HARM REDUCTION INTERNATIONAL

UHRN

Rapid Assessment of Harm Reduction Funding and Investment in Uganda

Final Report

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With Support from HARM REDUCTION INTERNATIONAL

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I am hopeful the findings in this report will go a long way in providing evidence that will enable partners on harm reduction programs to advocate for improved funding and investment in the programmes.

Wamala Twaibu
EXECUTIVE DIRECTOR

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
CSOs	Civil society organizations
DiCs	Drop-in centers
HRI	Harm Reduction International
UHRN	Uganda Harm Reduction Network
KIs	Key informants
MoH	Ministry of Health
NSP	National HIV and AIDS Strategic Plan
NSP	Needle and syringe programmes
PWUID	People who use and inject drugs
OST	Opioid substitution therapy
UAC	Uganda AIDS Commission

Executive Summary

This report presents the results of a rapid assessment on harm reduction funding and investment in Uganda. This assessment was conducted by the Uganda Harm Reduction Network (UHRN) with support from Harm Reduction International (HRI). The purpose of this assessment was to establish the harm reduction funding and investment in Uganda for the period 2017-2019 as well as COVID-19 related changes in 2020.

The rapid assessment was extensive involving consultations with key stakeholders including communities of people who use drugs, civil society, public sector, and donors involved in the implementation of harm reduction focused programs.

Key Findings

The total investment in harm reduction was funded primarily by international partners and implemented by local partners. There was no domestic funding. In 2019, 370,237, USD244,464, USD in 2018 and 201,317USD in 2017 was spent. The results show that this has increased over time and largely supporting advocacy interventions for harm reduction, which resulted in people who use drugs prioritised in the National HIV Strategic Plan, although no specific national Strategic Plan on Harm Reduction exists.
Other services supported by the available funding across the country include HIV prevention, treatment and care for people who use drugs. Services for people who inject drugs such as NSP and Medically Assisted Treatment (MAT) were limited in scope and covered only two districts of Kampala and Wakiso. There are no harm reduction initiatives available within prisons in Uganda and the government does not recognize harm reduction services in prisons as drug use is a criminal matter and not a health issue.

The results further show that not only harm reduction interventions are donor dependant, the overall HIV and AIDS interventions in Uganda are also funded by donors.

Results show that the National HIV and AIDS Strategic Plan remains the main source of information regarding the Ugandan government's support of harm reduction interventions. However, the plan doesn't highlight specific financing estimates towards harm reduction and specifically for particular groups other than broader programmatic statements.

The assessment also showed that there are no other studies on harm reduction financing such as harm reduction resource needs and funding gaps, or 'out of pocket' expenses of people who use drugs.

Study results also show that COVID-19 had a significant impact on access to health services by people who use drugs. Lockdown and police enforcement of standard operating procedures, shut down of public transport affected access to services, people who use drugs could not travel to facilities like drop-in centers to access NSP, HIV, STIs treatment, overdose management and other services.

When public transport services resumed, costs were high and therefore unaffordable to many. The earlier gains in behavior change communication were compromised as a result of reduced interventions. Community psychosocial support meetings were reduced however, the rate of psychological distress among people who use or inject drugs surged.

There were disruptions to sexual reproductive health and HIV prevention services due to restriction on movements not only to people who use drugs but also to the general population and this led to client drop-out of treatment. This disruption resulted in relapse among people who use drugs and were on treatment. Moreover, government priority was given to COVID -19 interventions.

Harm reduction interventions which are mainly implemented by civil society and community-based organizations, through drop-in centers and outreach suffered stock-outs of commodities like condoms, self-testing kits and family planning methods among others.

Assessment results also show that there were human rights violations during the lockdown. There were increased illegal arrests of most people who use drugs, and most ghettos were raided by police in a bid to implement and enforce COVID-19 restrictions.

The delayed hearing of on-going court cases for people who use drugs who were being held in prisons/confinement, created a backlog of uncompleted cases resulting in people staying longer in detention centers.

Results also show that COVID-19 had an impact on expenditure patterns. For instance, due to restrictions on the use of public transport, fees tripled. This affected accessibility to health facilities and drop-in centres for both clients and staff. This assessment, however, could not establish how much expenditure was incurred.

As a mitigation measure the assessment established that partners at both community and national level put in place mechanisms to address the challenges. These included at the community level, bicycles were provided so that peers could provide home-based services to the community of people who use drugs. In addition, a mobile crisis response team to respond to human rights violations of people who use drugs, and their health needs was constituted.

To ensure continuous provision of services to people who use drugs, all service providers adopted the new normal working modalities. For instance, virtual meetings and engagements, e-counselling, home delivery of services and targeted HIV Testing Services service delivery models were adopted.

Additionally, community follow-ups for people who use drugs who are HIV positive and their partners and community reach-out programs for refills were established to ensure continuity of service delivery for ART, PrEP and family planning services.

Conclusion:

Results indicate that from 2017-2019, there has been a significant increase in access to harm reduction services with support from various international partners with limited domestic support. There has been an improvement in targeted HIV case finding among people who use drugs which created some improvement regarding retention in care. However, the COVID-19 outbreak and associated shutdown has caused a grave retrogression regarding access to services such as ART, NSP, and other HIV prevention services.

From the assessment the following recommendations are suggested:

a. The government of Uganda should embrace harm reduction as the over-arching strategy to respond to drug-injecting related risks and harms. This calls for enabling legal and policy provisions as well as financial allocations that support the provision of comprehensive harm reduction services including services such as MAT and NSP programs.

b. Conduct policy and legal review to remove criminalisation of drug use

c. Conduct advocacy and lobby for approval of national mental health policy

d. Establishing evidence/data on people who use drugs to inform prioritization and advocacy for harm reduction interventions. Such data include national drug use prevalence which is lacking.

e. Undertake an assessment to estimate 'out of pocket' expenses for people who use drugs in Uganda.

f. Scaling up advocacy and coordination among the civil society orgnizations and engagement with public sector and international partners to support harm reduction services. This can be done through the establishment of a network of harm reduction champions among drug users, civil society leaders and development partners.

g. Conduct orientation of policymakers, law enforcers and the general public about the need to establish harm reduction interventions

h. Establish formal working and coordination mechanisms between government and non-public sector including private sector partners involved in rehabilitation as well as NGOs/CSOs currently supporting harm reduction. This will provide an opportunity for advocacy for harm reduction but also address the gaps in awareness.

i. Expand the scope of harm reduction interventions to include alternative services such as income generation that would enable people who use drugs have a source of livelihood.

j. Partners led by UHRN should conduct situational analysis to understand the needs and issues of people who use drugs in the context of COVID-19. This will facilitate the development of post-COVID-19 plans with defined priority issues/areas to be addressed and relevant strategy to address them based on evidence.

k. Develop a business continuity strategy for harm reduction implementing partners to enable them to find alternative funding sources to reduce donor dependency including advocating for domestic funding.

l. Develop a business continuity strategy to facilitate mitigation of challenges caused pandemic such as COVID-19.

SECTION ONE:

INTRODUCTION

This report presents the results of a rapid assessment on harm reduction funding and investment in Uganda. This assessment was conducted by Harm Reduction Network (UHRN) with support from Harm Reduction International.

1.0 Background:

UHRN, with support from Harm Reduction International, conducted a rapid assessment on harm reduction funding and investment in Uganda. The assessment focused on expenditure on priority harm reduction interventions including opioid agonist therapy (OAT), needle and syringe programmes (NSP) and antiretroviral therapy (ART) and provides contextual information on the sustainability of harm reduction financing in Uganda. For the period 2017-2019, the assessment considered investment for harm reduction. This assessment aimed at creating a platform to advocate for harm reduction funding in Uganda. The assessment further included the impact and current situational context of harm reduction funding and investment because of COVID-19 and also captured the changes that occurred in 2020.

It also serves to add to the evidence base on the situation before COVID-19 as well as assessing its impact and the response within Uganda. Through the country-level partners, harm reduction service providers and representatives of networks of people who use drugs were contacted to share their experiences.

COVID-19 presents a significant impediment to harm reduction outreach, service provision, linkages to broader health systems, and the funding mechanisms for these services. Harm reduction services must continue to operate amidst the pandemic and its associated challenges in the context of a future recession. The funding gaps and service closures result in increased HIV and hepatitis C infections and other blood bone viruses among people who use the drug, therefore, harm reduction funding must continue and be flexible enough to allow services to adapt so that service provision is sustainable. Interruptions also decrease the cost-effectiveness of services, so there is a strong economic argument for consistent investment.

An evidence-based understanding of how the COVID-19 pandemic has affected harm reduction funding and what actions civil society, communities, donors, and governments have taken to mitigate and protect against disruptions will guide future programming and policy decisions. This information is also necessary to inform advocacy for sustainable harm reduction financing at the national level and provide donors and governments with recommendations for protective action throughout the pandemic and post COVID-19 period.Harm reduction programmes in many low- and middle-income countries are overly reliant on international donors for sources of funding. To ensure the sustainability of services, there is an urgent need for increased national government investment in harm reduction approaches. The tracking of international and national investment in harm reduction is essential to inform advocacy for increased resources for harm reduction. This information is challenging to gather as most donors and governments do not record or disaggregate their budgets in a way that is useful for monitoring harm reduction spending. In light of the above, UHRN, received the funding from HRI to conduct a rapid assessment on the harm reduction funding and investment in Uganda for a period between 2017 2018 and 2019.

Objectives of the rapid assessment

The overall objective of the assignment was to establish harm reduction funding and investment in Uganda.

1) Identify harm reduction funding and investment in Uganda for the period 2017-2019 focusing on OAT, NSP and ART.
2) Map out harm reduction funding partners in Uganda.
3) Document the impact and current context of harm reduction funding and investment because of COVID-19.
4) Provide recommendations for improved investment of harm reduction in Uganda.

Approach and Methodology for the assessment

1.6.1 Overall Approach

The process of undertaking this assessment was extensive involving consultations with key stakeholders and interest groups including communities of people who use drugs, key civil society organizations, public sector, and donors involved in the implementation of harm reduction focused programs.

1.6.2 Methodology

A combination of methods was used to obtain primary and secondary data. The process heavily relied on primary data from stakeholders. Data was collected through face-to-face interviews and an extensive review of documents such as funding allocation and expenditure records. Interviews included people who use drugs, key civil society organizations, the Ministry of Health, (MOH), Uganda AIDS Commission (UAC), the Uganda Police, and donors involved in implementing harm reduction focused programs. A bottom-up approach was used which involved collecting data from the recipients of funds to support harm reduction interventions. More data was obtained through consultative/consensus meetings and was supplemented by secondary data from desk-based review of existing resource documents and other secondary data sources such as programme quarterly and annual report as well as research reports.

SECTION TWO

FINDINGS

2.1 General information

The general information in the MAT template includes:

1) the total number of MAT clinics nationwide: **One clinic as of 2020**

2) the number of people who use drugs enrolled in MAT: **85 as of 2020**

3) coverage of MAT among people who use drugs; and

4) the percentage of contribution of international funders 100%

Table 1: MAT National Services

Items	Notes	2017	2018	2019
Total No. MAT Clinics nationwide	Data source	**No Data**	**No Data**	**No Data**
No. enrolled on MAT Programmes nationwide	Data source	**No Data**	**No Data**	**No Data**
Coverage of MAT		**No Data**	**No Data**	**No Data**
Contribution of international funding (%)		**No Data**	**No Data**	**No Data**
Specific donor spends (%)		**No Data**	**No Data**	**No Data**

There were no MAT services offered from 2017 to 2019 in Uganda and therefore the table above presents no data available

Table 2: NSP National Services

Items	Notes	2017	2018	2019
Total No. NSP Clinics nationwide	UHRN final evaluation NSP demonstration report	-	**1**	-
No. enrolled on NSP Programmes nationwide	UHRN final evaluation NSP demonstration report	-	**120**	-
Coverage of NSP	UHRN final evaluation NSP demonstration report	-	**Kampala and Wakiso Districts**	-
Contribution of international funding (%)		-	**100%**	-
Specific donor spends (%)		-	**100%**	-

2.2 Situation of people who use drugs

There have been national population size estimates of all key populations which included people who inject drugs and/or people who use drugs. These studies include Makerere University School of Public Health, CDC and Ministry of Health Crane Survey, August 2013, AMICAALL/KCCA: Mapping and size estimation of the key affected population in Kampala, 2013 and Priorities for Local AIDS Control Efforts (PLACE) in 40 districts of Uganda Draft Report, 2018.

According to Synthesis, Consolidation and Building Consensus on Key and Priority Population Size Estimation Numbers in Uganda, December 2019, the national population size estimate of people who inject drugs and/or people who use drugs is 7,356.

Table 3: National population Size estimates of people who inject drugs

Key population	Age group	Population denominator	Population estimate	Lower bound	Upper bound
MSM	Men age 15+ years	9,065,192	22,663	12,692	32,635
FSW	Women 15-49 years	8,748,881	130,359	50,744	210,849
PWID	All people age 15+ years	18,388,692	7,356 (National Estimate)	1,839	11,034
Fisher Folk	All people age 15+ years	18,388,692	731,870	176,532	1,289,048

Source: Synthesis, Consolidation and Building Consensus on Key and Priority Population Size Estimation Numbers in Uganda, December 2019

Table 4: Access to ART by people who inject and/or use drugs

Items	Notes	2017	2018	2019
Total number of ART sites nationwide	Data source: Source: USAID/Uganda Health Supply Chain Management Sciences for Health, Dec 2017 and ACP Progress Report 2019	1,758	1,830	1,832
Number of people living with HIV (PLHIV) on ART nationwide	**Data source**: (DHIS2, 2017), UNAIDS 2019 HIV estimates, Epi-data 1990-2020: http://aidsinfo.unaids.org/Uganda HIV/ AIDS Country UAC: Progress Report July 2017-June 2018	1,070,761	1,140,550	1,169,066
Number of people who inject drugs living with HIV on ART nationwide	**Data source:** Key Population National Tracker by MOH, 2019	16	60	125
Contribution of international funding sources (%)	**Data source:** UAC (2018). Mid-Term Review of the National HIV and AIDS Strategic Plan (NSP) 2015/2016-2019/2020, Uganda AIDS Commission, Republic of Uganda		65	

2.3 Overall state of harm reduction funding

The findings indicate that for the three -year period covered by the assessment, the total investment in harm reduction was from international partners mainly implemented through local implementing partners.

The assessment of funding towards harm reduction during financial year 2019 shows that **UGX 370,237.59 USD,** 244,464.61USD in **2018 and 201,317.22 USD in 2017** was spent. The funding largely supported advocacy interventions for harm reduction, HIV testing and counselling, access to antiretroviral therapy (ART), prevention and treatment of sexually transmitted infections (STIs), condom programmes, targeted information, education and communication, legal aid assistance and psychosocial support services. The main donors include the US government through CDC and USAID, Global Fund, international NGOs such as Open Society East Africa and Frontline AIDS through the PITCH project. The harm reduction services were supported through national civil society organizations. The national NGOs include the Most At-Risk Population Initiative (MARPI), Mild May Uganda, Rakai Health Sciences and Harm Reduction Network (UHRN).

The assessment further indicates that there were no specific government funds spent on harm reduction interventions during the financial year 2019. It should be noted that all the funds spent (100%) were from donors.

Table 5: Source of funding for Harm reduction services in Uganda 2019.

Source of funding for harm reduction services	National NGOs	2017	2018	2019	Funding proportion
International donor					100%
Frontline AIDS-PITCH Project	UHRN	113,576,644	91,892,322	226,271,749	
Frontline AIDS-PITCH Project-National Coordination	RHU- Host Organization	250,000,000	250,000,000	250,000,000	
Global Fund	UHRN	272,870,422	228,056,570	117,422,362	
Global Fund	MARPI	0	44,160,000	230,376,000	
OSEIA	UHRN	101,159,689	281,585,687	175,670,149	
CDC	Infectious Disease Institute (IDI)			243,734,897	
CDC	Rakai Health Sciences			26,225,676	
CDC	Mild May			86,813,720	
Government of Uganda	MOH	In-Kind	In-Kind	In-kind	Nil
Total Funding - UGX		**737,606,755**	**895,694,579**	**1,356,514,553**	
Total Funding – dollars		**204,891**	**248,804**	**376810**	

Source: Projects' Annual Financial Reports 2019.

Results show that harm reduction interventions are not well funded. For example, there about 7 drop-in centres providing HIV services such as prevention across the country, however, NSP and MAT are limited to the Kampala and Wakiso Districts so people who use drugs in other regions are underserved. Also, supplementary, or alternative interventions such as income-generating activities are not funded.

The assessment further shows that no harm reduction resource needs and funding gaps studies have been undertaken in the past five years in Uganda. It should be noted, therefore, that with additional funding would not only support scaling up of NSP and MAT but also engagement with policymakers, law enforcement personnel and the general public to appreciate the needs of people who use drugs.

There are development partners who have played a key role in funding the HIV response in Uganda and harm reduction interventions. The country has been a beneficiary of a number of international funding mechanisms through bilateral and multilateral arrangements. These include the United States Government (USG), Department for International Development (DFID), IRISH AID, DANIDA, Swedish International Development Agency' (SIDA), for bilateral, and World Bank, Intergovernmental Authority on Development (IGAD), UN Agencies, The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) for the multilateral among others. The AIDS Development Partners (ADPs) channelled funding through the national budget with budget support, or directly to ear-marked projects. Additionally, funding is provided through NGOs and CSOs to support HIV and AIDS interventions.

The assessment findings further show that there was no specific budget allocated towards harm reduction by the government of Uganda. The government of Uganda budgetary allocation to the health sector and the local government is used to cover wages and non -wage recurrent costs at the central level and decentralised activities at the district level to support the provision of services to people who use drugs. Additionally, the government has provided a policy framework to enable implementation of harm reduction interventions in the country and support coordination.

In Uganda, there is no specific national strategic plan for harm reduction, however, the National HIV Strategic Plan 2020/21-2024/25 highlights injecting drug users as one of the key populations that must be targeted for HIV interventions. Such interventions include HIV testing and counselling, access to ART, prevention and treatment of STIs, condom provision, targeted information, education and communication, legal aid assistance and psychosocial support services. However, it should be noted that the National HIV plan does not refer to groups of people who use drugs, such as women and transgender populations, people in prison, or those living in rural communities but refers in general terms to people who use drugs including injecting drug users. The plan does not provide the recommended WHO service package for harm reduction for people who inject drugs.

The National HIV and AIDS Strategic Plan remains the main source of information regarding the Uganda government support to harm reduction interventions. However, the plan does not highlight specific financing estimates towards harm reduction and specifically for particular groups other than broader programmatic statements.

From the review of available documentation, there is no specific source of data on harm reduction funding in Uganda country other than specific projects being implemented by various civil society partners.

2.4 Source and distribution of Harm Reduction Funds

From programme document review and key informant interviews, the following were noted as the harm reduction services and interventions are available for people who use drugs (both injecting and non-injecting) in Uganda.

a. Needle and syringe programmes (NSP) - available but limited to Kampala and Wakiso districts
b. Opioid agonist therapy - available but limited to Kampala and Wakiso districts and was started in 2020
c. HIV testing and counselling – available in all drop-centres and KP clinics
d. Antiretroviral therapy – available in accredited clinics
e. Prevention and treatment of sexually transmitted infections - available in all drop-centres and key population clinics
f. Condom programmes for people who use drugs and their sexual partners - available in all drop-centres and key population clinics
g. Targeted information, education and communication for people who use drugs and their sexual partners - available but on small scale
h. Overdose prevention - available but in Kampala and Wakiso districts
l. Legal aid assistance- available through community paralegals and like-minded legal aid partners organizations

Table 6: Availability of Harm reduction Services in 2019

Service	Source	Notes	2019
Needle and syringe programmes (NSP)	Evaluation Report 2019, UHRN	Limited to Kampala and Wakiso districts – reached during 4 months	120
Medically Assisted Therapy (MAT)		No Data for 2019	
HIV testing and counselling	KP Trucker	National coverage (include districts)	2600
Antiretroviral therapy (ART)	KP Trucker	National coverage	89
Prevention and treatment of sexually transmitted infections (STIs)	KP Trucker	National coverage	2600
Condom programmes for people who use drugs and their sexual partners	KP Trucker	National Coverage	125000
Targeted information, education and communication	KP Trucker	Available but on small scale	6000
Overdose prevention		The service was not available in 2019	**0**
Legal aid assistance	KP Trucker	National Coverage	1023
Psychosocial support services	KP Trucker	National Coverage	2600

Source: Programme Reports, 2019

The results in Table 6 show that while harm reduction interventions are being implemented across the country, there are some interventions still limited in scale such as NSP and overdose prevention.

The above interventions are largely funded by international organizations through national civil society organizations and these include USG through CDC and USAID and Global Fund, international NGOs such as Open Society East Africa, Frontline AIDS, and Harm Reduction International.

For instance, during 2019, the needle and syringe programme was funded 64 million Uganda shillings approximately 17,000 USD by international partners. There was no government financial contribution to NSP.

The assessment shows that there were no funds invested in opioid agonist therapy in 2019 from either government or donors. Furthermore, the assessment could not establish funds allocated to antiretroviral therapy for people who use drugs in 2019, since funds are not disaggregated by population category. It should also be noted that there is no domestic funding for harm reduction in Uganda and there are no unit costs of delivering harm reduction services been calculated in Uganda.

The review of documents and key informant information shows that there is no data or estimates of 'out of pocket' expenses for people who use drugs. Future studies could prioritize this assessment.

Table 7: National Funding to HIV and AIDS in Uganda 2019

Area of support	Percentage (%)
Prevention	7.0
Treatment	87
Cross-Cutting (HR, Program support)	6.0
Prevention	16.3
Care and Support	11.7
Treatment	63.5
Strategic Information	2.2
Health System Strengthening	1.9
Management and Operations	4.4
GFATM	
Prevention	0
Treatment	79.6
Strategic Information	032
Health System Strengthening	2.9
Management and Operations	17.2

Source: Uganda AIDS Commission (2019), 12th Annual Joint AIDS Review (JAR), 2019

The table 7 above shows that overall, HIV preventions spending was about 7 per cent. This was mainly funded by support from the US Government.

It should be noted that the Ugandan government contribution to the HIV/AIDS response is higher than reflected as much of the resources for human resources, utilities infrastructure and operational costs have not been accurately attributed to HIV/AIDS response.

There are no harm reduction initiatives available within prisons in Uganda. From key informant interviews, it was noted that the government does not recognize harm reduction services in prisons since drug use is a criminal matter and not a health issue. Furthermore, it was noted that any health services available to prisons is held under the Directorate of Health Services in Prisons and the Ministry of Health provides policy oversight and technical guidance.

Table 8: National Harm Reduction Funding Situation at Glance in Uganda by 2019

Factor	Green	Amber	Red
Harm reduction coverage			
Availability of expenditure data			
Government investment in harm reduction			
Civil society representatives' view on the sustainability of funding			

2.5 Funding gaps, challenges and trends

The assessment established that there has been a change in drug use in Uganda in the past 3 years because of harm reduction programs implementation. For instance, in 2017, UHRN demonstrated the first NSP, established the first drop-in center with a comprehensive package for people who use drugs.

According to a study conducted by Community Health Uganda, heroin (44.8%) and cocaine (16%) are the most injected drugs in Kampala and Mbale (population estimation and rapid assessment on harm reduction and HIV prevention among people who inject drugs in Kampala City and Mbale Town, Uganda, 2017). However, with limited national studies done in the area of drug use and harm reduction; the assessment could not establish if there has been an increase in the use and/or injecting of amphetamine-type stimulants as well as a decrease in heroin use and/or injecting in other areas in the country. This therefore means that there is a need to have specific studies to establish the trends and patterns in use and/or injecting of amphetamine-type stimulants as well as a decrease in heroin use and/or injecting.

The financial data analysis shows that there has been an increase in harm reduction funding over the last years and these funds have mainly come from international donors such as USAID, CDC, Global Fund and International NGOs.

This has resulted in the widened scope of harm reduction interventions including services like MAT and NSP. As such, people who use drugs in Uganda can now access health services such as ART and HIV Testing Services (HTS)and this generally improved their standards of living.

The assessment shows that despite the increase in funding for harm reduction which is mainly from international partners, there is no government investment save for the provision of a policy framework and in-kind support such as buildings and human resources that provide health services. From key informant interviews this could be attributed to a lack of understanding of harm reduction services, recognition of drug use as a criminal matter by law or national competing health needs that require financial investment. Stigma associated with mental health at

individual, family, community and institutional levels could be one of the other factors affecting investment in harm reduction by government and other partners such as the private sector.

Other barriers highlighted include government and partners focus on biomedical interventions with limited investment in community-based interventions, and the lack of investment in research to generate evidence on effective harm reduction interventions, which would inform advocacy for improved investment.

Current advocacy efforts have resulted in the drafting of harm reduction guidelines - technical guidelines for universal access to HIV and AIDS, prevention, treatment and care of people who use alcohol, drugs and other substances by the MOH, which is now operational. The guidelines include people who use drugs in the HIV national strategic plan, the establishment of MAT clinics, operationalization of drop-in centers, and increased funding from in-country mechanisms. Global Fund, PEPFAR and the police developed standard operating procedures to guide people who used drugs upon arrest, availability of data on people who use drugs. It was also noted that services such as MAT and NSP are still limited in scope.

To address limited domestic investment in MAT and NSP, it's recommended that advocacy and lobbying government policymakers are scaled-up through champions in Uganda who may include development partners, civil society leaders and people who use drugs. Furthermore, the presence of the national Uganda Harm Reduction Network and its partners would facilitate advocacy for increased harm reduction program funding. The existence of nation-wide size estimation of people who use or inject drugs provides information for advocates as they lobby government and partners to support harm reduction services.

The assessment established that the current processes involved in accessing available funds include applications and proposal writing to international donors through in country funding mechanisms such as PEPFAR and Global Fund by civil society organizations. Through lobbying these mechanisms, allocation to key populations including harm reduction interventions in the country has enabled access to funding.

The only available information that shows national government political will to sustain investment in harm reduction for the next 5 years is the recognition of harm reduction in the National HIV/AIDS Strategic Plan. Additionally, inclusion of harm reduction as part of broader key population interventions in the country Global Fund grant indicates the evidence of government's commitment. It should be noted that although the harm reduction network is not represented at CCM, the needs of people who use drugs and the community are addressed through key population representation. The MoH has also developed and rolled out guidelines for harm reduction. However, the available plans are not costed and lack detailed investment plans. Furthermore, the national policy on mental health which encompasses harm reduction is yet to be approved.

Investment in harm reduction, therefore, lacks an overall policy framework for both public and private efforts. In Uganda, many people who inject drugs rely on Civil Society Organizations and private providers including private drug shops and clinics for treatment services (Population estimation and rapid assessment on harm reduction and HIV prevention among people who inject drugs in Kampala City and Mbale Town, Uganda, 2017). Besides, available rehabilitation interventions are implemented by the private sector. This is an opportunity to reach more people who inject drugs and efforts to engage with private sector needs to be undertaken by civil society to scale up the scope and lobby the sector to invest in harm reduction.

Funding for harm reduction in Uganda has marginally increased over time, however, this largely from international partners. Government support is limited to in-kind provision of policy framework and infrastructure to service delivery to the general population. It can be further concluded that there is less documented evidence of disaggregation of services to people who use or inject drugs. This affects systematic engagement with policy workers and enables review of existing legal and policy framework to facilitate scaling-up of harm reduction financing.

SECTION THREE

THE SECTION IMPACT AND CURRENT SITUATIONAL CONTEXT OF HARM REDUCTION FUNDING AND INVESTMENT AS A RESULT OF COVID-19.

3.0: Introduction:

The section presents the impact and current situation context of harm reduction funding as a result of the COVID-19 outbreak.

3.1 Impact of access to services:

Table 9: Shutdown Period

Activity	Shutdown Started	Shutdown Ended	Shutdown re-imposed
Lockdown/shut down in the city	**25th March**	**28th June**	**NA**
UHRN office	**24th March**	**30th June**	**NA**
UHRN services			
Critical harm reduction services by Government institutions	**No harm reduction service is provided by the government**		

Table 9 shows the timeline for the COVID-19 shutdown in Uganda. It should also be noted that there were no critical harm reduction services provided by government institutions to people who use drugs during the period.

Table 10: Number of PWUDs accessing NSP, OST, TB and ART during Covid-19 Shutdown

Variable	January	February	March	April	May	June	July	Source of Data
Number of clients who received NSP	**0**	**0**	**0**	**0**	**48**	**88**	**134**	NSP Report progress report (UHRN 2020)
Number clients who received MAT	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Number of NSP clients who received ART	**Not known ('nk')**	**'nk'**	**'nk'**	**'nk**	**'nk'**	**'nk'**	**'nk'**	
Number of Syringes distributed					**864**	**2112**	**3216**	NSP Report progress report (UHRN 2020)
Average number dosage given in the month per client	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Number of clients who received an HIV test	**53**	**87**	**101**	**5**	**3**	**10**	**11**	KP National Trucker
Number of clients who were tested for Tuberculosis	**4**	**3**	**2**	**1**	**3**	**4**	**3**	KP National Trucker
Number of clients who received an HIV test result	53	87	101	5	3	10	11	KP National Trucker
Number of MAT clients who received ART	**0**	**0**	**0**	**0**	**0**	**0**	**0**	
Number of clients reported sharing needle syringe	**54**	**66**	**44**	**32**	**12**	**9**	**6**	NSP Progress Report (UHRN 2020)
Number of Overdose cases reported	**13**	**27**	**15**	**06**	**02**	**09**	**11**	UHRN Programs data 2020

Table 8 shows the number of people who use drugs who accessed health services (NSP, tuberculosis, ART and HIV testing) during the COVID-19 shutdown. The results indicate that more syringes were distributed during June and July 2020 and this could be attributed to lifting of lockdown in early June by the government which allowed public transport to resume. Equally, more people accessed NSP during the same months of June and July. However, the results show that there were no syringes distributed during the period prior to lockdown due to stock outs.

Table 11: Number of people who use drugs tested for COVID-19

Number of Clients	January	February	March	April	May	June	July
Clients quarantined for COVID before getting tested for COVID	**0**	**0**	**0**	**16**	**19**	**34**	**11**
Clients who received a COVID test	**0**	**0**	**0**	12	09	17	06
Clients who received a positive COVID test results	**0**	**0**	**0**	**3**	**4**	**7**	**2**
Clients who died due to COVID	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Clients put in quarantine after testing positive for COVID	**0**	**0**	**0**	2	1	5	2

Source: **Community paralegal reports 2020**

Table 10 shows that people who use drugs were quarantined for COVID-19 and some were tested. The majority were quarantined in April, May and June before getting tested for COVID-19 and those who tested positive were quarantined.

The lockdown restrictions, police enforcement and suspension of public transport affected access to services, as people who use could not travel to facilities like drop-in centers to access NSP, HIV, STIs, overdose management and other services. Moreover, after opening public transport, the cost was high and therefore unaffordable to many. The earlier gains in behavior change communication were compromised as a result of reduced interventions. Community psychosocial support meetings reduced yet the rate of psychological distress among people who use or inject drugs surged.

Table 12: Expenditure incurred during Covid-19 Shutdown

Question	January	February	March	April	May	June	July
Staff cost	31,840,150	31,840,150	31,840,150	31,840,150	31,840,150	31,840,150	31,840,150
Training	25,247,000	53,789,000	23,096,500	12,945,000	84,502,000	40,248,000	58,438,000
Travel	0	0	0	300,000	0	0	300,000
Office rent	13,000,000	900,000	0	2,000,000	0	0	10,000,000
Rent/ Overheads	3,589,800	1,275,492	10,512,488	256,642	1,250,099	2,021,639	2,689,900
Medicines	0	0	0	0	0		0
If you have incurred any other cost, please specify the same and provide the expenditure	0	0	0	0			0
Total	73,676,950	87,804,642	65,449,138	47,344,792	117,592,249	74,109,789	103,268,050

The results in Table 12 show that there was increased expenditure especially for training during the months of May to July. This can be attributed to increased costs in order to observe standard operating procedures during COVID-19, more people were oriented on its impact, and physical trainings required more space.

3.2 Impact of Covid-19 on Harm Reduction Expenditure and Service Access

3.2.1 Impact on access to Health Services:

The assessment results from key informants show that there was enormous impact of COVID-19 service delivery but not only people who use drugs but to the general population.

There was disruption of sexual reproductive health and HIV prevention services mainly caused by limited access and utilization of related services which led to client drop-out for treatment since some preferred services brought nearly to them i.e. community outreaches targeting hotspot could not be undertaken. This disruption resulted in relapse among people who use drugs and were on treatment. Access to HIV treatment at facility level was compromised due to restriction of movement. Moreover, government priority was given to COVID -19 prevention and treatment and hence delivery of other health care services were affected.

"Our patient attendance between March and June, 2020 reduced due to lockdown…. however, there has been an upward attendance since July 2020." National key informant, participant.

Furthermore, as most of the harm reduction interventions are implemented by civil society and community based organizations, through drop-in centers and outreach there were challenges of stock-outs of commodities like condoms, self-testing kits and family planning methods among others since most of the partners that supplied these commodities had closed due to shut down.

The lack of commodities, there was human rights violations during the lockdown. There were increased illegal arrests of most people who use drugs, most ghettos were raided by police in bid to implement and enforce lock restrictions.

> ***"During lockdown, many of the ghetto boys and girls were arrested by police in pretext of enforcing COVID-19 prevention guidelines…our community were not accessing health services and here they were being arrested, this was double tragedy." Community based key informant***
>
> ***"We registered cases of mental health as a result of lockdown where people who use drugs were restricted to access their dens". National service provider key informant.***

The assessment findings further show that services for women who use drugs were unavailable. Community outreach always provided a room for integration of services but since most of them were stopped due to the lockdown, access to sexual reproductive health services like family planning became limited which might have facilitated an increase in unwanted pregnancies among women who use drugs.

> ***"Due to increased cases of gender based violence among women who use drugs so many related cases have not been attended to and some of those attended to are uncompleted." Community based key informant***

Regarding people who use drugs in prisons/ confinement, whose cases were still on-going in court, their hearing was delayed since all court sessions were halted. This has created a backlog of courts cases resulting in people staying longer in detention centers.

During COVID-19 shutdown, some of the people who use drugs faced the challenge of lack of support since they could not access rehabilitation and counselling services. Coping systems were disrupted and resulted in increased mental health illness cases for both new and old persons in rehabilitation. Some people who use drugs face stigma and discrimination within their communities since the community perceives them as criminals.

3.2.2 Impact on expenditure patterns

Donors called for repurposing of grants to respond to COVID-10 challenges, for example, changing physical meetings to virtual. The Global Fund allocated some financial resources to address COVID-19 related issues. Harm reduction programmes benefited from these resources in form of food relief and UNAIDS handwashing materials.

3.3 Mitigation strategy

Because of the challenges caused by COVID-19 pandemic, partners prepared mitigation measures to sustain the gains in HIV and harm reduction programming for people who use drugs. To ensure the measures implemented were working, people who use drugs and their networks conducted routine monitoring, such as one on one and online meetings, documentation and reporting by community paralegals.

Also, a situation analysis on the social economic impact of COVID-19 among people who use drugs in Uganda 2020 not published report was conducted by UHRN[1]. To address the needs of people who use drugs, UHRN and partners lobbied for food relief from the government and the Global Fund which benefited 450 people. Additionally, sanitation and hygienic packs, and face masks, were mobilized from UNAIDS through the National Forum for People Living with HIV. It should be noted that while there were attempts to meet the needs of people who use drugs, through routine community monitoring by paralegals, it was noted that needs remained enormous since most of them who were engaged in some livelihood activities lost them during the shutdown.

3.4 Involvement of people who use drugs in the decisions regarding COVID-19 related needs

In an attempt to ensure the needs of people who use drugs are addressed, a participatory approach was employed. For instance, both at national and community levels, a crisis response team that included representatives from the community of people who use drugs was constituted. The community of people who use drugs were consulted through phone calls, use of peer leaders and one on one meetings and their responses informed the decisions made to address the challenges caused by COVID-19. However, it was observed that while the government had taskforces at national and district level, they did not include representation from communities such as people living with HIV, people who use drugs and other key populations.

To obtain support in addressing the needs of people who use drugs, the partners involved shared with other networks such as local leaders and enforcement agents, key populations representatives at the national level, civil society and national stakeholders. It is against such efforts that some of the recommendations were considered in the Global Fund COVID-19 relief aid for key populations.

3.5 Partners involved in response to issues faced by people who use drugs

The assessment results show that largely partners involved in the response were donors and other networks of key populations and civil society. The donors mainly provided funds for food relief aid, sanitation and hygienic pack, bicycles and masks. Donors include Global Fund, UNAIDS through the National Forum for People living with HIV Networks, ARASA, Open Society East Africa, and FRONTLINE AIDS. The key populations coordination network at the national level provided a platform for advocacy and lobbying. It should also be noted that while the government provided food relief and distributed face masks people who use drugs were not included.

3.6 Workplace Experience with the COVID-19 Infections

The assessment established that following the outbreak of COVID-19 and the subsequent government directives, all partners whether public or non-public, ensured that virtual meetings and engagements, social distancing in the workplace, use of face masks, provision of handwashing equipment and stations at each entrance of institutions, use of gun thermometers, use of sanitizers, awareness materials for COVID-19 and working in shifts was implemented. However, some people who used drugs were quarantined but there were no special provisions such as MAT to respond to their needs. They received the general COVID-19 prevention and management counselling like any other persons in the quarantine Centre.

[1] https://ugandaharmreduction.org/blog/2020/08/22/the-effects-of-covid-19-on-people-who-use-drugs-pwuds/

To facilitate early identification of COVID-19 among people who use drugs, efforts were made to orient all peer leaders in the emergency response, which includes reporting all unusual illnesses within their communities, emergency numbers were distributed in all communities of people who used drugs and contact persons were identified. To ensure continuous provision of services to people who used drugs, all service providers adopted the new normal working modalities. These include virtual meetings and engagements, e-counselling, home delivery of services and targeted HIV testing services service delivery models. Additionally, community follow-ups for people who use drugs who are HIV positive and their partners and community reach-out programs for refills were established and to ensure continuity of service delivery for ART, PrEP and family planning services.

Regarding workload, there has been increasingly working long hours, and working beyond working hours because of different time zones. To address the burnout, e-counselling and undertaking regular exercises have been adopted. The assessment also established that due to COVID-19 and different working modalities, some of the service providers and beneficiaries have suffered stress and depression. People who use drugs feared increasing arrests targeting them, changes in their ways of living due to limited sources of income since most local businesses were closed, and new laws. People who are on ART found it hard to get food since most of them are unemployed due to the closure of most local businesses.

To address the above challenges, the existing drop-in centers provide psycho-social support through counselling. However, it was noted that this was not enough since there are inadequate full-time professional service providers to offer the service. Referral and linkages for mental health-related services are made to existing public and non-public facilities.

3.7 Strategies to meet the needs of people who use drugs during pandemics

The assessment established that respondents agreed with the strategies such as cash transfers, social protection, livelihood options, incentives for field staff such as additional travel costs, overtime payments, and institutional business continuity plans. They further suggested that establishing other income generation options would be to mitigate the challenges faced by the people who use drugs during such pandemic situations.

SECTION FOUR

RECOMMENDATIONS.

From the assessment results indicate that over the three years, there has been a significant increase in access to harm reduction services with support from various international partners, an improvement in targeted HIV case finding among people who use drugs, and this created some improvement regarding retention in care. However, the COVID-19 outbreak and associated shutdown has caused a grave retrogression regarding access to services such as ART, NSP, and other HIV prevention services.

The following recommendations are suggested:

1. The government of Uganda should embrace harm reduction as the over-arching strategy to respond to drug-injecting related risks and harms. This calls for enabling legal and policy provisions as well as financial allocations that support the provision of comprehensive harm reduction services including services such as MAT and NSP programs.
2. Conduct policy and legal review to remove criminalisation of drug use
3. Conduct advocacy and lobby for approval of national mental health policy
4. Establishing evidence/data on people who use drugs to inform prioritization and advocacy for harm reduction interventions. Such data include national drug use prevalence which is lacking.
5. Undertake an assessment to estimate 'out of pocket' expenses for people who use drugs in Uganda.
6. Scaling up advocacy and coordination among the civil society orgnizations and engagement with public sector and international partners to support harm reduction services. This can be done through the establishment of a network of harm reduction champions among drug users, civil society leaders and development partners.
7. Conduct orientation of policymakers, law enforcers and the general public about the need to establish harm reduction interventions
8. Establish formal working and coordination mechanisms between government and non-public sector including private sector partners involved in rehabilitation as well as NGOs/CSOs currently supporting harm reduction. This will provide an opportunity for advocacy for harm reduction but also address the gaps in awareness.
9. Expand the scope of harm reduction interventions to include alternative services such as income generation that would enable people who use drugs have a source of livelihood.
10. Partners led by UHRN should conduct situational analysis to understand the needs and issues of people who use drugs in the context of COVID-19. This will facilitate the development of post-COVID-19 plans with defined priority issues/areas to be addressed and relevant strategy to address them based on evidence.
11. Develop a business continuity strategy for harm reduction implementing partners to enable them to find alternative funding sources to reduce donor dependency including advocating for domestic funding.
12. Develop a business continuity strategy to facilitate mitigation of challenges caused pandemic such as COVID-19.

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