom Penh and HAARP partners (FHI360, KHANA, Korsang and Friends International, WHO and UNAIDS);
    - Vietnam: Mekong and Regional Hub (interviews with Minister Counsellor prior to 4 July 2014 and Counsellor); DFAT Hanoi, Central and Provincial Project Management Unit;
    - Laos PDR: DFAT Vientiane, UNODC;
    - China: DFAT Beijing, Yundi;
    - Myanmar: 3 MDG Fund.
- Host country government partners:
    - Cambodia: National Authority for Combating Drugs (NACD), Ministry of Health (MoH), Ministry of Interior (MoI), the National AIDS Authority;
    - Vietnam: Vietnam Administration of AIDS Control (VAAC); MoH
    - Lao: MoH, National AIDS Program.

Interviews with service users: The key objectives of this exercise are to document project achievements from project client's perspectives. In addition, this will help to identify the challenges faced by service users and insights into how these can be improved to increase future use. This is a key part of documenting the lessons learned for harm reduction services provided through HAARP, but will also serve as a learning for future programs and those that may continue to provide these services in project countries once HAARP has finished.

The method of PEER (Participatory Ethnography for Evaluation and Research) will be used for the collection of qualitative data. This method has previously been used for identifying service quality improvement in HAARP Lao and Cambodia, with PSI/VN support. Given that HAARP supported services are only currently provided in Cambodia and Vietnam, the following services will be assessed:

- Cambodia: Needle and Syringe Program (NSP) and Methadone Maintenance Treatment (MMT).
- Vietnam: NSP, Voluntary Counselling and Treatment (VCT), and MMT.

Where possible, input from previous RQA (Rapid Qualitative Assessment) and DQA (Data Quality Assessment) exercises will be integrated into the analysis and final report.

Consistent with PSI's RQA methodology, beneficiary questions will be developed around five key questions:

I. Why did you get involved with the service?
II. What difference has the service made to you?
III. What difference has the service made to people that you know that also use the service?
IV. What do you think is the most important achievement of the service?
V. What challenges have you and your friends faced in using the service?

Table 1: *country specific primary data collection plan*

Key informants	# Interviews		Key interview topics
	In-person	Telephone	
DFAT Bangkok			
DFAT Bangkok Program Management Team	1	1	• HAARP overall program design • Regional program management and support • Changes in management structure, influential to project outcome
DFAT Mekong and Regional Hub • Health Specialist	1	1	• Explore technical HAARP related areas and the HIV/AIDS contexts across countries
Vietnam			
DFAT Mekong and Regional Hub • Minister Counsellor • Counsellor	1		• Explore strategic aspects of HAARP, institutional challenges and regional perspective
DFAT Hanoi	1		• Project management and coordination • Communication between DFAT and implementing agencies

VAAC	1		• Contribution of HAARP to government funded program objectives • Coordination/integration between HAARP and government program
CPMU			
• Project director	1		• CP design • Annual work plan development • Program management • Coordination with government program • Communication with donor and implementing agencies • Key achievements/challenges by objectives
• Project coordinators	2		
PPMU (three provinces in HAARP)			
• Project coordinators	3		• Annual work plans development • Program implementation • Key achievements/challenges by objectives
• Technical staff (outreach, M&E, Methadone staff)	6		• Key achievements/challenges in providing services to PWIDs
Project clients			
• Outreach peer educators	5		• Service quality (achievements, challenges and accessibility)
• NSP and Methadone clients	10		• Service quality (achievements, challenges and accessibility), barriers or facilitators to service access that relate to gender and/or disability
Cambodia			
DFAT Phnom Penh	2		• Project management and coordination • Communication between DFAT and implementing agencies
NACD	1		• Contribution of HAARP to government funded program objectives
MoH	1		

NAA	1		• Coordination/integration between HAARP and government program
NGOs (Korsang, Mith Samlanh, KHANA and FI)			
• Project coordinator	4		• Annual work plan development • Program implementation • Key achievements/challenges by objectives
• Outreach manager	4		
• Methadone clinic manager	1		
Project clients			
• Outreach peer educators	5		• Service quality (achievements, challenges and accessibility), barriers or facilitators to service access that relate to gender and/or disability
• NSP and Methadone clients	10		
Lao PDR			
DFAT Vientiane		1	• Project management and coordination • Communication between DFAT and implementing agencies
UNODC/Lao		1	• Contribution of HAARP to government funded program objectives • Coordination/integration between HAARP and government program • Key achievements and limitations
China			
DFAT Beijing		1	• Key achievements and limitations of HAARP
Yundi		1	
Myanmar			
DFAT Yangon		1	• Key achievements and limitations of HAARP
3 MDG fund		1	

3. Data/information analysis, synthesis and reporting

Drawing together the information from document reviews, stakeholder interviews and service user assessments, reports will be produced for each country and integrated into a single document. This report will identify HAARP outcome level achievements and DFAT programmatic lessons through analysis, synthesis and reporting across the core areas below:

Program strengths and challenges: related to HAARP design, program management and country contexts over the life of the program

This will assess the extent to which the HAARP program communicated its specific objectives to partner governments and implementing agencies, and whether (and how) these objectives contributed to partner governments' development objectives. It will assess the extent to which a clear theory of change framework existed that clearly articulated the links between proposed activities to the strategic objectives of the program. Was the logic of the program clear to implementing partners for each CP, including government agencies with responsibility for harm reduction programming? How did this clarity – or lack thereof – shape the achievements and challenges of each CP? How did it shape the overall direction of HAARP?

This section will also look at the program management and technical support provided to CPs throughout the life of HAARP, the consistencies and variations in this, and the extent to which CPs were supported to both deliver high quality programs and to report against these. HAARP's early closure will also be covered in this section, and the consequential impact on program outcomes and management explored.

Key program achievements (outcomes): country and regional level

This will provide an overview of HAARP services within each CP and, where appropriate, assess these against set objectives/outcomes. This will include the type, scale and coverage of services provided, how these aligned with the harm reduction landscape in each country, and trends over the life of the program. This section will also detail the changes, scope and scale of each CP over the life of HAARP and the evolution of objectives/outcomes. It will also assess the extent to which annual work plans were operationalized, draw links to wider management arrangements and the HAARP context to provide deeper understanding of observed trends.

The most significant and enduring outcomes at the program level will be identified, contrasting explicit quantitative outcomes against implicit qualitative outcomes and describe the extent to which HAARP has impacted upon the enabling environment for harm reduction work, both intentionally and/or unintentionally. Specifically, it will detail how clients and service users experienced the services under HAARP, the extent to which they contributed to the reduction of risk and identify any unintended or unanticipated outcomes that program activities have supported. It will also highlight the barriers and facilitators to service access, including those that relate to gender and/or disability.

Where possible, HAARP data will be triangulated with other sources, sentinel surveillance for example, to assess potential impacts of activities for promoting safer behaviours, reducing HIV transmission, and improving quality of life among target populations.

It will look at the potential for the continuation of services and initiatives that have been supported by HAARP following the completion of the program in 2014. It will detail other sources of funding that services can draw upon to sustain their work, how services may change as a result of the cessation of HAARP funding, and providers' views on what the impact may be on longer-term harm reduction programming in each country.

Key program lessons learned: country and regional level

This section will clearly set out what we see as the key learning points from HAARP, for each CP, at the regional level and more generally for DFAT regional programs. It will identify where experiences from HAARP can and should contribute to a better understanding of effective methods of supporting harm reduction programming, the management and technical support arrangements that can facilitate success and/or create barriers, and importantly outline the lessons that may be relevant to future DFAT regional programs more generally

V. Timetable

Table 2: *Assessment timeline*

Activities	Timeline							
	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15
Preparation phase								
- Contact and share with HAARP country teams the assessment plan								
- Develop 4 interview guides with input from DFAT								
- Develop specific plans with country teams								
Desk review phase								
- Identify key partners who will provide existing data and project- related documents								
- Collecting of project documents and data								
- Data and information reviews								
- Development of interview guides								
Field work phase								
- Interviews								
• DFAT BKK (in-person)								
• Lao DFAT/UNODC (telephone)								
• China DFAT/NGO (telephone)								
• Myanmar (telephone)								
- Field visits for primary qualitative data collection								
• Vietnam								
• Cambodia								
Analysis and report development phase								