EXECUTIVE SUMMARY

End Evaluation of the Frontline AIDS Global Plan of Action

2023–2025

This report was produced as an independent external consultancy commissioned by Frontline AIDS.

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Holding the line on justice in a new AIDS emergency

This end evaluation examines Frontline AIDS' contribution under the Global Plan of Action (GPA) 2023–2025, a period marked by converging crises for communities most affected by HIV. It assesses what this way of working has made possible, and where its limits lie, as the organisation transitions toward its 2026–2030 strategy.

Donor funding has contracted, civic space has narrowed, and gender, racial and sexual rights have come under renewed attack, alongside conflict, displacement, climate shocks and economic precarity. In many contexts, people living with and most affected by HIV are fighting not only for treatment and prevention, but for bodily autonomy, safety, freedom of movement and the right to organise.

This evaluation starts from a political understanding: the struggle to end AIDS is not primarily a technical public-health challenge, but a question of justice. HIV persists not because communities lack knowledge of what works, but because power, resources and legitimacy remain unevenly distributed—and those most affected are often the first excluded when crises deepen and rights erode.

Over the GPA period of 2023–25, Frontline AIDS leaned further into a connector role within the Partnership rather than expanding large-scale direct service delivery. **It focused on linking community-rooted organisations and lived experience to decision-making spaces, translating practice into evidence and products that decision-makers, institutions and funding mechanisms can use, and brokering catalytic resources in increasingly constrained funding environments**. This end-evaluation sits at the hinge between the GPA and the new 2026–2030 strategy and asks what this way of working has made possible under sustained pressure.

Key messages

- Frontline AIDS' added value lies in enabling community leadership to shape decisions at scale—ensuring that community-led knowledge, practice and priorities inform standards, funding and norms that outlast individual projects.
- More durable change in people's lives emerges where service access, the embedding of community-led approaches within policies, systems and funding, and shifts in norms and protection reinforce one another.
- The Outcome Harvesting evidence base generated by Frontline AIDS is credible and usable for accountability and learning, but coverage needs further work and lived experience not yet consistently captured, pointing to a clear Monitoring, Evaluation and Learning (MEL) agenda for 2026–2030.

1 Purpose, scope and method

The primary purpose of this end-evaluation is accountability: to provide Frontline AIDS, its partners and strategic funders with an independent, evidence-based assessment of Frontline AIDS' contribution and added value during 2023–2025. Its secondary purpose is strategic learning: to identify patterns—not only successes—that can inform choices about where Frontline AIDS can be most effective in the 2026–2030 period.

This is a desk-based qualitative evaluation. It does not generate new primary data. Instead, it synthesises existing evidence, primarily Frontline AIDS' Outcome Harvesting dataset of approximately 160 outcomes reported between 2023 and 2025.

For this evaluation, 126 outcomes rated high or medium quality form the backbone of the analysis. These outcomes were read through Frontline AIDS' emerging strategic framework aligning three priorities (health systems; rights and gender justice; crisis resilience) and three core roles (advocacy and influencing; learning and innovation; funding and brokering resources)—to identify recurring contribution pathways and patterns of systems change.

The same body of evidence was interpreted across four evaluation questions (EQs): patterns of contribution and added value (EQ1); long-term potential for change in people's lives, systems and policies (EQ2); evidence quality and MEL (EQ3); and strategic pathways for the next strategy cycle (EQ4). The evaluation does not seek attribution or counterfactual impact, but assesses the plausibility and credibility of contribution given the evidence available.

2 What is Frontline AIDS' added value? (EQ1)

The evaluation finds that Frontline AIDS' added value lies in enabling community leadership to shape decisions at scale—ensuring that community-led knowledge, practice and priorities shape the decisions, standards and resources that govern HIV responses.

Added value is understood as the distinctive contribution Frontline AIDS makes as a Partnership actor where its engagement strengthens the connection between community leadership and institutional decision-making, so that innovations, rights claims and crisis responses do not remain isolated or temporary.

Across the outcomes, this contribution operates through a recurring connector function:

- translating community-led practice and lived experience into evidence and products that institutions can act on;
- enabling access to decision-making spaces where policies, standards and funding are set; and
- brokering relationships and resources that support the uptake, implementation and durability of community-led models, rights-based approaches and crisis-response mechanisms, including humanitarian and rights-focused funding.

This connector role reflects a deliberate orientation: communities at the frontlines are treated as political actors and sources of solutions whose knowledge must count in systems governing health, rights and crisis response.

3 What is plausibly changing in people's lives, systems and policies? (EQ2)

EQ2 examines what is plausibly changing in the day-to-day lives of people most affected by HIV, and what is likely to hold when funding contracts, backlash deepens or crises disrupt services.

The evidence is strongest where change is anchored in systems - guidance, procedures, mandates and financing - and lighter on direct measures of lived experience such as safety, stigma and sustained service use. Reading across the outcomes, three interlocking layers of change emerge:

- accessible service interfaces: the points of contact between people and services—such as outreach, referral pathways and delivery models—that are more reachable, inclusive and protective, improving continuity and dignity of care where sustained;
- system anchoring: decisions that institutionalise community-led models through policies, professional standards, procedures and budgets, reducing access barriers over time;
- norms and protection: shifts in social permission and narrative environments that make discrimination harder to sustain and help-seeking less risky.

These layers are unevenly present. Some outcomes show strong system anchoring—such as changes in policies, guidance or funding arrangements—while offering limited visibility on how these shifts are experienced in people's day-to-day lives; others document narrative shifts without clear pathways to implementation. Full trajectories are more often visible across clusters of outcomes rather than in single entries.

The most defensible conclusion is pattern-based, grounded in recurring combinations observed across multiple outcomes rather than single examples. Durability is most plausible where changes at the service interface are reinforced by system anchoring and shifts in norms and protection. Stronger evidence of such reinforced trajectories is documented in specific contexts and populations: for instance among adolescents and young people living with HIV in Zimbabwe and Malawi; women who use drugs in Burundi; and people living with HIV and other key populations in rights-focused work in Tunisia, Egypt and Jordan. In these settings, outcomes show service-level improvements supported by formal adoption into guidance, authorisations or financing decisions, providing a clearer line of sight between improved access and the conditions required for durability. Where one layer is missing, gains remain meaningful but more fragile, particularly under conditions of criminalisation, stigma and crisis.

Coverage remains uneven across regions and populations. Some groups—including trans people, sex workers, migrants, and adolescent girls and young women in crisis contexts—are under-represented in the current evidence base. These gaps reflect a combination of programme focus, operating conditions and documentation dynamics rather than levels of need. Addressing them is therefore a priority for the next strategy cycle, both in terms of strategic investment and more intentional evidence generation.

4 How credible is the evidence, and what does this imply for MEL? (EQ3)

Overall, the Outcome Harvesting dataset provides a credible and usable basis for assessing Frontline AIDS' contribution during the GPA period. Most outcomes are rated high or medium quality, with identifiable actors, decisions and timeframes. Credibility is strongest where outcomes are supported by external documentation such as policies, donor records and multilateral references.

At the same time, the evidence is stronger in documenting institutional and system-level change than in capturing lived experience at scale. This reflects Frontline AIDS' strategic focus on influencing policies, standards, financing and authorisation environments—where the organisation operates most consistently and at greatest reach—rather than on direct individual-level service delivery, which necessarily remains smaller in scale. Institutional outcomes and lived-experience evidence therefore serve different but complementary purposes: institutional change signals potential for large-scale and sustained impact, while lived-experience evidence helps assess how selected changes are implemented and what difference they make in people's lives. For 2026–2030, the MEL priority is not to shift focus away from institutional change, but to strengthen proportionate, non-extractive follow-up on a small number of significant institutional shifts, to understand how they translate into safety, dignity, stigma reduction and access in practice, building where possible on community-led monitoring and feedback systems.

To strengthen confidence in high-stakes findings, 11 outcomes were substantiated through the evaluation using predefined criteria and documentary review. Ten were fully substantiated and one lacked sufficient documentation; none were refuted. This supports the overall credibility of the evidence while highlighting manageable improvements in documentation and verification.

Rather than a wholesale redesign of Monitoring, Evaluation and Learning, the findings point to focused refinements. These include improving coverage across regions and populations; clarifying contribution narratives; making equity and power dynamics more visible; and normalising light, regular substantiation of high-stakes outcomes. It is also important to recognise that thinner evidence in some regions and populations reflects limited programme presence and funding constraints during the period reviewed; in such cases, the absence of outcomes should be understood as a boundary of the available evidence rather than as an indicator of lower relevance or need.

5 Strategic pathways for 2026–2030 (EQ4)

Patterns across the outcomes point to three interlocking strategic pathways where Frontline AIDS already has strength and where the next Global Plan can be more deliberate:

- community innovation to systems and norms: Accompanying community-embedded models from practice into policy, financing and narratives, and staying with partners through this full trajectory;

- rights-based protective ecosystems: Combining rights documentation, legal and paralegal support, professional standards, employer and faith engagement, and dedicated funds to make inclusion and crisis response safer and more scalable;
- crisis resilience and humanitarian influence: Supporting community-led organisations to adapt services during crises and to influence humanitarian decisions, while extending this work beyond a limited number of contexts.

These pathways rely on two enabling conditions: a Partnership that facilitates collective leadership and learning across contexts, and an organisation equipped to sustain a connector role through rapid learning, credible evidence translation, crisis-responsive accompaniment and responsible funding brokerage.

6 Implications and recommendations

Resource the connector role as a strategic asset

Invest deliberately in the capabilities that make Frontline AIDS' connector function work at scale: translating community practice into credible evidence and products, sustaining access to decision-making spaces, and brokering relationships and catalytic funding that enable uptake and durability.

Design and manage for full trajectories—from adoption to implementation and domestic responsibility

Plan priority themes with an explicit pathway from community innovation to policy/guidance, implementation systems (procedures, workforce, procurement, service delivery), and financing. Track where progress stalls (e.g., adoption without implementation; pilots without budgets) and support partners to move from commitments to delivery and longer-term domestic ownership.

Embed equity, feminist and anti-racist practice structurally

Treat shifts in power, leadership and resourcing as preconditions for sustainable systems change and crisis work—not add-ons. Make visible who leads, who benefits, who is protected, and who is still excluded, and ensure under-represented populations and contexts are intentionally covered.

Use MEL as trajectory and ecosystem sensemaking—while normalising proportionate substantiation

Strengthen Monitoring, Evaluation and Learning to better evidence lived experience (safety, dignity, stigma, continuity of access) alongside institutional change, using community-led and non-extractive approaches. Institutionalise light, regular of high-stakes outcomes and integrate crisis readiness and learning loops across all areas of work.

7 Conclusion

Within the limits of a desk-based Outcome Harvesting synthesis, the conclusion is clear: Frontline AIDS' value lies in helping community-led responses shape the systems that shape their lives. In a period of shrinking civic space, constrained funding and overlapping crises, the most strategic move is not to become bigger, but to become more deliberate in how community power is connected, amplified and sustained across health systems, rights and crisis resilience.