



**UNODC**

United Nations Office on Drugs and Crime

**Rapid Assessment of Substance  
Use and Associated Health and  
Social Services in Selected Relief  
and Humanitarian (Refugee)  
Settings and Situations**



**Assessment Report Uganda**

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## ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AOD	Alcohol and Other Drug
DALY	Disability-Adjusted Life Years
DRC	Danish Refugee Council
DR Congo	Democratic Republic of the Congo
FGD	Focus Group Discussion
HDI	Human Development Index
HIAS	Hebrew Immigrant Aid Society
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person(s)
INCB	International Narcotics Control Board
KI	Key Informant
mhGAP	Mental Health Gap Action Programme
NDPS	Narcotic Drugs and Psychotropic Substances
NGO	Non-Governmental Organisation
OPM	Office of the Prime Minister
PI	Principle Investigator
RMF	Real Medicine Foundation
PWID	People Who Inject Drugs
STI	Sexually Transmitted Infection
TB	Tuberculosis
UGX	Ugandan Shilling
UHRN	Uganda Harm Reduction Network
UN	United Nations
US	United States of America
USD	US Dollar
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

## **ACKNOWLEDGEMENTS**

UNODC would like to thank Nadine Ezard and David Basangwa for conducting the assessment and writing the report with inputs from Robert Page, Jonathan Brett. This effort has been coordinated by the UNODC Prevention, Treatment and Rehabilitation Section in close coordination with the UNODC Regional Office for East Africa, especially by Anja Busse, Hussein Manji, Jan-Christopher Gumm, Mahanam Mithun, Sylvie Bertrand and Giovanna Campello.

UNODC expresses its gratitude to the Office of the Prime Minister of the Republic of Uganda and the Commissioner Refugees at Office of the Prime Minister, for warmly accepting the mission, as well as the UNHCR Country Office, Uganda, and Field Office, Kiryandongo. UNODC further would like to thank all the participants who agreed to be interviewed for this assessment. UNODC would also like to thank Cecilia Driciru, Gladys Kyarikunda, and Daniel Katembe for facilitating interviews with refugees. Thank you to Dr Martin Byaba for sharing his time and expertise with us in Panyole. We also extend our thanks to the extended UNODC team in the Prevention, Treatment and Rehabilitation Section in Vienna (especially Emilie Finkelstein) as well as in the Regional Office in Eastern Africa (especially Anne Kivuva) for their support in preparing the mission. Finally, a big thank you to Brian Morales and Maria Skirk from the US State Department (INL) for joining us in the assessment mission and agreeing to be note takers and assisting in the data collection.

UNODC would like to thank the US State Department (INL) for financially supporting the refugee assessment as part of a series of assessments on substance use, prevention and treatment in refugee settings in different locations of the world.

## **DISCLAIMER**

This report has been drafted in 2018 and data referenced refer to that year and have not been updated, even though this report was first published in 2022. This report has not been formally edited.

## EXECUTIVE SUMMARY

Uganda has provided asylum to people fleeing conflict for more than five decades. The Government of Uganda extends an inclusive approach to refugee hosting to an estimated more than 1 million refugees from neighbouring countries, with a mix of protracted displacement and new arrivals.

With growing recognition of the vulnerability to substance use disorders among conflict-displaced populations, context specific information is required to design effective interventions.

UNODC commissioned a rapid assessment of substance use and associated health and social services in Kiryandongo rural refugee settlement and among urban refugees in Kampala, consisting of a literature review and field work conducted by a team of international and national researchers from 16-21 April 2018.

Results suggested that substance-use-related problems were of concern to the refugee population. The main substance use of concern, predominantly among men, were alcohol, cannabis, khat, tobacco, and, in the urban setting particularly, heroin, and cocaine including by injection, with emergence of methamphetamine use in the urban setting. There was recognition that substance use and related impacts occurred in a social context of protracted displacement, with growing vulnerability to substance use disorders associated with livelihood and educational constraints. HIV transmission and road accidents were identified as risks associated with substance use. Few interventions accessible to or targeting refugees were identified.

Findings must be interpreted with caution, and only limited conclusions can be drawn from this brief qualitative assessment. Nevertheless, potential recommendations to address key gaps are:

1. **SYSTEMS STRENGTHENING:** Strengthening Uganda's substance use disorders prevention and treatment capacity is key to improving response capacity for refugees and Ugandan nationals. Key responses include:
  - a. Conducting a high-level policy maker workshop on the nature, prevention and treatment of drug use disorders.
  - b. Mapping available treatment services in different regions in Uganda using the UNODC/WHO Substance Use Disorder Treatment Facility Survey (WHO & UNODC, 2018).
  - a. Establishing a Quality Assurance process to assess accessibility, affordability and quality of currently available treatment services in line with UNODC/WHO International Standards for the Treatment of Drug Use Disorders – Draft for Field Testing (2016<sup>1</sup>).

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<sup>1</sup> The updated version from 2020 is now available online  
[https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO\\_International\\_Standards\\_Treatment\\_Drug\\_Use\\_Disorders\\_April\\_2020.pdf](https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO_International_Standards_Treatment_Drug_Use_Disorders_April_2020.pdf)

- c. Measuring treatment demand through support to routine data collection in health services for host population and services providing care for refugees.
  - d. Including WHO/UNHCR mhGap for Humanitarian Situations and other relevant technical documents in Government of Uganda and UNHCR supported disaster preparedness plans.
  - e. Continue to build the capacity of health and social service providers at different levels to respond to substance use disorders in an effective way (including through training with available training packages such as the UNODC Treatnet package<sup>2</sup>, the WHO mhGAP package<sup>3</sup> or the Universal Treatment Curriculum UTC<sup>4</sup>).
2. OUTREACH SERVICES: Community agencies and peer workers have a key role in improving health of people who use drugs, including prevention of substance-related HIV transmission and referral for treatment of substance use disorder. Key responses include
    - a. Expansion of low-threshold services for people who use drugs and/or sex workers in refugee hosting areas.
    - b. Additional support to existing outreach services (e.g. NGOs such as UHRN and its partners) to reach vulnerable urban refugees.
  3. SCREENING, BRIEF INTERVENTION and REFERRAL. Key responses include:
    - a. Integration of routine substance use disorder screening into HIV and antenatal care.
    - b. Pilot procedures in Kiryandongo and Kampala by the Government of Uganda, UNODC, UNHCR, and Real Medicine Foundation to measure change in treatment demand.
  4. TREATMENT in NON-SPECIALISED SETTINGS. Improving primary care of substance use disorders for displaced populations living in protracted situations by:
    - a. Training health workers to detect and treat common coexisting health care needs, such as TB/STI/ hepatitis, and provide antenatal care.
    - b. Training health care workers on substance use disorder treatment using the WHO's mhGap package, UNODC Treatnet<sup>2</sup> and/or the UTC<sup>4</sup>.
    - c. Conduct translational research to test and evaluate training in Kiryandongo.
  5. SPECIALISED TREATMENT. Actions to improve access to effective treatment of substance use disorders includes:
    - a. Building capacity of service providers to deliver evidence-based treatment of substance use disorders in host and refugee communities.
    - b. Ensuring refugee needs are considered in efforts to expand specialised comprehensive treatment places, including access to medication assisted treatment.
  6. PREVENTION. Prevention efforts among refugees and host communities include:
    - a. Trialing the UNODC Strong Families Programme by the Government of Uganda, together with UNHCR and Real Medicine Foundation in

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<sup>2</sup> <http://www.unodc.org/unodc/en/treatment-and-care/treatnet-training-package.html>

<sup>3</sup> mhGAP Humanitarian Intervention Guide (mhGAP-HIG) (who.int)

<sup>4</sup> <https://www.issup.net/training/universal-treatment-curriculum>

Kiryandongo (reaching out to the refugee population and the host community).

- b. Learnings extended to other settlements and communities.
7. GLOBAL RESPONSE CAPACITY: Additional global initiatives could support Uganda's efforts to improve prevention, treatment and care of substance use disorder for refugees. For example:
- a. Including Substance Use modules of WHO/UNHCR mhGap for Humanitarian Situations in minimum standards for emergency responders, including at an international level with international NGOs.
  - b. Conducting translational research aiming to improve detection and response to substance use disorder in humanitarian settings.
  - c. Sharing of evidence, information, experience and best practices to inform future practice directions.

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## INTRODUCTION

Alcohol and other drug use is increasingly recognised as a major cause of morbidity and mortality in conflict or disaster affected situations, including conflict-displaced people (Ezard et al., 2011; Horyniak, Melo, Farrell, Ojeda, & Strathdee, 2016). Adverse consequences of alcohol and other drug use have been well documented in non-displaced populations and the harms, both individual and social, associated with such a disorder have been recognised (Loxley, Ministerial Council on Drug Strategy, NDRI, & Centre for Adolescent Health, 2004; Rehm, et al., 2006; Room et al., 2005). Worldwide, it is estimated that 28 million Disability-Adjusted Life Years (DALYs) were lost in 2015 due to drug use, excluding tobacco and alcohol use (UNODC, 2017). Additionally, in 2012, an estimated 5.9% of all global deaths, and an estimated 5.1% (139 million DALYs) of the global burden of disease and injury were attributable to alcohol consumption (WHO, 2014). Displaced populations may be particularly vulnerable to developing substance use disorder (Horyniak et al., 2016).

A displaced person is any person who is forced to leave their locality or environment – often due to reasons such as war, civil conflict, political issues, human rights violations, or natural disasters. According to the United Nations High Commissioner for Refugees (UNHCR) an unprecedented 65.6 million people around the world were forcibly displaced in 2016. Among these are 22.5 million refugees, defined as people displaced across national borders. Over half of refugees are under the age of 18 years and more than 80% are in situations close to conflict and in low-and middle- income countries (UNHCR, 2016). The majority of refugees are subject to protracted displacement of more than 5 years' duration and the mean length of displacement is greater than 10 years.

Displaced persons frequently experience a range of hardships that increase their risk of psychopathology, morbidity and mortality. When fleeing conflict, they may be at increased risk of exposure to violence, post-traumatic psychological sequelae, physical health problems and injuries (accidental and non-accidental) (Lori & Boyle, 2015; Toole & Waldman, 1997; UNHCR, 2016), as well as social and economic consequences and disrupted access to health care. Evidence describing substance use in refugee and displaced populations is slim and tends to be population and context specific. Most research on this topic addresses substance use in refugees who have relocated to stable and high-income countries as this population is easier to access (Horyniak et al., 2016). The experience of refugees in their new country of residence is varied. Some immigrant populations (usually those re-settling in high-income nations) may experience better health and less substance use disorder than host populations (Spiegel et al., 2010), whereas many experience increased morbidity and mortality (Ezard et al., 2011; Lori & Boyle, 2015; Room et al., 2005; Spiegel et al., 2010; Toole & Waldman, 1997).

Displaced populations may be vulnerable to substance use disorder for a number of reasons. These include pre- or post-migration stress and trauma, including loss of homes and livelihoods, violence, torture and family separation. Unsurprisingly, depression, anxiety and post-traumatic stress disorder are prevalent among displaced populations (Horyniak et al., 2016; Porter & Haslam, 2005; Steel et al., 2009). Being

male, being exposed to trauma and experiencing mental illness are commonly associated with substance use among forcibly displaced populations (Horyniak et al., 2016). Additionally, acculturative stress of adapting to a new setting may promote substance use.

Patterns of substance use within displaced populations vary around the world, influenced by prevailing availability and norms in both country of origin and host population (Johnson, 1996). The physical, psychological and social consequences of substance use are well-documented in stable populations, but refugees are likely to experience a disproportionate burden of these harms compared to people in stable populations (Ezard et al., 2011; Horyniak et al., 2016; Kozarić-Kovacić, et al., 2000; Ezard, 2012; Roberts et al., 2011; Roberts et al., 2014; Weaver & Roberts, 2010).

Despite the public health significance, little progress has been made to address the issue of substance use among conflict-displaced populations. Standards for prevention and treatment of substance use disorders in general have been outlined in the International Standards for Treatment of Drug Use Disorders (UNODC & WHO, 2016<sup>5</sup>) and the International Standards on Drug Use Prevention (UNODC & WHO, 2018). There is also emerging guidance for the provision of mental health and substance use disorder treatment in resource limited settings such as the WHO's Mental Health Gap Action Programme (mhGAP) (WHO, 2010). However, these guidelines are yet to be implemented at scale. The evidence base for effective treatment and prevention of substance use disorder amongst displaced populations is scant. As substance use and related harms is context-specific, intervention design must be guided by local assessment.

Uganda is host to one of Africa's largest refugee populations, with a mix of recent and protracted displacement (UNHCR, 2018a). Alcohol use is common (with almost 10% of the adult population estimated to have an alcohol use disorder (Kabwama et al., 2016). Population health concerns related to non-medical drug use are growing. Despite vulnerabilities to substance use disorder of conflict-displaced populations, little is known about substance use among refugees in Uganda.

## **AIM**

The aim of the assessment was to rapidly assess substance use, prevention and treatment services in selected refugee settings in Uganda. The information obtained will be used to orient decision makers towards effective actions and facilitate timely planning of low cost and sustainable needs-based interventions for drug prevention and treatment.

## **OBJECTIVES**

- Describe the social context of alcohol and other drug use in the settings specified;

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<sup>5</sup> The updated version from 2020 is now available online  
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- Describe alcohol and other drug use patterns and related risks and harms in the specific refugee settings as well as the local host community, including among children and adolescents;
- Identify relevant stakeholders involved in alcohol and other drug treatment and prevention;
- Identify existing treatment and prevention services;
- Identify opportunities, barriers and challenges in accessing relevant services;
- Provide recommendations for strategic responses to improve access to prevention and treatment for the populations studied.

## **STUDY POPULATION**

The study population included refugees and persons displaced by conflict residing in Uganda. Sites were selected to include experiences of both urban and rural refugees and were selected based on feasibility considerations (ready accessibility for the study team, security concerns, and support for the study by the Government of Uganda, UNHCR, and other relevant stakeholders).

Sites were:

1. Kiryandongo in Northwestern Uganda, a rural settlement first established in 1990 and re-opened to new arrivals in 2014. There are currently around 60,000 registered refugees, the majority from South Sudan, approximately 50% women and 50% under 18 years of age. Refugees make up 17 % of the district population (UNHCR & Uganda, 2018).
2. Urban refugees living in Kampala. There are an estimated 100,000 refugees living in Kampala (UNHCR, 2018c).

## **METHODS**

### **Design**

Methods used are in accordance with the WHO & UNHCR guidance on rapid assessment of alcohol and other substance use in conflict-affected and displaced populations (UNHCR, 2008). In brief, rapid assessment methods have been developed to overcome some of the logistic, methodological and ethical barriers of conducting research into substance use among populations displaced by conflict. Rapid assessments are intervention focused, informed by available data, and have an emphasis on rapidly collected qualitative data and an understanding of population health in its local environmental context.

We conducted this assessment in two stages: a review of the literature and available data, followed by field work.

## **LITERATURE REVIEW**

A rapid literature review was performed to establish background on the evidence for substance use in displaced populations, and interventions for same. We searched Ovid

MEDLINE, PsycINFO and Global Health databases as well as grey literature including reports from international agencies such as the office of the UNHCR, the UNODC and the WHO. We used key search terms relating to substance use disorder treatment in displaced populations between 2000 and 2017. Refer to Appendix 4 for search terms.

## **FIELD WORK**

Consistent with rapid assessment methods, the field work consisted of rapid qualitative methods (primarily interviews and focus group discussions).

### **Procedures**

A team of a one local consultant, one international consultant, and two UNODC staff members conducted the assessment in Kampala and Kiryandongo from 16-21 April 2018 (Appendix 1). The team was accompanied by a delegation from the US State Department/INL during the assessment mission.

#### ***Direct observation***

Team members observed key venues and behaviours relevant to alcohol and other drug use within the defined assessment geographical area, as well as hospitals, health centres, HIV programmes and community service facilities.

#### ***Interviews and focus group discussions***

Semi-structured interviews and focus group discussions were conducted with representatives of NGOs, governmental organisations, refugees, host populations, and other stakeholders. Interviews were conducted using a semi-structured interview guide, developed and informed by the literature (see Appendix 2 for English version). The interview team spoke French, Swahili, Acholi, and English. The majority of respondents spoke English, French, Swahili, Luo, Acholi, and/or Arabic languages. Interviews were conducted with the aid of translators employed with local services.

#### **Sampling and recruitment**

Refugees were recruited from both urban and rural settings with a sampling frame designed to reflect a range of experiences (gender, age, ethnicity, duration of displacement, personal experience of substance use) for both individual and focus group interviews. The sampling frame was informed by the literature and informal interviews with key stakeholders (Appendix 3). Interview subjects were invited to participate on the guidance of local service providers from Danish Refugee Council and Real Medicine Foundation in Kiryandongo, and Interaid and UHRN in Kampala. Data collection ceased when a range of informants were interviewed and information on key themes was repeated. The study design did not permit full investigation of new themes; these were identified for future study (see Limitations).

Seven focus groups and 11 key informant interviews were conducted, four with refugees, four with health service providers, and three with teachers (Table 1).

**Table 1: Interview data**

Location	Number of participants	Type of participant	Gender	Country of Origin	Date
<b>Focus groups</b>					
Kampala	10	Refugee	7 M, 3 W	DRC	17/4/2018
	5	Refugee	5 M	South / Sudan	17/4/2018
	4	Refugee	3 M, 1 W	South / Sudan	17/4/2018
	9	Refugee	7 M, 2 W	DR Congo	17/4/2018
	5	Refugee	5 M	Somalia	18/4/2018
Kiryandongo	5	Refugee	5 M	South / Sudan	19/4/2018
	4	Refugee	2 M, 2 W	South / Sudan	20/4/2018
<b>Key informant interviews</b>					
Kampala	1	Health worker	1 M	Uganda	18/4/2018
	1	Refugee	1 M	DR Congo	21/4/2018
Kiryandongo	1	Refugee	1 M	Kenya	19/4/2018
	2	Refugee	2 M	South / Sudan	19/4/2018
	3	Teacher	2 M, 1W	Uganda	19/4/2018
	3	Health worker	2 M 1 W	Uganda South / Sudan	20/4/2018

### **Data management**

Interviews were conducted in English, with the aid of an interpreter where required. Note takers recorded information shared during the interviews (summarizing the information provided and recording notes verbatim at times as indicated by the context and judgement of the note taker). Interviews were not audio-recorded. In addition, informal information and observations were recorded in notebooks throughout the study period by researchers and research assistants. Photographs were taken of relevant health services.

### **Data analysis**

Key themes were identified by the research team throughout the data collection period as they emerged, with exemplifying quotes recorded, alongside details about the informant. Interview data were triangulated with direct observation and secondary quantitative data, contextualized by documentary data from the desk review to give a greater understanding of the current situation regarding national and

local patterns of substance use amongst refugees and host communities as well as prevention and treatment services available, and to identify opportunities to expand existing services to fill the gaps in unmet needs against the UNODC/WHO International Standards for the Treatment of Drug Use Disorders (UNODC & WHO, 2016<sup>6</sup>) and the UNODC/WHO International Standards on Drug Use Prevention (UNODC & WHO, 2018).

### **Ethical implications**

This study had approval from the Makerere University College of Health sciences, School of Biomedical Sciences, Higher Degrees Research and Ethics Committee (SBS-HDREC) approval (SBS-517) and the University of Sydney Human Research Ethics Committee (2017/831). Permission to conduct the study was obtained by local authorities and refugee leadership. Written informed consent was obtained from individual and focus group participants, and participants were provided with a copy of written information about the study including contact details of the researchers. Participants remained anonymous and no identifying information was recorded. Demographic details are recorded for the purposes of situating respondents' narratives.

## **FINDINGS**

### **Literature review**

#### **Geopolitical context**

The Republic of Uganda (Uganda) is a landlocked country in the African Great Lakes region of Eastern Africa. It is bordered by the Republic of South Sudan to the north, Kenya to the east, Tanzania to the South, Rwanda to the southwest and Democratic Republic of Congo to the west. As of 2015, the estimated population of Uganda was 39.03 million, the average life expectancy of Ugandans at birth was approximately 62 years (UNHCR, 2015). Uganda is one of the poorest nations in the world, particularly in rural areas; in 2013, 34.6% of the population lived on less than the International Poverty Line US\$1.90 per day (The World Bank, 2016b). Uganda's 2015 Human Development Index (HDI) score, reflecting its national average of achievements in health, education and income is 0.493, which ranks it 163<sup>rd</sup> in the world. Uganda's official languages are English and Swahili, but many other region-specific languages are spoken as well.

Formerly a protectorate of Great Britain, Uganda gained independence in 1962. Since this time the nation has faced many challenges including significant political instability through the 1960s-1980s; a lengthy civil war against the Lord's Resistance Army in the Northern region; and the HIV-AIDS epidemic through the 1980s until today.

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<sup>6</sup> The updated version from 2020 is now available online  
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## **Refugees in Uganda**

Uganda has provided asylum to people fleeing conflict for more than five decades: more than 1 million arrivals have been recorded in only 18 months, and new arrivals continue from the Democratic Republic of the Congo (DR Congo) and South Sudan. As a result, Uganda is now considered the largest refugee hosting population in Africa, with an estimated 1.4 million people, making up over 3% of the country's population of around 44 million (UNHCR, 2018a). Children make up over half the refugee population. Approximately one million are South Sudanese and over 200,000 are from DR Congo. The remainder have come from Burundi and Somalia, as well as smaller numbers from other countries (UNICEF, 2017). The distribution of refugee populations through the country can be seen in Figure 1 (UNHCR, 2017d). Exact numbers of displaced people living in Uganda are not known: a verification exercise is currently underway.

Refugees in Uganda are afforded freedom of movement, freedom to work, the right to own business and property, and importantly, access to public education and health services (The World Bank, 2016a). Promotion of "self-reliance" for refugees is legislated for within the Ugandan Refugee Act (2006). Uganda's refugee policies are frequently reported as being among the best in the world (Hattem, 2017; Rwakaringi, 2017; Schiltz & Titeca, 2017) due to this promotion of self-sufficiency alongside UNHCR-provided support. However this is a resource limited context; the UNHCR is currently facing a funding shortfall of 63% (US\$356.8M) in Uganda alone (UNHCR, 2017c), putting additional strains on the community.

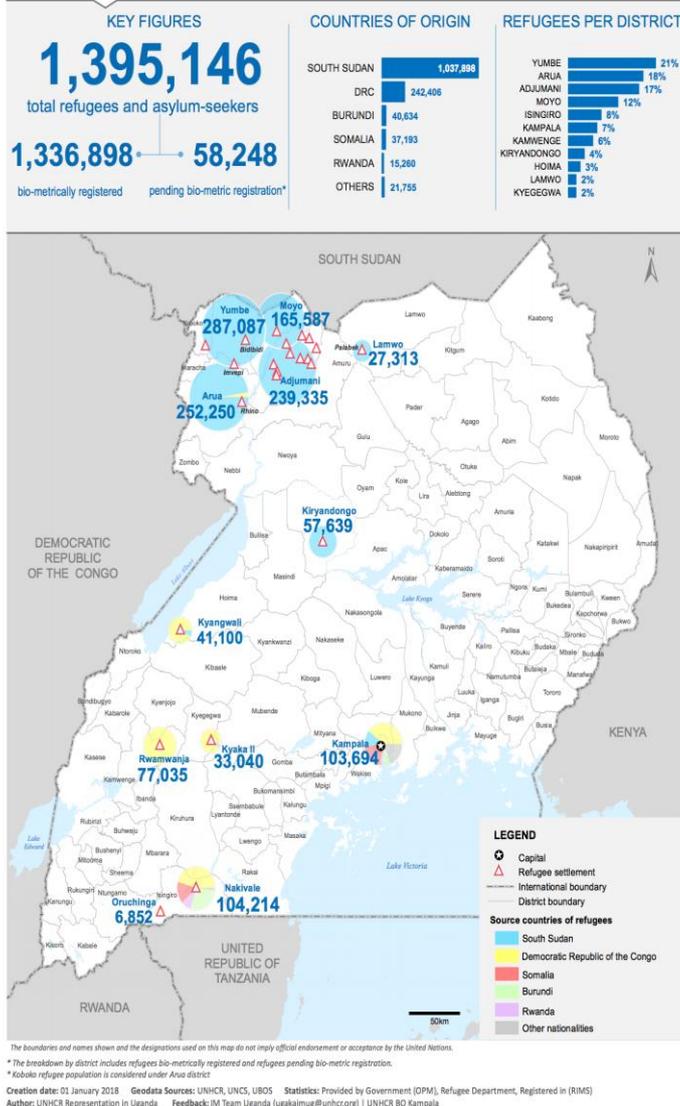


Figure 1: Distribution and place of origin of refugees in Uganda. UNHCR January 2018 (UNHCR, 2017d, 2018b). The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The number and distribution of refugees in Uganda has dramatically changed in the past year due to ongoing civil war in South Sudan. More than two million have fled South Sudan since the civil war began, and since 2017 (UNHCR, 2017b) and more than one million of these have entered Uganda through its northern border (UNHCR, 2017e). This number is likely to increase as the crisis shows no sign of abating. Limited funding means that the implications for sustained provision of services for refugees are uncertain and at risk. It translates into limited medical supplies (including general and antiretroviral medications, equipment and administrative materials) (Trombola, 2017), poor nutrition (UNHCR, 2017a) and limited access for children to education, meaning that refugees are subject to further challenges upon arriving in Uganda.

Displaced persons in Uganda may also come from rural areas within the country – Internally Displaced People (IDP), largely travelling south from areas near the border with South Sudan, have historically made-up significant numbers of those without permanent residence within the country.

The Ugandan Office of the Prime Minister’s Department of Refugees leads the refugee response in partnership with UNHCR. Services to refugees are provided by a number of NGOs. Funding for refugee (and many local) services is heavily reliant upon external aid.

### ***Refugees in Kampala***

Kampala is the capital of Uganda. Located on the northern shore of Lake Victoria, 1,507,080 people reside there, making it the most populous city in Uganda (Uganda Bureau of Statistics, 2016). As of February 2017, an estimated 90,351 refugees resided in the Kampala city district (this number is likely to have significantly increased since, given the large numbers of people daily arriving). The majority of refugees in Kampala are from South Sudan, DR Congo and Somalia (UNHCR, 2017d). Refugees living in Kampala are generally scattered in low-income areas within the city, or concentrated with those of similar origin (Refugee Studies Centre, 2013). Those refugees living in Kampala rely largely upon existing services for locals rather than those specific to refugees, as it is usually the case in refugee settlements. It also means that research into those specific problems that exist for such refugee groups may be problematic, as there is often little identifying information or clustering to allow such specific research.

### ***Refugees in Kiryandongo settlement***

Kiryandongo is the name of both a town and its surrounding district in Western Uganda. Originally used by the British Colonial Administration for resettlement of Kenyan refugees in the 1950s, in recent times the Kiryandongo area was officially gazetted for use by refugees in the early 1990s (Kaiser, 2002). There are more than 100,000 asylum seekers and refugees living in Kiryandongo Refugee Settlement, a majority of whom are from South Sudan (UNHCR & RMF, 2017). Kiryandongo Refugee Settlement is administered and managed by UNHCR.

### **National drug policy context**

In 2015 the Narcotic Drugs and Psychotropic Substances (NDPS) Act legislated penalties for those using, possessing or selling drugs controlled under the international drug control conventions (including cannabis, cocaine, and heroin). Both trafficking and possession of illicit substances are penalised with heavy fines and/or a prison sentence of between ten and twenty-five years (possession) or life (trafficking). The Act also criminalises the possession of pipes or utensils for non-medical use of such drugs. The possession, use and sale of khat was banned under the Narcotic Drugs and Psychotropic Substances Act 2015.

By contrast, alcohol production, use and sale is poorly regulated. The commercial sale of traditionally produced spirits is regulated by the Liquor Licensing act of 1964 that forbids the sale and consumption of crude Waragi (local spirit). Such a law is outdated, weak and not enforced. There are no national legal restrictions on on-premise nor off-

premise sales of alcoholic beverages; there are no legally-binding regulations on alcohol advertising, product placement, sponsorship or sales promotion; and no health warning labels are required on containers of alcohol (Kalema et al., 2015). Alcohol may be sold at any hour of the day. In recent years, local council bodies have acted to regulate or ban sales of certain types of alcohol (Wacha, 2012). But despite significant lobbying by private citizens and organized groups, alcohol manufacture, sale and advertising remain largely unregulated. As has been demonstrated elsewhere, the post-conflict environment may provide opportunities for alcohol producers to expand their markets, taking advantage of political instability and lax regulations on liquor sales and advertising (Wallace & Roberts, 2014).

Uganda's Ministry of Health maintains overall responsibility for prevention and treatment of substance use disorders through its Department of Clinical Services. Quality Assurance is coordinated through the Department of Quality Assurance, against existing clinical guidelines, largely through self-assessment methods. Community empowerment activities consistent with primary prevention fall under the mandate of the Ministry of Gender, Labour and Social Development, although not explicitly described as such.

Uganda's National HIV/AIDS prevention strategy does not include resource allocation nor clinical recommendations on interventions to reduce the negative health and social consequences of substance use such as safe injecting, distribution of clean injecting equipment for people who inject drugs (PWID), or pharmacological treatment for the treatment of opioid use disorders.

The Ministers' Meeting of the Second African Union Specialized Technical Committee on Health, Population and Drug Control attended by Uganda, was held in Addis Ababa in 2017 endorsed a number of recommendations, including: to consider and treat drug use disorders as health conditions; to fully develop and adopt national drug policies; to ensure that people who use drugs are provided with access to treatment and psychological services; to recognize the special risks that young women and girls face regarding drug use; and to include drug use prevention in core curricula of law enforcement and medical institutions in order to broaden the prevention workforce in Africa (INCB, 2017).

## **Substance use in Uganda**

### ***Alcohol***

The most commonly used psychoactive substance in Uganda is alcohol. The WHO Global Status Report on Alcohol and Health 2014 found that Uganda had the highest annual alcohol consumption in the East Africa region, with an estimated 9.8 litres per year of pure alcohol being consumed per capita among those aged 15 years and older; those who drink alcohol average 23.7 litres per year; (WHO, 2014).

Research findings have attributed high alcohol consumption to political instability, poverty, unemployment and culture. Uganda's protracted war and political turmoil made people demoralized, lose interest in the future and resort to excessive drinking

(Tumwesigye & Kasirye, 2005). Historically, alcohol consumption has been a cultural norm for Ugandan men and has been associated with virility.

Uganda, as many other countries, has a culture of local and individual production of alcohol, often using traditional or home-brew recipes. It is difficult to estimate how much alcohol is produced in this fashion, as such processes are typically unrecorded. Homebrewed beer and locally fermented and distilled alcohol (known locally by various names, including *tonto*, *ajon*, *omuramba* and *kweete*) comprise approximately 80% consumed alcohol in Uganda; the other 20% is made on a larger scale by commercial entities (WHO, 2004). Alcohol may be sold in and consumed from sachets as small as 100mL in volume. Despite little national regulation on alcohol production and use, local councils have banned this practice in places over fears that children and young people are more likely to be affected (Wacha, 2012).

### ***Other drug use***

While periodic UN surveys and Government research occurs on other substance use, little high-quality recent epidemiological data exist on other substance use in Uganda. The World Drug Report 2017 did not provide prevalence estimates for (non-alcohol) drug use in the East Africa region (UNODC, 2017).

Heroin and other opioid use was not considered to be a major issue within Uganda in a 2014 UNODC report, with few people presenting for treatment of opioid use disorder (UNODC, 2014). However, there are concerns about regional increases in heroin use that require further investigation (INCB, 2017). While pharmaceutical opioids legally require a prescription, there are reports of being able to access such drugs at urban pharmacies without prescriptions (UNODC, 2014).

Cannabis is both trafficked through Uganda and grown locally but the latest World Drug Report did not flag any increases in cannabis seizures or trafficking through Uganda (UNODC, 2017). In Uganda, as in other parts of sub-Saharan Africa, cannabis has traditionally been used with the intention to treat cough and headache. In Kampala, it has been sold as cigarettes and may be laced with heroin and other contaminants. A 2014 UNODC report found cannabis to be inexpensive and highly available in Kampala. This report also suggested that cannabis use was increasing amongst young people (UNODC, 2014).

While cocaine does not appear to be a major issue in terms of people seeking treatment, a 2014 UNODC report raised concerns regarding the production of methamphetamine and other synthetic stimulants in the East Africa region (UNODC, 2014). While Uganda has reported police seizures of methamphetamine, treatment seeking for stimulant use disorder was minimal within Uganda in 2014. However, the INCB report suggested increases in the use of amphetamine type substances across the whole of Africa (INCB, 2017).

Khat has been used in East African countries for centuries, traditionally for ceremonies such as funerals and weddings and its use is particularly common in Somali communities. Little data, however, are available regarding current prevalence of its

use in Uganda by local or refugee populations. No published information on rates of use has arisen since its possession, sale and use were made illegal under the Ugandan National Drugs and Psychotropic Substances Act 2015. However, prior to this, Khat was inexpensive and easily accessible and was an important source of revenue for some agricultural communities (UNODC, 2014). A 2004 cross-sectional survey data of 181 students, transporters and law enforcement officials in South-Western Uganda (70% male, 30% female) found that 31.5% had chewed khat before (Ihunwo et al., 2004).

Kuber is a smokeless tobacco product imported from India as a 'mouth freshener'. Kuber was introduced into Uganda around 2009 and was banned by the government in 2013 because of concerns about its increasing popularity. Typically, it contains tobacco, lime, water, oil, menthol, elaichi (ground cardamom), other spices and a range of added flavours enabling it to be perceived as no more than a mouth freshener.

Little data exist on the prevalence of injecting drug use in Uganda, and no formal surveys have been performed. Estimates from a 2007 WHO survey data suggest that 0.01% of Ugandans are injecting drug users (WHO, 2010). In a 2016 survey of more than 425 people from vulnerable populations in Uganda, 72 (17%) were injecting drug users and 24 (37%) were female (Most At-Risk Populations (MARPs) Network & Uganda Harm Reduction Network (UHRN), 2016).

### ***Young people***

Homelessness, family violence, sexual exploitation and sex work amongst children has been well documented in Uganda. A 2014 UNODC rapid assessment report found that substance use amongst street and slum children was high. Such use included inhalants such as aviation fuel, glue and paint thinner while others use cannabis and heroin to be able to take on several customers and absorb the pain that goes with it. Alcohol, cannabis and khat use was also documented (UNODC, 2014). Children are often involved with local alcohol sale and this is thought to increase their risk of alcohol use disorder (Tumwesigye & Kasirye, 2005).

Surveys of students have found substance use common at all levels of education. Surveys in 2016 of 2,902 local secondary school attendees (12-24yo) in Kampala found that 70.1% had ever used alcohol or other drugs, with 39.1% using regularly. Alcohol was most commonly used (23.3%), followed by kuber (10.8%), khat (10.5%), aviation fuel (10.1%), and cannabis (9.2%) (Abbo et al., 2016).

### ***Gender***

One survey showed that men are more than twice as likely to consume alcohol daily than women (Tumwesigye & Kasirye, 2005). Men had more than twice the odds of being a medium-to-high end user (at least 4 standard drinks per occasion) than women (at least 2 standard drinks per occasion) (Kabwama et al., 2016). Gendered social controls influence consumption patterns: alcohol use is masculinised (Wolff et al., 2006; Kafuko & Bukuluki., 2008); women who drink contravene social norms of femininity. There is some suggestion these norms are changing, with convergence of uptake of alcohol consumption among young women (28%) and young men (26%)

(Tumwesigye & Kasirye, 2005). There was little information regarding gender and other drug use in Uganda.

### ***Refugees***

Little information exists on substance use among refugees or displaced populations in Uganda. A 2006 cross-sectional survey of internally displaced persons in Northern Uganda found an estimated prevalence of alcohol use disorder of 17%, with a level of 66% amongst those who drank alcohol more than once per month. Exposure to a higher number of traumatic events was correlated with an increased likelihood of having alcohol use disorder (Roberts et al., 2014).

A separate 2006 assessment of substance use in internally displaced population settlements in Northern Uganda found that alcohol was readily available and was considered by those interviewed to be an important public health problem. A number of problems associated with alcohol use were reported, including unsafe sex, health problems, dependence, and interpersonal and gender-based violence. Alcohol brewing was considered to be an important source of income for many refugee women. There were also reports of persons within settlements using rations to brew alcohol to drink or sell. Alcohol use was considered by some surveyed to be a response to dispossession, joblessness and loss of traditional gender roles. Its use was considered likely to have a negative impact on community cohesion. Cannabis use was mentioned by some refugee respondents, but little was established regarding its use and impact (Spiegel et al., 2010).

### **Patterns of substance use pre-displacement**

The vast majority of refugees in Uganda are from South Sudan, which gained its independence in 2011. Data on alcohol and other drug use in this region are scant. A 2016 cross-sectional study of alcohol use in 500 people in North-Western South Sudan found similar rates of high-risk problem drinking (14.2%) as in other countries in Southern Africa (Lien et al., 2016). Press reports indicate that alcohol and cannabis are popularly considered to be among the most problematic substances used in South Sudan, and that alcohol is being brewed in communities and refugee settlements (O'Grady, 2017; Richard, 2017). It should be noted that alcohol is legally prohibited in Sudan but not in South Sudan. Khat use and cultivation are also prohibited in South Sudan.

Data on substance use in DR Congo and Somalia are also of low quality. Rates of cannabis cultivation and use in DR Congo are reportedly high (Strochlic, 2017), and in Somalia, khat and cannabis appear to be commonly used, especially among combatants or those affected by conflict (Bhui & Warfa, 2007; Odenwald et al., 2007).

### **Substance-related harm**

#### ***Alcohol***

Research analysing data from the most recent large-scale survey, the 2014 Non-Communicable Disease Risk Factor Baseline Survey, indicates that the level of alcohol use among adults in Uganda is high, with an estimated 9.8% of the adult population having an alcohol-use disorder (Kabwama et al., 2016). Adverse consequences of

alcohol use disorders for individuals and populations are well recognised. These include an increased risk of certain physical illnesses (infectious disease, cancer, diabetes, cardiovascular disease, liver and pancreatic disease); neuropsychiatric disease; and intentional and unintentional injury (Rehm, 2011) as well as a range of other negative social consequences such as loss of earnings, family violence and community disintegration. A 2011 worldwide survey of the negative impacts of alcohol consumption suggested that Uganda experiences the highest level of personal and social negative consequences associated with alcohol use in the world (Graham et al., 2011).

Injuries are an important direct harm associated with alcohol use in Uganda. A 2009 analysis of 3572 Ugandan emergency department presentations with injury found that among adults, alcohol use was significantly associated with injuries, with 12.5% of those with injuries reported alcohol use prior to the injury. Alcohol use was strongly associated with severe injuries (Wandera et al., 2010).

A number of indirect harms have been documented. Intimate partner violence, which is common in Uganda, is an estimated six times more likely to occur in Ugandan women whose partners drink, compared with those whose partners abstain from alcohol (Tumwesigye et al., 2012). Research in Kampala found high rates of childhood suicidal tendency associated with alcohol-related parental neglect (Swahn et al., 2012). Research in post-conflict Northern Uganda has found alcohol to have been an important factor in a majority of suicides (Kizza et al., 2012) and to increase risk of intimate partner violence in settlements for internally displaced populations (Annan & Brier, 2010).

Alcohol use in Uganda is associated with increased sexual risk behaviour and with HIV seropositivity (Mbulaiteye et al., 2000) as well as with poorer HIV medication adherence and a decreased likelihood of notifying sexual partners of HIV status (Wandera et al., 2015). Among female sex workers in Kampala, alcohol was reported to affect HIV medication adherence and to contribute to violence, unsafe sex and poor decision making (Mbonye et al, 2014).

### ***Other drugs***

There is little formal information on the effects of other drug use in Uganda. According to the 2013 Uganda HIV and AIDS Country Progress report, “persons that inject drugs do not contribute significantly to new HIV infections, and are therefore not explicitly targeted in the Uganda HIV response” (The Republic of Uganda Ministry of Health, WHO, & UNDP, 2014a). Recent data suggest injecting drug related HIV is growing in Uganda. Service data from the Ugandan Harm Reduction Network (UHRN) suggest high prevalence of HIV among people who inject drugs (PWID) (including refugees) estimated at around 45% (Ugandan Harm Reduction Network & International HIV/AIDS Alliance, 2017), compared to Uganda’s estimated 2016-2017 general adult population HIV seroprevalence of 6.2% (The Republic of Uganda, The President’s Emergency Plan for AIDS Relief, & The Centers for Disease Control and Prevention, 2017). Sharing of injecting equipment is common as is condomless sex (Ugandan Harm Reduction Network & International HIV/AIDS Alliance, 2017). Alcohol and drug use

was highlighted as one of the risk factors driving the HIV epidemic in Uganda (UNAIDS & Uganda AIDS Commission, 2009). While Uganda's current HIV/AIDS strategic plan sets out the country's comprehensive approach to reduce new infections and morbidity and mortality related to HIV/AIDS (Uganda AIDS Commission, 2015), the effects of alcohol and other drug use or injecting on HIV risks is almost completely omitted from the strategy.

A 2014 UNODC report suggested that increased use of cannabis among young people had led to more youth being admitted to residential treatment services for cannabis-related mental health problems (UNODC, 2014). In addition, cannabis use amongst young people was frequently leading to school expulsion and interruption of education.

The impact of khat use on the health of the Ugandan population is unknown. In low doses, khat ingestion results in decreased appetite, euphoria and hyper-alertness. High doses and chronic use can cause adverse neurological, psychiatric, cardiovascular, dental, gastrointestinal and genitourinary effects, as well as increasing digestive tract cancer risk (Ageely, 2008; Hassan et al., 2007). There is also evidence that benzodiazepines are used with khat to counteract the stimulant effects and this may predispose users to benzodiazepine use disorder (UNODC, 2014). Kuber is a stimulant drug and like other forms of chewing tobacco it can lead to dependence and can contribute to mouth and other forms of oral cancer.

### **Health services in Uganda**

Uganda's health services comprise a combination of public entities, private services and non-governmental organisation (NGO)-provided services. The public sector includes two National Referral Hospitals (Mulago and Butabika both in Kampala) , 14 regional referral hospitals and 40 general hospitals as well as a system of Health Centres. Each sub-district Health Centre serves an estimated 100,000 people (Uganda Ministry of Health, Health Systems 20/20, & Makerere University School of Public Health, 2012).

The elimination of user fees at state health facilities in 2001 led to improved equity of access and overall health, with an 80% increase in visits at these facilities, more than 50% of which came from the poorest 20% of the population (Vandemoortele, 2010). Additionally, private providers include both for-profit health care providers, not-for-profit organisations (including NGOs), and traditional and complementary medicine practitioners.

### ***Health services in Kiryandongo settlement***

Public health services in Kiryandongo consist of two Level II Health Centres in Kiryandongo (providing antenatal care) and an enhanced Level III Health Centre supported by UNHCR and the US registered non-profit NGO Real Medicine Foundation (UNHCR & RMF, 2017). This Centre, Panyadole III, serves a population of 100,000 (around half refugees) with 100 inpatient beds and an outpatient service including mental health, antenatal care (to approximately 80 women at any one time) and HIV treatment (for around 1500 people). Services provided include hygiene improvement,

family planning (including hormonal contraceptive and condom dispensation), antenatal care, vaccination services, cervical cancer screening, HIV/AIDS care, and nutritional supplementation. Alcohol and other drug use disorders may be detected through HIV services and antenatal services, although there is no routine screening. Staff include doctors, nurses, midwives, laboratory technicians, pharmacists and administrative staff. Additionally, RMF provides vocational training to high-school graduates in order to improve their future economic and health prospects. The health centre refers to Kiryandongo hospital then on to regional referral hospitals in Gulu and Kampala; severe mental illness (including alcohol and drug dependence) is referred to Butabika Mental Health Hospital in Kampala.

### ***Health services in Kampala***

In Kampala, refugees are provided equal access to health care as the national population. Additional support is provided to urban refugee populations through Interaid.

### **Interventions for Substance Use Disorder in Uganda**

The Ministry of Health Uganda Clinical Guidelines (Ugandan Ministry of Health, 2016) advise stepwise management of substance use disorders:

- Level I: assessment of substance use withdrawal, intoxication, dependence, coexisting conditions (e.g. HIV infection), along with psychoeducation and counselling
- Level II: psychoeducation and counselling for harmful substance use
- Level III: psychoeducation and counselling for dependence
- Referral to hospital: more comprehensive care.

Despite this guidance, mainstream first-line services for those with alcohol use disorder primarily provide stand-alone withdrawal management only (Kalema et al., 2017). It is estimated that less than 10% of those with alcohol or other drug use substance use disorder in Uganda have access to treatment (Kalema et al., 2017). Refugees may use services for host populations, but the level of such use and its effectiveness is unknown. Treatment services comprise a mix of Government, NGO or privately-run services. A list of all identified drug dependence and treatment service providers can be found within the 2014 UNODC report (UNODC, 2014).

Substance use services in Uganda primarily focus upon treatment of established substance use disorder as opposed to prevention or low threshold interventions to reduce the negative health and social consequences of drug use and dependence. In Kampala, low threshold outreach is provided by Uganda Harm Reduction Network. Nevertheless, the provision of unconditional low-threshold health and social services reducing negative health consequences and treatment services to those who use illicit substances is difficult because of fear of legal consequences for the possession or use of controlled substances.

### ***Prevention***

Current substance use prevention in Uganda focuses heavily on criminal penalties for those possessing, using or trafficking controlled drugs. Non-punitive alcohol and drug

prevention campaigns in Uganda comprise a combination of Government and NGO-provided initiatives. Government-run preventive campaigns largely comprise television or radio advertisements raising awareness of alcohol and drug use and their potentially harmful effects on individuals and society. The WHO ATLAS report for Uganda estimated that in 2006 less than 50% of the population had been reached with audio-visual messages relating to substance use, and that less than 25% were reached by print media, school-based or community-based alcohol prevention programmes (WHO, 2010).

In the city of Kampala, Butabika National referral mental hospital conducts outreach services to communities and schools within a 30 km radius to offer preventive education on substance use. The same team does follow up home visits for selected patients.

A number of NGO and charity-run services provide preventive initiatives for alcohol and drug use. These are not centrally coordinated, and largely comprise education regarding the potential harms of alcohol and drug use. Some also resource community development, including vocational training, family and community support. Such programmes do not specifically target substance use, but promote individual and community well-being, education and vocational training. RMF provides such services in Kiryandongo Refugee Settlement and surrounds. Similarly, Jesuit Refugee Service trains refugees in Kampala in a combination of life skills and trades. This includes education for peer counsellors on a matter of subjects, including recognising and managing substance use and dependence. Unfortunately, little information is available regarding the number of people (from host and refugee communities) impacted by such programmes. Though it is recognised that such programmes may beneficially impact rates of initiation of substance use or progression to substance use disorder (UNODC, 2015), this has not been studied in Uganda.

No information could be obtained on the availability or implementation of programmes with a high evidence of effectiveness in line with the International Standards on Drug Use Prevention (UNODC & WHO, 2018).

### ***Community-based outreach***

Community based outreach activities exist but are limited in nature. Butabika Hospital staff run outreach clinics within the city of Kampala. The clinics offer both general mental health and addiction services. The 14 regional referral hospitals also run similar services but more limited in nature and less regular. UHRN recently established Uganda's first needle-syringe program pilot in Kampala (International HIV/AIDS Alliance, 2017) and coverage is yet to reach public health significance.

Very little evidence exists for NGOs providing outreach services for Ugandans with substance use disorders. The National Care Centre (NGO) in Kampala reports providing community outreach for people with substance use disorder. However, no information is available on the form of such outreach, services provided, or number of people impacted.

General health outreach is provided by RMF in Kiryandongo Refugee Settlement – to both refugee and host populations. No data are available on whether substance use is screened for. Nevertheless, it is likely that such outreach would incidentally positively impact the health of persons with substance use disorders who are provided with services.

### ***Screening, brief interventions and referral to treatment***

There is no evidence of systematic clinical screening for substance use in Uganda currently. A study of primary health care facilities in Kampala showed that only 7% of all admitted patients were asked about their alcohol use by health care professionals (Kullgren et al., 2009). It should also be noted that screening for alcohol consumption is not part of routine antenatal care in Uganda. While not systematic, it is reported that health care workers and police officers will at times refer people for rehabilitation (Kalema & Vanderplasschen, 2015).

### ***Outpatient treatment***

Outpatient treatment is offered at the National Referral Mental Hospital at Butabika. It is also available to a limited extent at 6 out of the 14 regional referral hospitals in the country. Outpatient treatment is generally provided in the context of post-rehabilitation aftercare (discussed below in *recovery management*). Pharmacological treatment for opioid use disorders (methadone or buprenorphine, naltrexone) is not provided in Uganda.

Some 60% of the population seek general health care from spiritual or traditional healers, who commonly claim to treat alcohol use disorders. Their methods are diverse and often treated with suspicion by mainstream health care providers. Little is documented regarding the type, distribution, and patients with substance use disorder reached by such services (Kalema et al., 2017).

### ***Inpatient treatment***

Uganda has one Government-run specialist Substance Use Disorder treatment facility. This is located in Kampala at the National Referral Mental Hospital at Butabika. All of the 14 public regional referral hospitals have mental health units where patients with substance use problems can be admitted and managed. General hospitals, including Kiryandongo General Hospital, will admit people with alcohol use disorder for withdrawal management on the respective male or female wards. However, stigma remains a significant barrier to treatment. Kampala is also the home of eight private (NGO or charity)-run inpatient withdrawal management/rehabilitation services for substance use disorder. These are predominantly 12-step based and abstinence focused. The concentration of services for alcohol use disorder in the city does not meet the needs of the majority of those in need of treatment, who predominantly live in rural settings. Many of the NGOs, though non-profit, charge fees for services that are unaffordable for most Ugandans (Kalema et al., 2017).

Examples of non-Government treatment services for problematic alcohol and other drug use in Kampala include Serenity Centre and Hope and Beyond (both of which are Christian charities). Both provide inpatient withdrawal management and rehabilitation services.

### ***Recovery management***

The costs involved with aftercare following withdrawal management are prohibitive for most clients (Kalema et al., 2017). Such care will typically involve reporting to treatment centres and counselling and support by clinical or pastoral staff. In many cases, after discharge from rehabilitation services, ongoing support is limited.

### ***Refugee-specific services***

We could identify no refugee-specific services for alcohol or other substance use disorders in Uganda. Refugees may access Government health services or may pay to use the private system.

While there are not specifically tailored drug and alcohol services, there are a number of NGOs providing health and social services to refugees in Uganda. As it is recognised that social determinants of ill-health – poverty, poor social cohesion, and unemployment – may underlie substance-related harm (NDARC, 2004), services may be considered more broadly relevant to addressing substance related harm among refugee populations. The Hebrew Immigrant Aid Society (HIAS), for example, provides services for vulnerable refugees in Kampala, where an estimated 75,000 refugees reside. Services include emergency housing, food assistance, medical referrals, psychosocial care, legal protection, vocational training and employment assistance. As mentioned above, RMF provides refugee-specific services within Kiryandongo for health care and community-development. Other organisations provide childhood education, schooling and microfinance for refugee communities.

In view of the limited information regarding patterns of substance use, prevention and treatment services amongst displaced populations in Uganda, we conducted a rapid assessment to inform service development.

## **QUALITATIVE FINDINGS**

Key themes that emerged from the interview data and direct observation are outlined below.

### ***Experiences of substance use***

The main substance of concern in both rural and urban areas was alcohol, which was considered a drug. In Kiryandongo this includes an artisanal distilled liquor made from grains such as sorghum. In urban and rural areas commercially manufactured clear distilled liquor of 40% ethanol/volume called waragi was sold in 100ml sachets reported to cost between 500 and 700 UGX (around 3 US cents per standard drink of 10mg ethanol). Participants believed that both men and women use alcohol, and that men use alcohol more frequently than women. As explained by one participant, “Alcohol is a very big problem, 80% of refugees use it” [male FGD participant, Congolese community, Kampala].

Following alcohol, cannabis was consistently mentioned as the next most frequently used substance. Cannabis was also known as “bang”, “bhangi”, “bongo”, “weed” and “opium” and usually smoked mixed with tobacco in a rolled cigarette. It is mainly smoked by young men.

The third substance of concern to the community was khat (also known as miraa). Leaves and sticks are chewed mainly by men from the Somali community in both rural and urban settings. Khat was reported to cost around 3,000 UGX (0.80 USD) for leaves and 15,000 UGX (4.00 USD) for leaves and sticks for a quarter of a kilogram.

Tobacco emerged as the next substance of concern. Collectively smoked pipe tobacco (called “shisha”) and chewing tobacco (called “kuber”) were both considered drugs. 20 sticks of cigarettes (one box) cost 4,000 UGX (1.00 USD).

Heroin use was known in Kiryandongo but no participant reported first-hand experience of using heroin in the camp. By contrast, refugee informants in Kampala reported experience of using heroin by a range of routes: smoked (mixed with tobacco), insufflated (sniffed) and injected intravenously. One informant [male, KI, Kampala] reported that heroin costs 10,000 UGX (2.40 USD) / “packet” or 150,000 UGX (40.40 USD) a gram. Other opioids mentioned were pethidine [male FGD participant, Sudanese community, Kiryandongo] and codeine syrup (consumed with soda and chewed with khat) [male FGD participant, Somali community, Kampala].

Cocaine (also known as “sniff”, although the term was sometimes used for heroin as well) was known but not reportedly used in the camp. As indicated by one informant it is “too expensive, costs \$200” [male FGD participant, Sudanese community, Kiryandongo]. In Kampala refugee informants reported using cocaine by insufflation and intravenous injection, as well as inhaling the vapour of “crack” cocaine base. One informant described his experience of mixing bicarbonate of soda with cocaine to make “a rock”; 1g cocaine costs 120,000 UGX (32.30 USD) and when made into crack, a small scraping of the rock is sold for 10,000 UGX (2.70 USD). This same informant also described his experience of inhaling methamphetamine (“ice”) vapour from broken lightbulbs. [male KI, Kampala]. According to another participant methamphetamine was used by female sex workers who had been working in Dubai [male KI, Kampala].

In the settlement, injecting drug use was reported but hidden, associated with a hilly area of the camp informally known as “Baghdad”, also characterized by a water tank on top of the hill. When we visited the area, we found empty alcohol sachets and condoms, and neighbours close to the hill confirmed that this is an area where people gather in the evenings, but we could not find any injecting equipment or verify the assumption that injecting drug use takes place there from a second source. In Kampala, needle-syringes were available from pharmacies for 500-1000 UGX (0.13-0.27 USD) or from friends. Cocaine and heroin were mentioned as drugs which could be injected.

Other substances mentioned were inhalants (glue, petrol) and pharmaceuticals (diazepam). Additionally, one person mentioned “blue tablet which makes your mouth blue and very heavy, cannot sleep after consuming” [male FGD participant, Somali community, Kampala]. Another mentioned a substance called “saoud, you put it under your tongue and feel good – I deal it” [male FGD participant, Sudanese community, Kiryandongo]. And another spoke of “a drug that is placed under the feet

and it feels like you're smoking heroin" [male FGD participant, Congolese community, Kampala].

### ***Substance use and protracted displacement***

Substance use was considered a growing concern in displacement. Some substance use behaviours were believed to have predated displacement and been brought with the community into Uganda – such as khat use among Somali men. Nevertheless, alcohol and drug use was believed by many respondents to be more common in the host community, in both Kiryandongo and Kampala and “integration with the host community is leading to increased alcohol and drug use” [male teacher, Kiryandongo]. Youth substance use patterns in particular were believed to be adapting to host community norms, in the context of weakening parental and community controls in displacement. “Youth are lost, don't take advice from elders... divert to other cultures” [male FGD participant, Sudanese elders, Kampala]. He went on to explain, “Alcohol use is not part of our culture, youth learn in refugee settlement especially”. Nevertheless, the same participants acknowledged that these changing patterns reflected growing global concerns with alcohol and other drug use, and that alcohol use was a “factor in the war, leaders consumed alcohol”.

“Idleness” emerged as the most prominent rationale for problem substance use among participants (also reflected in the Uganda Clinical Handbook (2006)). Discrimination emerged as an important concept underlying idleness and joblessness, contributed to by lack of identity papers, limited work opportunities, and language barriers. “Although we work harder, we are paid less [than Ugandan nationals]” [male FGD, Congolese community, Kampala]. Lack of secondary education opportunities were also believed to underlie idleness and therefore drive substance use among Sudanese community focus groups in Kampala and Kiryandongo.

Other rationalizations for substance use among refugee communities included trauma experience, stress, homelessness, food insecurity and loss of contact with family. As one participant explained “I have no house, no job, sleep outside so I need drugs to cover inside” [male FGD participant, Congolese community, Kampala]. According to one respondent, psychoactive substances also assisted with working “I lost my husband, have three children, and need to support them so I am a sex worker. I use cocaine, marijuana, and alcohol with clients, sometimes inject” [woman FGD participant, Congolese community, Kampala].

Some substance use was considered beneficial by some interview partners. Psychoactive substance use could promote socialization, provide enjoyment and leisure, forgetting problems, and relieving stress. Khat, specifically, “gives energy” [male FGD participant, Somali community, Kampala].

There were however a number of perceived problems associated with the use of a range of substances identified. For example: alcohol could cause mental problems, sleepiness, forgetfulness, behaviour change, loss of coordination, physical health problems (cancer, TB, aging, liver failure, dental and eye problems), loss of control, “make you believe you are strong...lose your mind...don't feel shame” [male Sudanese

FGD, Kampala]. Community elders in Kiryandongo described alcohol related liver failure “We had two people here who died of liver problems from alcohol, swelled up, edema of feet, yellow eyes, mental problem” [male FGD participant, Sudanese community, Kiryandongo].

HIV transmission risk was identified as related to both injecting drug use and alcohol use among refugee populations. Young men from Kiryandongo reported going “out to clubs in Bweyale [nearby town] even though their parents disapproved due to the risks involved: road accidents at night, unsafe sex, alcohol and drug use. “When you are intoxicated you don’t use a condom” [male FGD participant, Sudanese community, Kiryandongo]. Similarly, this risk discounting was reported in the context of heroin dependence in Kampala “when you are using [heroin dependently] you don’t care” about HIV [male KI, Kampala]. This same respondent used the term “sick” to describe HIV infection among people who inject drugs.

Social problems mentioned by participants included economic impacts, including diversion of scarce household resources, family conflict, violence against women, and job loss. Criminal justice problems and engagement with the police were also concerns. Participants in Kiryandongo and Kampala reported being arrested for drug use, which in turn impacts negatively on refugee status determination. Protecting children from criminal justice consequences was a particular concern for one parent in Kiryandongo whose child had been arrested for cannabis use. Atypically, one participant mentioned “reproductive impacts” of substance use, seen as preventing young people from getting married and having children [male FGD participant, Sudanese community, Kampala].

Economic survival imperatives were believed to underlie substance-related risks. Women elders in Kiryandongo were concerned about girls (aged 12-17 years) exchanging sex for alcohol, in the context of limited family resources “[we are] not [talking about] our children, [we are talking about children of] other women where there is not enough money” [women FGD participant, Sudanese community leaders, Kiryandongo]. Some occupational groups were linked to substance use related injuries and HIV transmission, specifically: women sex workers and young men *boda boda* [motorcycle taxi] drivers. These same imperatives drove mobility in and out of the camps, particularly young men. Three out of five members of one focus group of Sudanese refugees who were living in situations of protracted displacement in Kiryandongo reported running jobs and errands to the nearby trading town at least weekly, as well as further afield to Kampala in the last month. One participant had recently moved back after two years in Kampala, although now he regretted this decision: “In Kampala I knew how to get by” [male FGD participant, Sudanese community, Kiryandongo]. This preference for the urban context was echoed by another participant, who said although life in Kampala was “a struggle.... camps are more than hell” [male FGD, Congolese community, Kampala,].

One participant explained that substance dependence can be both caused by and enhance discrimination and social exclusion. In speaking of his own khat use: “I cannot enter the mosque, [I get] stress relief while chewing but lazy and irritated the next

day, get annoyed easily ... more discrimination, but the body needs to have it" [male FGD, Somali community, Kampala]. Other participants also described their struggles with dependence. One described an unpleasant experience of being acutely unwell with opioid withdrawal syndrome ("taki"/"turkey") while incarcerated [male KI, refugee from DRC, Kampala]. Another respondent explained: "Me I can't stop drinking even though I burnt my house and business. Why leave drugs when it helps you forget your pain? I have children, where can I get help? Nowhere to go" [woman FGD participant, Congolese community, Kampala].

### ***Intervention points***

Although respondents reported that health service access was free of charge, there was a perception that treatment was limited to 'only paracetamol' [male FGD participant, Congolese refugees, Kampala]. For substance use disorders specifically, "we don't know where to go if we wanted help", said one respondent [male FGD participant, Somali community, Kampala]. Similarly, another respondent stated: "There are no services unless they develop mental problems then they can go to Butabika [the national mental health referral hospital in Kampala]" [male FGD participant, Congolese community, Kampala]. Butabika Hospital was also mentioned as a sole treatment option for substance use disorders known in Kiryandongo, though some 4 hours away by road. The perception that the service was a mental health service, not a drug treatment service, could act as a barrier to treatment seeking for some. According to one health worker "[family members will say]. "Don't send him to Butabika, he is not mad" [male health worker, Ugandan, Kiryandongo]. The need for specialised drug treatment was highlighted by another participant with first-hand experience of dependence: "Butabika is for mad people. It is a punishment. Drug use is not a madness, it is a sickness" [male KI, Kampala]. No participant mentioned other community or health supports, although several men and women suggested "counselling" without specifying where this could be obtained. One health worker expressed frustration at lack of counselling skills or capacity to support families, explaining "patients are usually brought in by family and don't come back ... [it is] very hard to tell them to stop, they relapse" [male KI, health worker, Kiryandongo]. Two participants described self-help strategies. To manage alcohol dependence "I feel better playing music, seeing the sun" [male KI, Kiryandongo]. Another said of his own heroin dependence: "no treatment needed, just need to make up your mind...before I was not thinking my brain – network jammed" [male KI, Kampala].

Community members in Kampala and Kiryandongo suggested vocational training to prevent substance use problems "we would like opportunities for vocational skills and trainings for employment - carpentry, driving licence, electrical - so we won't be idle" [male FGD, Congolese community, Kampala]. Similarly, in Kiryandongo, "organise *boda boda* drivers in camp, driver education and licensing, motor bike maintenance" was offered as a prevention for idleness and substance use problems – particularly due to alcohol [male FGD participant, Sudanese community, Kiryandongo]. However, another participant was not so hopeful, describing a similar initiative that had been taken in the past but did not progress. Although there was a dominant belief that "jobs will take away idleness" [male FGD, Congolese community, Kampala] and therefore prevent substance use problems, one participant suggested a need for programmes

to “address stress, because even when some people have work, they still drink” [male FGD participant, Sudanese community, Kampala]. Another respondent also reflected his personal experience of relapsing to alcohol dependence despite having work [male FGD participant, Sudanese community, Kiryandongo].

A number of family and community supports were also suggested by participants. Church group affiliation was suggested by one FGD participant [male FGD participant, Sudanese community, Kampala]. A safe space to smoke cannabis was requested by one participant with first-hand experience of use in Kampala [male FGD participant, Congolese community, Kampala]. A community elder suggested this response also in Kiryandongo “to protect young men from being arrested and getting into trouble in town” [male FGD participant, Sudanese community, Kiryandongo]. This same participant requested family support for addressing substance use disorders among young people, as did one health worker. In Kampala refugee FGD respondents requested a drop-in centre and support services; they were not aware of any existing support and outreach services.

Other community interventions mentioned by respondents included community education on substance use, harms, and interventions particularly for young people. One respondent, who described his own problems with substance dependence, thought that peer support may be beneficial [male FGD, Sudanese community, Kiryandongo]. Laws to restrict availability of alcohol (hours and outlets) were also suggested [male KI, teacher, Kiryandongo], with one Sudanese elder in Kampala noting that alcohol sale was banned in Sudan.

## **LIMITATIONS**

There were several important limitations to the study methods which must be taken into account when interpreting the findings. First, the data collection period was short – four days. Longer duration of collection may have allowed for development of relationships with respondents and access to hidden populations and behaviours. In particular further exploration of refugees’ experiences of sex work and substance use in the neighbouring host community to Kiryandongo camp was indicated.

Second, the study site was restricted to Kampala and one settlement, Kiryandongo, a situation of protracted displacement. It is not known how the information obtained is generalizable to other settings of protracted displacement or settings hosting new arrivals.

Third, although community elders were interviewed in Kiryandongo, no community advisory group was engaged prior to the assessment. Lack of engagement may limit capacity to direct the assessment in ways that have meaning for the community, and to build and direct subsequent interventions.

Fourth, sampling was opportunistic. Greater engagement with community groups and affected people prior to the assessment may have permitted snowballing and more directed sampling of affected community members. Opportunistic sampling may limit the breadth of experiences reflected in the findings.

Fifth, limited data were available for secondary quantitative analysis. No estimates can be made on the prevalence of stigmatized and illegal behaviours such as methamphetamine, heroin, and cocaine consumption and their use disorders. Integration of refugee populations into data collection activities is required.

Sixth, interview data are recognised as co-produced by respondents and interviewers (Rhodes et al., 2010). Interviews were conducted by a team of interviewers and note-takers of varied backgrounds and nationalities, different to those of the communities studied. Furthermore, there are opportunities for misunderstanding where the majority of those interviewed were interviewed in English, which was a second, third, fourth or fifth language for respondents, and a first, second, or third language for research team members. Where interpreters were used, they were themselves community members. This social context must be taken into account when interpreting the data, recognizing that interpreters can find themselves in a complex relationship between community members and researchers.

Finally, interviews were not recorded, transcribed, and analysed extensively. Instead, handwritten notes were taken and a short period of thematic analysis conducted, largely intervention focused against the 'gold standard' of the UNODC/WHO International Standards for the Treatment of Drug Use Disorders (UNODC & WHO, 2016<sup>7</sup>) and the UNODC/WHO International Standards on Drug Use Prevention (UNODC & WHO, 2018). Deeper analysis may have developed a more nuanced understanding of substance use for the communities studied, and findings presented with a stronger grounding in and contribution to theory.

## **DISCUSSION**

Substance use and related problems emerged as an important concern for participants. As for the Ugandan population, alcohol was the primary drug of concern among refugees. It is ubiquitous, cheap and readily available. Cannabis and khat were considered widely used in urban and rural settings. In the urban setting in particular, heroin and cocaine were also used, although less prominently, including injecting routes of administration. Substance use and related problems were gendered, perceived as more prominent among men than women. Urban life offered a greater range of opportunities and challenges, including exposure to an increasing range of substances and problems associated with them.

Dominant rationalisations for problem use were stress, idleness, limited educational opportunities, future uncertainty, discrimination, and livelihood constraints. Opportunities were seen by some as increasingly constrained with the duration of displacement, particularly in the rural settlement. These understandings are consistent with the international literature (Ezard et al., 2011; Horyniak et al., 2016) and Ugandan data associating trauma and alcohol use disorder among displaced

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<sup>7</sup> The updated version from 2020 is now available online  
[https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO\\_International\\_Standards\\_Treatment\\_Drug\\_Use\\_Disorders\\_April\\_2020.pdf](https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO_International_Standards_Treatment_Drug_Use_Disorders_April_2020.pdf)

populations (Roberts et al., 2011). Groups perceived to be most at risk of substance related problems were considered mobile young men and women without family financial support, particularly women sex workers and men *boda boda* drivers. Nevertheless, while respondents believed that the displacement experience may make refugee populations vulnerable to substance use disorders, there was no suggestion that they were prominent among displaced than host populations.

Health concerns related to substance use included alcohol related liver disease, dependence, accidents and injuries. Consistent with literature review findings from Uganda, there was a dominant perception among refugees that substance use and dependence may promote risky behaviours for HIV transmission, while limiting testing and treating behaviours. This is particularly concerning in the context of a generalized HIV epidemic, economic constraints, and cross-border and rural-urban population mobility and mixing.

Socio-economic concerns cited by participants were similar to those reported from the literature concerning Ugandan communities. These included alcohol-related domestic and family violence and disruption to child-rearing, household economy, livelihoods, and education. Criminal justice consequences were of particular concerns to refugees – especially parents – as they had additional implications for refugee status determination.

Although refugees have access free of charge to the Ugandan national health care system, there was limited knowledge about and limited recognition of access to treatment for substance use disorders. This lack of treatment access is consistent with estimated treatment coverage of 10% among the Ugandan population (Kalema et al., 2017). In view of suggested increased heroin use in Uganda (INCB, 2017) and our discussions with out-of-treatment refugees with heroin dependence, this would suggest the need for access to evidence-based specialist treatment for substance use disorders. Of note, the national HIV strategy makes no provision for prevention of injecting drug related HIV transmission or pharmacological treatment of opioid dependence.

There was limited epidemiological data on substance use disorder among refugees. This observation highlights the importance of and improved routine treatment data collection, survey data on problematic drug use, and inclusion of refugees in data collection activities. In view of increased use of amphetamine-type stimulants across Africa, reports of methamphetamine use from respondents in urban settings signals the need to be alert to emergence of methamphetamine use disorder among Ugandan and refugee populations.

## **CONCLUSIONS AND RECOMMENDATIONS**

Despite the limited scope of this short qualitative study conducted by a large external team, the study revealed useful information on key intervention gaps. There is no evidence to suggest that refugees in Uganda experience greater problems due to

substance use than host Ugandan populations. Socio-economic and psychosocial vulnerability resulting from the displacement experience, particularly in protracted displacement, warrants additional resource investment. Given the context of free access to the public health care system, the findings of this report suggest excellent opportunities to strengthen national primary and referral level treatment for substance use disorder, including for refugees.

Key recommendations are:

1. **SYSTEMS STRENGTHENING:** Strengthening Uganda’s substance use disorders prevention and treatment capacity is key to improving response capacity for refugees and Ugandan nationals. Key responses include:
  - f. Conducting a high-level policy maker workshop.
  - g. Mapping available treatment services in different regions in Uganda using the UNODC/WHO Substance Use Disorder Treatment Facility Survey (WHO & UNODC, 2018).
  - b. Establishing a Quality Assurance process to assess accessibility, affordability and quality of currently available treatment services in line with UNODC/WHO International Standards for the Treatment of Drug Use Disorders – Draft for Field Testing (2016<sup>8</sup>).
  - h. Measuring treatment demand through support to routine data collection in health services for host population and services providing care for refugees.
  - i. Including WHO/UNHCR mhGap for Humanitarian Situations and other relevant technical documents in Government of Uganda and UNHCR supported disaster preparedness plans.
  - j. Continue to build the capacity of health and social service providers at different levels to respond to substance use disorders in an effective way (including through training with available training packages such as the UNODC Treatnet package<sup>9</sup>, the WHO mhGAP package<sup>10</sup> or the Universal Treatment Curriculum UTC<sup>11</sup>).
2. **OUTREACH SERVICES:** Community agencies and peer workers have a key role in improving health of people who use drugs, including prevention of substance-related HIV transmission and referral for treatment of substance use disorder. Key responses include
  - c. Expansion of low-threshold services for people who use drugs and/or sex workers in refugee hosting areas.
  - d. Additional support to existing outreach services (e.g. NGOs such as UHRN and its partners) to reach vulnerable urban refugees.
3. **SCREENING, BRIEF INTERVENTION and REFERRAL.** Key responses include:

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<sup>8</sup> The updated version from 2020 is now available online

[https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO\\_International\\_Standards\\_Treatment\\_Drug\\_Use\\_Disorders\\_April\\_2020.pdf](https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO_International_Standards_Treatment_Drug_Use_Disorders_April_2020.pdf)

<sup>9</sup> <http://www.unodc.org/unodc/en/treatment-and-care/treatnet-training-package.html>

<sup>10</sup> mhGAP Humanitarian Intervention Guide (mhGAP-HIG) (who.int)

<sup>11</sup> <https://www.issup.net/training/universal-treatment-curriculum>

- c. Integration of routine substance use disorder screening into HIV and antenatal care.
  - d. Pilot procedures in Kiryandongo and Kampala by the Government of Uganda, UNODC, UNHCR, and Real Medicine Foundation to measure change in treatment demand.
4. TREATMENT in NON-SPECIALISED SETTINGS. Improving primary care of substance use disorders for displaced populations living in protracted situations by:
- d. Training health workers to detect and treat common coexisting health care needs, such as TB/STI/ hepatitis, and provide antenatal care.
  - e. Training health care workers on substance use disorder treatment using the WHO's mhGap package, UNODC Treatnet<sup>10</sup> and/or the UTC<sup>12</sup>.
  - f. Conduct translational research to test and evaluate training in Kiryandongo.
5. SPECIALISED TREATMENT. Actions to improve access to effective treatment includes:
- c. Building capacity of service providers to deliver evidence-based treatment in host and refugee communities.
  - d. Ensuring refugee needs are considered in efforts to expand specialised comprehensive treatment places, including access to medication assisted treatment.
6. PREVENTION. Prevention efforts among refugees and host communities include:
- c. Trialing the UNODC Strong Families Programme by the Government of Uganda, together with UNHCR and Real Medicine Foundation in Kiryandongo (reaching out to the refugee population and the host community).
  - d. Learnings extended to other settlements and communities.
7. GLOBAL RESPONSE CAPACITY: Additional global initiatives could support Uganda's efforts to improve prevention, treatment and care of substance use disorder for refugees. For example:
- d. Including Substance Use modules of WHO/UNHCR mhGap for Humanitarian Situations in minimum standards for emergency responders, including at an international level with international NGOs.
  - e. Conducting translational research aiming to improve detection and response to substance use disorder in humanitarian settings.

Sharing of evidence, information, experience and best practices to inform future practice directions.

## **APPENDIX 1: Team members**

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## APPENDIX 2: Semi-structured interview guides

### Refugees/host community members

Thank you for agreeing to take part in this< interview/focus group>. The purpose of the study is to find out what people think about alcohol and drug use in <study site>. Talking to you as someone who lives in <study site> will help us to understand how alcohol and drug use affects your life and those around them. We will use this information to help develop better services for alcohol or drug use in <study site>. We do not intend on collecting any information from you such as your name or date of birth. Therefore, anything you say cannot be traced back to you. We may record this interview if you have agreed to this so that we can listen to this at a future date. This recording will not be shared with anyone outside the research team. Otherwise, we will just make notes while we speak.

1. First I want to ask you a general question. What are the main difficulties that people face here?

2. Can you tell me about alcohol or other drug use here?

*Probes:*

*How common is alcohol and other drug (AOD) use in the refugee community?*

*What kind of substances are used and how common are each (list top 5)?*

*How are they used? Injected, smoked, snorted ...*

3. What effects do you think substance use has?

*Probes:*

*To individuals: health, behavior, family, work, finances?*

*To refugees and the community in general?*

4. What kind of help do you think people who use AOD need?

*Probes:*

*What kind of health services do people need? What would a good service look like?*

*What might be helpful to prevent people running into problems with AOD?*

*What might be helpful for those who have AOD problems e.g, withdrawal services, harm reduction (e.g. NSP), opioid substitution therapy, community support, residential rehabilitation?*

*What else might be helpful? e.g. primary health care, women and babies, youth groups, care for infectious diseases.*

5. Where can people go to get help with AOD problems?

*Probes:*

*Do you know of any help that is available for people with AOD problems? Can you tell me any stories about people who have accessed this help?*

*What makes it difficult to get help with AOD problems?*

*What would make it easier to get help for AOD problems?*

6. [Interviews with refugees only if indicated: Can you describe your personal journey as a refugee [if not answered in Q1]?

*Probes:*

*What was your journey to this country?*

*How long have you been living in this area and what do you think of it?*

*What difficulties have you faced since reaching this country?]*

7. Is there anything else you would like to share?

## Health service providers

Thank you for agreeing to take part in this interview. The purpose of this study is to describe substance use amongst refugees at <study site> as well as the issues they face. We also hope to describe the current services that are available for refugees and local host community members experiencing substance use issues at <study site>. We hope to use this information to help optimise service provision and access for alcohol or drug use in <study site>. None of what you say can be traced back to you as we will not collect any information that could identify you as an individual. We may record this interview if you have agreed to this so that we can listen to this at a future date. This recording will not be shared with anyone outside the research team. Otherwise, we will just make notes while we speak. Do you have any questions before we start?

1. First I want to ask you a general question. What services do you provide?

*Probes:*

*Describe the population you serve and provide details of the problems you help people with.*

*Give an estimate the volume of people your service sees.*

*Describe any specific AOD services you provide.*

2. What is your impression of alcohol and other drug use here?

*Probes:*

*Is it different for refugees and the local population?*

*What substances do you think are being used in this population (list 1-5)?*

*What routes of administrations and patterns of use?*

3. What impact do you think alcohol and other drugs have?

*Probes:*

*For refugees – health impacts, social, financial, community*

*For local host communities – health impacts, social, financial, community*

4. What could be done to reduce the impact of alcohol and other drugs?

*Probes:*

*What are the opportunities to improve access to existing AOD services for refugees?*

*Describe any opportunities for training or service improvement.*

## Policy makers

Thank you for agreeing to take part in this interview. The purpose of this study is to describe substance use amongst refugees at <study site/country> as well as the issues they face. We also hope to describe the current services that are available for refugees and local host community members experiencing substance use issues at <study site/country>. We hope to use this information to help optimise service provision and access for alcohol or drug use in <study site/country>. None of what you say can be traced back to you as we will not collect any information that could identify you as an individual. We may record this interview if you have agreed to this so that we can listen to this at a future date. This recording will not be shared with anyone outside the research team. Otherwise, we will just make notes while we speak. Do you have any questions before we start?

1. What do you think the major issues affecting refugees (list 5)?

*Probes:*

*What are the specific health issues?*

*What are the specific AOD issues?*

2. What do you know about AOD problems affecting refugees?

*Probes:*

*What do you think is the cause of AOD problems amongst refugees?*

*What do you think is the extent of substance issues amongst refugees? Substances, routes of use?*

3. What do you think are the consequences of AOD use amongst refugees?

*Probes:*

*What are the health, family, community consequences?*

*How does this impact on local host communities?*

4. What policies are you aware of that impact on refugee AOD use?

5. What services are available to assist refugees with AOD use?

6. What opportunities are there to improve services for refugees with AOD use?

## APPENDIX 3: Timeline

Date	Location	Office	Activity	Name	Position
16 April 2018	Kampala	Office of the Prime Minister	Meeting	Mr Simon Gerald Menhya Ms Vivienne Okello	Ag Commissioner for Refugees Lawyer
		UNHCR	Meeting	Dr Julius Kasozi Dr Dieudonné Yiwesa	Public Health Officer, Uganda Senior Regional Public Health Officer, Kenya
		Ministry of Health		Dr Olaro Charles	Director, Clinical Services
		TPO	Meeting	Mr Ngabirano Emmanuel	Knowledge Development Manager
17 April 2018		Interaid Uganda	Meeting	Mr Wandera Moses Ms Cecilia Driciru	Psychosocial Worker Mental Health Nurse
			Focus groups x 4		
		UNDSS	Security Briefing		
		UHRN	Meeting	Mr Chris Bayama Mr Sirius Asura Mr Daniel Katende	Program Head
			Meeting	Ms Jean Woynicki in attendance	Regional Refugee Coordinator, Great Lakes Region, U.S. Mission Kampala – Bureau of Population, Refugees, and Migration
18 April 2018		Interaid Uganda	Meeting	Ms Lamunu Prossy	Legal Officer
			Key informant interview x 1		

Date	Location	Office	Activity	Name	Position
			Focus group x 1		
19 April 2018	Kiryandongo	Office of the Prime Minister	Meeting	Mr Mukasa Ali	Deputy Camp Commander
		UNHCR	Meeting	Mr Frédéric de Woelmont	Protection Officer
		Danish Refugee Council	Meeting	Ms Gladys Kyrikunda	
		Settlement	Men's group meeting, informal meeting Walk through and observation School visit Key informant interviews x 6 Focus group x 1		
		Kaboye Town Council	Meeting	Mr Guy Manavah Mr Paul Mikikaski	Town Counsellor Health Inspector
20 April 2018		Settlement	Direct observation Focus group x 1 Key informant interviews x 3 Health service observation Women's group, informal meeting Police, informal meeting		
			Meeting	Dr Byaba Martin	RMF Medical Officer

Date	Location	Office	Activity	Name	Position
21 April 2018	Kampala	UHRN	Direct observation, Kabalagana and Kibuli Key informant interview x 1 Informal interview x 1		

## APPENDIX 4: Rapid Literature Review Search Terms

Databases: Ovid MEDLINE, PsycINFO, Global Health

Dates: 1980 – 2017

#	Search Statement	Results
1	refugee*	9458
2	limit 1 to english language	8927
3	limit 2 to human	8536
4	limit 3 to yr="1980 -Current"	8431
5	alcohol	427152
6	substance	330900
7	displaced	34243
8	limit 7 to english language	31985
9	limit 8 to human	21027
10	limit 9 to yr="1980 -Current"	20021
11	treatment	4916207
12	intervention	739579
13	services	958210
14	11 or 12 or 13	6129005
15	5 or 6	699710
16	4 or 10	39879
17	fracture	169172
<b>18</b>	<b>(14 and 15 and 16) not 17</b>	<b>187</b>

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