HARM REDUCTION INFORMATION NOTE -Uganda

HARM REDUCTION INTERNATIONAL

This information note has been compiled by Harm Reduction International (HRI) in collaboration with The Uganda Harm Reduction Network (UHRN) to support Global Fund Grant Cycle 8 processes.

1. Epidemiological Data

1.1 People who use drugs, HIV and Hepatitis C (HCV).

- There are an estimated 9,500 people who inject drugs living in Uganda in 2024, with the majority located in the Kampala, Wakiso, Mbale and Mbarara districts.[1] [2]
- There is an estimated HIV prevalence of 17% among people who inject drugs in 2024[3], disaggregated as 8% among men who inject drugs and 24% among women who inject drugs.[4]
- The estimated prevalence of viral hepatitis (HCV) in the general population is 0.75%[5] in 2024, and among people who inject drugs it is 2%.[6]

1.2 Prevention and harm reduction programmes after recent funding shifts.

- Opioid agonist therapy (OAT) coverage data is not available in the country[7], though our research shows that only one OAT clinic remains in operation.[8]
- The US Government through PEPFAR (The US Pesidents's Emergency Plan for AIDS) previously supported OAT and other HIV prevention services across clinics in Butabika, Kampala; Mbale, Eastern Uganda.[9]
- The shuttered OAT clinics in Butabika Regional Referral Hospital and the Kampala Region HIV Project previously supported an estimated 800 people who inject drugs with "medication assisted therapy"[1] under PEPFAR funding.[10]
- The Ugandan Harm Reduction Network reported a drug overdose crisis as a stop-work orders interrupting OAT.[11]
- Needles Syringe Programmes (NSP) in the country is provided by the Global Fund in Kampala, Wakiso, Mbale and Mbarara, and was impacted by reprioritisation and reduced capacity from absorbing the impact of the closure of PEPFAR funded services.[12]

2. Harm Reduction Financing

- PEPFAR and the Global Fund have provided most of the funding for harm reduction programmes in Uganda. The Global Fund has supported OAT, NSP, PrEP, and other HIV prevention services, while PEPFAR has focused on OAT provision.
- Uganda's reliance on international funding and a complete absence of domestic funding led to huge impacts from the funding shifts, including increased overdose, service closures, loss of staff and increased stigma and discrimination.[13]
- There have been some indications of domestic support to ensure continuity of OAT, as the government works to integrate services within the Ministry of Health. So far this has been limited to the deployment of healthcare workers.[14] [15]
- PEPFAR allocations for interventions for people who use drugs in Uganda totalled USD 235,000 for 2024, before the funding cuts.[16]
- From the Global Fund HIV country grant, Uganda had allocated USD 905,317 for people who inject drugs and their sexual partners. Following re-prioritisation this was reduced to USD 821,173. This amounts to a 9.3% reduction, or USD 84,144. Uganda's Grant Cycle 8 HIV allocation represents a 10.2% reduction on Grant Cycle 7. [17]
- In December 2025, Uganda entered into a bilateral MoU with the US Government, securing funding from PEPFAR from April 2026. There is no agreement in place for this funding to be

[1] Medication Assisted Therapy is a term used by PEPFAR for OAT services

used for harm reduction programming and given the restrictive legal and policy environment in the country it is unlikely this funding will target key population groups at all.[18]

- While the Ugandan government has promised to scale up HIV prevention and treatment in 2026, there is little evidence this will reach people who inject drugs. Performance indicators related to this include increasing HIV testing and treatment, as well as access to condoms, with no reference to harm reduction interventions, people who inject drugs, or key population groups.[19]

3. Recommendations for Integration of harm reduction services into broader health system.

A rushed integration process without undertaking careful planning could further dismantle already inadequate HIV prevention and harm reduction services for key populations. Thus, the Global Fund country dialogues and integration process for prevention and harm reduction programmes should fulfil the following factors as key pre-requisites for successful and sustained integration.

- Secure Government Funding Before Integration:

Though the Ugandan government will co-finance 15% of the upcoming Global Fund GC8 allocation, there is currently no domestic funding for harm reduction within the country. Since the funding cuts and associated disruption to OAT and other HIV prevention interventions, the government of Uganda recognizes the importance of maintaining OAT access and has facilitated service provision through deployment of healthcare workers. The government of Uganda also recognised the impact of its own low contribution to even HIV treatment medicines, describing it as "critically low".[20]

A devolved system of governance in Uganda, with decentralisation providing more power and opportunities to local governments. Local government is structured across 5 levels, from village, parish municipal council/ divisions, district to national which are responsible for public health delivery. This offers opportunities for provincial financing for harm reduction in the country; however currently local governments are extremely reliant on transfers from the central government to finance programmes which leaves little possibility for locally financed harm reduction.[21]

The need for domestic harm reduction financing in the country is given further legitimacy by the inclusion of people who inject drugs in the National HIV Strategic Plan 2020/21-2024/25, though this has yet to be updated. Further, the East African Community Regional Policy on Alcohol, Drugs and Substance Abuse aims to scale up harm reduction programmes in the seven East African states, including Uganda. This legitimacy and recognition of the need for domestic harm reduction funding is yet to become reality.

The Global Fund funding request process should obtain concrete government commitments and financing for key populations and harm reduction programmes before initiating integration. Co-financing policies should include strict, enforceable conditions such as tying disbursements to earmarked government allocations for HIV prevention programmes for people who use drugs including harm reduction.

- Protect and resource community-led organisations.

Funding cuts and reprioritisation have reduced community systems and reduced advocacy, monitoring, outreach, training, campaigns and caused the loss of skilled human resources consistently across countries. Communities and community-led services have remained resilient, offering crucial services to mitigate the impact of service disruption. Communities bridge the gap

between services and marginalised populations such as people who inject drugs, making crucial contributions to the overall health system.

While the Ugandan government has made healthcare workers available to support OAT distribution previously funded and procured by PEPFAR and the CDC, the funding cuts have had a significant impact on the community. Critical community-led roles that were previously supported under PEPFAR funding including demand creation, initial client assessment, peer engagement, and psychosocial support provided by civil society organizations were not considered in the transition and consequently lost funding support.[22]

Furthermore, the government has not provided support for the operationalization of community-based harm reduction drop-in centres. As a result, the two of the harm reduction drop-in centres were closed, and the Mobile Van Dispensing services also came to a halt following the funding shifts. These developments have significantly affected community outreach, accessibility, and continuity of harm reduction services and care for people who use and inject drugs.

The Global Fund funding request should allocate dedicated funding to community-led organisations, including support for budget advocacy to mitigate the equity risks of integration and to ensure community-led service delivery is not interrupted. Community-led and civil society organisations must have sufficient resources to meaningfully engage throughout the integration process and to drive domestic resource mobilisation. Integration must not equate to the closure of community-led services.

These demands come within the context of an extremely restrictive legal and policy environment for key populations. Possession of illegal drugs is punishable under the Narcotic Drugs and Psychotropic Substances (Control) Act by 15 years in prison, or life for those judged to be involved in the supply chain, while the Anti-Homosexuality Act imposes life imprisonment or even the death penalty on the LGBTQ+ community. These policies further jeopardizing the HIV response by limiting community engagement, uptake of healthcare services, and targeting those working in community-led organisations.

- Prioritise Social Contracting as a core integration safeguard

The Global Fund funding request should prioritise establishing and expanding social contracting mechanisms for community and key population organisations, recognising community systems as a critical component of the wider health system. Community-led and civil society organisations must be engaged meaningfully throughout this process and the Global Fund should allocate resources to budget advocacy to unlock social contracting grants at national, provincial and county levels.

This is only feasible if the necessary changes are made to ensure a supportive legal and policy framework for community-led organisations and civil society to lead service delivery. While Ugandan policy framework allows for social contracting at national and sub-natonal levels, however the restrictive environment for civil society and community-led organisations creates a significant barrier.[23]

Additional notes:

- Integration and the Global Fund Modular Framework

The Global Fund Modular Framework is the guide to organise proposed programme activities into standard modules and interventions for the three diseases (HIV, TB and Malaria) and RSSH (Resilient and Sustainable Systems for Health).[24] The framework includes a list of modules (broad

programmatic area), interventions (specific programmes within modules), activities (operational activities for interventions) and standardised indicators to measure the result linked to modules.

It is useful for activists and those involved in the Global Fund country dialogues to understand the modular framework to be able to propose realistic and specific interventions, activities under each module; and also to locate and track the activities, budget and indicators in the funding request document up to and during the grant-making phase.
The most relevant activities related to integration are found within the RSSH component of the GC8 Modular Framework. There are 11 modules within RSSH and each module contains different interventions related to integration such as policy, governance, financing, community-systems, human resource, procurement, data quality etc. The list of relevant interventions with useful tips for activists to engage during country dialogue and funding request is found in an annex 1.

- Useful resources on integration and harm reduction

Below are some resources specific to integration and harm reduction. Some are already listed under the reference section.

- Harm Reduction International: Key Messages on Harm Reduction and Integration for Grant Cycle 8. https://hri.global/publications/key-harm-reduction-messages-on-integration-for-grant-cycle-8/
- Harm Reduction International and UHRN: Impact of PEPFAR Funding Cuts in Harm Reduction in Uganda. https://hri.global/publications/impact-of-pepfar-funding-cuts-in-harm-reduction-in-uganda/
- The Global Fund: Grant Cycle 8- Enabling Impact: Strengthening Sustainability. https://resources.theglobalfund.org/media/fptatfhe/cr_gc8-enabling-guidance-sustainability_presentation_en.pdf
- International Network of People Who Use Drugs: Integration Without Erasure: Brief to the Global Fund https://inpud.net/integration-without-erasure/
- Harm Reduction International: Harm Reduction Funding Landscape Analysis Uganda. https://hri.global/publications/harm-reduction-financing-landscape-analysis-in-uganda/

Annex 1

Component	Module	Intervention	Additional comments
RSSH: Resilient and Sustainable Systems for Health	Health Sector Governance and Integrated people-centered services	– National health and cross-sector policy strategy and coordination – Planning, management and delivery of integrated people centred-services	This module (and interventions) will include the integration related discussions and initiative at national (policy) level, involving different line ministries, health sectors etc. The country dialogues should identify measures and platform for communities to be engaged meaningfully in these policy-level discussions.
	Community System Strengthening	–Community-led monitoring and advocacy –Community coordination and engagement in decision making	This module is key to strengthen and safe-guard community engagement during the integration process.

		– Organisational and leadership development	The funding request should have adequate allocations for CSS module to be able to engage at different policy, financing, human resource planning and implementation discussions of integration.
	Health Financing systems	– Health financing schemes – Health financing analytics, advocacy, strategies and planning – Social contracting	This module includes strategies and analytics for integration of HIV and TB services into national health financing schemes, pooling of funds, budget impact analysis and economic evaluation. The funding request should have funding on budget advocacy for civil society and communities to be able to engage in the financing discussions and understand how to access the social contracting.
	Health Products Management System	– Policy, strategy and governance	The module includes integration of disease-specific vertical systems into a broader cross-program national system. The country dialogue should discuss the opportunity of having civil society and community-led watch-dog (accountability) mechanism to ensure smooth procurement without disruption and stock-outs of drugs and commodities. The costing of such accountability mechanism can be in-built in CSS module.
	Human Resources for Health and Quality of Care	– HRH planning, management and governance including for community health workers (CHWs) – Pre-service training, remuneration and deployment, continuous professional development of new health workers (excluding community health workers). – Integrated supportive supervision for health workers (excluding CHWs)	Activities related to strengthening integration and sustainability of human resources for health (HRH) policy, planning and governance, including community health workers (CHWs) (all types including peer and community workers). The funding request should ensure that community workers from respective key populations are included in the HRH planning.
	Laboratory Systems	– Laboratory-based surveillance – Specimen referral and transport system	Activities include support the establishment of integrated specimen referral and transport systems.
	Monitoring and	– Data governance	Activities include integration of data repositories and analytics platforms, disease-specific and/or integrated data quality

	Evaluation Systems	– Routine reporting and administrative data sources – Data quality	audits/reviews, tools to monitor data quality generated through community-led monitoring mechanisms. The country dialogue should adequately discuss and have mitigation measures to safeguard data confidentiality of key populations, ability to generate disaggregated data of respective key populations and strengthen community-led monitoring.
	Reducing human-rights related barriers to HIV, TB and Malaria services	– Expanding Access to Quality and Discrimination-free Health Care – Improving health-related laws, regulations and policies to enable access to HIV, TB and malaria services – Preventing and responding to violence against women and girls	This module is key to ensure that key populations access quality integrated services without any stigma and discrimination. The funding request should have adequate allocations for this module to mitigate potential equity risks, particularly for key populations. The CCM should consider allocating advocacy funding for decriminalisation of drug use in the context of HIV as guided by the new UNAIDS guidance note.[xv]

References:

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[17] Mind the Gap: Emerging Gaps in Global Fund Programs.
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