# HARM REDUCTION FINANCING LANDSCAPE ANALYSIS IN UGANDA

HARM REDUCTION INTERNATIONAL

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**Harm Reduction International (HRI)** is a leading non-governmental organisation (NGO) dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies. The organisation is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

Research and analysis for this report was carried out by Bharam Namanya, in consultation with Catherine Cook and Gaj Gurung.

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# LIST OF ABBREVIATIONS

| | |
|---|---|
| AGHA | Action Group for Health Human Rights & HIV/AIDS |
| CCM | Country Coordination Mechanism |
| CEHURD | Centre for Health, Human Rights and Development |
| CHAU | Community Health Alliance Uganda |
| CLOs | Community Led Organisations |
| COP | Country Operation Plan |
| CSBAG | Civil Society Budget Advocacy Group |
| CSOs | Civil society organisations |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| HRAPF | Human Rights Awareness and Promotion Forum |
| HRI | Harm Reduction International |
| ICDNL | Iway Community Development Network Limited |
| ICWEA | International Community of Women Living with HIV Eastern Africa |
| KPs | Key Populations |
| MAT | Medically Assisted Treatment |
| MIMHA | Mouthpiece Initiative for Mental Health and Addiction |
| MoH | Ministry of Health |
| NAFOPHANU | National Forum of People Living with HIV/AIDS Networks in Uganda |
| NDPSCA | Narcotic Drugs and Psychotropic Substances (Control) Act of 2016 |
| NFM IV | New Funding Mechanism Four |
| NSP | National HIV and AIDS Strategic Plan |
| NSPs | Needle and syringe programmes |
| PEPFAR | The US President's Emergency Plan for AIDS Relief |
| PWD | People with Disability |
| PWUDs | People Who Use Drugs |
| SMUG | Sexual Minorities Uganda |
| SN | Serial Number |
| UAC | Uganda AIDS Commission |
| UGANET | Uganda Network on Law, Ethics and HIV/AIDS |
| UHRN | Uganda Harm Reduction Network |
| UKPC | Uganda Key Population Consortium |
| UNAIDS | The Joint United Nations programme on HIV & AIDS |

| | |
|---|---|
| UNASO | Uganda Network of AIDS Service Organisations |
| UNDP | United Nations Development programme |
| UNGASS | United Nations General Assembly on AIDS |
| UNODC | United Nations Office on Drugs and Crime |
| UNYPA | Uganda Network of Young People Living with HIV/AIDS |
| WHO | World Health Organisation |

# EXECUTIVE SUMMARY

This report presents the results of a landscape analysis on domestic financing for harm reduction in Uganda conducted by Harm Reduction International (HRI). The objectives of the landscape analysis and community and civil society consultation were to assess the legal and policy environment for harm reduction, assess the financial landscape, and to map opportunities and targets for harm reduction advocacy, as well as partners for advocacy for harm reduction funding in Uganda.

The approach adopted desk review of relevant documents, as well as a narrative descriptive qualitative assessment. It followed a formative assessment using key informant interviews with key stakeholders drawn from relevant institutions, civil society organizations (CSOs), and key population (KP) community groups. The stakeholders interviewed included representatives of networks of people who use drugs, and CSOs, particularly those involved in harm reduction, legal, and human rights issues. Other stakeholders included individuals from the Ministry of Health (MOH), the Uganda AIDS Commission, and UNAIDS.

The landscape assessment found that while the national legal and policy framework in place can facilitate harm reduction investment, there is no social contracting policy framework. Ugandan laws, particularly primary laws such as the Constitution of the Republic of Uganda and the Non-Governmental Organisations Act, are largely positive and enabling in scope, assuring non-discriminatory and equal provision of, and access to, services for all. Moreover, Ugandan laws do not prohibit anybody from providing or accessing health services. Furthermore, they provide a conducive and enabling environment for the NGO sector and the strengthening and promotion of the capacity of NGOs and their mutual partnerships with governments. The policy framework also provides platforms for CSOs and community-led organisations (CLOs) to participate in the planning and design of health interventions at both the national and sub-national levels. The findings further showed that there is no domestic financing of harm reduction, and ongoing harm reduction interventions are largely financed by international partners.

However, the analysis established that there exist numerous punitive and discriminatory laws and policies that limit the provision of harm reduction services. The major challenges facing CSOs identified during the research include:

1. Various laws and regulations applicable to CSOs that may limit the supportive environment for their operations;
2. Lengthy and cumbersome registration processes and multiple centres such as the NGO Board, Uganda Registration Services Bureau, and the District Administration;
3. Discretionary powers of the NGO Board and other government agencies that may deny CSOs registration or deregister an existing organisation;
4. High level of dependence of CSOs on external sources of funding which affects the programming and sustainability of their interventions;
5. Lack of vibrant formal grant-making mechanism, especially for smaller CSOs that cannot compete with larger, better established CSOs for the same donor resources due to capacity gaps.
6. Near total absence of structured local philanthropy, except in relation to religious CSO causes.

In view of the challenges, the following recommendations are made to enhance access to harm reduction services:

1. The government should review provisions in the Narcotic Drugs and Psychotropic Substances Act 2015 and other laws that create barriers to accessing harm reduction and health care services for people who use drugs.
2. The government should prioritise funding for harm reduction by both including and integrating harm reduction interventions within the development plans at the national and sub-national levels. These interventions should be aligned to the standard international guidelines.
3. The government should allow full participation of community-led organisations, civil society, and people who use drugs in the design, delivery, and monitoring of supported harm reduction programmes. This will require their participation in the national and sub-national planning and budgeting mechanisms.
4. The government should ensure that people who use drugs are able to access membership to any existing planning and budgeting platforms at the national and sub-national levels to ensure meaningful participation.
5. Capacity building for health service providers in harm reduction services provision should be promoted.
6. Establish mechanisms for contracting and funding CSOs by developing policy guidelines to deliver harm reduction services.
7. International donors should increase funding for harm reduction programmes.
8. International donors should engage governments to prioritise and budget funding for harm reduction programmes.
9. Civil society organisations should form advocacy coalitions and technical working groups to act as advocates to engage in planning and budgetary processes.
10. Civil society organisations should train and sensitise law enforcement officials on the rights of people who use drugs and take measures to reduce violence and human rights violations against them.
11. Civil society organisations working with people who use drugs should prioritise further research on drug use trends and epidemiology. This can be undertaken in collaboration with research institutions and international donors.

# SECTION 1: INTRODUCTION AND BACKGROUND

## 1.1 Introduction

This report presents the results of a landscape analysis on domestic financing for harm reduction in Uganda conducted by Harm Reduction International (HRI).

Since HRI commenced monitoring funding for harm reduction over 15 years ago, the findings have been consistently dire. Available funding continues to be so far from meeting the estimated need that the funding 'gap' is more accurately described as a failure to fund. Research undertaken by HRI revealed that in 2019, USD 131 million was allocated for harm reduction in low- and middle-income countries – just 5% of the USD 2.7 billion annual investment UNAIDS estimates is required for an effective response to HIV among people who use drugs by 2025.[1]

Domestic investment in harm reduction remains disproportionately low compared with other areas of the HIV response.[2] Where it does exist, there are often challenges in ensuring community and civil society organisations can be contracted to deliver services and that services are people-centered, human rights-based, and of high quality. There is an urgent need to mobilise domestic investment in people-centered, human rights-based harm reduction programming, particularly in countries where international donor funding is being reduced. HRI conducted a landscape analysis and a consultation with community and civil society partners in Uganda which was aimed at informing advocacy for increasing domestic public financing for harm reduction. The analysis focused on the legal and policy environment, financial landscape, mapping of opportunities, as well as targets and partners for advocacy.

Uganda experiences a generalised HIV/AIDS epidemic. Between 2010 and 2019, HIV infections have been reduced by 43% and mortality by 61%. Overall, >60% of the new HIV infections are among adolescent girls and young women (AGYW) and key and priority populations. A growing body of epidemiological evidence in Uganda shows that some population groups continue to bear a disproportionately high burden of HIV infection.[3] The national population estimate of people who inject drugs is 7,356.[4] Available national information, through a combination of UNAIDS and UNODC data, provide estimates that HIV prevalence among people who inject drugs in Uganda is 17%.[5] A small-scale study among 67 sex workers who use drugs found a HIV prevalence rate of 31.3%.[6] Regarding funding for harm reduction in Uganda, available information shows that there is no domestic financing, and all available funding primarily comes from international donors channelled through national civil society organisations.[7]

Health care services in Uganda are delivered by both public sector (government) and private

1 HRI (2021) Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries. HRI, London. https://www.hri.global/files/2021/08/09/HRI-FAILURE-TO-FUND-REPORT-LOWRES.PDF
2 HRI (2018) the Lost Decade. Neglect for harm reduction funding and the health crisis among people who use drugs. HRI, London. https://www.hri.global/files/2018/09/25/lost-decade-harm-reduction-funding-2018.PDF
3 UNAIDS/UAC Key Population Size Estimation 2019
4 http://library.health.go.ug/publications/hivaids/synthesis-consolidation-and-building-consensus-key-and-priority-population-size
5 https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pd
6 https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pd
7 Ugandan Harm Reduction Network & Harm Reduction International (2021) Rapid Assessment of Harm Reduction Funding and Investment in Uganda. https://hri.global/wp-content/uploads/2022/10/Final_Harm_Reduction_Investment_Assessment_Report_2021-1.pdf

entities, including private-not-for-profit (PNFP) and private-for-profit (PFP) organisations, civil society, and complementary health service providers, such as traditional medicine providers. The public health facilities contribute 45% of the total health care facilities in Uganda, while PNFP and PFP contribute 14.5% and 40%, respectively, in FY 2017/18.[8] In Uganda, the MOH performs the national-level stewardship functions. In the public sector, health services are delivered through the national referral hospitals, regional referral hospitals, and district health services, including general hospitals and health centres (IVs, IIIs and IIs).

The district-level health service includes the district health management team, general hospitals, and an array of primary care facilities (health centres (HCs)). The district health service is under a District Health Officer who is appointed by and accountable to the district local government. Because the decentralised system of governance adopted in 1995 devolved most functions and powers to districts, the district health services are administratively independent of regional hospitals and report directly to the MoH. The health system is organised at both the national and sub-national levels.

## 1.2 Objectives

To conduct the landscape analysis and community and civil society consultation to assess the legal and policy environment, assess the financial landscape, and map out opportunities, targets, and partners for advocacy for harm reduction in Uganda.

## 1.3 Methodology

The approach adopted desk review of relevant documents as well as a narrative descriptive qualitative assessment. It followed a formative assessment using key informant interviews, with key stakeholders drawn from relevant institutions, CSOs, and KP community groups. The stakeholders interviewed included representatives of networks of people who use drugs, , and CSOs, particularly those involved in harm reduction, legal, and human rights issues. Other stakeholders were individuals from the MOH, the Uganda AIDS Commission, and UNAIDS.

The desk review focused on secondary sources of information in the public domain. Broadly, information sources included government agency websites, such as the MOH, Finance, Internal Affairs, National AIDS Coordinating bodies, Parliament and President's Office websites; community or civil society websites; or those of UN and donor agencies present in Uganda.

The landscape analysis focused on key areas, as outlined in the HRI tool, which included:

- Legal and policy environment for CLOs, CBOs, and CSOs;
- Policy framework and mechanisms for social contracting of CLOs, CBOs, and CSOs;
- Integration of harm reduction in national planning processes at the national and sub-national level;, current levels and sources of harm reduction funding in the country; domestic financing for the harm reduction response; existing analyses on the resources required to fund harm reduction at the national or subnational level, including resource needs estimates, resource gap analyses, and/or allocative efficiency analyses, existing prioritization processes, and mechanisms for improving efficiency in national or sub-

8 Ministry of Health. 2018. Health Facilities Master List[3] Ministry of Health, Oct-Dec 2021 HIV Quarterly Report, HIV AIDS Information system

national programme planning and resource allocation; opportunities for harm reduction funding within broader domestic health financing environment; and community and civil society monitoring of harm reduction funding.

The community consultations were primarily conducted via email, with follow-up phone call interviews, where it was possible, to verify the findings. A structured and open-ended questionnaire based on the set of questions was used. The questions focused on the following areas: community and civil society perspectives on the challenges and opportunities for increasing domestic financing for harm reduction at the national and subnational level.

## 1.4 Structure of the report

This report is presented in three chapters: chapter one covers the background methodology; chapter two covers the findings of operational landscape analysis; and chapter three presents community consultation findings. An annex of reference materials is provided at the end of the report.

## 1.5 Limitations:

Some limitations were faced during this assessment. These include:

1. Time constraints that affected the amount of literature reviewed and the number of interviews held, inevitably impacting the level of corroboration of information collected;
2. Some interviewees were somewhat reluctant to respond to the questionnaire sent online and follow-up calls didn't help, especially with government officials. This therefore limits the findings to the views of the few respondents that provided feedback.

# SECTION 2: OPERATIONAL LANDSCAPE ANALYSIS FINDING

## 2.1 Legal and policy environment

### 2.1.1 Legal and policy environment for CLOs, CBOs, and CSOs

#### Constitution of the Republic of Uganda, 1995

Uganda's constitutional framework broadly supports the operation of CLOs, CBOs, and CSOs. The 1995 Constitution of the Republic of Uganda under Article 29 (e) protects the right of freedom of association, which includes the freedom to form and join civic organisations. In addition, Article 38 (2) provides that "every Ugandan has a right to participate in peaceful activities to influence the policies of Government through civic organisations". Also noteworthy is clause (vi) of the National Objectives and Directive Principles of State Policy, which provides that "civic organisations shall retain their autonomy in pursuit of their declared objectives". While the right to form a CSO in Uganda is guaranteed by the 1995 Constitution of the Republic of Uganda, the relevant legislation requires CSOs to register with the NGO Board. This registration process, however, entails multiple endorsement processes and can be extremely laborious and bureaucratic.

#### The Non-Governmental Organisations Act, 2006, (NGO Act)

The Non-Governmental Organisations Act was intended to provide a conducive and enabling environment for the NGO sector and to strengthen and promote the capacity of NGOs and their mutual partnership with the government.[9] The Act places special obligations on NGOs, including the requirement to register with the NGO Bureau, apply for a permit, keep accounting records, submit periodic reports to the Bureau, and maintain high standards of governance, transparency, and accountability.[10] However, the NGO Act has two provisions which present constraining factors to service access and the realisation of rights of people who use drugs. The first is under section 44, subsections (d) and (f), which stipulate that an organisation shall not engage in any act that is prejudicial to the security and laws of Uganda or the interest of Uganda and the dignity of the people of Uganda. The terminology used in these two subsections is overly broad and the terms are not properly defined in the Act, which allows for unfair limitation to freedom of association of CLOs, especially those that support programmes for KPs, including harm reduction in an arbitrary manner.[11] It is possible that organisations providing harm reduction services to people who use drugs may be deemed as undertaking activities "prejudicial to the laws of Uganda," since conduct associated with many KPs (such as drug use, sex work, and same-sex relations) are criminalised.[12]

The other constraining provision is section 30(1) of the Act, which empowers the NGO Bureau to refuse the registration of an organisation if the objectives of that organisation are

9 The Non-Governmental Organisations Act (2016). Long title of the Act.
10 Ibid, Sections 29, 30, 32, 39.
11 Human Rights Awareness and Promotion Forum (HRAPF) (2016), Position Paper on the Non-governmental Organisations Act, 2016, 3.
12 Ibid. Article 2(2) provides: 'If any other law or custom is inconsistent with any of the provisions of this Constitution, the Constitution shall prevail, and that other law or custom shall, to the extent of its inconsistency, be void.'

in contravention of the laws of Uganda. Organisations providing harm reduction services and who engage in criminalised conduct (such as drug use, sex work, and same-sex sexual relationships) may be refused registration on the basis of this provision.

Furthermore, Regulation 18 of NGO Registration Regulations, 2009, specifies that CBOs are not required to be incorporated under the NGO Registration Act. Regulation 2 defines a CBO as "an organisation wholly controlled by Ugandans operating at a sub-county level and below, whose objective is to promote and advance the wellbeing of its members or the community". Despite the no incorporation option, in practice, CBOs must register with the District local government of the area in which they operate. This requirement provides a framework for CBO operations in Uganda but puts them under the mandate of the District local government, which must issue a certificate of registration authorising the CBO to operate. This leaves CBOs vulnerable to the fiat of this local government in so far as they can easily be denied a certificate enabling their lawful operation. This is buttressed by the provision of a penalty for carrying out activities through unregistered organisations.[13]

### The Companies Act 2012

The Companies Act governs and regulates business associations, profit-making (companies limited by shares), and charitable undertakings (companies limited by guarantee). Generally, it focuses on the incorporation and management of companies. It would pass as a fine piece of legislation but for section 36(2), which provides that "no-name shall be reserved, and no company shall be registered by a name, which in the opinion of the registrar is undesirable." This law gives unlimited discretion to the Registrar of companies to reject undesirable company names, which has the potential to marginalise groups perceived as operating unlawfully in Uganda, such as sex workers and LGBTQI+ communities. There is a precedent to this, when in 2015 the Uganda Registration Services Bureau (URSB) refused to reserve and register the name of a KP-led organisation, 'Sexual Minorities Uganda' (SMUG), on the grounds that "the proposed name was undesirable and un-registrable because the proposed organisation was to be formed to advocate for the rights and wellbeing of lesbians and gay persons among other LGBTIs, which persons are engaged in activities labelled criminal acts under Section 145 of the Penal Code Act."[14] Subsequently, on 5th August 2022, the NGO Bureau officially wrote to SMUG stopping their operations.[15]

### Narcotic Drugs and Psychotropic Substances (Control) Act of 2016 (NDPSCA)

The Narcotic Drugs and Psychotropic Substances (Control) Act of 2016 (NDPSCA) criminalises not just the trafficking of narcotic drugs and psychotropic substances, but also their possession or use. Vulnerable people who use and/or inject drugs are a key high-risk population group who need to be encouraged to access HIV prevention, testing, and other services in the interest of public health. By criminalising individual drug use and possession and imposing heavy penalties for transgression, the Act forces people who use and inject drugs into hiding and secrecy, contrary to the harm reduction approach.

The consequences of this law are constraining, limiting the range of medical interventions

13 See section 2 (4) of the NGO Registration Act, Cap 113 and Regulation 8 (3) of the NGO Registration Regulations 2009
14 Letter by URSB, dated 16th February 2015.
15 Statement by Uganda Key Populations Consortium UKPC, 5th August 2022

available and accessible to people who use and inject drugs and discouraging this group from openly seeking healthcare services, including HIV and AIDS-related services. Emphasis on criminal approaches to drug use worsens the stigma and discrimination against people who use and inject drugs and increases discrimination by some health service providers, thereby making people who use and inject drugs more vulnerable to dangerous practices, such as needle sharing, which increases the risk of their being exposed to and/or infected with HIV.

### Equal Opportunities Commission Act, 2007

Legislation was duly enacted to establish the Equal Opportunities Commission (EOC), as required by Articles 32(3) & (4) of the Constitution, with a "mandate to eliminate discrimination and inequalities against any individual (...) and take affirmative action in favour of groups marginalised on the basis of sex, gender, age, disability, or any other reason created by history, tradition, or custom for the purpose of redressing imbalances which exist against them." The EOC monitors compliance with the Equal Opportunities Commission Act, as well as affirmative action of marginalised groups and has the power of a court to investigate discrimination, marginalisation, and denial of equal opportunities.[16]

The EOC has been operating since it was established in 2010 to enforce the rights of people living with HIV, as well as other groups with compounded vulnerabilities (including vulnerability to HIV infection). However, section 15 (6)(d) of the Act stipulates that the EOC cannot investigate "any matter involving behaviour considered to be (i) 'immoral and socially harmful' or (ii) 'unacceptable by the majority of the cultural and social communities in Uganda.'"[17] This provision undermines the purpose of the EOC by excluding stigmatised groups most in need of the assistance of the EOC, including people who use drugs. This issue was resolved when the Constitutional Court struck down this clause in the case of Adrian Jjuuko v. Attorney General Constitutional Petition 1 of 2009.[18]

### The HIV and AIDS Prevention and Control Act, 2014

The HIV and AIDS Act, 2014 (HIVPCA), ensures universal access to HIV and AIDS services with specific guidance for prevention, diagnosis, testing, and care, and defines the rights and obligations of people, as well as the State.

HIVPCA regulates access to facilities, goods, and services related to HIV prevention, testing, counselling, and care. Its provisions embrace equality, discrimination, consent, and privacy issues. It requires the State to ensure the right of access to HIV and AIDS services, including the provision of essential medicines and universal HIV treatment to all persons on a non-discriminatory basis.[19] The state is also under an obligation to promote awareness of the rights of people living with HIV; promote and ensure non-discriminatory participation of people living with HIV in government HIV and AIDS programmes; provide care and support to people living with HIV; and provide adequate funding for HIV and AIDS programmes.[20] One provision established the HIV Trust Fund to "Secure a predictable and sustainable means of procuring

16 Equal Opportunities Commission Act (2007), Part III (14.1)
17 Equal Opportunities Commission Act (2007), Section 15(6)(d).
18 Human Rights Awareness and Promotion Forum (HRAPF) (2019), A Guide to the Normative Legal Framework on the Human Rights of LGBTI Persons in Uganda, 28.
19 Ibid. Section 24(1)(a), (b).
20 Ibid. Section 24 (d-k)

goods and services for HIV and AIDS testing, counselling, and treatment.[21]

HIVPCA fosters an enabling environment to eliminate HIV stigma by prohibiting discrimination. It prohibits any discrimination in health institutions to ensure that no person can be denied access to healthcare services or charged a higher fee for such services on the grounds of their actual, perceived, or suspected HIV status.[22] It also requires health institutions and medical insurers to provide services to people living with HIV without discrimination on the basis of their HIV status.[23]

HIVPCA's provisions prohibiting discrimination are commendable. However, they do not extend to the most marginalised groups, the key and vulnerable populations (KVPs) who face stigma and discrimination based on their actual or perceived HIV status along with their identity as a person who uses or injects drugs, including sex workers, gay men and other men who have sex with men, and transgender persons. HIVPCA does have a commitment that priority should be given to 'most at risk populations,' but narrowly defines these as fishing communities, people in prisons, migrant populations, and "other areas as may be determined by the Minister from time to time."[24] The majority of specific KVP groups prioritised by UNAIDS – sex workers, people who use or inject drugs, gay men and other men who have sex with men, and transgender persons – are not mentioned at all, with no specific provision for making services more accessible to them. This has the effect of rendering these groups invisible within the context of the Act.

### 2.1.2 Policy framework and mechanisms for social contracting of CLOs, CBOs, and CSOs

At present, no accurate and reliable data exists on policy framework and mechanisms on social contracting of CLOs, CBOs, and CSOs in Uganda. Most CSOs rely on grants from international donors to function, and struggle to secure these grants. Most donors in Uganda have combined their resources into basket funding mechanisms, thus decreasing the number of individual funding opportunities open to CSOs. Examples of basket funding include the Democratic Governance Facility (DGF), established in July 2011 by Development Partners (DPs) as a five-year governance programme aimed at providing harmonised, coherent, and well-coordinated support to state and non-state entities to strengthen democratisation, protect human rights, improve access to justice, and enhance accountability in Uganda. These partners include: Austria, Denmark, Ireland, the Netherlands, Norway, Sweden, the European Union, the Global Fund, and PEPFAR. These partners regularly issue calls for proposals (Requests for Applications - RFA) through the media and websites. These RFAs usually provide the guidance on eligibility criteria for applicants, selection, and award process, as well as programmatic and financial reporting requirements for awardees. The other funding mechanism was The Civil Society Fund (CSF), launched in May 2007 to create a streamlined funding mechanism to better coordinate activities of CSOs in the areas of HIV and AIDS, orphans and other vulnerable children (OVC). However, this mechanism closed in 2016.[25]

Therefore, the contracting mechanisms are those developed and managed by donors. At

21 Ibid, Sections 2–28.
22 Ibid, Section 37.
23 Ibid, Section 39.
24 Ibid, Section 24(2).
25 CSF Governance, Management, and Operations Manual – Revised November 2010

present, there is no law in Uganda preventing CSOs from accessing donor funding.[26] At the same time, the Financial Institutions Anti-Money Laundering Regulations 2010[27] do make it more difficult for CSOs to access external funds. It provides general criminal elements which may be used against NGOs seeking foreign funding, such as: Part 1 Section 3, which gives general prohibitions; Part 1 Section 5, which imposes separate crimes; Part 11, which imposes enduring reporting obligations and cross border movement of cash; and Part 5, which imposes undue restrictions by establishing powers of the Authority to inspect premises in case where an organisation may be suspected of committing foreign crimes. This Act, much as it is not solely meant for CSOs, may be used against them since their principal sources of funds are foreign donations. Unofficial donations, in particular, are complicated by a requirement for documentation of the source of funds and enhanced government mechanisms for tracking how the funds will be used. The regulations also create impediments for the movement of funds from external donors. With the above regulations (the Financial Institutions Anti-Money Laundering Regulations 2010) therefore, it is difficult for CLOs, CBOs, and CSOs who work on harm reduction to access funding not only externally, but also internally, since drug use is considered as criminal.

### 2.1.3 Integration of harm reduction in national planning processes

#### Health Sector Development Plan (HSDP) 2021-2025

The Health Sector Development Plan (HSDP) 2021-2025 reiterates the commitment to the international and regional human rights agreements such as the CEDAW, CRC, the Universal Declaration for Human Rights, the International Conference on Population and Development Programme of Action, and the Beijing Declaration and Platform of Action. These highlight human rights and the need to use human rights-based approaches, as well as promoting Universal Health Coverage (UHC) to enhance equity, accountability, and participation. While the plan indicates that a non-discriminatory approach to health care should be taken, it does not explicitly state how the services for KPs such as female sex workers, gay men and other men who have sex with men, people who inject drugs, people in prison, and transgender people are to be delivered.

#### National HIV/AIDS Strategic Plan, 2020/21-2024/25

Over the last years, Uganda has seen an increase in drug use.[28] In contrast to previous HIV National Strategic Plans, the National HIV and AIDS Strategic Plan 2020/21 – 2024/25[29] identifies HIV prevention programs for people who use drugs, including opioid agonist therapy (OAT) and needle and syringe programs (NSP). Strategic objective 1.1.7 of the National HIV and AIDS Strategic Plan aims to “introduce and scale up harm reduction programmes for people who use drugs.” These intentions therefore provide opportunities for advocating for harm reduction programming, although there are no corresponding budget allocations in the operational plans.

26 The NGO Act amendment proposals section 11(h), (b, d, e) only proposes the organization to submit annual returns and estimates to the District authority in the area of operation
27 The Anti-Money Laundering Act 2013
28 National Key Population Size Estimation 2018
29 National HIV and AIDS Strategic Plan 2020/21-2024/25 pg. xvi

**Leave No-One Behind: A National Plan for Achieving Equity in Access to HIV, TB, and Malaria Services in Uganda 2020-2024 (2019).**

This National Action Plan sets out a comprehensive response to remove human rights- and equity-related barriers to HIV, TB, and malaria services.[30] It defines 'health equity' as follows: "that all individuals have fair opportunities to avoid infection or to live with their disease in full health and dignity in the absence of barriers or other limits based on avoidable, unfair, or remediable differences."[31] Barriers to HIV services include: poverty and social exclusion; HIV-related stigma and discrimination; high levels of stigma, discrimination, and violence against KVPs, including people who use or inject drugs; problematic laws, regulations, and policies; challenges with places of detention; gender based violence (GBV); as well as gender inequality and harmful gender norms.[32]

The 'Leave No-One Behind' Plan prioritises the following KVPs: people living with HIV; uniformed services personnel; inmates and other detainees; AGYW; people who use or inject drugs; older persons; and people affected by ethnic, geographic, religious, or cultural barriers.[33] The Guiding Principles of the Plan are: (1) equality and non-discrimination; (2) do no harm; (3) privacy and confidentiality; (4) meaningful participation of people living with HIV, vulnerable populations, and KPs including people who use or inject drugs; and (5) respect for personal dignity and autonomy, which is encompassed by various international human rights standards and extends to people in prison and other closed settings.[34]

One of the goals is to address health-related equity barriers for specific KVPs. The Plan discusses specific interventions for people with disabilities, people in closed settings like prisons, refugees, asylum-seekers, and other displaced populations.[35] While these detailed interventions aimed at specific KVPs are a positive step towards reducing stigma and increasing HIV service uptake for these three groups, the Plan does not provide detailed interventions for other KVPs, including those listed as 'prioritised' such as uniformed personnel, elderly persons, or persons affected by 'ethnic, religious, or cultural barriers'. Additionally, the Plan does not make any mention of KPs, such as gay men and other men who have sex with men, transgender persons, sex workers, or people who use or inject drugs, and thus does not fully succeed in its attempts to fulfil the country's commitments with respect to the international HIV framework. It is, therefore, unfortunate that a plan with the phrase 'Leave no-one behind' in its title, leaves out a significant number of key populations, including people, in the detailed interventions and actions to address barriers to health equity.

**The Harm Reduction Guidelines (2020)**

The MOH's Harm Reduction Guidelines have enabled the establishment of the first Medically Assisted Therapy (MAT) centre for the treatment of people who inject drugs. The centre was launched in December 2020 and is based at Butabika National Mental Health Referral Hospital. These guidelines set a benchmark opportunity to ensure that people who use or

30 Ministry of Health (MoH) (2019), Leave no-one behind: A national plan for achieving equity in access to HIV, TB and Malaria services in Uganda 2020-2024, 5.
31 Ibid, 2.
32 Ibid, 3.
33 Ibid, 7.
34 Ibid, 8.
35 Ibid, 24-28

inject drugs are included in the national HIV and AIDS response despite a punitive legal environment that criminalises them. These guidelines represented a fundamental shift from the previous approach that treated people who use or inject drugs as criminals, to a harm reduction approach which seeks to reduce the negative consequences of drug use, policies, and laws. Harm reduction is grounded in social justice and human rights and focuses on achieving positive change among people who use drugs without subjecting to judgement, coercion, discrimination, or criminal prosecution.

**The 1997 Local Government Act**

The five–year District Development Plans are a legal requirement for all higher and lower local governments in Uganda. They form a baseline tool for tracking the implementation of government programmes, and the basis of controlling the pace and direction of development investment. It is in these plans that stock of what is identified at lower local governments is elicited and integrated into the district expectations to inform the National Development Plan as required by article 190 of Constitution of the Republic of Uganda 1995, which is further operationalized in the 1997 Local Government Act, cap 243 Section 36 and 78. The Act mandates the District Council to consult lower level local governments and administrative units in their respective areas of jurisdiction during preparation of the district development programme and plans, incorporating the concerns about the plans of the lower local government and administrative units at the sub county and parish levels. In addition, the Ministry of Local Government issued guidelines for participatory planning by local governments that require that stakeholders, including CSOs, be consulted during the preparation of the local government plans.

**Health Financing Strategy 2015/16-2024/25**

The second Health Financing Strategy for Uganda is aligned to the global commitment towards the Sustainable Development Goals (SDGs) and UHC. It is anticipated that this strategy will serve as a critical element in Uganda's pathway to achieving the health-related SDGs and attaining UHC. UHC emphasises access to good quality health care according to need, while at the same time limiting exposure to financial risk for those who seek care. The Strategy outlines the financial health reforms strategies that must be undertaken in order to achieve UHC. These include: increased revenue collection through government un-earmarked taxes, innovative options-earmarked taxes, external grants and loans, insurance – out of pocket; risk pooling through joint fund, social insurance (mandatory), community insurance (voluntary/ mandatory); strategic purchasing (input-based purchasing – payment against investments); results-based purchasing – payments against deliverables; and process-based purchasing – payment against activities.[36] These strategic intentions are meant to deliver the minimum essential services. However, the minimum essential services do not mention a package for harm reduction.[37]

### 2.1.4 Community and civil society perspectives on participation and involvement in planning and decision-making platforms at national and sub-national levels.

Available data shows that CSOs are part of various planning technical working groups at the national level, including the following: at the national level, the community of people who use

36 The Second Health Financing Strategy 2015/16-2024/25
37 The Ministry of Health Strategic Plan 2020/21 – 2024/25

or inject drugs is a member of the National HIV Prevention Committee hosted at the Uganda AIDS Commission. People who use or inject drugs are also represented at the National MARPs Steering Committee hosted at the MOH. The community through Uganda Harm Reduction Network (UHRN) is also a representative of the MAT Task Force that is chaired by the MOH whose role is to provide oversight on the implementation of the MAT programme in Uganda. In addition, the community is represented at CCM through the KP representatives (gay men and other men who have sex with men and sex workers) elected by the entire KP community (gay men and other men who have sex with men, transgender persons, sex workers, people who use drugs). These platforms provide oversight, technical guidance, and monitoring and reporting to programming for KP interventions. It should be noted that the above platforms have facilitated advocacy for inclusion of harm reduction in the national planning and service agenda.

## 2.2 Financial landscape

### 2.2.1 Current level and sources of funding on harm reduction response

Harm reduction funding is an area of concern in Uganda. The findings highlight three factors that underpin the funding challenges: predominance of punitive responses to drugs, poor political support for harm reduction, and lack of awareness on the benefits of harm reduction. There is a lack of political and financial support for harm reduction from most government agencies/ departments in Uganda, with initiatives relying heavily on international donor funding. A rapid assessment on harm reduction funding in 2021 by UHRN in collaboration with HRI found that there has been minimal progress in domestic funding for harm reduction programmes with current funding primarily coming from international donors.[38] It was noted that available domestic support includes policy framework and institutional support, such as the MAT clinic at Butabika Mental Referral Hospital, which is a nationally managed health facility. Between 2017 and 2019, a total USD 816,018 was invested in harm reduction programmes in Uganda. All the funding came from international partners and was implemented by local partners with no domestic funding. 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 the CDC and USAID, the Global Fund, international NGOs such as the Open Society Initiative for Eastern Africa and Frontline AIDS through the PITCH project. The harm reduction services were supported through national civil society organisations. The national NGOs include the Most At-Risk Population Initiative (MARPI), Mild May Uganda, Rakai Health Sciences, and the Ugandan Harm Reduction Network (UHRN). Currently, the Global Fund NFM3 (2021-2023) grant supports a harm reduction package for people who use drugs (including people who inject) through facility and community drop-in centres. In addition, the US government through the CDC supports the MAT clinic at Butabika Mental Referral Hospital.

38 Ugandan Harm Reduction Network & Harm Reduction International (2021) Rapid Assessment of Harm Reduction Funding and Investment in Uganda. https://hri.global/wp-content/uploads/2022/10/Final_Harm_Reduction_Investment_Assessment_Report_2021-1.pdf

### 2.2.2 Domestic funding for harm reduction

While the policy and strategic plans indicate inclusion of harm reduction services, the government support is limited to in-kind provision of policy framework and infrastructure to service delivery for the general population. There is no indication of harm reduction costing in national operational plans at either the national or sub-national level.

According to the Report of National AIDS Spending Assessment study for FY 2014/15, 2015/16, and 2016/17,[39] Uganda spent UGX 1.210 trillion (USD 433.5 million) on HIV and AIDS in 2014/15.

The spending dramatically increased by 53.8% to UGX 2.269 trillion (USD 666.8 million) in 2015/16 and increased by 3.7% from 2015/16 to 2016/17 to UGX 2.411 trillion (USD 691.8 million). Of the total HIV and AIDS expenditure, public sources contributed 9.4% (USD 40.6 million) in 2014/15, which declined by 24.5% as a proportion of total spending in that year to USD 30.7 million in 2015/16 and rose again in 2016/17 by 33.5% to USD 40.9 million. The Private Not For Profit sector decreased from USD 4.9 million in 2014/15 to USD 1.9 million (2015/16), a decrease of 60.9%, and then rose again to USD 2.6 million (2016/17), an increase of 35.9%. The public resources are used to support care treatment through purchase of essential drugs, strategic Information, systems strengthening and infrastructure, and management and operations.

External sources contributed 89.5% (USD 388.0 million) of total HIV and AIDS expenditure in Uganda in 2014/15. External aid rose by 63.5% between 2014/15 and 2015/16, from USD 388.0 million to USD 634.2 million, and in 2016/17, it increased slightly by 2.2 % to USD 648.0 million. It is important to note that the largest portion of external sources for HIV and AIDS funding comes from Government of the United States of America (USG) through PEPFAR, contributing 99.8% on average of the total bilateral funds, over the three-year period. Among the multilateral organisations, the Global Fund contributed the highest share of HIV and AIDS financing, with 90.7% in 2017/18 and 87.5% in 2018/19. The available information further shows that United Nations agencies and international NGOs together contributed the smallest share of total HIV and AIDS financing, at 5.8% in 2017/18 and 7.2% in 2018/19. PEPFAR and the GF largely supported HIV prevention, care, and treatment; social support; strategic information; systems strengthening; and management and operations. In addition, the GF support goes to TB and malaria programmes.

It should further be noted that, in Uganda, local governments are heavily dependent on central government transfers to finance their programmes and services. Yet, despite the fact that local governments deliver most services to communities, the bulk of central government spending is not passed along to local governments. Local governments receive less than 30% of the central government's total budget resources. Furthermore, most of the financial resources that local governments receive from central government are in the form of conditional grants, or "earmarked" for specific sector allocations in education, infrastructure, public administration, health, and other areas, thereby restricting local government's ability to allocate funds according to local needs. Local governments are permitted a limited reallocation of conditional

39 National AIDS Spending Assessment study for Financial Years 2014/15, 2015/16 and 2016/17

grant funding within the same sector – no more than 10% of conditional grant funding – with permission from the Ministry of Local Government and the Ministry of Finance. With this background, it would be hard for local governments to allocate funding to harm reduction, even if it was not treated as a criminal issue. With such a scenario, therefore, more advocacy efforts need to be put on the national level to ensure the planning and costing for health interventions mainstream harm reduction services.

### 2.2.3 Resource gaps, needs, allocative efficiency

It is difficult to document resource gaps, needs, and allocative efficiency relating to harm reduction investment in Uganda. This is due to a lack of effective tracking systems and budgeting for harm reduction, but also due to lack of external studies on harm reduction-related resource allocations. This lack of documentation of resource gaps and needs impedes effective harm reduction programme planning as well as advocacy for harm reduction.

# SECTION 3: COMMUNITY, CIVIL SOCIETY AND STAKEHOLDER CONSULTATION FINDINGS

## 3.1 Mapping processes and opportunities

### 3.1.1 Mechanisms for prioritisation, efficiency, resource allocation

The consulted stakeholders stated that there are opportunities that could facilitate prioritisation and resource allocation to harm reduction at the national and sub-national levels. Below are the identified mechanisms;

- Mid-term evaluation of the Health Sector Development Plan (HSDP) 2021-2025 which is due in last quarter of the year 2022
- Mid-term evaluation of the National HIV and AIDS Strategic Plan 2020/21 – 2024/25 (November –December 2022)
- Planned Health Sector annual general assembly (November 2022)
- Joint HIV Annual review meeting (October-November 2022)
- New Funding Mechanism IV and country application process 2022-2023 including CCM constituency engagement meetings (November 2022-March 2023)
- NFM IV writing process (January –March 2023)
- Country Operations Plan 2023 (COP23) country consultations
- Annual Local Government Review Meeting 2022 (November 2022)
- National and Local Government budget process for FY 2023/24 (October 2022-March 2023)

> *… we have planning and policies which are public health oriented, and they seek to support and ensure equitable access to services, for all populations. All people are eligible to receiving health services with no discrimination". KI Public Sector Official).*

### 3.1.2 Opportunities for harm reduction funding

- The Global Fund New Funding Mechanism 4 (NFM4) and country application process 2022-2023 including CCM constituency engagement meetings
- NFM 4 writing process (January –March 2023)
- PEPFAR Country Operations Plan 2023 (COP23) country consultations
- Parish Development Model on-going implementation
- United States Government Localisation of programmes agenda in Uganda-on-going process
- Bilateral Cooperation strategy development processes e.g USG, SIDA, DANIDA, Netherland's Government and UK AIDS-on-going processes

While the above are opportunities for prioritisation and funding for harm reduction, there are barriers that may limit community led organisations participation and advocacy for harm reduction and these include;

- Criminalisation of individual drug use and possession
- Lack of allies, strategic partners and influence
- Lack of awareness among public agencies about harm reduction
- Limited knowledge and capacity of community advocates to influence and engage with budget processes
- Lack of government social contracting policy guidelines
- Lack of political will for harm reduction funding and program by the government
- Lack of national drug policy
- Limited research in harm reduction domestic financing to support advocacy for harm reduction domestic funding
- Lack of community capacity to demand, monitor and follow up domestic funding
- Competing priorities for domestic funding might affect access to domestic funding for harm reduction

> *"If we are treated as criminal…how do you expect the government to allocate funds to harm reduction interventions?" (PWUD Led Organisation)*

> *"There is systematic violence - the system doesn't recognise, doesn't include, and doesn't prioritise PWUD's needs - not seen as a health issue but issues of spoilt persons". CSO Leader.*

> *"Some of the KPs feel marginalized, and cannot access the health service freely, most especially the people who inject drugs. – They fear getting to the facilities because the law enforcers always target their hot spots and arrest them". (KI PWUD Led CLO)*

**3.1.3 Community and civil society perspectives on priority actions to overcome these challenges, including identifying information and capacity gaps for budget advocacy.**

- Strengthen research in harm reduction domestic funding to avail more evidence to support advocacy agenda
- Strengthen advocacy for a national drug policy to guide implementation of harm reduction programs for people who use drugs in Uganda. This could be undertaken to create more awareness about harm reduction and reduce stigma and discrimination against people who use and inject drugs.
- Establish advocacy champions through forming coalitions for harm reduction program in Uganda. The coalition members can be from CSOs that support not only harm reduction but those that are engaged in human rights and health advocacy.

### 3.1.4 Community and civil society perspectives on upcoming opportunities for harm reduction budget advocacy

The assessment participants noted that upcoming platforms and processes such as health general assembly, joint annual HIV review, NFM 4, COP 23, mid-term evaluation of national strategic plans (Health, and HIV/AIDS) provide strong advocacy platforms for harm reduction prioritisation and budgeting. These are public platforms where CSO representatives are represented and participate. As such advocates for harm reduction should ensure they are represented and participate.

## 3.2. Mapping partners

### 3.2.1 Community and civil society monitoring of harm reduction funding

Community Led Monitoring led by International Community of Women Living with HIV in East Africa (ICWEA) in partnership with HEPS. Community-led monitoring (CLM) is a technique initiated and implemented by local community-based organizations and other civil society groups, networks of key populations (KP), people living with HIV (PLHIV), and other affected groups, or other community entities that gather quantitative and qualitative data about HIV services. The CLM focus remains on getting input from recipients of HIV services in a routine and systematic manner that will translate into action and change. Addressing continuing challenges in the quality of and access to services is inextricably linked to addressing this accountability deficit in the HIV response. Community-led monitoring model offers an opportunity to harm reduction advocates to monitor harm reduction funding and services.

**Community scorecard (CSC) process supported by the Global Fund through TASO:**

A CSC is an effective method of assessing how well an intervention is understood and embraced by beneficiary communities. The tool is used for soliciting views of community members using participatory appraisal approaches from within the communities consuming the services so as to provide their opinion on how well the interventions respond to their needs. It is also meant to strengthen the culture of observing a minimum set of standards for service delivery. Implementation of the CSC is aimed at reducing human rights related barriers in accessing and utilizing HIV, TB and malaria services to improve treatment outcomes and retention in care. It is aimed at improving the quality, timeliness, affordability, availability, and accessibility of services at community and health facility levels. The tools capture service and human rights indicators focussing on general population but also key and vulnerable populations including people who use and inject drugs. This is being implemented by partners implementing global fund activities including Uganda Harm Reduction Network between, September –December 2022. The model can also be used to monitor and establish harm reduction funding and interventions in Uganda.

### 3.2.2 Community and civil society perspectives on upcoming opportunities for harm reduction budget advocacy

***National Level Platforms/audiences:*** Parliamentary Committee on Social Services: The committee provides oversight, monitoring of programs and projects in the health and education

sectors. They ensure equitable allocation and utilisation of resources from the public and non-public sector. The harm reduction advocates should target this committee for increasing resource allocation to health and harm reduction in particular.

***Health Policy Advisory Committee (HPAC)*** is an advisory committee for health sector with representation from (DGHS, Directors, Commissioners, Representation from Health Development Partners (HDPs), and private sector, CSOs, Line Ministries, Referral Hospitals, District health offices (DHOs) and semiautonomous Institutions. The main role is to provide policy and technical services to the sector and ensure set priorities to meet the development goal and objectives of the health sector.

***Uganda AIDS Commission (UAC)*** is responsible for overseeing the implementation of the Three Ones in the coordination of the national response (i.e., one national AIDS coordinating authority, one action plan and one M&E framework). UAC disseminates the NSP and its accompanying documents (i.e., the National HIV and AIDS Monitoring and Evaluation Plan, the National HIV and AIDS Priority Action Plan [NPAP] and the Abridged Version of NSP); mobilises resources required for implementation; liaises with sectors, government, MDAs, local governments and CSOs to ensure their active involvement in the implementation of the NSP; oversees an effective management information system to facilitate implementation and offers technical guidance to sectors, local governments and civil society actors.

***HIV and AIDS Partnership Committee:*** With a membership from public sector, non-public sector (civil society), supports UAC with coordination, the HIV and AIDS national response. The partnership committee facilitates minimisation of duplication; maximisation potential for synergies, learning and peer support; and pools efforts for scaling up the response.

***The Health Development Partners (HDP) Group:*** The HDP Group meets monthly, with the overall purpose of coordinating development partners in Uganda. The group's aim is to strengthen the partnership between GoU and the HDPs to ensure more effective implementation of the national strategic plan and to reduce transaction costs for both agencies and Government. The HDP Group chooses one agency to be their coordinator for each GoU Financial Year (FY). The coordinator chairs the monthly meetings and acts as a contact point between group members and MoH.

***AIDS Development Partners:*** The ADPs Group meets monthly, with the overall purpose of coordinating HIV and AIDS development partners in Uganda. The group's aim is to strengthen the partnership between GoU and the ADPs to ensure more effective implementation of the national HIV/AIDS strategic plan and to reduce transaction costs for both agencies and Government. The ADP Group chooses one agency to be their coordinator for each GoU Financial Year (FY). The coordinator chairs the monthly meetings and acts as a contact point between group members and Uganda AIDS Commission and Ministry of Health. Their monthly meetings are convened by UNAIDS.

***The Uganda Country Coordinating Mechanism (CCM)*** is the country's Global Fund governing body. It is a multi-stakeholder entity vested with the mandate to develop and submit funding requests to the Global Fund and oversee the grants to fight HIV, Tuberculosis and Malaria based on the national priority needs. The CCM is set up on a partnership basis with representatives from public sector, non-public sector (civil society), private these members

act as the in-country Global Fund Board that plays the oversight role over the management of grant funds and oversees the implementation of the programmes that the Global Fund approves for Uganda. The Uganda CCM has a Secretariat that supports its functions through technical guidance and management of resources.

***NFM 4 writing teams:*** This is a team with representatives from public sector, non-public sector (civil society), and private that lead the drafting of the Global Fund national proposal with support from identified consultants.

***Sub-National Level:*** There a number of platforms that can be targeted for advocacy and these include among other; Regional Cities – Councils with a membership of City Mayors, Lord Councillors and Town Clerks and health technical teams; Local Governments and Municipalities- Councils with membership of Local Councillors, Chief Administrators, and District Health teams and Town

***Civil Society:*** There are other partners to engage in harm reduction budget advocacy and these include; CSO platforms like Civil Society Budget Advocacy Group (CSBAG), Uganda Key Population Consortium, HEPS, Action Group for Health Human Rights & HIV/AIDS (AGHA Uganda), Uganda Network of Aids Service Organisations (UNASO) and HEPS Uganda. Additionally, Private sector, School Management and Recovered drug users should be considered.

# SECTION 4: CONCLUSIONS AND RECOMMENDATIONS

The landscape assessment found that, while there is national legal and policy framework that can facilitate harm reduction investment, there are punitive and discriminatory laws and policies; that limit provision of harm reduction services. The major challenges faced by CSO identified during the research include:

1. Various laws and regulations applicable to CSOs that may limit the supportive environment for their operations;
2. Lengthy and cumbersome registration processes and multiple centres such as the NGO Board, Uganda Registration Services Bureau, and the District Administration;
3. Discretionary powers of the NGO Board and other government agencies that may deny CSOs registration or deregister an existing organisation;
4. High level of dependence of CSOs on external sources of funding which affects the programming and sustainability of their interventions;
5. Lack of vibrant formal grant-making mechanism, especially for smaller CSOs that cannot compete with larger, better established CSOs for the same donor resources due to capacity gaps.
6. Near total absence of structured local philanthropy, except in relation to religious CSO causes.

From the document review and community consultation, the following recommendations are made to enhance the access to harm reduction services.

**To Government**

1. The government should review provisions in the Narcotic Drugs and Psychotropic Substances Act 2015 and other laws that create barriers to accessing harm reduction and health care services for people who use drugs.
2. The government should prioritise funding for harm reduction by both including and integrating harm reduction interventions within the development plans at the national and sub-national levels. These interventions should be aligned to the standard international guidelines.
3. The government should allow full participation of community-led organisations, civil society, and people who use drugs in the design, delivery, and monitoring of supported harm reduction programmes. This will require their participation in the national and sub-national planning and budgeting mechanisms.
4. The government should ensure that people who use drugs are able to access membership to any existing planning and budgeting platforms at the national and sub-national levels to ensure meaningful participation.
5. Capacity building for health service providers in harm reduction services provision should be promoted.
6. Establish mechanisms for contracting and funding CSOs by developing policy guidelines to deliver harm reduction services.

**To International Partners:**

1. International donors should increase funding for harm reduction programmes.
2. International donors should engage governments to prioritise and budget funding for harm reduction programmes.

**To CSO, CLOs working on Harm reduction:**

1. Civil society organisations should form advocacy coalitions and technical working groups to act as advocates to engage in planning and budgetary processes.
2. Civil society organisations should train and sensitise law enforcement officials on the rights of people who use drugs and take measures to reduce violence and human rights violations against them.
3. Civil society organisations working with people who use drugs should prioritise further research on drug use trends and epidemiology. This can be undertaken in collaboration with research institutions and international donors.

# SECTION 5: ANNEXES

## 5.1: List of community, civil society and stakeholder consultation participants

| SN | Name | Title | Organization / individual | Organization type (CBO/CSO) |
|---|---|---|---|---|
| 1 | Twaibu Wamala | ED | UHRN | CSO |
| 2 | Dan Katende | Officer | UHRN | CSO |
| 3 | Dr. Peter Kyambadde | ED | MARPI & MOH | CSO |
| 4 | Mwebaze Edward | | HRAPF | CSO |
| 5 | Betty Balisalamu | ED | Women With Mission | CSO |
| 6 | Gracias Atwine | Deputy ED | CEHURD | CSO |
| 7 | Macklean Kyomya | ED | AWAC | SW CLO |
| 8 | Lillian Mworeko | ED | ICWEA | CSO |
| 9 | Apako William | ED | Trannetwork | CSO/CLO |
| 10 | Opio Joel | ED | MIMHA | CLO |
| 11 | SHAMEEM NAJJENGO MYRAEJ | ED | ICDNL | CLO |

## 5.2 List of key organisations and individuals active in budget advocacy and accountability

| SN | Name | Title | Organization / individual | Organization type (CBO/CSO) |
|---|---|---|---|---|
| 1 | Kenneth Mwehonge | ED | HEPS | CSO |
| 2 | Nakibuuka Noor | ED | CEHURD | CSO |
| 3 | Lillian Mworeko | ED | ICWEA | CSO |
| 4 | Mwebaze Edward | | HRAPF | CSO |
| 5 | Flavia Kyomukama | | AGHA | CSO |
| 6 | Stella Kentusi | | NAFOPHANU | CSO |
| 7 | Gracias Atwine | | CEHURD | CSO |
| 8 | Julius Mukunda | | CSBAG | CSO |
| 9 | Kennedy Otundo | | UNASO | CSO |
| 10 | Dr. David Bitira | | CHAU | CSO |

## 5.3 Appendix A: A list of the laws, policies, strategies, guidelines, and other literature reviewed.

### Laws, Government of Uganda


- Constitution of the Republic of Uganda. 1995. https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/44038/90491/F206329993/UGA44038.pdf.
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- HIV and AIDS Prevention and Control Act. July 17, 2014. https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/110805/137931/F-1081306421/UGA110805.pdf.
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- Non-Governmental Organisations Act: Act 5 of 2016. March 14, 2016. https://media.ulii.org/files/legislation/akn-ug-act-2016-5-eng-2016-03-03.pdf.
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- Health Sector Development Plan (HSDP) 2021-2025MoH Strategic Plan 2020_25.pdf
- UNAIDS Harm Reduction Policy 2019
- The Harm Reduction Guidelines (2020)
- Health Financing Strategy 2015/16-2024/25
- The Civil Society Fund Governance, Management and Operations Manual, Revised Version November 2010- CSF Manual

**Reports**

- Ugandan Harm Reduction Network & Harm Reduction International (2021) Rapid Assessment of Harm Reduction Funding and Investment in Uganda. https://hri.global/wp-content/uploads/2022/10/Final_Harm_Reduction_Investment_Assessment_Report_2021-1.pdf
- National Key Population Size Estimation 2018KPSE Final Draft Report_18Oct2019 (1).pdf
- Human Rights Awareness and Promotion Forum (HRAPF) (2019), A Guide to the N ormative Legal Framework on the Human Rights of LGBTI Persons in Uganda, 28
- HRI (2021) Failure to Fund: The continued crisis for harm reduction funding in low- and middle-income countries. HRI, London. https://www.hri.global/files/2021/08/09/HRI-FAILURE-TO-FUND-REPORT-LOWRES.PDF
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