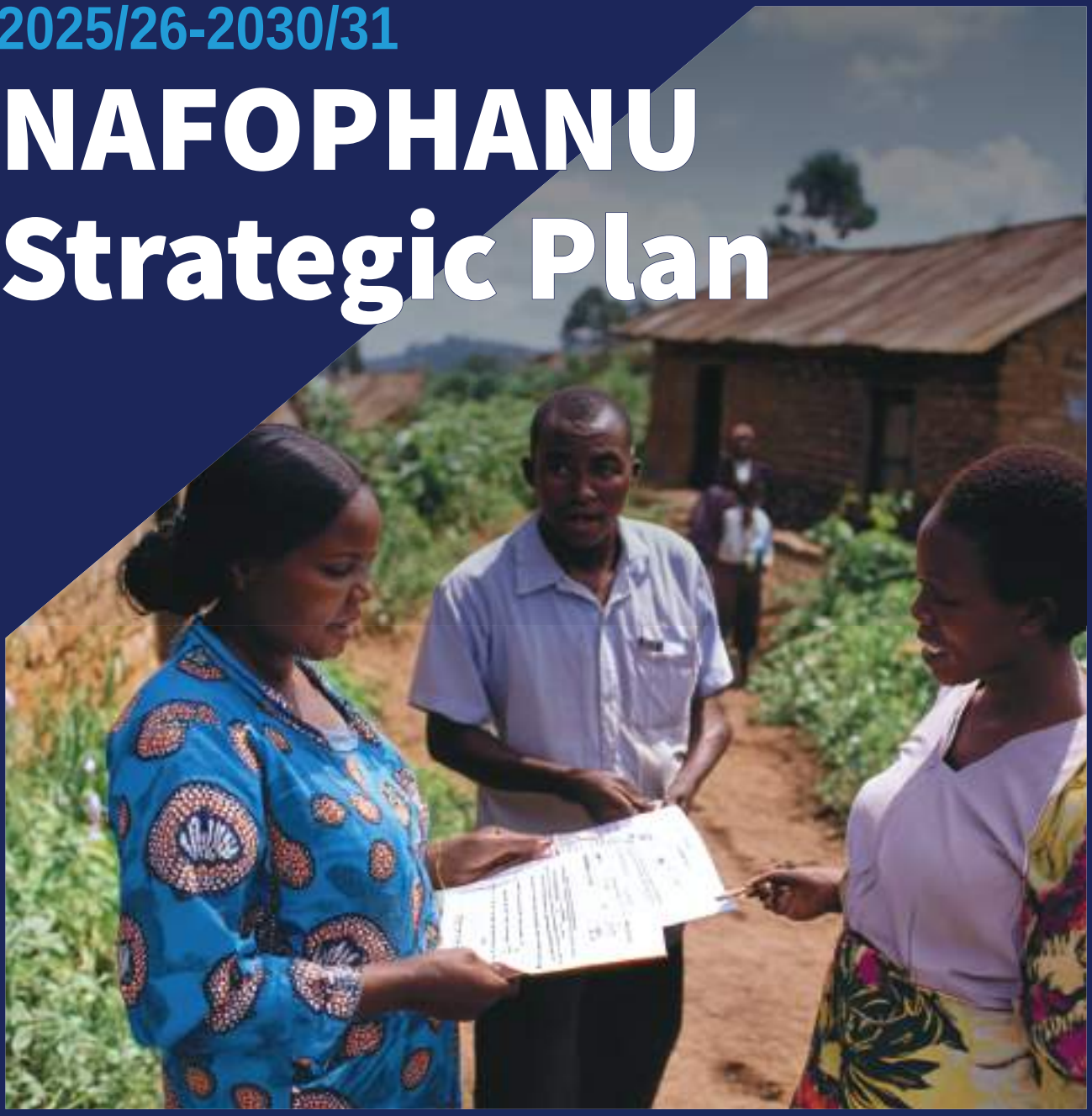
NAFOPHANU

2025/26-2030/31

# NAFOPHANU Strategic Plan



Bridge gaps through reconnecting the chain of community-led systems and sharing lived experiences for a Sustainable HIV and Health Response by 2030

© National Forum of People Living with HIV/AIDS Networks in Uganda, 2026

**NAFOPHANU STRATEGIC PLAN 2026-2030/31 | Bridging gaps for a sustainable HIV and health response through reconnecting the chain of community-led response**

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NAFOPHANU

2025/26-2030/31

# NAFOPHANU Strategic Plan

Bridge gaps through reconnecting the chain of community-led systems and sharing lived experiences for a Sustainable HIV and Health Response by 2030

## OUR **VISION**

People living with HIV live longer, productive and quality lives

## OUR **MISSION**

Bridge gaps through reconnecting the chain of community-led systems and sharing lived experiences for a Sustainable HIV and Health Response by 2030

## LONG-TERM **GOAL**

To mobilise support and coordinate the efforts of People Living with HIV for improved wellbeing.

## STRATEGIC **PILLARS**

1. Coordination
2. Community-led access to health care
3. Social protection
4. Digitalisation and documentation

# Preface

**OUR LEADERSHIP, RESILIENCE, AND INNOVATION REMAIN CENTRAL TO ENDING AIDS, TUBERCULOSIS, MALARIA, AND OTHER PANDEMICS AS PUBLIC HEALTH THREATS BY 2030.**

*Salome Atim – National Forum of People Living with HIV and AIDS Chairperson, Board of Directors*



The HIV epidemic and related health challenges remain a major concern in Uganda, affecting millions of individuals and communities. People living with HIV (PLHIV) are central to the response, bringing lived experience, collective memory, and proven solutions that have shaped the HIV response for over four decades. Our leadership, resilience, and innovation remain central to ending AIDS, tuberculosis, malaria, and other pandemics as public health threats by 2030.

As anchors of community-led systems, we drive HIV prevention, treatment adherence, and retention in care, while confronting stigma, discrimination, gender inequality, and structural barriers to health. We champion the integration of HIV services with tuberculosis, malaria, sexual and reproductive health and rights (SRHR), and mental health, advancing people-centred approaches aligned with universal health coverage (UHC).

Guided by the Greater Involvement of People Living with HIV and AIDS (GIPA) principle, we define and safeguard the development priorities of PLHIV in all their diversity. We are not passive beneficiaries of programmes—we are co-creators, implementers, and accountability partners in health and development responses.

For nearly forty years, PLHIV networks have delivered impactful health and social services through peer leaders, expert clients, and community mentors. Our contributions span health promotion, treatment literacy, screening and testing, research and innovation, community mobilisation, service quality monitoring, and demand creation for HIV and broader health services. Our voices have shaped national and global responses to HIV, SRHR, tuberculosis, malaria, cervical cancer, emerging epidemics such as COVID-19 and Ebola, and non-communicable diseases.

At a time of declining HIV financing and growing health system pressures, sustaining progress toward ending AIDS by 2030 requires renewed investment in community leadership. Reconnecting and strengthening peer networks is essential to advancing equitable access to quality services, protecting human rights, and ensuring that no one is left behind.

It is against this backdrop that we present the **NAFOPHANU Strategic Plan 2026-2030/31**. This Strategy articulates our vision, mission, strategic priorities, and interventions to support people living with HIV, their families, and affected communities. In partnership with government, civil society, the private sector, and development partners, NAFOPHANU commits to accelerating progress toward national and global HIV and health targets—placing communities at the centre of the response.



**Salome Atim - National Forum of People Living with HIV and AIDS**
**Chairperson, Board of Directors**

# Foreword

> ***NAFOPHANU WILL USE THIS STRATEGIC PLAN TO STRENGTHEN PLHIV LEADERSHIP, SAFEGUARD GAINS, AND ACCELERATE PROGRESS TOWARD ENDING AIDS AS A PUBLIC HEALTH THREAT.***
>
> *Prof. Vinard Nantulya – NAFOPHANU Patron*



On behalf of NAFOPHANU, I am honoured to present the Strategic Plan 2026-2030/31. Since its establishment on 23 May 2003, NAFOPHANU has served as the national coordinating body for PLHIV networks, mobilising resources, championing advocacy, promoting stigma reduction, and building the capacity of networks across Uganda. The organisation was formed to provide a systematic and inclusive coordination structure for PLHIV networks, associations, and support groups, enabling them to play advocacy, policy, and decision-making roles within the national HIV/AIDS response.

Over the years, NAFOPHANU has steadily grown as a community-led entity under the Uganda HIV/AIDS Partnership Forum. It has mobilised and sub-granted resources to its networks, advanced the advocacy agenda for the PLHIV movement, promoted stigma reduction, strengthened the rights of PLHIV, partnered with diverse stakeholders to improve service delivery, and built the capacity of networks in multiple technical areas. The successes of the outgoing Strategic Plan (2020–2025) have been consolidated for replication, yet HIV and its comorbidities remain major national and societal challenges that require meaningful participation of PLHIV in the design, implementation, and monitoring of policies, budgets, and programmes.

The Strategic Plan 2026-2030/31 introduces innovative approaches informed by current trends in HIV prevalence, pandemic responses, and policy research, and is designed to enhance the voice, leadership, and accountability of PLHIV as central actors in the national HIV and pandemic response. It responds to new realities, including the closure of community-led programmes by USG, and aligns with the National HIV Strategic Plan 2025/6–2029/31, the National HIV Policy Framework, the National HIV Sustainability Framework, the Integration Framework, the Global AIDS Strategy, and other relevant policies. The Plan emphasizes the need to reconnect community leadership for HIV prevention, care and treatment, social support, protection, and systems strengthening to achieve the goal of ending AIDS as a public health threat by 2030. This Strategy provides guidance to all NAFOPHANU network members involved in HIV and AIDS programmes, integrating sexual and reproductive health, tuberculosis, gender-based violence (GBV), cervical cancer, malaria, and emerging pandemics such as Mpox, Ebola, and COVID-19, which continue to affect communities of PLHIV.

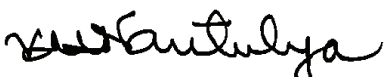
The Strategic Plan focuses on four key thematic areas over the next five years:

1. **Coordination:** Strengthening collaboration across PLHIV networks for advocacy, policy influence and service delivery.
2. **Community-Led Health Care Access:** Promoting equitable, community-driven access to HIV prevention, care and treatment services.
3. **Social Protection:** Safeguarding the rights, welfare and socio-economic wellbeing of PLHIV and affected communities.
4. **Digitalisation and Documentation:** Improving data management, reporting and record-keeping for better decision-making and accountability.

These priorities will help NAFOPHANU **safeguard achievements, sustain the community-led HIV response,** and **strengthen governance and capacity** of its network members at district and national levels. The Plan serves as a framework for PLHIV communities, their families, and those affected for the next five years.

I commend the continuous support of the Government of Uganda, development partners, civil society, faith-based organisations, youth-led organisations, the private sector, academia, cultural institutions, and all stakeholders who have supported PLHIV communities to advance the national goal of ending AIDS by 2030. With your continued partnership, NAFOPHANU will use this Strategic Plan to strengthen PLHIV leadership, safeguard gains, and accelerate progress toward ending AIDS as a public health threat.

**"Lead and Rise to Recover."**



**Prof. Vinard Nantulya**
**NAFOPHANU Patron**

# Acknowledgements



> ***THIS PLAN RESPONDS TO EVOLVING NEEDS WHILE STRENGTHENING NAFOPHANU'S ROLE AS A LEADER IN COORDINATING A COMMUNITY-LED RESPONSE.***
>
> *Flavia Kyomukama – Executive Director*

The process of formulating the NAFOPHANU Strategic Plan 2026-2030/31 provided an opportunity to reflect on past successes and challenges, refine our vision, and set future goals. It allowed us to develop strategies that respond to evolving needs while strengthening NAFOPHANU's role as a leader in coordinating a community-led response.

With the conclusion of the 2020–2025 Strategic Plan, it was necessary to develop a new plan to guide NAFOPHANU's strategic and programmatic efforts for the next five years.. To support this process, NAFOPHANU collaborated with the UNAIDS Country Office and Ms. Sarah Nakku, the Community and Networking Adviser to facilitate the development of this strategic plan. She was supported by the communication officer Ms Caroline Magambo to review the document. Appreciation further goes to all NAFOPHANU stakeholders that participated in the development of this Plan. Special gratitude to the Technical Working Group, headed by Ms. Flavia Kyomukama, Joselyne Mbawadde, James Lule plus the Board members Ms. Salome Atim, Ms Betty Kwagala, Ms Jane Mwirumubi, Mr. Richard Serunkuuma, Ms, Grace Nayiga Atwooki that ensured broad input and ownership of the Strategic Plan.

We particularly wish to acknowledge the insightful contribution and guidance from the members of the Uganda AIDS Commission specifically Ms. Lillian Tatwebwa and Mr. Tom Etii.

Last but not least, we thank the entire PLHIV community members that allowed to participate in various focus group and individual interviews whose feedback played a critical role in shaping the Strategic Plan.

**Flavia Kyomukama**
**Executive Director**

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# Acronyms

| | |
|---|---|
| **AHD** | Advanced HIV Disease |
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **AGYW** | Adolescent Girls and Young Women |
| **ART** | Antiretroviral Therapy |
| **ARV** | Antiretroviral |
| **BOD** | Board of Directors |
| **CAB-LA** | Cabotegravir Long-Acting |
| **CCM** | Country Coordinating Mechanism |
| **CHW** | Community Health Worker |
| **CSO / CSOs** | Civil Society Organisation(s) |
| **ED** | Executive Director |
| **EOI** | Expression of Interest |
| **FP** | Family Planning |
| **GBV** | Gender-Based Violence |
| **GFATM** | Global Fund for AIDS, Tuberculosis and Malaria |
| **GIPA** | General Involvement of People living with HIV |
| **GoU** | Government of Uganda |
| **HEPS** | Coalition for Health Promotion and Social Development |
| **HIV** | Human Immunodeficiency Virus |
| **HMIS** | Health Management Information System |
| **HPV** | Human Papillomavirus |
| **ICT** | Information and Communication Technology |
| **IEC** | Information, Education and Communication |
| **IGA / IGAs** | Income Generating Activity / Activities |
| **KPI** | Key Performance Indicator |
| **LGBTI** | Lesbian, Gay, Bisexual, Transgender and Intersex |
| **M&E** | Monitoring and Evaluation |
| **MARPs** | Most At Risk Populations |
| **MERL** | Monitoring, Evaluation, Research and Learning |
| **MIPA** | Meaningful Involvement of People living with HIV |
| **MOH / MoH** | Ministry of Health |
| **NAFOPHANU** | National Forum of People Living with HIV/AIDS Networks in Uganda |
| **NCD / NCDs** | Non-Communicable Disease(s) |
| **NDPIV** | National Development Plan IV |
| **NGOs** | Non-Government Organisations |
| **NSP** | National Strategic Plan |
| **OACA** | |
| **OPD** | Outpatient Department |
| **OVC** | Orphan and Vulnerable Child |
| **PC** | Partnership Committee |
| **PDM** | Parish Development Model |
| **PEP** | Post-Exposure Prophylaxis |

| | |
|---|---|
| **PLHIV** | People Living with HIV |
| **PMTCT** | Prevention of Mother to Child Transmission |
| **PrEP** | Pre-Exposure Prophylaxis |
| **RFA** | Request for Applications |
| **RMNCAH** | Reproductive Maternal Newborn Child Adolescent Health |
| **SACCO** | Savings and Credit Cooperative Organisation |
| **SALT** | Supporting, Appreciating, Learning and Transferring |
| **SCE** | Self-Coordinating Entity |
| **SDG / SDGs** | Sustainable Development Goal(s) |
| **SEG** | |
| **SRHR** | Sexual Reproductive Health and Rights |
| **TA** | Technical Assistance |
| **TB** | Tuberculosis |
| **TOC** | Theory of Change |
| **ToT** | Training of Trainers |
| **UAC** | Uganda AIDS Commission |
| **UDHS** | Uganda Demographic and Health Survey |
| **UGANET** | Uganda Network on Law, Ethics and HIV |
| **UNAIDS** | Joint United Nations Programme on AIDS |
| **UNASO** | Uganda Network of AIDS Service Organisations |
| **UNGASS** | United Nations General Assembly Special Session on HIV/AIDS |
| **UPHIA** | Uganda Population-Based HIV Impact Assessment |
| **USAID** | U.S. Agency for International Development |
| **USG** | United States Government |
| **VHT** | Village Health Team |
| **VPK / VPKs** | |
| **VSLA** | Village Savings and Loan Association |
| **WASH** | Water, Sanitation and Hygiene |



# Executive Summary

*The NAFOPHANU Strategic Plan 2026–2030/31 responds to emerging realities and challenges in the HIV response by placing communities at the centre.*

The NAFOPHANU Strategic Plan 2026–2030/31 responds to emerging realities and challenges in the HIV response. It addresses key issues affecting people living with HIV (PLHIV), including gaps in coordination, community led access to health, social protection, digitalization and documentation plus stigma and discrimination.

This Strategic Plan aligns with the National Development Plan IV, National HIV Strategic Plan 2025/26–2029/30, National Integration Framework 2025, National Community Health Strategy, Global AIDS Strategy 2026–2031, the renewed National HIV Policy, and other reference documents. It envisions a community of PLHIV free from stigma and discrimination, able to access and adhere to HIV, SRHR, mental health, and non-communicable disease services, even amidst integration challenges and the closure of USAID community programmes.

The Plan provides guidance to NAFOPHANU and its network members to implement and promote interventions that sustain access, utilization, and retention of HIV and health services that contribute to the goal target of Ending AIDS as a public health threat by 2030.

Lessons learnt from the previous strategic plan, including COVID 19, Ebola, Mpox, and other pandemics, alongside the termination of former USAID community led programs, have informed a strong focus on coordination, community led access to health, social protection, digitalization and documentation as key strategic pillars for this strategy. Th e Strategic Plan is therefore anchored pillars that reflect enhanced commitments and leadership of PLHIV as summarised below:

## Summary of the new Strategic Plan focus areas

| THEMATIC AREA | STRATEGIC OBJECTIVES |
|---|---|
| Coordination<br>PILLAR 1 | • Strengthen coordination of PLHIV constituency members and partners to enhance advocacy for access to HIV, SRHR, mental health, GBV, and NCD services.<br>• Strengthen institutional infrastructure to support coordination and service delivery for NAFOPHANU and its member organisations.<br>• Increase sustainable financing for NAFOPHANU and its constituency members.<br>• Strengthen advocacy for increased domestic health financing and establishment of the National Health Insurance Scheme. |
| Community-Led Health Care Access<br>PILLAR 2 | • Reduce stigma and discrimination to advance human rights and equitable access to HIV and related health services.<br>• Strengthen integrated HIV prevention, care, treatment, and social protection services in line with the principle of leaving no one behind.<br>• Strengthen provision of psychosocial support and mental health services for PLHIV communities. |
| Social Protection<br>PILLAR 3 | • Operationalise and scale up the NAFOPHANU PLHIV SACCO to improve economic resilience and social well-being of PLHIV.<br>• Advocate for inclusion of PLHIV in Parish Development Model (PDM) and other government economic empowerment programmes.<br>• Mobilise sustainable domestic resources to support social protection programmes for PLHIV.<br>• Strengthen partnerships with private sector institutions to promote economic empowerment and social inclusion of PLHIV.<br>• Strengthen leadership, mentorship, and economic empowerment of adolescent girls, young women, and young people living with HIV.<br>• Promote education retention and protection of adolescents and young people living with HIV.<br>• Establish a PLHIV Leadership, Training, and Consultancy Academy<br>• Establish a PLHIV Wellness and Leadership Support Centre. |
| Digitalisation and Documentation<br>PILLAR 4 | • Leverage digital technology to strengthen coordination, communication, and advocacy across PLHIV networks.<br>• Strengthen community-led monitoring and reporting systems using digital tools.<br>• Strengthen media engagement and digital advocacy to promote HIV and integrated health services<br>• Strengthen documentation and knowledge management to support evidence-based programming and advocacy.<br>• Honour county, national, regional and global reporting obligations for PLHIV |



# Introduction and Context

*Uganda has made notable progress in its HIV response — yet 243,000 people living with HIV are not yet enrolled in care and treatment.*

## Epidemic perspective

Uganda has made notable progress in its HIV response, with an estimated 1.5 million people living with HIV (PLHIV), of whom approximately 1.3 million are accessing antiretroviral therapy (ART). This progress reflects the impact of treatment as prevention and declining HIV-related mortality. However, HIV remains a significant public health and development challenge, driven by persistent structural barriers including stigma and discrimination, gender-based violence, unfavourable legal environments, socio-economic inequalities, low education levels, poverty, climate change, and recurring pandemics. These factors continue to disrupt service continuity and disproportionately affect women, young people, and key and priority populations. In response, NAFOPHANU has renewed its Strategic Plan and aligned it with the National HIV Strategic Plan 2025/26–2029/31, the National HIV Policy Framework, the National HIV Sustainability Framework, the National Integration Framework, and the Global AIDS Strategy, emphasizing strengthened community leadership across HIV prevention, care and treatment, social support, and systems strengthening to achieve the goal of ending AIDS as a public health threat by 2030.

# Key data facts

Uganda has made measurable progress in the HIV response. By 2025, 94% of people living with HIV (PLHIV) were aware of their status, 92% of those diagnosed were on antiretroviral therapy (ART), and 96% of people on treatment achieved viral suppression (UAC, 2025). Despite these gains, critical gaps persist. In 2024, Uganda recorded 36,648 new HIV infections, 20,335 AIDS-related deaths, and approximately 200,000 PLHIV not yet on treatment, with treatment disparities concentrated among children under 15 years (72%), adolescents aged 10–19 years (89%), men (95%), and key and priority populations. HIV–TB co-infection remains a concern, with 3,807 HIV-positive TB cases reported, of which only 3,568 were linked to care. Viral load suppression gaps are especially notable among children (87%) and adolescents (89%) compared to adults (97%).

Internalised stigma affects over 52.7% of PLHIV, with higher levels among young people under 24 years (70.1%) and those living with HIV for less than one year (78.8%) (HIVSD Survey 2023). More than half of PLHIV report difficulty disclosing their status, particularly youth, and retention in care remains suboptimal for adolescents, young people, men, and key populations. HIV prevalence remains disproportionately high among key populations, including men who have sex with men (MSM), sex workers (SWs), transgender persons (TGs), and people who inject drugs (PWID), with legal and social barriers limiting service access.

Co-morbidities compound these challenges. Cervical cancer remains a major public health concern, with an estimated 6,959 new cases and 4,607 deaths annually, largely driven by persistent infection with high-risk HPV strains, which disproportionately affect women living with HIV (WGLHIV) and female sex workers. Integration of HIV services with sexual and reproductive health (SRHR), mental health, and TB services remains critical to improving outcomes. Teenage pregnancy persists at 21–24%, with adolescents and young people experiencing poor SRH outcomes, limited access to family planning, and early sexual debut (12% of girls by age 15). HIV testing among adolescents is further constrained by legal requirements for parental consent for those below 12 years.

Historical trends indicate progress since 2010, with new HIV infections and AIDS-related deaths declining by 61% and 63%, respectively. However, geographic and population disparities remain, leaving gaps in access, adherence, and viral suppression. The 2025 suspension of USAID community programmes disrupted critical services, including ART provision, community outreach, and youth-friendly services, disproportionately affecting rural and marginalised communities. Stigma, discrimination, gender-based violence, and socio-economic vulnerability (41.7% of Ugandans live in poverty), continue to limit access to HIV, TB, SRHR, and co-morbidity services.

These data underscore the need for sustained investment in community-led, rights-based, and integrated HIV responses, including TB, cervical cancer, and SRHR services. Strengthening community-led coordination, enhancing multisectoral collaboration, leveraging digital tools for data and advocacy, and improving socio-economic resilience of PLHIV are critical strategies to protect gains, close gaps, and accelerate progress toward ending AIDS as a public health threat by 2030.



**94% PLHIV**
**were aware of their status**

**92.0%** of those diagnosed were on ART

**96.0%** achieved viral suppression.



**Internalised stigma affects**
**over 52.7% of young PLHIV**

**70.1%** Young people under 24 years

**78.8%** Living with HIV less than 1 year



**6,959 new**
**cases of cervical cancer**

**4,607** estimated deaths annually

**Teenage pregnancy**
**24%**
Limited access to family planning and early sexual debut

**12.0%** of girls by the age of 15



Progress since 2010, with new HIV infections and AIDS-related deaths declining

**61%**
**New infections**

**63%**
**AIDS-related deaths**



# Development of the Strategic Plan 2026–2030/31

*A participatory and inclusive approach was adopted for the development of NAFOPHANU Strategic Plan 2026–2030/31, which consisted of four distinct phases.*

## 01 Phase One: Preparatory stage

Phase One was a preparatory stage that involved conceptualization process, development of the tools and establishment of a Technical Working Group (TWG) that consisted of NAFOPNAHU staff who were charged with the responsibility of compiling a report for the ending Strategic Plan 2020–2025, the Calendar of events to facilitate the strategic plan development process was developed. Summary of achievements for the previous strategic plan were compiled, and utilised for this development process. Phase one also focused on the development of an online survey tool that was pretested among 11 (eleven) participants and later utilised by over 36 PLHIV community members to assess the achievements of the past strategic plan.

# 02 Phase Two: Literature review

Phase two focused on the review of literature that involved published and grey literature plus experiences from the PLHIV community members, program, policy documents, reports and guidelines. Other current research reports reviewed in relation to HIV and AIDS, focused on women's health, gender equality and youth and development to identify any possible translation of research findings to policy or programme actions.

## Documents Reviewed:

- Uganda Vision 2040
- National Development Plan IV 2025/26-2030/2031
- Global AIDS Strategy 2026 – 2031
- Uganda HIV response Sustainability Roadmap 2025
- National HIV Policy (under review)
- Strategic Plan for the Global Network of People living with HIV 2023- 2026,
- National HIV and AIDS Strategic Plan 2025/6 -2029/30
- Sustainable Development Goals (SDGs) - 2030
- Uganda National Response Plan for Ebola and Mpox 2025
- NAFOPHANU Resource mobilisation Strategy 2024 – 2026
- Impact of the US cuts on the National HIV Response 2025 Report
- Rapid assessment of the Impact of US government stop – work orders in Uganda's Health Sector 2025.
- National Policy guidelines on ending HIV stigma and discrimination 2020
- Promising practices of SRHR/ HIV key population programming in Uganda 2020-2024
- National Integration Framework for Health services (draft)
- Assessment of the magnitude and correlates of HIV Stigma and Discrimination and its effects on the Country HIV Prevention Interventions 2023
- National HIV Action Plan for Faith Sector 2021/22- 2024/25
- Presidential Fast Track Initiative to End AIDS as a Public Health Threat in Uganda by 2030.
- Uganda Population Based – HIV Impact Assessment 2018

From the review of the national and global strategies and available research, the following observations and conclusions were noted:

The National HIV Strategic Plan documents together with the Global AIDS strategy are scaling up community led response to HIV despite the reduction of donor related financing to communities-based and community led activities, These documents urge for immediate investments in HIV prevention, sustainability agendas, increased financing for HIV and SRHR and community-led programs. Innovative solutions like long-acting HIV prevention and options, affordable medicines are at the core of these documents. They call for global solidarity, maintaining funding, investment in technologies and upholding of human rights and as key elements to reversal of new infections.

The National HIV Strategic Plan 2026 and 2030/31 further emphasizes that HIV prevention options that bring together biomedical, structural and community behaviors are critical for Uganda to achieve the 2030 targets. It indicates the rising vulnerability, stigma discrimination and inequalities that have already severely impacted efforts to maintain sustainable HIV prevention programs. With more people losing access to lifesaving HIV services, while vulnerable communities face rising HIV infections due to closure of USG community based and led programs. The analysis for these documents emphasis addressing stigma and discrimination plus upholding the rights of People living with HIV as critical milestones to achieve the 2030 targets. Conclusively, there is strong emphasis on supporting PLHIV rediscover their power as communities that started and are also responsible for Ending AIDS by 2030.

# 03 Phase Three: Stakeholder consultations

Phase three involved inclusive stakeholder consultations to review progress made under the previous strategic plan and to identify priority focus areas for the upcoming strategy. Engagements were conducted with NAFOPHANU Board members, network members and partners through focus group discussions, key informant interviews, and an online survey administered using a structured questionnaire.

The consultation process drew active participation from over 175 stakeholders, including the Network of Young People Living with HIV, Positive Women with Disabilities, Lungujja Community Health Organisation, International Community of People Living with HIV, Uganda Network on Laws and Ethics, Friends of Canon Gideon, Hoima Network of People Living with HIV, Salt Helpline, Agha Foundation, and the Movement of Women Living with HIV, among others.

Across the stakeholder meetings and the online survey, a central theme emerged with the urgent need for NAFOPHANU to strengthen its focus on the welfare of people living with HIV, need to merge and align the constituency members, importance of embracing digitalization and intensifying advocacy to ensure sustained access to HIV and other health care service, documentation, strong focus on mental health and peer to peer approaches particularly in the context of ongoing service integration.

## Review of the Previous Strategic Plan (2020/21–2025/26)

The mid-term and end-term reviews of the previous Strategic Plan were not conducted thus limited the ability to effectively and efficiently assess achievements against planned targets. However, annual NAFOPHANU reports for the period 2021–2025 were utilised as the primary benchmarks to analyse progress.

## Progress Against Strategic Objectives

### Strategic Objective 1

**Strengthening Governance, Leadership, and Management Systems of the Secretariat and Network Members**

Between 2021 and 2025, NAFOPHANU and its network members registered notable progress in strengthening governance and coordination structures. Zonal coordination offices for PLHIV networks were established in 10 districts to enhance partner coordination and improve internal accountability at both national and district levels.

During the strategic period, 16 quarterly Board meetings were held out of a target of 20, and 3 Annual General Meetings (AGMs) were conducted against a target of 5. A NAFOPHANU fundraising home was launched, one Board development session was held, and key institutional documents—including the Advocacy and Communication Strategy and the Resource Mobilisation Strategy—were developed.

The Strategic Plan aimed to strengthen the capacity of 88 network members. However, only 8 district-based networks benefited from institutional capacity strengthening, which included support such as motorcycles, bicycles, laptops, and other operational materials. In addition, sub-county AGMs were conducted in 21 districts, falling short of the strategic target of 75 districts.

Despite these achievements, significant gaps remained under this objective. The operational capacity of district networks continues to be limited, a situation that was further exacerbated by the termination of USAID-funded projects supporting NAFOPHANU. Key challenges identified included lack of office space and physical addresses, inadequate staffing, and limited institutional capacity at both Secretariat and network levels. Addressing these constraints should be prioritised in the upcoming strategic period.

## Strategic Objective 2

### Mobilising Resources for Adequate and Sustainable Programming

Through the ending Strategic Plan, NAFOPHANU exceeded its partnership target by securing 16 new partnerships against a target of 15. Resources valued at approximately USD 13.47 million were mobilised from partners including USAID/CSSA, Embassy of Ireland, Reckitt Benckiser, Global Fund, Aidsfonds, ITPC, GNP+, Aga Khan Foundation, HIVOS, AIC, CEHURD, TASO, AfroCAB, ICWEA, Uganda AIDS Commission, Ministry of Health, EGPAF, and others.

The Strategic Plan emphasised diversification of partnerships to strengthen the resource base of the Secretariat and network members. As a result, more than three private sector institutions were engaged, including Reckitt Benckiser, 4Life Solutions (through social enterprise initiatives), and the Aga Khan Foundation. Overall, this objective recorded the highest level of achievement compared to the other strategic objectives.

However, the majority of network-level grants ended between 2023 and 2024, compounded by the termination of USAID support, leading to significant resource constraints across the HIV response. Over-reliance on external donor funding remains a major risk. There is therefore an urgent need to diversify funding streams through increased private sector engagement, social enterprises, and alternative resource mobilisation mechanisms to ensure long-term financial sustainability for the organisation and the welfare of people living with HIV. Additionally, sustained advocacy is required for operationalization of the National Health Insurance Scheme and the development of policies and guidelines to support social contracting.

## Strategic Objective 3

### Empower PLHIV to Engage in Activities and Enterprises for Improved Wellbeing

Significant progress was registered under this objective, particularly in improving the wellbeing of PLHIV communities and their families through reduced stigma and discrimination at both community and individual levels. PLHIV networks in over 20 districts actively advocated for continued access to HIV and health services during multiple public health emergencies. During the COVID-19 pandemic, a national waiver was granted to selected PLHIV community structures to enable continuity of peer-led service delivery despite national lockdown restrictions.

Leveraging community-led response structures, HIV services were successfully integrated into broader pandemic responses, including COVID-19, Ebola, and Mpox. Several economic and social empowerment interventions were implemented. Through a partnership with Reckitt Benckiser, over 30,000 PLHIV across 56 districts benefited from hygiene kits (JIK and Dettol) to support COVID-19 prevention through improved hand hygiene. Food assistance was provided to 20,150 PLHIV, while 50 youth and 20 Male Action Groups were supported to promote HIV literacy.

During the five-year strategic period, 80 Expert Clients and Mentor Mothers were supported through Action Groups, contributing to re-engagement in care for 345 children, 65 pregnant women, and 23 lactating mothers. In addition, Expert Clients from 10 districts were supported with operational tools, including 10 motorcycles, 10 laptops, 10 printers, 154 bicycles, bags, gumboots, raincoats, sanitizers, and digital data tools.

To address psychosocial wellbeing, 91 psychosocial support groups were established across nine districts in Northern and West Nile regions, reaching 1,360 PLHIV. An online stigma reduction campaign was launched in partnership with GNP+, generating 50,474 online engagements and increasing visibility of PLHIV issues. Complementary services included home visits, facility-based sessions, and counselling through the SALT helpline, including support for Ebola survivors.

NAFOPHANU also launched a PLHIV SACCO during this strategic period and provided monthly stipends and airtime support to 158 Expert Clients and peer buddies. Furthermore, 54 rights holders across five districts were trained to undertake Community-Led Monitoring (CLM).

Despite these achievements, several targets under this objective were either undefined or not fully realised. Where targets existed, performance was below expectations. For example, increased demand for paediatric HIV care and treatment showed progress but lacked defined targets. Planned soft-skills and solutions training for 10,000 PLHIV could not be

confirmed in implementation reports. Although the strategy envisaged establishment of PLHIV SACCOs in 10 districts, only one SACCO was launched, and no systematic sensitisation on savings and financial inclusion was conducted during the five-year period.

While external stigma reduced, the evaluation highlighted persistent internal stigma and over-expectations among PLHIV communities, which constrained social and economic integration, particularly during pandemics. Additionally, a critical gap was noted in addressing the mental health needs of PLHIV, underscoring the need for more deliberate psychosocial and mental health programming in the next strategic period.

## Strategic Objective 4

### Enhance Advocacy and Communication for PLHIV in the National HIV Response

An Advocacy and Communication Strategy was developed to strengthen NAFOPHANU's behaviour change communication and amplify PLHIV voices within the national HIV response. The organisation actively participated in advocacy strategy meetings with partners including UGANET, HIVOS, and CEHURD, and contributed to Community-Led Monitoring steering forums coordinated by ICWEA.

A total of 30 community dialogues and media campaigns were conducted, reaching over 2,000 participants in districts including Soroti, Mityana, Mubende, Kyenjojo, Amuru, Gulu, and Terego. These engagements enhanced PLHIV awareness of their rights and access to HIV and health services. Additionally, 56 online posters and electronic fact sheets were produced to sustain advocacy messaging during pandemics.

Media engagement remained strong, with 33 radio talk shows, 16 television appearances, five Twitter chats, and three Zoom dialogues conducted on issues such as treatment access, stigma and discrimination, and viral load testing. Media tours were conducted in Kamuli, Isingiro, and Terego districts, alongside training of 40 journalists and influencers on stigma-sensitive reporting.

However, this strategic objective was largely characterised by process-level outputs with limited measurable outcome-level results. Reports emphasised participation in national events such as World AIDS Day (Rakai, 2023), Candlelight Memorial Day (Hoima, 2023), Philly Lutaaya Memorial (2022–2023), Joint Annual AIDS Review (JAAR), and the National HIV Scientific Symposium (Kampala, 2023). While these platforms enhanced visibility, their direct contribution to targeted advocacy outcomes was not clearly demonstrated.

Similar to Objective 3, most targets under this objective were either undefined or weakly articulated, limiting the ability to assess impact beyond activity completion.

## Strategic Objective 5

### Knowledge Management, Monitoring, and Accountability

Under this objective, 24 rights holders were trained in Community-Led Monitoring, reaching 2,766 PLHIV aged 25 years and above, 2,784 aged 24–25 years, and 1,662 children under 15 years, resulting in 3,417 service referrals. Scorecard assessments were conducted in 19 districts and 21 health facilities, engaging over 270 stakeholders.

To strengthen accountability at district level, more than 180 district officials in the Karamoja region were trained in scorecard utilisation. Findings were disseminated and action plans developed to improve service access across seven districts. Follow-up engagement with 25 health facilities contributed to improved retention and enrolment in care, increasing from 656 to 836 clients.

**Challenge:** Weak documentation systems at district level and limited use of data for decision-making, Constrained the organisation's ability to track progress, demonstrate impact, and effectively communicate results to the various stake holders. This further impacted on Advocacy for improved service delivery programs.

**Recommendation:** Develop and implement a comprehensive knowledge management program, including investment in digital infrastructure and capacity building for district-level staff to improve data collection, reporting, analysis, and use for decision-making.

## Lessons Learned and Recommendations from the Previous Strategic Plan

The 2021–2025 Strategic Plan demonstrated strong alignment with national HIV policies and priorities. However, performance gaps were observed in resource mobilisation sustainability and monitoring and evaluation systems. While several of the issues identified in this review are addressed in the new Strategic Plan, they require more robust and consistent implementation.

## General Recommendations

- Strengthen district-level leadership, governance, and operational capacity
- Diversify funding sources and strengthen local fundraising and partnerships.
- Promote documentation, digital tools and mobile platforms for service delivery, advocacy, reporting and data management.
- Integrate mental health, Psychosocila support, and gender-based violence interventions into PLHIV programs.
- Strengthen social protection systems, economic empowerment and wellness for the PLHIV communities.

# 04 Phase Four: Development and Validation of the new Strategic Plan

The fourth and final phase involved development of the Strategic Plan, led by the Community Support Adviser from UNAIDS. The draft Strategic Plan underwent stakeholder review and peer review processes before being presented to broader PLHIV and civil society stakeholders for validation. Due to limited resources and travel constraints, the validation process was conducted virtually. Following validation, the Strategic Plan was finalised, designed, printed, and prepared for dissemination to support implementation.



# The Strategy 2025/26-2030/31

*This Strategy marks a shift towards an empowered, resourced, and digitally enabled community-led response that is inclusive, multisectoral, transformative, and sustainable.*

## Overview

The NAFOPHANU Strategy 2025/26–2030/31 replaces the outgoing Strategic Plan (2020/21–2025/26), which guided the organisation's strategic and programmatic direction over the past five years. The new Strategy responds to emerging realities in the HIV response, including the stop order and declining external financing for HIV and AIDS programming, while foregrounding the evolving needs and priorities of people living with HIV (PLHIV) in Uganda.

The Strategy is aligned with key national and global frameworks, including the National Integration Agenda, Uganda's Fourth National Development Plan (NDP IV), the National HIV Strategic Plan (2025/26–2029/30), and the Global AIDS Framework. It builds on achievements and lessons learned from the previous Strategic Plan, informed by extensive stakeholder consultations, routine NAFOPHANU and CSO coordination meetings, and evidence from community-led responses.

The Strategy provides strategic guidance to NAFOPHANU stakeholders engaged in addressing HIV, sexual and reproductive health and rights (SRHR), tuberculosis, gender-based violence (GBV), cervical cancer, malaria prevention, and public health emergencies such as Mpox, Ebola, and COVID-19. It also responds to persistent structural and system-level gaps that continue to undermine health outcomes for communities living with and affected by HIV.

The Strategic Plan is anchored on clearly defined strategic thrusts that position NAFOPHANU to contribute meaningfully to a sustainable, inclusive, and community-led national HIV response. In addition to programmatic priorities, the Strategy deliberately strengthens organisational capacity, governance, and management systems at both national and district levels. It is therefore intended to serve as a unifying framework for the entire PLHIV constituency in Uganda over the next five years.

NAFOPHANU recognises the interconnectedness of structural, social, economic, and environmental determinants in achieving HIV epidemic control and addressing related co-morbidities. Addressing the socio-economic impacts of HIV on PLHIV and their families, advancing human rights, reducing stigma and discrimination, and promoting gender equality are treated as cross-cutting priorities throughout this Strategy.

## Challenges

People living with HIV play a critical role in mobilising communities to prevent new HIV infections, sustain treatment outcomes, promote gender equality, improve child development, and strengthen sexual, reproductive, maternal, newborn, and adolescent health. As the national secretariat for PLHIV networks and groups in Uganda, NAFOPHANU coordinates and amplifies these efforts within the national HIV and health response.

Despite notable progress, the PLHIV constituency continues to face significant and interconnected challenges:

### 1 Still Out of Reach

An estimated 243,000 people living with HIV are not yet enrolled in care and treatment, while 76,822 PLHIV are not virally suppressed. Although AIDS-related deaths have declined by 61% and 63% from previous peaks, Uganda still records approximately 20,335 AIDS-related deaths annually, equivalent to 56 deaths per day and 392 deaths per week, with persistent geographic and population-level disparities.

### 2 Stigma Runs Deep

Stigma and discrimination remain disproportionately high among adolescents and young people aged 14–24 years, key populations, women, urban residents, unmarried PLHIV, individuals newly initiated on ART, PLHIV in poor health, and those with mental health challenges. This contributes to missed clinic appointments, poor adherence, and lower viral suppression rates. Retention in care at 12 months stands at 79%, with lower rates among children and adolescents, contributing to declining paediatric ART coverage (Makerere University School of Public Health Stigma Survey, 2023).

### 3 Fragmented Care

Integration of HIV services with non-communicable diseases, mental health, and maternal care remains limited. Significant gaps persist in screening and management of tuberculosis, hepatitis B, cervical cancer, and advanced HIV disease among PLHIV (National HIV Strategic Plan 2025/26–2029/30).

### 4 Poverty Blocks Progress

Social and economic inequalities continue to undermine access to ART, particularly for children, adolescents, and young people. Poverty, unemployment, and food insecurity affect treatment adherence and health-seeking behaviour.



**243,000 PLHIV**

are not yet enrolled in care and treatment



**52.7% of young PLHIV**

experience internalised stigma — rising to 70.1% among young people under 24 years

**Significant gaps persist** in TB, hepatitis B, cervical cancer and mental health integration



**41.7% Ugandans**

live in poverty — directly undermining treatment adherence

### 5 The Cost of Staying Alive

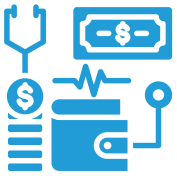
High out-of-pocket health expenditures remain a major barrier. Over half (53.1%) of households affected by HIV and tuberculosis face catastrophic health expenditures, spending 20–40% of household income on care. Average costs per episode are estimated at USD 303-404 for first-line HIV treatment, USD 1,020 for second-line, and USD 3,428 for third-line treatment. Costs are substantially higher for PLHIV with co-morbidities such as cervical cancer and non-communicable diseases. Yet only 39% of HIV/TB patients receive any form of social protection (Lancet Commission on Tuberculosis, 2019.

### 6 Deprioritised and Underfunded

Psychosocial support has been deprioritised amid declining global health financing, the termination of USAID support, and limited investment in community-led services. Evidence consistently shows that counselling and psychosocial support improve emotional wellbeing, reduce stigma, enhance treatment adherence, and promote positive coping and behaviour change among PLHIV.

### 7 A Missing Link

Nutrition remains inadequately integrated into HIV programming, despite its central role in treatment success, immune recovery, and overall wellbeing of PLHIV.



**53.1% of HIV/TB**

households face catastrophic health expenditure — spending 20–40% of income on care

Counselling and psychosocial support consistently shown to improve outcomes — **yet investment has declined**

**Nutrition remains critically overlooked** despite its central role in treatment success and immune recovery

## Strategic Response

To ensure the national multisectoral response remains effective — and that PLHIV communities are central — NAFOPHANU proposes four strategic focus areas for 2025/26–2030/31. These priorities are fully aligned with the National HIV Strategic Plan (2025/26–2029/30), which emphasises strengthening community-led coordination, differentiated service delivery, multisectoral integration, and resilience to pandemics. The Strategy also aligns with broader national and global policy commitments as detailed in the literature review.

The Strategy is anchored on four strategic pillars that reflect PLHIV commitments and priorities. These priorities are fully aligned with the National HIV Strategic Plan (2026–2029/30), which emphasises:

| Coordination | Community-Led Health Care Access | Social Protection | Digitalisation and Documentation |
|---|---|---|---|
| PILLAR 1 | PILLAR 2 | PILLAR 3 | PILLAR 4 |
| Strengthening collaboration across PLHIV networks for advocacy, policy influence and service delivery | Promoting equitable, community-driven access to HIV prevention, care and treatment services | Safeguarding the rights, welfare and socio-economic wellbeing of PLHIV and affected communities | Improving data management, reporting and record-keeping for better decision-making and accountability |

**ALIGNED WITH:** *National HIV Strategic Plan 2025/26–2029/30 • Uganda's Fourth National Development Plan (NDP IV) Global AIDS Strategy 2026–2031 • National Integration Framework 2025*

- Strengthening community-led coordination and differentiated service delivery models;
- Enhancing multisectoral integration across HIV, SRHR, social protection, and economic empowerment;
- Scaling up targeted prevention for AGYW and key populations.
- Improving data systems and use for responsive programming;
- Building resilience to pandemics and humanitarian shocks; and
- Reforming discriminatory laws and policies to reduce stigma and improve access.

## What Is New in the 2026-2030/31 NAFOPHANU Strategic Plan

The 2026-2030/31 NAFOPHANU Strategic Plan is deliberately designed to respond to Uganda's evolving HIV and health landscape, particularly the national integration agenda and the changing realities of HIV financing. The Strategy places the priorities and lived realities of people living with HIV (PLHIV) at the centre of an increasingly integrated health system, while aligning with key national and global frameworks, including the National Development Plan IV, the National HIV Strategic Plan (2025/26–2029/30), the National Integration Framework (2025), the Global AIDS Strategy (2026–2031), the renewed National HIV Policy, and other relevant policy instruments.

Unlike previous strategies, this Plan explicitly addresses the implications of declining donor financing and the closure of many community-led programmes. It envisions empowered PLHIV communities that are free from stigma and discrimination and able to access, utilise, and adhere to integrated services for HIV, sexual and reproductive health and rights (SRHR), mental health, and non-communicable diseases within the current integration framework.

The Strategy provides clear guidance to network members on bridging persistent gaps to achieve a sustainable HIV and health response by 2030. Building on gains from the 2020–2025 Strategic Plan, it prioritises scaling up proven community-led interventions that sustain access to care, improve retention and viral suppression, address stigma and discrimination, and strengthen the social and economic wellbeing of PLHIV.

A defining shift in this Strategic Plan is the deliberate positioning of PLHIV at the core of social mobilisation, psychosocial and mental health support, follow-up of clients lost to care, accelerated linkage and differentiated treatment packages, and advocacy for resilient, people-centred health systems. The Strategy recognises that meaningful HIV epidemic control cannot be achieved without empowered PLHIV leading demand creation, accountability, and community-level service delivery.

Informed by lessons from COVID-19, Ebola, Mpox, and other public health emergencies, the Strategy adopts and institutionalises community-led HIV response models as a foundation for pandemic preparedness and response. A strong emphasis is placed on digitalised documentation, data use, and knowledge management to enhance coordination, accountability, and real-time decision-making.

Overall, the 2026-2030/31 Strategic Plan marks a shift towards an empowered, resourced, and digitally enabled community-led response that is inclusive, multisectoral, transformative, and sustainable. The Strategy is anchored on strategic pillars that reflect PLHIV commitments and priorities, as outlined below.

### OUR VISION

People living with HIV live longer, productive and quality lives

### OUR MISSION

Bridge gaps through reconnecting the chain of community-led systems and sharing lived experiences for a Sustainable HIV and Health Response by 2030

### LONG-TERM GOAL

To mobilise support and coordinate the efforts of People Living with HIV for improved wellbeing.

### STRATEGIC PILLARS

1. Coordination
2. Community-led access to health care
3. Social protection
4. Digitalisation and documentation




# Implementation Approach

*Four strategic pillars reflect the commitments and leadership of PLHIV — anchored in coordination, health access, social protection, and digital innovation."*

## Strategic Pillar 1: Coordination

**VOICE FROM THE FIELD**

> ***COORDINATION SHOULD BE ABOUT TAKING CHARGE OF THEIR MANDATE, VISION, AND MISSION FOR THE GOOD OF THE PLHIV CONSTITUENCY.. WITH LIMITED RESOURCES, THE SECRETARIAT MUST CONCENTRATE ON UPSTREAM WORK TO ENABLE DISTRICT CONSTITUENCIES DELIVER PROGRAMMATIC OUTPUTS.***
>
> *— Chair AIDS Development Partners' Representative*

> ***THE GIPA PRINCIPLE PROVIDES A BLUEPRINT FOR MEANINGFUL RELATIONSHIPS BETWEEN SERVICE USERS AND PROVIDERS. EVEN WHEN THE LEGAL ENVIRONMENT IS CONDUCIVE, MANY HEALTH WORKERS LACK KNOWLEDGE ON SELF-CARE AND PSYCHOLOGICAL MANAGEMENT. SOCIAL CONTRACTING CAN HUMANIZE AND DE-MEDICALISE HEALTH BY ENABLING EXPERT CLIENTS, PEERS, AND MENTORS LIVING WITH HIV TO SHAPE INCLUSIVE SERVICE DELIVERY, PARTICULARLY FOR KEY POPULATIONS." NAFOPHANU SHOULD WIDEN THEIR SOCIAL NETWORK AND MOVE AWAY FROM THE FOUNDER SYNDROME , OPEN UP THE SPACE TO LOOK OUT FOR WHO EVER IS LIVING WITH HIV, EMBRACE THE BROAD COMMUNITY AND, ALLOW THEMSELVES TO BE CHALLENGED , ACCEPT GOOD AND NEGATIVE FEEDBACK TO PUSH THE ORGANISATION FORWARD IN THE INTEGRATION AGENDA.***
>
> *— Executive Director, SRHR Alliance*

> ***IF WE ARE LOOKING AT MOVEMENT THAT HAS TRIED THEIR BEST TO EXIST AMIDST REDUCED RESOURCES IT'S NAFOPHANU, THEY HAVE THE STRUCTURES THAT ARE COMMUNITY-LED AND GROUNDED AND THEY EXIST TO SERVE THE COMMUNITY, THERE IS NO VILLAGE IN UGANDA THAT ONE CAN REACH AND THEY ARE TOLD THERE NO PEOPLE LIVING WITH HIV. WITH THIS COORDINATION STRUCTURES NAFOPHANU SHOULD NOT RUN BACK BUT REVIVE, TAKE A STEP BACKWARD TO REDISCOVER IT'S POWER , REFLECT ON HOW CHANGE HAPPENED IN THE EARLY 2000'S WITHOUT RESOURCES AND RECONNECT AGAIN BY EMBRACING INNOVATIONS LIKE ECONOMIC EMPOWERMENT THROUGH HOME GARDENING, LOCAL DOMESTIC ECONOMIC ACTIVITIES THAT CAN YIELD SUPPORT FOR THE PLHIV COMMUNITY EVEN WITHOUT DONOR SUPPORT. NAFOPHANU HAS THE POWER TO REVAMP, REDISCOVER AND RECONNECT THE CHAIN OF COMMUNITY-LED LEADERSHIP.***
>
> *— Executive Director Alliance of Women Advocating for Change*

> ***NAFOPHANU SHOULD WIDEN THEIR SOCIAL NETWORK AND MOVE AWAY FROM THE FOUNDER SYNDROME , OPEN UP THE SPACE TO LOOK OUT FOR WHO EVER IS LIVING WITH HIV, EMBRACE THE BROAD COMMUNITY AND ALLOW THEMSELVES TO BE CHALLENGED , ACCEPT GOOD AND NEGATIVE FEEDBACK TO PUSH THE ORGANISATION FORWARD IN THE INTEGRATION AGENDA.***
>
> *— Focus group interviewees*

### Goal

**To convene, coordinate, and provide strategic oversight and governance for PLHIV forums, national PLHIV networks, and constituency members in order to strengthen resourcing, collaboration, and effective management of HIV and health programmes by 2030.**

## Strategic Approach

NAFOPHANU will strengthen coordination across its constituency to ensure a coherent, well-resourced, and accountable community-led HIV and health response. Coordination will focus on both national-level leadership and district-level implementation to maximise impact within an integrated health system.

Specifically, NAFOPHANU will coordinate and support: 136 district PLHIV forums, 10 city PLHIV forums, 18 national PLHIV networks, and Partner civil society organisations (CSOs) at both national and sub-national levels.

Through this coordination, the Strategy will:

- Enhance communication and collaboration among PLHIV networks and partners.
- Strengthen policy engagement and advocacy for increased public financing and sustainable resources for community-led PLHIV organisations.
- Build institutional and programmatic capacity of national and district PLHIV networks;
- Improve reporting, transparency, accountability, and collective learning across the constituency.

NAFOPHANU will continue to convene inclusive dialogue platforms that bring together PLHIV—including priority, vulnerable, and key populations—alongside broader CSOs and government actors to shape HIV and health programming, promote the GIPA principle, and advance social contracting and other community-led service delivery models.

The table below highlights the Strategic Objectives for this pillar, projected activities together with expected results.

| Strategic Objective | Strategic Interventions | Expected Outcomes |
|---|---|---|
| **1.1 Strengthen coordination of PLHIV constituency members and partners to enhance advocacy for access to HIV, SRHR, mental health, GBV, and NCD services.** | 1. Strengthen governance and accountability of national and district PLHIV Forums and networks through support for annual workplans, quarterly reporting, functional boards, and audited financial systems.<br>2. Build institutional capacity of PLHIV networks and support groups in registration, leadership, governance, strategic planning, resource mobilisation, and financial management. | • Functional and adequately resourced PLHIV district forums and national networks.<br>• Approved and implemented annual workplans across PLHIV networks.<br>• Timely submission and dissemination of quarterly and annual reports and audited accounts.<br>• District mentorship and coordination hubs established.<br>• Increased institutional capacity and collaboration among PLHIV networks.<br>• Increased number of registered and compliant PLHIV forums and networks. |
| **1.2 Strengthen institutional infrastructure to support coordination and service delivery for NAFOPHANU and its member organisations.** | 1. Advocate for financing and establishment of the NAFOPHANU "Home of Hope" national coordination centre.<br>2. Engage district leadership to secure office space for district PLHIV networks.<br>3. Map and reclaim PLHIV infrastructure established by previous partners and donors.<br>4. Advocate for formal allocation and handover of PLHIV infrastructure to district forums and networks. | • Fully functional and operational national coordination office established.<br>• Office space secured for PLHIV networks in at least 50 districts and 10 cities.<br>• PLHIV infrastructure mapped and documented nationally.<br>• At least 10 PLHIV coordination facilities secured and operationalised. |
| **1.3 Increase sustainable financing for NAFOPHANU and its constituency members.** | 1. Advocate for social contracting and domestic financing through partnerships with government ministries, private sector, and development partners.<br>2. Organise national and international resource mobilisation forums, symposiums, and donor engagement events.<br>3. Promote visibility of community-led HIV responses through partner engagement visits and knowledge sharing. | • Increased domestic and international financing for PLHIV community-led programmes.<br>• At least USD 1 million secured from Global Fund and additional development partners.<br>• Increased social contracting partnerships with government institutions.<br>• Increased proportion of funding from diversified sources from 10% to 40%.<br>• Increased total financing for PLHIV programmes from USD 780,000 (2025) to USD 7 million by 2030.<br>• Increased number of strategic partnerships established. |
| **1.4 Strengthen advocacy for increased domestic health financing and establishment of the National Health Insurance Scheme.** | 1. Strengthen partnerships with CSOs and advocacy coalitions to promote domestic health financing.<br>2. Advocate for increased national health budget allocation from 8% to 15% in line with global commitments.<br>3. Engage Parliament, Ministry of Finance, and Ministry of Health to accelerate establishment of the National Health Insurance Scheme.<br>4. Promote public awareness and policy advocacy through media and stakeholder engagement.<br>5. Advocate for implementation of social contracting and utilisation of district HIV mainstreaming funds. | • Increased national health budget allocation to at least 15% by 2030.<br>• National Health Insurance Scheme established and operational.<br>• Increased domestic financing for HIV, TB, NCD, SRHR, and mental health services.<br>• Increased utilisation of district HIV mainstreaming funds.<br>• Social contracting guidelines developed and implemented.<br>• Increased number of PLHIV-led programmes financed through domestic resources. |




## Strategic Pillar 2: Community-Led Health Care Access

**VOICE FROM THE FIELD**

> ***PUTTING PEOPLE AT THE CENTRE OF THE HIV RESPONSE IS KEY TO UNLOCKING BARRIERS TO DEMAND, RETENTION, AND UPTAKE OF SERVICES. NAFOPHANU CAN BENEFIT FROM SOCIAL CONTRACTING TO ENHANCE COMMUNITY-LED RESPONSES, BUT INNOVATIONS TAPPING INTO AGRICULTURE, EDUCATION, SPORTS, LOCAL GOVERNMENT, GENDER, TRANSPORT, AND ICT SECTORS ARE REQUIRED.***
>
> *— Director, Partnerships, Uganda AIDS Commission*

> ***IMPORTANT FOR NAFOPHANU TO FOCUS ON "MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SHOULD BE AN INTEGRAL PART OF NAFOPHANU PROGRAMMING. YOUNG PEOPLE'S HEALTH OUTCOMES CANNOT BE ATTAINED UNLESS NAFOPHANU CLEARLY ADDRESSES THE PSYCHOSOCIAL DIMENSIONS OF THEIR LIFESTYLES.***
>
> *— Executive Director Trans Network Uganda*

> ***NAFOPHANU HAS ALWAYS CHAMPIONED COMMUNITY-LED MONITORING WITH RETENTION IN CARE, EMPOWERING PLHIV TO TRACK SERVICE DELIVERY AND VIRAL LOAD SUPPRESSION, THIS SHOULD BE THEIR ANCHOR AS A STRATEGY THAT REDUCES EXPENSES ON CENTRALISED MONITORING. NAFOPHANU SHOULD BE ABLE TO PRIORITISE TRAINING MORE COMMUNITY VOLUNTEERS FOR SOCIAL SUPPORT AND STIGMA REDUCTION. IN THE DIRECTION OF SUSTAINABILITY, THEY SHOULD CONTINUE TO ENGAGE LOCAL INVESTORS AND PRIVATE SECTOR COMPANIES TO STRENGTHEN COLLABORATION AND PARTNERSHIPS AS A SUSTAINABILITY STRATEGY".***
>
> *— Programme & Advocacy Coordinator, AHF Uganda Cares.*

> ***MAKE HIV CONVERSATIONS FOR EVERYBODY NOT FOR WOMEN AND GIRLS ALONE BUT FOR WHOEVER IS AFFECTED OR INFECTED IN ONE WAY OR THE OTHER , WHETHER WOMEN, MEN, TRANSGENDER, MSMS, PEOPLE NOT LIVING WITH HIV, LESBIANS AND OTHERS".***
>
> *— Key population focus group interview*

> ***NEED TO SEE MORE YOUTH ENGAGEMENTS IN NAFOPHANU, CONVERSATIONS, WITH TRUMP'S ERA AND REVOLUTION THE ENTIRE COMMUNITY HAS BEEN AND EVERY ONE IS STRUGGLING, HOW CAN NAFOPHANU EMBRACE MORE OF DOMESTIC FINANCING SINCE THEY HAVE ALREADY ACHIEVED LOT THROUGH ADVOCACY AND THIS NEEDS TO BE DONE ACROSS THE SPECTRUM WITHOUT LEAVING THE LGBTIQ+ AND SEX WORKERS BEHIND".***
>
> *— Focus group interview with sex workers*

## Goal

**To improve health outcomes by promoting people-centred, equitable, and community-led access to healthcare for PLHIV and affected communities.**

## Strategic Rationale and Approach

The UNAIDS Strategic Plan 2026–2030 emphasizes the central role of community-led organisations in achieving epidemic control. Specifically, it calls for:

- Community-led organisations to deliver 30% of HIV testing and treatment services, including HIV testing, linkage to treatment, adherence and retention support, and treatment literacy
- Community-led organisations to deliver 80% of HIV prevention services for populations at higher risk of HIV infection, including women within these populations
- Community-led organisations to deliver 60% of programmes supporting societal enablers, including stigma reduction, human rights, and community empowerment

This strategic pillar draws its focus from UNAIDS Global Guidance, the Ministry of Health HIV Integration Strategy, and the National Community Health Strategy, all of which recognise communities as essential partners in service delivery and health system accountability.

Since 2003, NAFOPHANU has consistently centred the voices of PLHIV and other vulnerable communities by advocating for people-centred approaches; providing psychosocial support; sharing lived experiences to reduce stigma and discrimination; promoting equitable access to health services; monitoring the availability of HIV commodities at health facilities; advocating for treatment refills; improving quality of care through community-led service delivery; mobilising HIV financing advocacy; and empowering PLHIV to know and claim their rights.

However, a 78% reduction in funding for community-based health care, largely from the USG funding portfolio, has resulted in a significant decline in the utilisation of community-led and community-based health services.

At the same time, the Ministry of Health adopted integrated service delivery guidelines, phasing out stand-alone HIV and TB clinics and integrating services into general outpatient departments (OPDs). Under this model, clinicians managing chronic conditions such as hypertension, diabetes, hepatitis, and other illnesses also provide HIV and TB services.

While integration aims to reduce stigma and improve efficiency, emerging district-level evidence highlights unintended consequences. Data from Kamuli, Jinja, Wakiso, Mbarara, and other districts indicate that although PLHIV access services at OPD level, many fail to collect their treatment refills from central pharmacies and do not return for follow-up.

> ***"THERE IS A TIME BOMB FOR NON-SUPPRESSION AND TREATMENT FAILURE AMONG PLHIV DUE TO FAILURE TO PICK TREATMENT FROM THE CENTRAL PHARMACY. INTERNALISED STIGMA AND DISCRIMINATION ARE DRIVING INCREASING LOSS TO FOLLOW-UP EVERY MONTH, DESPITE ENGAGEMENT OF VHTS AND CHWS."***
>
> *— In-Charge, Nankadulo Health Centre IV, Kamuli District*

These observations from frontline clinicians underscore the urgent need to strengthen people-centred and community-led approaches within integrated service delivery models. Without deliberate community engagement, integration risks undermining adherence, retention, and viral suppression outcomes.

## Strategic Focus

In response, the NAFOPHANU Strategic Plan prioritises Community-Led Health Care Access as a core pillar to bridge gaps in service access and utilisation under the Ministry of Health's integrated OPD model. This pillar emphasizes meaningful engagement of PLHIV, peer-led navigation, psychosocial support, stigma reduction, and accountability mechanisms to ensure continuity of care.

## Proposed Objectives

By advancing community-led health care access, NAFOPHANU will aim to:

1. Strengthen peer-led psychosocial support, treatment literacy, and client navigation to improve adherence and retention.
2. Reduce stigma and discrimination within integrated OPD settings through PLHIV-led advocacy and health worker engagement.
3. Improve treatment pickup, continuity of care, and viral suppression among PLHIV accessing integrated services.
4. Expand social contracting and multi-sectoral partnerships to sustain community-led HIV service delivery.
5. Strengthen community monitoring, feedback, and accountability mechanisms at health facility and district levels.

| Strategic Objective | Strategic Interventions | Expected Outcomes |
|---|---|---|
| **2.1 Reduce stigma and discrimination to advance human rights and equitable access to HIV and related health services.** | 1 Engage partners to conduct the National HIV and Co-morbidities Stigma Index<br>2 Promote meaningful engagement of PLHIV, priority, vulnerable, and key populations to share lived experiences and inform delivery improvements.<br>3 Scale up integrated, PLHIV-led treatment literacy and community sensitisation programmes.<br>4 Strengthen "Know Your Rights" advocacy campaigns across health facilities, schools, communities, correctional facilities, transport corridors, workplaces, and judicial systems.<br>5 Promote gender equality and put in place frameworks to address all forms of violence (including sexual harassment and sexual and gender-based violence) prevention programmes in the community, educational institutions, workplaces, among others. | • Increased treatment retention among PLHIV.<br>• Reduced loss to follow-up.<br>• Improved adherence to HIV, TB, cervical cancer, and NCD treatment.<br>• Reduced HIV co-infections and advanced HIV disease complications.<br>• Reduced HIV-related morbidity and mortality.<br>• Improved quality and responsiveness of HIV and TB services.<br>• Increased utilisation of community knowledge hubs and support services.<br>• PLHIV networks with policies on prevention of sexual and gender based violence. |
| **2.2 Strengthen integrated HIV prevention, care, treatment, and social protection services in line with the principle of leaving no one behind.** | 1 Collaborate with UAC, MoH, and Local Governments to expand access to differentiated HIV prevention and treatment services (including PrEP, PEP, CAB-LA, and Dapivirine vaginal ring).<br>2 Advocate for inclusion of PLHIV champions and community experts within national, regional, and district health systems.<br>3 Engage peer leaders and expert clients to increase awareness and utilisation of treatment refill systems and decentralised drug distribution models.<br>4 Strengthen capacity of community-led organisations to implement, monitor, and report on HIV, TB, STIs, viral hepatitis, and related services. | • Increased access to HIV and integrated health services.<br>• Improved viral load suppression rates.<br>• Reduced new HIV infections.<br>• Reduced HIV-related mortality.<br>• Improved retention in HIV care and treatment programmes.<br>• Reduced loss to follow-up.<br>• Increased utilisation of advanced HIV disease (AHD) services.<br>• Strengthened community-led service delivery systems. |
| **2.3 Strengthen provision of psychosocial support and mental health services for PLHIV communities.** | 1 Expand psychosocial support services targeting youth, elderly persons, women, refugees, persons with disabilities, and key populations living with HIV.<br>2 Mobilise resources to strengthen functionality of community support platforms, including helplines and peer support networks.<br>3 Integrate mental health services into HIV programming using peer support models and tailored interventions. | • Increased access to psychosocial and mental health services.<br>• Improved treatment adherence and viral suppression, especially among AGYW and vulnerable populations.<br>• Reduced stigma, depression, and social isolation among PLHIV.<br>• Sustained functionality of community support platforms including helplines.<br>• Reduced gender-based violence affecting PLHIV. |

| Strategic Objective | Strategic Interventions | Expected Outcomes |
|---|---|---|
| **2.4 Strengthen risk preparedness and continuity of HIV services during public health emergencies, pandemics, and humanitarian crises.** | 1 Build capacity of PLHIV networks in emergency preparedness, risk reduction, and response planning.<br>2 Engage in national climate change, disaster preparedness, and emergency response planning to ensure inclusion of PLHIV needs.<br>3 Strengthen cross-border and transport corridor HIV service continuity mechanisms.<br>4 Establish partnerships with government and humanitarian actors to ensure continuity of HIV treatment and social protection during emergencies. | • Improved continuity of HIV treatment and care during emergencies.<br>• Reduced HIV-related mortality during public health emergencies.<br>• Strengthened emergency preparedness capacity among PLHIV networks.<br>• Improved access to HIV services across borders and transport corridors.<br>• Formalized partnerships with government and emergency response institutions.<br>• Strengthened resilience of PLHIV communities to health and climate-related shocks. |
| **2.5 Strengthen community-led monitoring of HIV and health service delivery to improve quality, accountability, and access.** | 1 Scale up community-led monitoring systems to assess service quality, accessibility, and client satisfaction.<br>2 Document and report community feedback on service availability, stigma, and discrimination.<br>3 Advocate for improved commodity security and reduced stock-outs.<br>4 Engage policymakers and leaders using evidence generated from community-led monitoring. | • Reduced stock-outs of ART and essential medicines.<br>• Improved quality and responsiveness of health services.<br>• Reduced stigma and discrimination in health facilities.<br>• Increased accountability in HIV service delivery.<br>• Increased government commitment and financing for HIV programmes.<br>• Increased budget allocation to community-led HIV interventions. |



## Strategic Pillar 3: Social Protection

**STAKEHOLDER REFLECTIONS**

> ***THERE IS NEED FOR NAFOPHANU TO REALIGN AND SEE HOW IT IS TALLYING WITH THE CHANGING ENVIRONMENT, THE NEED TO MERGE AND ALIGN THE CONSTITUENCY MEMBERS IS REQUIRED. IT SHOULD REVIEW ITS MISSION AND VISION, IS IT STILL RELEVANT, DO THE DISTRICT NETWORK ORGANISATIONS STILL NEED TO BE COORDINATED SINCE THEY CAN MOBILISE THEIR RESOURCES? BEING AN UMBRELLA ORGANISATIONS, IT SHOULD BRIDGE THE GAP OF ON COMMUNITY-LED MONITORING, CARE ASSESSMENTS OF PLHIV HIV AND HEALTH RESPONSE, REFOCUS ON BUILDING A CASE OR COME UP WITH PAPER FOR SOCIAL PROTECTION FOR PEOPLE LIVING WITH HIV AND PREVENTION AMONG YOUNG GIRLS".***
>
> *— International Labour Organisation Health Specialist*

> ***NAFOPHANU SHOULD PREACH LOVE, WHERE THERE IS LOVE THERE ARE REDUCED MENTAL HEALTH RELATED PROBLEMS, GROWTH AND SISTERHOOD, ONCE THIS IS ATTAINED, TB AND HIV SCREENING WILL BE ENHANCED, ACCESS TO TREATMENT AND RETENTION. ISSUES LIKE CLIMATE CHANGE SHOULD BE INTEGRATED IN NAFOPHANU PROGRAMMES BECAUSE THIS COULD ALSO BE A CHALLENGE AMIDST INNOVATIONS.***
>
> *— Focus group interview with young women living with HIV*

## Goal

**Reduce HIV-related mortality and improve the social and economic well-being of PLHIV and their families.**

## Strategic Rationale and Approach

Social protection is enshrined in the 1995 Constitution of the Republic of Uganda and reinforced by Uganda Vision 2040, which identifies social protection as a primary avenue for supporting vulnerable populations to become resilient and empowered. Similarly, National Development Plan IV (NDPIV) recognises social protection as a critical strategy for achieving middle-income status.

HIV-sensitive social protection encompasses a range of interventions, including:

- Legal reforms protecting PLHIV and marginalised populations
- Economic empowerment programmes
- Cash transfers and contributory social protection schemes

These interventions have demonstrated potential to mitigate drivers of HIV infection, reduce exclusion of PLHIV, and strengthen resilience against social and economic shocks.

The importance of social protection has grown, particularly given the withdrawal of key donors from HIV and community-led services, which has disrupted access to essential services and exacerbated economic inequalities. PLHIV communities have been disproportionately affected by:

- Job losses and reduced income-generating opportunities
- Deeply entrenched stigma and discrimination
- Criminalisation and arrests targeting key populations
- Rising gender-based violence

In 2023, UNAIDS partnered with NAFOPHANU to launch the PLHIV SACCO with a seed grant, providing community members with access to financing and opportunities to create or expand sustainable business initiatives. This initiative not only strengthens economic resilience but also ensures community well-being even in scenarios where free medications or other support services may be limited.

Recognizing these challenges and opportunities, NAFOPHANU has prioritised Social Protection as a core strategic pillar in the 2026-2030/31 Strategic Plan, with a focus on economic empowerment, risk mitigation, and sustainability for PLHIV communities.

## Proposed Objectives

By advancing social protection, NAFOPHANU aims to:

1. Expand access to HIV-sensitive financial mechanisms, including SACCOs, microfinance, and livelihood programmes.
2. Strengthen economic resilience of PLHIV through income-generating and entrepreneurship initiatives.
3. Reduce vulnerability to financial shocks that negatively impact treatment adherence and health outcomes.
4. Advocate for legal and policy reforms to protect PLHIV and key populations from discrimination and economic exclusion.
5. Integrate social protection considerations into community-led HIV service delivery and broader health programmes.

| Strategic Objective | Strategic Interventions | Expected Outcomes |
|---|---|---|
| **3.1 Operationalise and scale up the NAFOPHANU PLHIV SACCO to improve economic resilience and social well-being of PLHIV.** | 1 Roll out and strengthen the NAFOPHANU PLHIV SACCO across constituency and network members.<br>2 Support Village Savings and Loan Associations (VSLAs), apprenticeships, and provision of enterprise start-up kits.<br>3 Facilitate linkages to national social protection and livelihood programmes.<br>4 Advocate for integration of PLHIV support groups into national development and economic empowerment programmes. | • Increased economic resilience among PLHIV.<br>• Improved retention in HIV care and treatment due to improved socio-economic stability.<br>• By 2030, at least 5,000 PLHIV supported to access livelihood and economic strengthening programmes.<br>• By 2028, at least 60% of supported PLHIV report increased household income compared to baseline.<br>• Increased number of PLHIV networks and support groups accessing government development funds. |
| **3.2 Advocate for inclusion of PLHIV in Parish Development Model (PDM) and other government economic empowerment programmes.** | 1 Engage Parish Development Model coordinators and district leadership to enroll PLHIV into PDM initiatives.<br>2 Strengthen PLHIV groups' capacity to access and utilise government economic empowerment funds.<br>3 Advocate for equitable inclusion of vulnerable PLHIV in national poverty reduction programmes. | • Increased number of PLHIV accessing Parish Development Model funds.<br>• By 2030, at least 40,000 vulnerable PLHIV supported to access government economic empowerment programmes.<br>• Improved household economic stability among PLHIV beneficiaries.<br>• Reduced socio-economic vulnerability among PLHIV households. |
| **3.3 Mobilise sustainable domestic resources to support social protection programmes for PLHIV.** | 1 Launch a national "UGX 2,000 Social Protection Drive" to mobilise domestic resources for PLHIV .<br>2 Partner with celebrities, media, and entertainment venues to support fundraising initiatives.<br>3 Establish sustainable community-led financing mechanisms. | • Increased domestic resource mobilisation for PLHIV social protection programmes.<br>• Improved sustainability of NAFOPHANU social protection initiatives.<br>• Increased number of PLHIV benefiting from economic empowerment programmes. |
| **3.4 Strengthen partnerships with private sector institutions to promote economic empowerment and social inclusion of PLHIV.** | 1 Establish partnerships with private sector companies (e.g., MTN, Airtel, Movit, Mukwano, Jesa, hotels, and others).<br>2 Promote social marketing and income-generating opportunities through PLHIV networks.<br>3 Facilitate employment, entrepreneurship, and mentorship opportunities through private sector engagement. | • Increased number of private sector partnerships supporting PLHIV programmes.<br>• Increased income-generating opportunities for PLHIV.<br>• Improved financial independence and economic inclusion among PLHIV. |

| Strategic Objective | Strategic Interventions | Expected Outcomes |
|---|---|---|
| **3.5 Strengthen leadership, mentorship, and economic empowerment of adolescent girls, young women, and young people living with HIV.** | 1 Partner with youth-led organisations to implement leadership and mentorship programmes.<br>2 Support economic empowerment and entrepreneurship programmes targeting AGYW and young people.<br>3 Promote participation of young people living with HIV in leadership and decision-making platforms. | • Increased number of young people living with HIV in leadership roles.<br>• Improved economic empowerment of AGYW and young people living with HIV.<br>• Increased participation of young people in HIV and social protection programmes. |
| **3.6 Promote education retention and protection of adolescents and young people living with HIV.** | 1 Conduct awareness and sensitisation programmes in schools to reduce stigma and discrimination.<br>2 Advocate for policies supporting access to HIV, SRHR, and GBV services for adolescents and young people.<br>3 Support dissemination and implementation of national HIV disclosure guidelines. | • Reduced stigma and discrimination in educational institutions.<br>• Increased school retention among adolescents living with HIV.<br>• Reduced teenage pregnancies and gender-based violence.<br>• Strengthened policy environment supporting adolescents living with HIV. |
| **3.7 Establish a PLHIV Leadership, Training, and Consultancy Academy.** | 1 Conduct annual mentorship and leadership development programmes.<br>2 Provide technical assistance and consultancy services to partners.<br>3 Organise annual leadership retreats and capacity-building programmes. | • Increased number of trained and empowered PLHIV leaders.<br>• Increased number of PLHIV leaders engaged in consultancy and technical support roles.<br>• Strengthened institutional capacity of PLHIV networks. |
| **3.8 Establish a PLHIV Wellness and Leadership Support Centre.** | 1 Establish a wellness centre providing mental health, counselling, and peer support services.<br>2 Conduct wellness retreats and psychosocial support programmes.<br>3 Provide safe spaces for counselling, peer engagement, and leadership support. | • Improved mental health and well-being of PLHIV leaders.<br>• Strengthened leadership capacity and resilience among PLHIV.<br>• Improved sustainability of PLHIV leadership and community engagement. |



## Strategic Pillar 4: Digitalisation and Documentation

**VOICE FROM THE FIELD**

> ***EMBRACING TECHNOLOGY AND DIGITALISATION, LET NAFOPHANU LOOK AT THE POWER OF SOCIAL MEDIA LIKE TIKTOK, THIS IS MAKING TREMENDOUS CHANGES IN THE DEVELOPMENT WORLD, CURRENTLY CUSTOMERS NO LONGER MOVE FROM ONE PLACE TO ANOTHER, HOW CAN WE USE THE SMART PHONES TO DO THE COORDINATION WORK, BUSINESS AND MONITORING OF THE PROGRAMME.***
>
> *— Executive Director, Alliance of Women Advocating for Change*

### Goal

**To use digital technology to improve data validity, enhance ownership, and increase participation of staff and partners in documenting results and tracking health outcomes.**

### Strategic Rationale and Approach

As societal and health challenges become increasingly complex, PLHIV communities and networks will leverage digital tools and technologies to improve operations, outreach and service delivery. Digital transformation enables greater engagement with stakeholders, streamlined organisational processes, real-time dissemination of information and improved efficiency and accountability.

Effective utilisation of ICT strengthens Monitoring, Evaluation, Research, and Learning (MERL), drives innovation, and supports meaningful communication within NAFOPHANU. Digital solutions reduce operational costs, enhance data quality, and foster participatory ownership among staff and partners.

NAFOPHANU recognises that access to and impact of digital health technologies vary across diverse communities of PLHIV. To address this, the organisation will:

- Engage communities in research to understand the benefits, gaps, and risks associated with digital technologies.
- Empower PLHIV communities through digital literacy initiatives.
- Strengthen community capacity to engage with and advocate for safe, effective, and innovative digital health solutions.
- Integrate digital tools across HIV treatment, care, and prevention services to improve service delivery and monitoring.

By prioritising digitalisation and documentation, NAFOPHANU aims to create a more responsive, accountable, and inclusive community-led HIV and health response.

## Proposed Objectives

1. Implement digital tools to improve monitoring, evaluation, research, and learning (MERL) across programmes.
2. Increase participation of PLHIV, staff, and partners in accurate and timely documentation of results.
3. Enhance data quality and validity to support evidence-based decision-making.
4. Strengthen digital literacy among PLHIV communities to ensure equitable access to health information.
5. Promote innovation and adoption of safe, effective digital health technologies to support HIV service delivery and advocacy.

| Strategic Objective | Strategic Interventions | Expected Outcomes |
|---|---|---|
| **4.1 Leverage digital technology to strengthen coordination, communication, and advocacy across PLHIV networks.** | 1 Utilise NAFOPHANU virtual platforms (websites, mobile platforms, webinars, and digital forums) for coordination, information dissemination, training, and advocacy.<br>2 Leverage youth-led, key population-led, and community digital platforms to enhance outreach, engagement, and service access.<br>3 Establish digital communication systems to enable real-time reporting on service access, stigma, and commodity stock-outs. | • Improved coordination and communication across PLHIV networks at national and district levels.<br>• Increased access to timely and accurate information on HIV, SRHR, mental health, GBV, and NCD services.<br>• Increased participation of PLHIV in digital advocacy and coordination platforms.<br>• Strengthened responsiveness to service delivery gaps, including commodity stock-outs. |
| **4.2 Strengthen community-led monitoring and reporting systems using digital tools.** | 1 Deploy digital tools for community-led monitoring, data collection, and reporting on HIV and related health services.<br>2 Train PLHIV networks and constituency members on digital data collection, reporting, and use of data for advocacy.<br>3 Establish digital dashboards for monitoring service access, treatment retention, and community feedback. | • Improved availability, quality, and timeliness of community-level HIV data.<br>• Strengthened community-led monitoring and social accountability mechanisms.<br>• Increased use of data for advocacy, planning, and programme improvement.<br>• Improved tracking of progress toward national and global HIV targets. |

| Strategic Objective | Strategic Interventions | Expected Outcomes |
|---|---|---|
| **4.3 Strengthen media engagement and digital advocacy to promote HIV and integrated health services.** | 1 Establish partnerships with media organisations (radio, television, and digital media platforms) to support HIV and health advocacy campaigns.<br>2 Strengthen capacity of young PLHIV leaders and networks to use digital platforms for advocacy and communication.<br>3 Implement social media campaigns to promote HIV prevention, treatment adherence, mental health, and GBV prevention. | • Increased public awareness of HIV, SRHR, mental health, self-care, and GBV issues affecting PLHIV.<br>• Increased visibility and representation of PLHIV voices in media and public discourse.<br>• Strengthened advocacy for people-centred and integrated HIV services.<br>• Increased engagement of young PLHIV in advocacy and leadership. |
| **4.4 Strengthen documentation and knowledge management to support evidence-based programming and advocacy.** | 1 Develop and disseminate knowledge products including policy briefs, reports, publications, newsletters, and advocacy materials.<br>2 Strengthen documentation of best practices, lessons learned, and community-led interventions.<br>3 Establish digital knowledge management systems to facilitate data sharing and organisational learning. | • Increased availability of evidence to inform HIV programming and advocacy.<br>• Improved documentation and dissemination of PLHIV community experiences and best practices.<br>• Strengthened organisational learning and institutional memory.<br>• Improved stakeholder engagement and information sharing. |
| | 1 Support PLHIV networks to contribute to national, regional, and global HIV reporting processes.<br>2 Establish technical working groups to coordinate knowledge management and reporting.<br>3 Facilitate documentation and integration of PLHIV perspectives into national and global HIV reports. | • Increased representation of PLHIV voices in national, regional, and global HIV reports.<br>• Strengthened accountability and visibility of community-led HIV responses.<br>• Improved alignment of community priorities with national and global HIV strategies.<br>• Strengthened capacity of PLHIV networks in strategic information and reporting. |

# Cross-Cutting Themes

**The following thematic areas are central to NAFOPHANU and will be integrated across all four strategic pillars.**

## Gender Equality

HIV affects women and men disproportionately, with women remaining at unacceptably high risk. Gender inequality and unequal power dynamics continue to significantly influence the epidemic. Biological factors that make women and girls more vulnerable to HIV infection are compounded by socio-cultural and structural factors, including poverty, harmful cultural practices, limited decision-making power, restricted mobility, violence, limited educational opportunities, and inadequate sexual and reproductive health services.

For this Strategic Plan, gender will be a cross-cutting theme across all four pillars. NAFOPHANU will prioritise initiatives that align with broader development agendas to empower young women, girls, and women ageing with HIV, thereby reducing their vulnerability to HIV and associated non-communicable diseases (NCDs).

## Psycho-Social Support and Protection for Children, Adolescents, and Young People

Children, adolescents, and young people living with or affected by HIV require targeted care and support. Findings from the PLHIV Stigma Index indicate that many young people face stigma in school settings, which impedes adherence to treatment and negatively affects viral suppression. There is an urgent need to address the social support requirements for orphans and vulnerable children (OVCs), including child protection, family support, and education. NAFOPHANU will expand and strengthen sustainable social support and protection programmes for OVCs and young people affected by HIV.

## Linking Nutrition and HIV

Adequate nutrition is critical for PLHIV to maintain immune function, manage opportunistic infections, optimise responses to ART, sustain physical activity, and improve overall quality of life. WHO and national HIV care guidelines recommend integrating nutrition support into HIV care packages. Food insecurity and malnutrition remain pervasive in Uganda, compounded by limited household access to nutritious foods and insufficient knowledge about dietary requirements for ART clients. NAFOPHANU will focus on promoting food security, nutritional support, and education as part of positive living for PLHIV.

## Linking HIV, Vulnerability, and Human Rights

Certain communities face disproportionate HIV risk due to stigma, discrimination, and criminalisation. These include sex workers, lesbian, gay, bisexual, transgender, and intersex (LGBTI) populations, people who use drugs, and men who have sex with men. Punitive laws often drive these populations underground, limiting access to life-saving HIV services. Violence, stigma, and discrimination remain major barriers. Advancing the rights of these vulnerable communities is essential to an effective HIV response and achieving epidemic control.

## HIV and Older Adults, and Refugees

The rise of non-communicable diseases (NCDs) in Uganda, coupled with increased ART adherence, has resulted in a growing population of older adults living with HIV. This presents new challenges in service delivery, health promotion, and care for ageing PLHIV. NAFOPHANU will design strategies for integrated prevention and management of HIV and NCDs among the elderly. Similarly, refugees remain vulnerable to HIV due to gaps in comprehensive HIV programming. The Strategic Plan will ensure that these populations are included in prevention, care, and support services.

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# Appendices

## Appendix 1: Organisational History

NAFOPHANU was established in May 2003 as a national, non-government and not-for-profit organisation, to provide a country-wide systematic and all-inclusive coordination structure for People Living with HIV (PLHIV) networks, associations and support groups in order to play advocacy, policy and decision-making roles in the HIV and AIDS partnership. The decision to form NAFOPHANU was reached after identification, acknowledgement and recognition of gaps within PLHIV initiatives in the national response. This decision to establish NAFOPHANU was reached through a consultative process between members from several PLHIV initiatives in Uganda, with support from UNAIDS and the HIV and AIDS Partnership Committee of UAC. Since inception, NAFOPHANU has championed the cause of PLHIV and has widened her membership countrywide to have structures in all districts in Uganda.

With this strategic thrust, NAFOPHANU will be able to make meaningful contribution towards protecting the gains and sustaining the community-led multi sectoral National HIV response. While doing this, it will also pay attention to the organisational capacity of its network members by strengthening their governance at district and national levels. It is expected therefore that this plan will act as a framework for the efforts of all PLHIV communities, their families and those affected in Uganda for the next 5 years by highlighting Coordination, community-led health access, digitalisation and documentation, social protection as key strategic focus areas in the led to 2030.

### OUR **VISION**

People living with HIV being able to live quality and productive life in a sustainable manner.

### OUR **MISSION**

Bridging gaps through reconnecting the chain of community-led systems, coordination, policy and budget advocacy, research and documentation, joint resource mobilisation and sharing lived experiences for a Sustainable HIV and Health Response by 2030.

### OUR LONG-TERM **GOAL**

To mobilise support and coordinate the efforts of PLHIV for improved wellbeing

## CORE **VALUES/GUIDING PRINCIPLES**

1. **POSITIVE LIVING:** NAFOPHANU shall encourage PLHIV to act responsibly & adopt a health seeking behaviour, while adhering to whatever treatment that they have been put on. PLHIV will be encouraged to explore their potential and make themselves available for any opportunities that they may come across.

2. **INTEGRITY:** The staff, management and Board members of NAFOPHANU shall act with utmost truthfulness and transparency while transacting the affairs of the organisation.

3. **PROFESSIONALISM:** The staff, management and Board members of NAFOPHANU shall adhere to their various professional standards while performing duties for and behalf of NAFOPHANU.

4. **RESPECT FOR HUMAN DIGNITY:** In all her dealings, NAFOPHANU shall promote respect for life and all human beings irrespective of their age, health condition, gender, race, language and social economic status.

5. **AFFIRMATIVE ACTION:** NAFOPHANU being a national forum of PLHIV networks shall promote foremost, the interests of PLHIV and will provide opportunities for qualified and competent PLHIV.

6. **TEAMWORK:** NAFOPHANU shall focus on team development amongst her staff and members and shall do everything possible to promote teamwork, inter and intra-functional collaboration and shall recognise successful team efforts.

## Governance and organisational oversight

The supreme organ is the annual general meeting but the responsibility of corporate governance rests with the Board of Directors (BOD). The BOD is guided by a code of corporate governance and charter which stipulates the roles and against which functioning of the board will be monitored. The BOD has the legal, moral and fiduciary responsibility for NAFOPHANU and its major responsibilities that are key to the growth and sustainability which include: acquiring and protecting organisational assets; making certain that NAFOPHANU is working to fulfil its mission; strategic thinking and oversight.

## Leadership and management

NAFOPHANU's operational management is delegated by the Board of Directors to the Executive Director whose role is to provide leadership to senior management team with the responsibility of managing the day-to-day activities of the secretariat. To implement this strategic plan, NAFOPHANU will review its human resources to reflect the new mandate. A human resource deployment plan, aligned to this strategic plan will be developed following a thorough human resource audit at the secretariat.

1. Management teams at senior and lower levels will be responsible for coordination, planning, programming, advocacy, financing, technical supervision, monitoring and evaluation, organisational capacity building, management of data, information and knowledge, logistics management and financing.

2. NAFOPHANU secretariat will review the current organisational structure and institutional policies to have a robust system which will translate the strategic intents into tangible results that are measurable and commensurate with resource investment. Key among policies for consideration will be the human resource management. This will require identification of vital positions for filling in addition to review of performance contracting arrangements for the existing staff.

## Appendix 2: Theory of Change




This strategic plan is a commitment of its shared contribution to the fulfilment of the social change, quotient of how different target populations or communities will be different after reaching them. The theory of change will allow NAFOPHANU to think and measure its contribution to comprehensive solution to the impact of HIV in Uganda, rather than aiming at bringing solutions on its own. This strategic plan underpins a TOC informed by various strategies of health promotion and behaviour change, theories that are valuable foundations for developing comprehensive communication strategies and programmes. The TOC approach in NAFOPHANU is therefore intended to match the needs for long-term actions with short-term financing opportunities while demonstrating robust indicators of progress towards long-term goals. NAFOPHANU has identified pathways that are needed in achieving long-term goal and logically compelling measurable short-term outcomes.

The plan portrays actions and outcomes of many players including individual clients from target population groups, local community systems, local implementing partners, and local governments. The model of change processes is those related to health promotion for behaviour change and stigma reduction exhibited by qualitative or quantitative indicators. Implications of using the TOC in NAFOPHANU point to structural changes for widening its feedback system that will engage the population it seeks to influence, developing common standards and quality control for its evaluation function.

The TOC approach will be used in the design and evaluation of interventions and application of the TOC in NAFOPHANU will include setting up M&E methods that are based on learning and reflection, providing a framework for reflection, and for making changes to the premises about what works. Learning approaches will begin with understanding programme design and intent (ToC) and connecting inputs, outputs and expected outcomes.

The TOC approach in NAFOPHANU articulates: the long-term, sustainable social change it wishes to bring about. It also states what needs to happen for this change (or vision of success) to come about. It also states what needs to happen in order to achieve the pre-conditions to change or short-term goals or outcomes as pathways of the desired change. The approach also describes the indications of success that will show that the targets have been achieved, success and specific visible changes that will tell that change has happened including evidence of success. In this strategic direction, attention will go to the following preconditions:

1. **Coordination:** Strengthening collaboration across PLHIV networks for advocacy, policy influence and service delivery.
2. **Community-Led Health Care Access:** Promoting equitable, community-driven access to HIV prevention, care and treatment services.
3. **Social Protection:** Safeguarding the rights, welfare and socio-economic wellbeing of PLHIV and affected communities.
4. **Digitalisation and Documentation:** Improving data management, reporting and record-keeping for better decision-making and accountability.

# Appendix 3: SWOT/R Analysis

## Internal and external environmental assessment

A comprehensive environmental assessment was conducted to identify the internal barriers to NAFOPHANU success and to address the inter-relationship with external stakeholders like UAC, Ministry of Health (MOH), Ministry of Local Government, Ministry of Gender, District Local Governments, Development Partners, Private Sector NGOs and other Implementing Partners.

Strength, Weakness, Opportunity, Threat/ Risk (SWOT/R) analysis and a thorough review of all statutory and given mandates of NAFOPHANU was carried out. The external environment assessment included the analysis of the data, information and knowledge in the various national and global strategy documents, relevant evaluation reports, research articles related to global public health. Meetings were also held with the NAFOPHANU staff to elicit feedback at the critical points in the strategic planning process.

The SWOT/R analysis revealed the solid core strengths that can be leveraged to build and chart a future direction and opportunities that exist for NAFOPHANU while playing its critical role of coordinating the PLHIV community and other CSOs working on health and social protection.

| Strengths | Weaknesses |
|---|---|
| • Existence of national networks and district forums that coordinate PLHIV communities.<br>• Existence of qualified NAFOPHANU staff at the secretariat.<br>• Board of Directors with diverse knowledge as well as technical expertise in organisational development and operations.<br>• Functional internal control systems for finance, human resource management, programme implementation, monitoring, and evaluation.<br>• Good working relationships with district, local government leadership and public health sector.<br>• Willingness of the PLHIV to volunteer in implementation of the HIV response. | • Absence of a permanent NAFOPHANU office.<br>• Inadequate staffing both at the secretariat and district level.<br>• Over-reliance on external donors to finance community-led HIV and health programming.<br>• Impact of the USA government (USG) funding freeze that has affected programming for NAFOPHANU.<br>• Limited use of technology as an innovation to facilitate programming.<br>• Unsatisfactory knowledge management systems to collate and disseminate information to other stakeholders in a timely manner.<br>• Limited/no funding for coordination activities, to make PLHIV structures function better. |
| **Opportunities** | **Threats/Risks** |
| • Knowledge in research and with other CSOs and academic institutions.<br>• Existence of free helpline/online to offer psycho-social support to the PLHIV.<br>• Political will to finance HIV treatment programmes after the funding cuts.<br>• Establishment of additional funding mechanism through the proposed community health insurance scheme, health insurance service providers and the national health insurance schemes.<br>• Currently well-established good working relationships and partnerships with other stakeholders and NGOs.<br>• Existence of the National Health Integration Framework and National Community Health Strategy.<br>• Increasing involvement of the private sector in resource mobilisation and fight against HIV and other health-related burdens. | • Over dependency on external funding (donors) amidst shifts in donor funding priorities considering the agenda under the global health.<br>• Social media technology spreading uncensored sexuality information especially among the youth and young people.<br>• There are limited resources for HIV prevention and mainstreaming of HIV funding across sectors and projects.<br>• Corruption tendencies that affect the efficiency and effectiveness of policy, programme implementation.<br>• Suspension of USAID funding and limited investment in community-led services.<br>• Shifting global investment priorities.<br>• Other epidemics and pandemics. |



## Appendix 4: Implementation and Fund Management

> ***PUTTING PEOPLE AT THE CENTRE OF THE HIV RESPONSE IS KEY TO UNLOCKING THE BARRIERS TO DEMAND AND UPTAKE OF SERVICES. RESOURCED COMMUNITY-LED RESPONSES WILL BENEFIT FROM LOCALISED INNOVATIONS AND SOLUTIONS TO ACCELERATE PROGRESS***
>
> *— ED Alliance of Women Advocating for Change*

### The Scope

This new plan responds to the new realities of the Stop Work Order on HIV and AIDS programming and brings to the forefront the issues surrounding PLHIV in this environment while aligning to the National Health Integration Agenda, Development Plan IV, National HIV Strategic Plan 2025–2030 and the Global AIDS Framework of the HIV response. It highlights coordination, digitalisation and documentation and community-led health access and social protection to make meaningful contribution towards a sustainable, community-led, inclusive National HIV response. While doing these, the plan also pays attention to the organisational capacity, the aspect of strengthening management and governance as well as her members at district and national levels.

### Performance management

NAFOPHANU will continue to invest in developing, supporting and sustaining its management, programming and financing capabilities for effective implementation of the scope outlined in this strategic plan and measurement plan for tracking strategic objectives versus progress.

### Monitoring and Evaluation

One of the greatest values of monitoring and evaluation of this strategic plan is the advantage of ensuring that the organisation is following the direction established during the strategic planning process. Pursuant to NAFOPHANU's core values of integrity and accountability for resources and

results entrusted to all stakeholders, the monitoring and evaluation of this strategic plan will use approaches that increase accountability, stakeholder participation and utilisation of data for decision making. Knowledge of what works and what does not work will be the basis of developing rational allocation of resources. The first step in effecting monitoring and evaluation of this strategic plan will be the development of an M&E framework, plans and tools which will guide systematic implementation. Monitoring and evaluation will be carried out in five ways namely;

1. **Monitoring by NAFOPHANU BOD** where the Executive Director will be expected to report on a quarterly basis to the full BOD about the status of implementation of the strategic plan, including progress towards each of the overall strategic goals.
2. **Monitoring by the Executive Director** where on a monthly basis reports will be expected from Programme Manager, Finance and Administration Manager regarding the status towards achieving the goals and objectives assigned to them.
3. **Monitoring teams based at the secretariat** will monitor implementation of the strategic plan in the field and district forums.
4. **Joint monitoring on an annual basis** by NAFOPHANU secretariat, BODs and NAFOPHANU partners.
5. **Evaluations by external teams** commissioned by NAFOPHANU and/or its partners at midterm and end of the strategic plan period.

The current M&E system of NAFOPHANU will be modified, upgraded and re-designed to monitor and evaluate implementation of the strategic plan to achieve key outcomes and results from the respective interventions. A functional M&E system will be established, and its functionality will depend on defined

- Institutional structures for NAFOPHANU M&E function
- Human resource capacity
- M&E partnerships
- M&E framework
- M&E costed work plans
- Advocacy and communication for M&E
- Surveys
- Routine programme monitoring
- Knowledge management databases
- Supervision and data auditing
- HIV/sexual reproductive health rights learning and research and;
- Data dissemination and information sharing

M&E partnerships will be essential for NAFOPHANU's M&E system to function, and these will be linked with district planning units, district health offices, MOH-HMIS departments, UNAIDS M&E, UAC M&E department and situation room, among others. Although NAFOPHANU will not fund the establishment and maintenance of these partnerships, it will participate in MOH and UAC M&E and other relevant technical working groups.

An M&E framework will be essential to guide operationalisation of NAFOPHANU's M&E system, and an M&E framework and plan will be developed with a set of outputs, outcomes and impact indicators as broadly defined in the implementation framework. Indicators will be in line with those applied by MOH, UAC and UDHS under Uganda Bureau of Statistics. Proposed key performance indicators include indicators directly related to HIV and AIDS prevention, treatment and mitigation, measures of systems strengthening, and measures of NAFOPHANU knowledge management. To the extent possible KPIs will be adopted from the NSP, United Nations General Assembly Special Session on HIV/AIDS (UNGASS) indicators, which Uganda as a country is already committed to collect and report upon. Indicators for NAFOPHANU knowledge management efforts will be adopted from national and global M&E frameworks for global health.

## Mitigating Risks

Risk monitoring and mitigation is an important function to ensure that NAFOPHANU delivers on its strategic objectives and achieves its anticipated impact in order to achieve its overall mission. Four broad risk categories are relevant to NAFOPHANU: strategic, operational, financial, and environmental. While strategic, operational, and financial risks are largely within NAFOPHANU's control, environmental risks are not.

## Assumptions and Enablers

| Key Assumption | Risk Level | Control measures in place |
|---|---|---|
| **Political Will:** Political remains sufficiently strong for NAFOPHANU to provide systematic and all-inclusive coordination structure for PLHIV networks, associations and support groups. | **Medium** | • Strengthen Political Will for increased financing for Health and HIV programmes |
| **Financing challenge:** Limited financing for HIV programming and new HIV prevention technologies such as: Dapivirine Ring, and Cabotegravir for AGYW) and populations who are most at risk of HIV infection i.e.; AGYW and VPKs. | **Medium** | • Advocate for increased domestic resource mobilisation/fund-raising from the regular donors,<br>• Advocacy for social contracting for CSOs<br>• Strengthen meaningful partnerships with Private-sector, social actors, media and Civil society groups. |
| **Lack of operational space** for staff and network members | **High** | • Establish a home/office for PLHIV and its network members<br>• Strengthen district planning allocation of resources for HIV awareness and prevention programmes to create demand for available services.<br>• Advocacy with MoH and district leadership for integration of HIV network organisations in district buildings / offices. |
| **Lack of critical human resources** to support the implementation of this strategic plan | **Medium** | • Efforts to mobilise additional finances to make critical strategic plan implementors available<br>• Continuous recruitment of volunteers and seconded staff to support the strategy implementation |
| **Organisational resilience** amidst disruptions of HIV and health financing for community-led organisations. This involves the | **Medium** | • Capacity to rapidly assess risks, challenges, and re-orient the organisation's strategic direction to identify what is working |
| **Stigma and discrimination** continue to affect the HIV response negatively, limiting access to information for prevention, adherence, early HIV testing, screening for tuberculosis and cervical cancer. | **Medium** | • Conduct another stigma and discrimination survey and continue addressing individual stigma. |

## NAFOPHANU Sustainability plan

The goal of NAFOPHANU's sustainability strategy is to improve the well-being of the PLHIV communities, improve NAFOPHANU's technical expertise, managerial and financial capacity for continuity with minimal dependence on external support. The strategic pillars include; Coordination, Digitalisation and Documentation, Community-led health access, Social Protection.

## Institutional sustainability

NAFOPHANU will focus on keeping within a well-articulated clear mission, developing strong innovative leadership, recruiting qualified staff and rewarding excellent performance, strengthening management systems at all levels, while remaining responsive to the changing PLHIV needs and environment.

## Programme sustainability

This will remain relevant to its clients by continuously understanding PLHIV needs and how to meet them, providing high quality services, implement knowledge management activities to support application of evidence-based management and offering HIV/FP/SRHR services and programmes effectively to the PLHIV.

# Appendix 5: Implementation plan Framework

The above strategic actions will be implemented over the 5 years as per table below. Monitoring processes are embedded within the implementation plan to enable easy tracking of outputs as implementation progresses.

## Five-Year Implementation Framework

| Strategies | Key outputs | Indicators | Means of Verification | Target | Responsible office | Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 1 | 2 | 3 | 4 | 5 |
| **Strategic Pillar 1: Coordination** | | | | | | | | | | |
| **Strategic Action 1.1: Enhance coordination of the constituency members and its partners for advocacy on access to HIV, SRHR, Mental health, GBV and non-communicable diseases among PLHIV communities.** | | | | | | | | | | |
| **1.1.1.** Work with national and district PLHIV network to approved annual workplans, quarterly reports, functional boards and audited accounts for the secretariate | • Functional PLHIV district networks<br>• Forum systems and structures strengthened | • # of district networks functional | • Approved annual workplans, quarterly reports,<br>• Functional boards and audited accounts for the secretariat | • 56 district networks | • ED and Programme Coordinator | | | | | |
| **1.1.2.** Carry out midterm evaluation | • Strategic plan evaluated to track progress and achievements | • # of reports | • Report | • 1 | • ED | | | | | |
| **1.1.3.** Mentor and coach district and national constituency members on registration process, budgeting, workplan development, resource mobilisation, leadership and management plus other governance related issues. | • Mentoring and coaching sessions held | • # of networks registered, with annual workplans, resource mobilisation plans and with staff to implement programmes | • Registration certificates,<br>• Annual workplans,<br>• Resource mobilisation plans,<br>• Operational plans in place | • 110 out of 136 | • ED and District Network coordinators | | | | | |
| **1.1.4.** Carry out BOD development sessions | • BOD development sessions | • # of BOD development sessions | • Report | • 5 | • ED and NAFOPHANU executive management team | | | | | |

| Strategies | Key outputs | Indicators | Means of Verification | Target | Responsible office | Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 1 | 2 | 3 | 4 | 5 |
| **1.1.5.** Conduct AGM | AGMs conducted | # of AGMS conducted | • AGM report | • 5 | ED and NAFOPHANU Executive Management team. | | | | | |
| **Strategic Action 1.2: Establishing workspace/ office for NAFOPHANU and its member Organisations.** | | | | | | | | | | |
| **1.2.1.** Advocate for financing NAFOPHANU Home of Champions | • Fully furnished office for NAFOPHANU | • Physical plan for NAFOPHANU Home for NAFOPHANU | • Physical building for NAFOPHAN<br>• Physical plan and bill of quantities U | • 1 | • ED and Board for NAFOPHANU | | | | | |
| **1.2.2.** Advocate with district leadership to proclaim NAFOPHANU structures constructed by donors in early 2000 for district PLHIV networks occupation. | • NAFOPHANU offices proclaimed for PLHIV occupation | • # of Districts Networks with functional offices | • Transfer agreements<br>• MoU's on possession of buildings | • 10 | • ED, Board members and NAFOPHANU District Coordinators | | | | | |
| **1.2.3.** Work with the district leadership (CAO, DHO, CBO and Mayors/Chairpersons) to secure working spaces for PLHIV networks at the district level | • Capacity of Networks and forums strengthened | • # of PLHIV networks hosted at the district/city head quarters | • District reports<br>• PLHIV Network reports<br>• Physical office at the district headquarters | • 20 | • District Network coordinators | | | | | |

| Strategies | Key outputs | Indicators | Means of Verification | Target | Responsible office | Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 1 | 2 | 3 | 4 | 5 |
| **Strategic Action 1.3 Mobilise additional financing for NAFOPHANU through the non-regular partners** | | | | | | | | | | |
| **1.3.2.** Partner with UAC, Ministry of Health, Gender, Local Government, Transport CSO's, Private Sector and the public to advocate for social contracting and resource allocation to PLHIV community-led organisations at the national and district level to give leadership on community-led HIV programming | • Social contracting agreements with NAFOPHANU and its Network members | • Resources generated out of social contracting of partners | • Social contracting agreements signed<br>• MoU' with partners to implement work on HIV | • 3million USD secured through social contracting partnerships with government sectors | • ED, Board members and project coordinators | | | | | |
| **1.3.3.** Organise community-led health and HIV symposiums to show case NAFOPHANU's work and mobilise resources from non-ordinary partners like Sweden, GIZ, UNFPA, UNICEF, Danish, Iceland, Canada, and Netherlands | • MoUs with private sector/CSOs to co-fund community-led initiatives | • # of symposiums held<br>• Increase Non-Global fund and government funding from less than 10% to 40%.<br>• PLHIV financing from the current 780,000- USD as of 2025 NAFOPHANU financial statement to 25 million USD by 2030 | • M&E report | • 15 | • ED and BOD | | | | | |
| **1.3.4.** Show case the work done by NAFOPHANU as a community-led constituency through conducting community field visits and financial symposiums with potential partners/ funders | • community field visits and financial symposiums held | • # of non-formal partners initiated | • Symposium meeting minutes,<br>• Reports | • 10 new partnerships | • Board members and NAFOPHANU Executive | | | | | |

| Strategies | Key outputs | Indicators | Means of Verification | Target | Responsible office | Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 1 | 2 | 3 | 4 | 5 |
| **Strategic Action 1:4: Advocate for increased health budgets and the National Health Insurance** | | | | | | | | | | |
| **1.4.1.** Advocate for increased National health budgets from 7% to 15% by 2030. | • Increased national health budget | • # of quality financial analyses and reports submitted | • Financial reports | • 3 | • CSO's, NAFOPHANU member organisations and programme implementing staff | | | | | |
| **1.4.2.** Work with UAC and MOH to develop social contracting guidelines | • Social contracting guidelines in place | • Social contracting put in practice | • NAFOPHANU and its partners benefiting from social contracting | • 1 | • NAFOPHANU Secretariat Executive Leadership and UAC and MoH | | | | | |
| **1.4.3.** | • National Dialogues conducted<br>• PLHIV represented in national policy and budget conferences<br>• National HIV financing conference conducted<br>• Health care insurance established<br>• Dialogues held with HIV and health parliamentary association | • Policy on health insurance<br>• implementation guidelines on health insurance | • Annual report<br>• Policy, Guidelines<br>• Laws on National health insurance<br>• Sensitisation lists for parliamentarians | • Law on health insurance | • NAFOPHANU secretariat and it's NAFOPHANU Networks, UAC and other CSO's partners | | | | | |
| **1.4.4.** Partner with CSO organisations like AGHA, CEHURD and CSBAG to accelerate advocacy for National Health Insurance | • Partnerships with like-minded CSO's established | • # of partnerships established with CSO's on accountability and budgeting | • Partnership memorandums signed<br>• Reports<br>• Meeting minutes report<br>• Joint publications in media | • 6 | • NAFOPHANU secretariate and it's Network members | | | | | |

| Strategies | Key outputs | Indicators | Means of Verification | Target | Responsible office | Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 1 | 2 | 3 | 4 | 5 |
| **1.4.5.** Work with the district leadership to utilise the 0.01% budgets on HIV mainstreaming for prevention, care and treatment programmes targeting communities | • Enhanced partnerships with the districts and NAFOPHANU network members at the district. | • #of NAFOPHANU network members with social contracting agreements with districts. | • Districts HIV<br>• Workplans<br>• Budgets inclusive of<br>• PLHIV networks in the districts<br>• meeting minutes | • 40 | • NAFOPHANU secretariat and it's Network members | | | | | |
| **1.4.6.** Accelerate advocacy through social media platforms, radios and televisions on the need to increase financing for the health care sector | • Increased dialogues on the need to amplify funding for HIV and health | • # of social media advocacy tags, tweets on need to increase HIV and health financing | • Social media tweets, | • 60 | NAFOPHANU secretariat and it's Network members | | | | | |
| **Strategic Objective 2:** To improve health outcomes by promoting people-centred and equitable access to healthcare for PLHIV and affected communities. | | | | | | | | | | |
| **Strategic Action 2.1: Reduce stigma and discrimination to advance rights and access to services.** | | | | | | | | | | |
| **2.1.1.** Work with partners to conduct the National Stigma Index on impact on Hlitsd it's comorbidities | • Stigma index report published | • # of PLHIV's participating in the survey | • Stigma survey report | • % experience of various forms of stigma | NAFOPHANU district Networks and its members | | | | | |
| **2.1.2.** Share expert knowledge combined with lived experience from people living with HIV and people from priority, vulnerable and key populations to inform and improve health-care service deliver | • Increased adherence on HIV treatment<br>• Reduced HIV infection<br>• Reduced mortality rates due to HIV | • # of PLHIV enrolling and adhering on treatment<br>• # of PLHIV disclosed their HIV status to loved ones for care | • Reports,<br>• Minutes from meetings | • 1.4 million kept and adhering to treatment | ED and NAFOPHANU Secretariat | | | | | |

| Strategies | Key outputs | Indicators | Means of Verification | Target | Responsible office | Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 1 | 2 | 3 | 4 | 5 |
| **2.1.3.** Accelerate treatment literacy sensitisation programmes, | • Increased number of PLHIV accessing HIV, TB, Mental health, non-communicable treatment | • #Number of PLHIV knowledgeable about their treatment regime | • Increased adherence on HIV, TB, mental health, non – communicable and malaria treatment | • At least 900,000 people on treatment know their regimes | ED and NAFOPHANU Secretariat | | | | | |
| **2.1.4.** Enhance know your rights advocacy campaign to reduce all forms of stigma and discrimination among PLHIVs, at the health care centres, schools, in prisons, workplaces and Judiciary | • reduced stigma and discrimination in health care setting, schools, workplaces and Judiciary<br>• Reduced arrests among the target communities living with HIV | % reduction in stigma and discrimination | • stigma index report | • Individual stigma reduced further by 10% | NAFOPHANU and network members | | | | | |
| **Strategic Action 2.2: Integrated HIV prevention, treatment, care and support services, embracing the principle of 'leaving no one behind'.** | | | | | | | | | | |
| **2.2.1.** Mobilise UAC, MoH and Ministry of local government to work with the PLHIV constituency and its network members to implement the Ministry of Health Integration framework. | • Issued paper on the integration of PLHIV communities in the national Integration framework.<br>• Increased efficiency in access to HIV and other health related services by PLHIV, | #Number of dialogues held with the Ministry of Health focal points won | • report<br>• Integration frameworks cognisant on the role of PLHIV. | % of PLHIV roles, duties and responsibility mainstreamed in sector international frame works | NAFOPHANU Executive, Board and network members | | | | | |

| Strategies | Key outputs | Indicators | Means of Verification | Target | Responsible office | Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 1 | 2 | 3 | 4 | 5 |
| **2.2.2.** Reinforce advocacy for inclusion of PLHIV in the Ministry of health community-based structures at the national and district level to deliver community-led HIV, SRHR, mental health, TB and Non communicable diseases services for increased quality access. | • Increased efficiency in access to HIV and other health related services by PLHIV,<br>• Resources secured to support PLHIV community-led implementation | # Number of programmes cognisant of the role of PLHIV's as part of the national community-based implementing structures | • reports<br>• MoH data base for community health care workers with PLHIV experts or peers | • 3 National Health, Gender and Local government frameworks cognisant of PLHIV | Executive members, Board and NAFOPHANU network member | | | | | |
| **2.2.3.** Work with peers and expert clients to Increase awareness on community and central pharmacy treatment distribution mechanisms. | • PLHIV's increasingly access ARVs' through pharmacies<br>• Increased demand for treatment refills and access to other related health care service by PLHIV communities | #Number of PLHIV accessing services through pharmacological model | • Reports,<br>• Minutes,<br>• Data tools for service access | • 24% of the PLHIV community accessing treatment through pharmacies. | Executive, Board and network member | | | | | |
| **2.2.4.** Strengthen the capacity of community-led responses to implement and report on HIV, TB, STIs and viral hepatitis | • Advocacy issues addressed from community-led<br>• Established dashboard with community-led health issues response, capacity | # of health and HIV issues raised out of community-led response | • Reports<br>• Advocacy issues<br>• Dashboard for community-led monitoring | • Joint dashboard for community related issues | Executive, Board and network member | | | | | |

| Strategies | Key outputs | Indicators | Means of Verification | Target | Responsible office | Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 1 | 2 | 3 | 4 | 5 |
| **Strategic Action 2.3: Strengthen provision of psychosocial support for mental – well-being and self-care for PLHIV communities.** | | | | | | | | | | |
| **2.3.1.** Provide psychosocial support for self-care and well-being of communities of young people, women PWDs ands and priority, vulnerable and key populations living with HIV | • increased access and retention to treatment<br>• Improved mental well – being for people living with HIV<br>• Decreased number of mental health cases among PLHIV | • # of PLHIV supported psychologically<br>• # accessing HIV and other health related treatment regime's with minimal fear | • Reports<br>• Health care registers | • % decline in mental health cases among PLHIV<br>• % access and retention to HIV treatment | NAFOPHANU Executive and | | | | | |
| **2.3.2.** Mental health sessions for women, youth, PWDs, and KP. | • Increased access to treatment and viral load suppression mainly among the AGYW<br>• Reduced Gender based violence | • # of PLHIV suppressing their viral load<br>• # of PLHIV utilising Salt Help line | • Reports | • 1 million | ED and NAFOPHANU members<br>SALT Helpline | | | | | |
| **Strategic Action 2.4: Establish a risk preparedness plan for PLHIV community to ensure continuity of HIV services during pandemics and emergencies.** | | | | | | | | | | |
| **2.4.1.** Enhance capacity of PLHIV networks and its constituency members on risk preparedness, reduction and mitigation against impact of disasters and pandemics for PLHIV communities, | • Risk preparedness plan established<br>• Increased number of PLHIV accessing services amidst pandemics out breaks | • # Number of PLHIV networks implementing work on disaster reduction and pandemics<br>• % of HIV network organisations implementing work on pandemics and disaster preparedness<br>• Reduced mortality rates | • Reports on Risk preparedness plans | • 55 Districts/ networks | NAFOPHANU and network members | | | | | |

| Strategies | Key outputs | Indicators | Means of Verification | Target | Responsible office | Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 1 | 2 | 3 | 4 | 5 |
| **2.4.2.** Join National dialogues and programmes on climate mitigation and response to reduce the impact on food security, human migration and | • Increased nutritional health quality,<br>• Reduced economic stress<br>• Reduced mental health<br>• Increased immunity | • #Number of PLHIV's integrating climate change in their work<br>• % of PLHIV adhering on treatment | • MoUs & Contracts signed on climate change | • 20 districts/ networks | NAFOPHANU Executive Director | | | | | |
| **Strategic Pillar 3: Social Protection** | | | | | | | | | | |
| **Strategic Objective 3 Reduce the incidence of mortality and improve the well-being of PLHIV** | | | | | | | | | | |
| **Strategic Action 3.1: To operationalise PLHIV SACCO to build and strengthen the capacity of PLHIV to use, save and invest available resources to mitigate vulnerability and access livelihood opportunities in all sectors.** | | | | | | | | | | |
| **3.1.1.** Identify & link networks to income generating opportunities. | • Networks identified & linked to IGA opportunities | • # of Networks linked<br>• #IGAs identified | • Reports<br>• IGA projects on ground | • 50 | PM<br>Partnerships & Networking Officer | | | | | |
| **3.1.2.** Support district networks to form branches for the national PLHIV SACCO. | • Branches of network PLHIV SACCOs established | • # of network PLHIV SACCOs | • Functional SACCO offices | • 10 | NAFOPHANU Secretariate and it's Network members | | | | | |
| **3.1.3.** Social Enterprise Projects | Number of social enterprise projects | Number of social enterprise projects established | • Reduced teenage pregnancies, Gender Based violence and<br>• Voices of PLHIV integrated in the national life skills, Health and Education Framework, Adolescent Health Policy, | • 50 trainings | Livelihood Officer | | | | | |

| Strategies | Key outputs | Indicators | Means of Verification | Target | Responsible office | Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 1 | 2 | 3 | 4 | 5 |
| **3.1.4.** Advocate and support integration of PLHIV among the beneficiaries of the Parish Development Model funds | By 2030, support ≥40 vulnerable PLHIV to access Parish model resources | • # of PLHIV with registered with the Parish model schemes | • Reports<br>• Economic skills gained<br>• Economic empowerment projects initiated | • ≥40 vulunerable PLHIV to access Parish model resources | PM | | | | | |
| **3.1.5.** Entrepreneurship skills building for PLHIV | PLHIV equipped with entrepreneurship skills | • # of trainings<br>• #of PLHIV training<br>• #Entrepreneurship schemes established | • Reports<br>• Lists of trained members | • 75 | NAFOPHANU Executive and Member Organisations Officer | | | | | |
| **Strategic Action 3.2: Engaging in high level advocacy for keeping adolescent and young people Living with HIV in schools** | | | | | | | | | | |
| **3.2.1.** Create awareness sessions with school's stakeholders to address education related stigma and discrimination in schools | National HIV disclosure guidelines developed and disseminated | • # of stigma reduction sessions conducted in schools<br>• % of reduced stigma and discrimination among PLHIV in schools<br>• National HIV disclosure guidelines on place | • Stigma survey in schools<br>• Reports | • 2500 schools in districts with low rates of adherence | NAFOPHANU executive and it's member Organisations. UAC, UNESCO | | | | | |
| **3.2.2.** Work with the Ministry of Education and Health to contribute to the development of develop policies that guide adolescents and young people in and out of school to access HIV and related SRHR, SGBV information and services | Guidelines and policies developed by and Ministry of Education with sensitivity towards PLHIV | • # Number of policies or guidelines mentioning NAFOPHANU member or Organisations' contribution | • reports<br>• Meeting minutes | • 2 | NAFOPHANU Executive and Board members | | | | | |
| **3.2.3.** Promote WASH services among PLHIV | WASH programmes promoted among PLHIV | • # Number of persons reached | • Reports<br>• Availability of social enterprise projects | • 100000 | NAFOPHANU Executive and it's network members | | | | | |

| Strategies | Key outputs | Indicators | Means of Verification | Target | Responsible office | Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 1 | 2 | 3 | 4 | 5 |
| **Scale up partnerships with Private sector companies like Movit, Jesa, Mukwano, MTN, RIHAM, Hotels, Airtel for enhanced social marketing approach for PLHIV** | | | | | | | | | | |
| **3.3.1.** Enhance partnerships with private sector companies by increasing products attractions through NAFOPHANU network members and their social media platforms. | • 12 partnerships enhanced with Private sector companies to improve the well-being of PLHIV | • # of partnerships established with private sector companies<br>• # of products marketed through social marketing by PLHIV | • MoUs signed with private sector companies | • 12 | NAFOPHANU secretariate and it's network members | | | | | |
| Enhancing AGYW and ABYW leadership and mentorship programmes | • Work with young people led organisations to implement programmes and projects that enhance leadership and management roles for the AGYW | • # of AGYW and ABYW occupying leadership spaces | • Reports<br>• ABYW and AGYW testimonies about NAFOPHANU's support | • 350 | • NAFOPHANU secretariat and it's network members | | | | | |
| **3.3.3.** Provide nutritional education to PLHIV households | Nutritional education to PLHIV households provided | • # of educational sessions<br>• # of People reached | • Training report | • 250 | • Executive Leadership of NAFOPHANU and its network members | | | | | |
| Institute a PLHIV training/ fellowship and consultancy academy | • annual mentorship programme Conducted<br>• PLHIV consultancies conducted | • Number of PLHIV leaders, mentored and graduated<br>• Number of Partners host PLHIV mentees<br>• Number of partners procured consultancy services from NAFOPHANU | • Reports<br>• Contracts and MOU with partners<br>• Testimomies | • 75 | • ED and Programme Manager | | | | | |

| Strategies | Key outputs | Indicators | Means of Verification | Target | Responsible office | Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 1 | 2 | 3 | 4 | 5 |
| Set up a wellness and human ness centre | • Wellness centre established<br>• Conduct annual wellness and retreats for Staff and Bord members<br>• Conduct hybrid, and safe space, counselling and support for PLHIV leaders and champions | • Sustained PLHIV leadership health and movement building<br>• PLHIV leaders confidence to lead, support peers and networks and live strengthened | • reports | • 25 | • ED and Board Executive | | | | | |
| **Strategic Action4: Digitalisation and Documentation** | | | | | | | | | | |
| **Strategic Objective 4: Leverage on technology to enhance coordination of the constituency, research for real time information on stock outs, access to HIV, SRHR, Mental health, GBV services among PLHIV communities** | | | | | | | | | | |
| **Strategic Action 4.1: Use NAFOPHANU virtual platforms for coordination engagements, dissemination of information, trainings and policy advocacy.** | | | | | | | | | | |
| **4.1.1.** Engage communities in research to better understand benefits of digital technologies. | Improved access to care and health information as well as the gaps and risks such as privacy, exclusion and misinformation. | # of reports, studies and surveys published | • M&E reports<br>• Survey reports | • 10 | • NAFOPHANU Secretariate | | | | | |
| **4.1.2.** Empower communities of people living with HIV through digital literacy and strengthen collective ability to engage with and advocate for safe, effective and | • Accountability forums attended<br>• Advocacy agenda advanced | • # of accountability forums attended.<br>• # Advocacy agendas advanced | • Activity Reports | • TBD | • NAFOPHANU Secretariat and it's network members | | | | | |
| **4.1.3.** Participation in HIV advocacy days. | • Participate in advocacy days | • # of advocacy days attended<br>• # of persons that participate in the advocacy days | • Activity reports<br>• Event statement | • 4 | • NAFOPHANU Secretariate and its Network members | | | | | |

| Strategies | Key outputs | Indicators | Means of Verification | Target | Responsible office | Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 1 | 2 | 3 | 4 | 5 |
| **4.1.4** Media Engagement | • Media houses engaged | # of adverts, print media publishing about PLHIV | • Reports, publications, | • 12 media houses<br>• 10 social media platforms<br>• 120 adverts & publications | • NAFOPHANU Executive, board members and network members | | | | | |
| **4.1.5** Co-convene National Health financing Conference | • Health financing conferences and other budget conferences convened | • # of budget priorities generated and position papers shared with duty bearers | • Position papers, reports, publications | • 5 position papers<br>• Annual engagements with parliaments, MoH, MOFPED and Development partner | • Ed, Advocacy Manager | | | | | |
| **Strategic Action 4.2: Strengthen PLHIV strategic information management systems for monitoring, reporting and decision making.** | | | | | | | | | | |
| **4.1.** Capacity building for strategic management | • Improved capacity in strategic management | • # of network s<br>• # of secretariat staff<br>• # of capacity building sessions | • Capacity building reports | • 30 | • NAFOPHANU Executive and network members | | | | | |
| **4.2.** Enhancing information & communication infrastructure. | • Required ICT infrastructure acquired | • # of ICT infrastructure<br>• Proportion of staff utilizing ICT infrastructure | • Training ICT reports<br>• Data base system | • ICT Database | • ICT staff<br>• NAFOPHANU Executive team | | | | | |

| Strategies | Key outputs | Indicators | Means of Verification | Target | Responsible office | Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | 1 | 2 | 3 | 4 | 5 |
| **4.3.** Promoting knowledge generation | • Increased research & knowledge generation | • # of networks conducting research<br>• # of networks with an information and management system | • Research reports<br>• Functional information and management systems | • 15 studies, surveys, assessment, & knowledge products | • NAFOPHANU Executive team and its network members | | | | | |



## Appendix 6: Proposed Organisation Structure

The organisation structure proposed below is aimed at addressing the current leadership and management challenges that NAFOPHANU is faced with, and at the same time strive to sustain the gains but also remain on the right path to attain the 2030 health targets amidst decreasing financing for HIV to advance quality health care. This strategic plan is aligned with NAFOPHANU's systematic and all-inclusive coordination structure for PLHIV networks, associations and other CSOs groups in order to play advocacy, policy and decision-making roles in the HIV and AIDS and Health partnership.

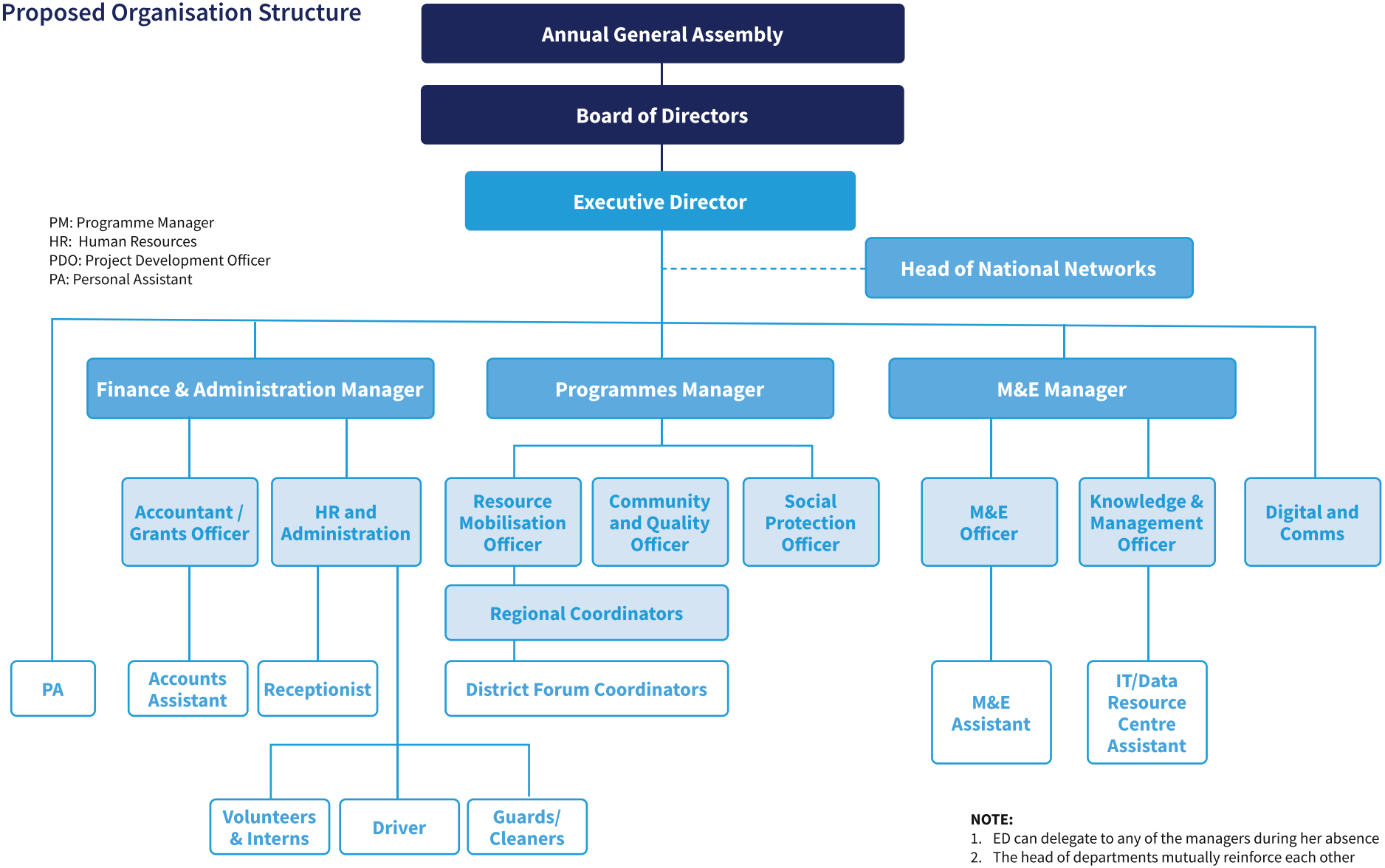
The structure proposes three departments: Finance & Administration; Programme Coordination; and Quality Assurance and management, each headed by a manager. Finance and Administration will be responsible for managing the financial, administrative and human resource function of NAFOPHANU. Programme Coordinator will be responsible for programme design, resource mobilisation and implementation and will constitute sections for advocacy, networking & partnerships, livelihood as well as programme development (resource mobilisation). Quality assurance will be responsible for ensuring programme quality (in both design and implementation) and will provide management, the board and key stakeholders with information for decision-making through its knowledge management functions: mapping, gathering, and filtering information; developing new knowledge; converting personal knowledge into shared knowledge resources; understanding and learning; adding value to information to create knowledge; enabling action through knowledge (performance and management); processing shared knowledge resources; delivering (transferring) explicit knowledge; and building adequate technical infrastructures. The quality assurance department will constitute M&E as well as research and knowledge management.

The proposed structure also seeks to strengthen the Executive Director (ED)'s office to allow it focus on strategic aspects of the organisation including public relations and partnerships. To this end, 3 new positions of Community, Membership and Quality Assurance Officer, Digital and Communication, Social Protection and Resource Mobilisation.

This structure is aimed at improving NAFOPHANU's management efficiency and effectiveness through promotion of separation of duties, pro-activeness, focus on the core business through evidence-based programming, as well as providing for adequate support functions.

The above functions are summarised below.

## Proposed Organisation Structure




PM: Programme Manager
HR: Human Resources
PDO: Project Development Officer
PA: Personal Assistant

**NOTE:**
1. ED can delegate to any of the managers during her absence
2. The head of departments mutually reinforce each other

# Appendix 7: Results Framework

| Output | Key Process Indicators | Baseline | Targets | Means of Verification | Key implementors |
|---|---|---|---|---|---|
| Enhance coordination of the constituency members and its partners for real time information and advocacy on access to HIV, SRHR, Mental health, GBV and non-communicable diseases among PLHIV communities | • # of district networks with registration certificates at the district level<br>• # of constituency members with physical offices<br>• # Quarterly BOD meetings conducted<br>• AGM held<br>• # of NAFOPHANU members with enhanced capacities in resource mobilisation, advocacy and governance<br>• #Functional networks offices established<br>• # of functional PLHIV systems and structures | 42 | 111 | • NAFOPHANU's physical office<br>• Physical existence in the districts<br>• Registration certificates<br>• Staff registers<br>• Approved and costed workplans<br>• BOD meetings report<br>• Lists of trained network members<br>• Approved AGM reports<br>• Signed annual reports | NAFOPHANU Secretariat and district networks |
| Mobilise close to 25 million USD to support the operationalisation of NAFOPHANU strategic plan by 2030 | • # resources secured from Global fund and other development partners<br>• # funds secured from social contracting partnerships with government sectors,<br>• # MoUs signed with private sector/CSOs to co-fund community-led initiatives.<br>• # financial management, accountability and reporting templates in place | 13 million USD | • 25 million USD<br>• 7 private sector partnerships enhanced | • Annual workplans<br>• AGM reports<br>• Registration certificates,<br>• Annual workplans,<br>• Resource mobilisation plans,<br>• Operational plans in place | NAFOPHANU Secretariat and district networks, other CSO members |
| Social contracting agreements with NAFOPHANU and its Network members | • % of resources generated out of social contracting of partners | 0 | 3 million USD | • Social contracting agreements signed<br>• MoU' with partners to implement work on HIV | UAC, Ministry of Health, Gender, Local Government, Transport CSOs, Private Sector |

| Output | Key Process Indicators | Baseline | Targets | Means of Verification | Key implementors |
|---|---|---|---|---|---|
| Advocate for increased health budgets and the National Health Insurance | • # % Increased of the National Health budget from 7% - 15%.<br>• -National Health Insurance established<br>• - % Increase in government budget for HIV commodities<br>• # Number of dialogues held on radio and television stations on Health insurance<br>• # Number of social media posts done on increased budgets for Health and the Insurance | 8%<br><br><br><br>0 | 15%<br><br><br><br>1 | • National Health insurance policy<br>• Utilisation of the district 0.01% mainstreaming budgets with PLHIV networks<br>• National health budget with 15% share | NAFOPHANU and its Network members, U, CSBURG, AGHA, Ministry of Health, UAC |
| | • # of sub county networks established<br>• # of district forums established and strengthened<br>• # of workplans and operational plans in existence | | 35 | • Registration certificates,<br>• Annual workplans,<br>• Operational plans in place<br>• Financial reports submitted | NAFOPHANU district networks and its member Organisations |
| Strong systems for financial management, accountability and reporting at the Secretariat put in place | • # of quality financial reports submitted | 1 | TBD | Financial report | NAFOPHANU Secretariat and district networks |
| Mechanisms in place to ensure proper functioning of NAFOPHANU BOD | • # BOD meetings held | 13 | 20 | BOD report | NAFOPHANU district networks and its member Organisations |
| Committed work force attracted and retained | • # of staff retained | 6 | 27 | Annual report | NAFOPHANU district networks and its member Organisations |
| Institutional home for NAFOPHANU completed | • Home constructed | 0 | 1 | Annual report | NAFOPHANU district networks and its member Organisations |
| Secretariat and networks undergo OACA | • # of OACA assessments done | 0 | 5 times | OACA report | NAFOPHANU district networks and its member Organisations |
| Inventory of donors & funding timelines developed | # of donors mapped<br># of RFAs responded to | 0 | 1 | • Availability of a database<br>• Copies of proposals and grants submitted | NAFOPHANU district networks and its member Organisations |

| Output | Key Process Indicators | Baseline | Targets | Means of Verification | Key implementors |
|---|---|---|---|---|---|
| Concepts, EOIs & proposals in response to RFAs Submitted | • # concepts, EOLs and proposals submitted<br>• # proposals won | 15 | 30 | • # of Copies of submitted proposals<br>• # of Projects running | NAFOPHANU district networks and its member Organisations |
| TA provided to member networks to enhance fundraising capacities | • # of network members trained in fundraising<br>• # of proposals developed<br>• # of grants won | 21 | 70 | • Resource mobilisation strategy by the networks | NAFOPHANU district networks and its member Organisations |
| PLHIV rolled out with increased membership of PLHIV SACCO. | • # of SACCO members subscribed<br>• % increase of the savings among PLHIV | 0 | 150 | • Financial reports<br>• Member list | NAFOPHANU district networks and its member Organisations |
| Strategic Partners identified and engaged | • # of structures signing MoUs with strategic partners<br>• # of structures working with strategic partners<br>• # of meetings held with Partners<br>• # of presentations made to donors<br>• # of donor forums held | 25 | 125 | • District forum reports<br>• National network reports<br>• M&E reports | NAFOPHANU district networks and it's member Organisations |
| PLHIV involved in Livelihood and IGAs | • # of people who benefited from livelihood programmes | 140 | 30000 | • M&E reports | NAFOPHANU district networks and its member Organisations |
| Improved nutritional practices and food security among PLHIV | • # of sessions on good nutritional practices conducted<br>• # of PLHIV trained in good nutritional practices<br>• # of grants on nutrition | 400 | 10,000 | • Training reports<br>• Financial reports<br>• Lists of members trained | NAFOPHANU district networks and its member Organisations |
| PLHIV equipped with entrepreneurship skills | • # of trainings<br>• # of PLHIV training<br>• # of Entrepreneurship schemes established | 140 | 30000 | • Reports<br>• Lists of trained members | NAFOPHANU district networks and its member Organisations |
| Branches of PLHIV network SACCOs established | • # of active PLHIV SACCO branches | 0 | 10 | • Functional SACCO offices and report | NAFOPHANU district networks and its member Organisations |
| Establish social enterprise projects | • # of social enterprise projects implemented | 20 | 60 | • Progress report | NAFOPHANU district networks and its member Organisations |

| Output | Key Process Indicators | Baseline | Targets | Means of Verification | Key implementors |
|---|---|---|---|---|---|
| Increased enrolment of adolescent and young PLHIV in schools | • # of person who are accessing and retained in school | 0 | TBD | • M&E report | NAFOPHANU district networks and its member Organisations |
| Social protection services including access to PDM schemes, SEG, nutritional and education packages provided to PLHIV households | • # of educational sessions<br>• # of People reached | 24000 | 10,000 | • Training reports<br>• PDM beneficiary reports | NAFOPHANU district networks and its member Organisations |
| Treatment Literacy programmes accelerated during pandemics and humanitarian crises | • # of people reached with treatment literacy | 93 | 240 | • M&E reports<br>• Treatment literacy manuals | NAFOPHANU district networks and its member Organisations |
| Expert groups and task forces to coordinate knowledge management established | • # of expert groups established | 0 | 5 | • Meeting reports, volumes of work done | NAFOPHANU district networks and its member Organisations |
| Media platforms utilised and visibility enhanced | • # of media engagements<br>• # of reports & IEC materials uploaded<br>• # of visitors on the website<br>• # of bloggers engaged<br>• # of tweets done on X and LinkedIn<br>• # of TikTok videos posted | 121 | 438 | • Report<br>• Functional website<br>• Videos posted<br>• Hit rate report<br>• Tweets posts and likes | NAFOPHANU district networks and its member Organisations |
| PLHIV consultancy firm established | • Consultancy arm established | 0 | 1 | • Meeting reports<br>• Consultants engaged | NAFOPHANU district networks and its member Organisations |
| NAFOPHANU website revitalised and up to date | • Operational website | 1 | 1 | • Functional website | NAFOPHANU district networks and its member Organisations |
| PLHIV Wellness centre established | • # of PLHIV accessing Psychosocial services<br>• # of PLHIV and families accessing the centre | 1 | 2 | • Salt Reports<br>• Psychosocial reports | NAFOPHANU and SALT |
| Private sector companies engaged and in partnership with NAFOPHANU | • # of agreements<br>• # of MoUs | 4 | 38 | • Research report<br>• MoUs<br>• Agreements | NAFOPHANU district networks and its member Organisations |

# Appendix 8: Projected Budget for Implementation

The total estimated cost of implementing the NAFOPHANU five-year plan is projected at USD 25 million. This reflects the prioritisation of high-burden populations and geographies, streamlined service delivery models, and cross-sectoral investments in community-led systems, coordination of NAFOPHANU network and its members, social protection and pandemics response, digitalisation and documentation.

To implement this strategic plan, resources are required to finance strategic actions and their attendant tasks. The projected implementation budget provides a projection of costs required to implement the strategic plan. Specific financial commitments for individual activities shall be reviewed and determined on an annual basis based on available resources, and subject to Board of Directors review and approval. The projected budget areas include programme costs, staffing costs and procurements for goods and services. In the computation of costs, salaries for staff and all other costs are expected to rise by 10% each year to cater for costs of living and inflation.

Like other countries in the region, Uganda is faced with a pressing need to end its 40-year HIV epidemic as a public health problem during the remaining four years to 2030 and sustain the gains for the long-term. Despite achieving 1.4 million people living with HIV being on HIV treatment by the end 2030. there are 138,000 new HIV infections in 2024 and with close to a half million HIV-positive individuals not yet on HIV treatment. The treatment gaps remain especially among children, adolescent girls and young women, men, and key and priority populations.

Achieving the 95% population level viral load suppression, 10-10-10, 30-60-80% targets on laws, gender-based violence prevention, reduction of stigma and discrimination plus the community-led service provision targets to meet national targets is contingent on a focused and accelerated response to bridge gaps in specific populations in the short-term, while re-envisioning approaches and strategies towards a longer-term sustainable response, including national-led service delivery integrated into primary care. If Uganda is to meet its 2030 targets increased investments in HIV is required, it's estimated that between 2021-2025 4 billion USDs were required to implement the HIV programme yet only 2.8 billion USD was secured placing the country in a precarious situation.

## Cost Summaries per Strategic Objective

| Strategic objectives | | Projected Budget over the Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|
| | | Year 1 (Ush '000') | Year 2 (Ush '000') | Year 3 (Ush '000') | Year 4 (Ush '000') | Year 5 (Ush '000') |
| **Pillar 1: Coordination** | | | | | | |
| **1.1** | Strengthen coordination of PLHIV constituency members and partners to enhance advocacy for access to HIV, SRHR, mental health, GBV, and NCD services. | 550,000 | 390,000 | 380,000 | 350,000 | 350,000 |
| **1.2** | Strengthen institutional infrastructure to support coordination and service delivery for NAFOPHANU and its member organisations | 350,000 | 395,000 | 370,000 | 290,000 | 290,000 |
| **1.3** | Increased sustainability financing for NAFOPHANU and its constituency members | 430,000 | 351,000 | 246,000 | 242,000 | 189,000 |
| **1.4** | Strengthen advocacy for increased domestic health financing and establishment of the National Insurance Scheme | 326,000 | 280,000 | 290,000 | 260,000 | 240,000 |
| *Pillar 1 Subtotal* | | | | | | |
| **Pillar 2: Community-led Health Care Access** | | | | | | |
| **2.1** | Reduced stigma and discrimination to address human rights and equitable access to HIV and related health services | 420,000 | 420,000 | 420,000 | 420,000 | 420,000 |
| **2.2** | Integrating community-led response in HIV prevention, treatment, care and support services, embracing the principle of 'leaving no one behind. | 248,000 | 190,000 | 190,000 | 279,000 | 172,000 |
| **2.3** | Strengthen provision of psychosocial support and mental health services for PLHIV communities. | 299,000 | 273,000 | 280,000 | 269,000 | 270,000 |
| **2.4** | Strengthen risk preparedness and continuity of HIV services during public health emergencies, pandemic and humanitarian services. | 390,000 | 480,000 | 380,000 | 280,000 | 270,000 |
| **2.5** | Promote accountability and responsiveness for availability of quality essential medicines and commodities for PLHIV and communities of people living with TB, malaria, cervical cancer and hepatitis through community-led monitoring | 388,000 | 360,000 | 351,000 | 341,000 | 291,000 |
| *Pillar 2 Subtotal* | | | | | | |

| Strategic objectives | | Projected Budget over the Implementation Period (Years) | | | | |
|---|---|---|---|---|---|---|
| | | Year 1 (Ush '000') | Year 2 (Ush '000') | Year 3 (Ush '000') | Year 4 (Ush '000') | Year 5 (Ush '000') |
| **Pillar 3: Social Protection** | | | | | | |
| **3.1** | Operationalise and scale up PLHIV SACCO to improve economic resilience and social wellbeing of PLHIV | 530,000 | 470,400 | 430,000 | 430,000 | 321,000 |
| **3.2** | Advocate for inclusion of PLHIV among the beneficiaries of the Parish Development Model funds and other government economic empowerment programmes | 190,000 | 152,000 | 150,000 | 150,000 | 130,000 |
| **3.3** | To mobilise sustainable domestic resources to support social protection programmes for PLHIV | 180,000 | 160,000 | 160,000 | 150,000 | 150,000 |
| **3.4** | Strengthen leadership, mentorship and economic empowerment of adolescent girls, young women and young people living with HIV | 372,000 | 361,000 | 356,000 | 356,000 | 356,100 |
| **3.5** | Establish a PLHIV leadership, training and consultancy academy | 395,000 | 270,000 | 170,000 | 162,000 | 162,000 |
| **3.6** | Advocate for education, retention and protection of adolescent and young people living with HIV | 247,000 | 235,000 | 135,000 | 135,000 | 135,000 |
| **??** | Establish a PLHIV Wellness and leadership support centre. | 296,000 | 196,000 | 160,000 | 140,000 | 138,000 |
| *Pillar 3 Subtotal* | | | | | | |
| **Pillar 4: Digitalisation and Documentation** | | | | | | |
| **4.1** | Leverage on digital technology to strengthen coordination, communication and Advocacy across PLHIV networks. | 250,000 | 350,000 | 240,000 | 238,000 | 231,000 |
| **4:2** | Strengthen community-led monitoring and reporting systems using digital tools | 380,000 | 380,000 | 350,000 | 350,000 | 170,000 |
| **4.3** | Strengthen media engagement and digital advocacy to promote HIV integrated services | 242,000 | 242,000 | 211,000 | 211,000 | 160,000 |
| **4.4** | Strengthen documentation and knowledge management to support evidence-based programming and advocacy | 280,000 | 250,000 | 182,000 | 166,000 | 190,000 |
| **4.6** | Honour county, national, regional and global reporting obligations for PLHIV | 187,000 | 149,000 | 151,000 | 229,000 | 127,000 |
| **4.7** | Establish expert groups and task forces to coordinate knowledge management, validate and rapidly translate strategic information to practice. | 227,000 | 219,000 | 219,000 | 191,000 | 171,000 |
| *Pillar 4 Subtotal* | | | | | | |
| **Total projected implementation costs** | | | | | | |



*Photo moment for the new NAFOPHANU board of Directors together with the patron*



***Proposed NAFOPHANU Home Of Champions***

NAFOPHANU

2025/26-2030/31

# NAFOPHANU Strategic Plan



Bridge gaps through reconnecting the chain of community-led systems and sharing lived experiences for a Sustainable HIV and Health Response by 2030