

**A QUICK SCAN OF THE LAWS
AND POLICIES AFFECTING
THE HIV RESPONSE AMONG
PEOPLE WHO INJECT DRUGS
IN UGANDA**



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PROJECT TEAM

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KEY DEFINITIONS

People Who Inject Drugs (PWIDs): people who inject themselves with psychotropic drugs; such as opioids, hallucinogens and cocaine; for purposes that are not medical.

Narcotic drugs: substances that are addictive and that induce sleep, relieve pain or dull the senses. When taken in heavy doses, these drugs could also cause a coma.

Psychotropic substances: chemical substance that acts primarily upon the central nervous system where it alters brain function, resulting in temporary changes in perception, mood, consciousness and behavior.

Key populations: these are groups of people at a higher risk of contracting HIV than the rest of the population because of some unique characteristics about them.

Sexual and reproductive health: refers to a state of well-being in all matters related to sexuality and the reproductive system.

Harm reduction: refers to policies, programmes and practical strategies to reduce the harm that comes along with the use of drugs for people who are either unwilling or unable to stop.

Stigma: a set of negative and unfair beliefs that society has about a group of people that is somewhat different from most people in society.

Discrimination: treating a person or group of people differently or worse because of characteristics like their race, ethnicity, age or beliefs.

Post Exposure Prophylaxis (PEP): emergency treatment which reduces the likelihood of HIV infection for a person who has been exposed to the blood or other body fluids of someone who could have potentially been infected with HIV.

LIST OF ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
EOC	Equal Opportunities Commission
HIV	Human Immunodeficiency Virus
HCT	HIV Counselling and Testing
ICWEA	International Community of Women living with HIV/ AIDS Eastern Africa
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MARPI	Most at Risk Populations Initiative
NGO	Non-Governmental Organisation
NSP	National HIV and AIDS Strategic Plan
OST	Opioid Substitution Therapy
PEP	Post-Exposure Prophylaxis
PWD	People With Disabilities
PWIDs	People Who Inject Drugs
PWUDs	People Who Use Drugs
SRHR	Sexual and Reproductive Health and Rights
UAC	Uganda AIDS Commission
UGANET	Uganda Network on Law Ethics and HIV/AIDS
UHRN	Uganda Harm Reduction Network
UNAIDS	Joint United Nations Programme on HIV
WHO	World Health Organization

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1 INTRODUCTION

In Uganda, about 30% of all new HIV infections occur among members of key population groups and their partners.¹ Countries around the world agree that members of these key population groups themselves are in the best position to take the lead in the fight against HIV/AIDS.²

One key population or ‘most at risk’ group is People Who Inject Drugs (PWIDs). Globally, 13% of PWIDs are also living with HIV and PWIDs are 28 times more likely to contract HIV than the rest of the population.³ In Uganda, this group receives little attention in terms of treatment and care and scant research has been carried out concerning their rights and welfare. This group also faces immense stigma and prejudice which alienates its members from the healthcare system and prevents them from accessing HIV prevention and care services. The main reason why PWIDs are treated so badly in society is because individual drug use and possession is criminalised in Uganda and drug users are therefore viewed as criminals who deserve to be punished.

The alienation of PWIDs from the healthcare system leads to the spread of HIV since PWIDs will most likely not know about their HIV positive status and will not be able to access anti-retroviral treatment which helps to prevent HIV transmission.

PWIDs also have unique sexual and reproductive health needs⁴ and regular drug use makes it difficult to consistently use anti-

1 World Health Organization (WHO) *Policy brief: Consolidated guidelines on HIV Prevention, Treatment and Care for Key Populations* (2014) 2.

2 UNAIDS ‘Reaffirming the leadership of people living with HIV in the AIDS response’ 18 July 2016 available at http://www.unaids.org/en/resources/presscentre/featurestories/2016/july/20160717_living2016 (accessed 10 January 2017).

3 UNAIDS *The GAP Report* (2014) 173.

4 See International Network of People Who Use Drugs (INPUD) and Global Network of People Living With HIV (GNP+) *Advancing the Sexual and Reproductive Health and Human Rights of Injecting Drug Users living with HIV: A policy briefing* (2010).

retroviral treatment.⁵

Uganda has very few policies which address these particular needs of PWIDs.

This booklet identifies and analyses the laws and policies that affect the Sexual and Reproductive Health and Rights (SRHR) and access to HIV prevention and care services of PWIDs in Uganda. The purpose of the booklet is to inform advocacy for a more enabling environment.

The booklet is written in easy to understand language with illustrative examples. It identifies areas for advocacy for each of the laws. The booklet is aimed at empowering PWIDs with knowledge about the legal framework which would enable them to take the lead in the fight against HIV and to advocate for their increased access to HIV prevention and care services.

We hope that the community finds the quick scan useful.

5 J Nchenga, M Hislop, H Nguyen, DW Dowdy, RE Chaisson & L Regensberg 'Antiretroviral therapy adherence, virologic and immunologic outcomes in adolescents compared with adults in southern Africa' (2009) 51:1 *Journal of Acquired Immuno Deficiency Syndrome* 65 - 71.

2

HOW DOES UGANDAN LAW AFFECT THE SRHR AND ACCESS OF HIV PREVENTION AND CARE SERVICES BY PWIDS IN UGANDA?

2.1 What are the sources of law in Uganda?

Uganda's law has different sources which are applied in a specific order or hierarchy. These sources are both written and unwritten.

The Constitution is the supreme law in Uganda and first in this hierarchy. All other laws in the country must be in line with it. Written laws, known as statutes or Acts of Parliament, are the second most important source of law in the country. Statutes are followed by subsidiary legislation which are laws made by actors such as ministers with the authority given to them by Parliament. Subsidiary legislation includes rules and guidelines. Policies are usually developed by ministries and other technical bodies stating the government's position on certain issues. Subsidiary legislation is not enforceable in court but they do give a strong indication of the government's position on particular matters and the direction in which the government intends to move.

Uganda also recognises common law and equity which is created through a long line of court judgments handed down by English courts. Finally, Uganda also recognises customs and tradition provided they do not contravene the written law.

International law only becomes applicable if it has been included in an Act of Parliament. However, international law principles do require of the state to respect obligations that they have signed on to in good faith. This means that treaties and agreements that Uganda has signed have an impact in the country even when they have not been enacted into an Act of Parliament.

2.2 What does Ugandan law say about PWIDs and how does it affect their SRHR and access to HIV prevention and treatment?

Domestic law makes it clear that individual drug use and possession is criminalised in Uganda. This criminalisation has a profound impact on PWIDs as a group, since the model that is followed is

that of criminalisation rather than harm reduction. While the protection of the rights of PWIDs is not specifically mentioned, the rights of people in Uganda in general are protected and this includes the rights of PWIDs. There are also a number of laws which impact upon the rights of PWIDs, even though they are not explicitly mentioned in these laws. Below is an analysis of the key laws among these:

a) ***The Constitution***

The Constitution is the supreme law in Uganda.⁶ It provides that all persons are equal and should not be discriminated against on grounds such as age, gender, race, social status and ethnicity.⁷ The list does not include 'being a drug user' among the protected grounds. However, one can argue that the reference to 'social or economic status' may include being a drug user. That aside, the non-inclusion does not mean that PWIDs are not protected under the equality provision as the listed grounds are simply an elaboration of the general protection clause.

Even though drug use is criminalised, PWIDs are still entitled to their fundamental rights which can only be limited according to the Constitution itself.⁸ The Constitution itself provides special protections for individuals whose rights are limited through the criminal justice system. These special protections or 'due process guarantees' include being presumed innocent and being informed of the reason for the arrest.⁹

All the rights in the Constitution including the rights to: freedom from torture, inhuman and degrading treatment; liberty; privacy and the right to freedom of association apply to all persons, including PWIDs. The Constitutional Court has declared unconstitutional a provision that had the effect of stopping the Equal Opportunities Commission from investigating cases of discrimination concerning groups whose behaviours are considered to be 'immoral and socially harmful' or 'unacceptable by the majority of the cultural and social communities in Uganda'.¹⁰ These groups include PWIDs.

The Constitution does not explicitly protect the right to health

⁶ Article 2.

⁷ Article 21.

⁸ Article 43.

⁹ Article 28.

¹⁰ *Adrian Jjuuko v Attorney General* Constitutional Petition No. 1 of 2009.

along with other fundamental rights that are protected in its fourth chapter. However, the right to access health services is recognised in Objective XIV of the National Objectives and Directive Principles of State Policy. In 2005, the Constitution was changed to provide that the country shall be governed on the basis of these objectives and principles.¹¹ This change in the Constitution meant that the responsibility to ensure the realisation of the right to access health services was placed on the State.¹² The Constitution also includes all other rights which may not be specifically recognised in the Constitution.¹³

Since all persons are equal before and under the law and enjoy the same rights except as these may be limited according to the Constitution, PWIDs should not be denied enjoyment of their SRHR and access to HIV prevention and treatment services.

Areas for advocacy

Even though the Constitution is the supreme law of Uganda, it can be amended by a bill of Parliament passed by a two thirds majority of all its members. Advocacy can help to bring to the fore issues that require constitutional amendment such as the inclusion of the right to health expressly within the Bill of Rights. The other avenue is to go to the Constitutional Court to seek the court's interpretation of the different provisions of the Constitution affecting PWIDs.

b) *Laws made by Parliament (statutes)*

Statutes are second to the Constitution in terms of hierarchy. The ones which have the greatest impact on PWIDs are the following:

i) *The National Drug Authority and Policy Act, 2006*

This Act currently regulates drug use and possession in Uganda. It has a number of provisions which have a profound impact on PWIDs.

11 Section 8A of the Constitution, see CEHURD *Advocating for the right to reproductive healthcare in Uganda: The import of Constitutional Petition No. 16 of 2011* (2011) 20.
12 The Republic of Uganda Ministry of Health *The Second National Health Policy: Promoting Peoples' Health to Enhance Socio-Economic Development* (2010) 1.
13 Article 45.

The Act provides that any person who is in possession of narcotic drugs, other than certain listed persons such as wholesale dealers or license holders, commits an offence and is liable to a fine of UGX 2,000,000 or to a prison sentence of not more than five years or both.¹⁴ It also makes it clear that no person may be in possession of narcotic drugs without lawful excuse.¹⁵ These provisions mean that it is a criminal act for a person to be in possession of even a small amount of drugs that is for personal use.

The criminalisation of possession of drugs for personal use has severe human rights implications for PWIDs.¹⁶ It has caused PWIDs to be stigmatised and marginalised and has led to an absence of rehabilitation and other medical services for them.¹⁷ The availability of clean needles and syringes as well as treatment which makes use of other drugs to rehabilitate people who are addicted to injecting drugs or has overdosed are considered as elements of the realisation of SRHR and HIV prevention and care services to PWIDs. However, due to the criminalisation of drug use, none of these services are available in public facilities in Uganda.¹⁸

Apart from the unavailability of the harm reduction elements for HIV prevention, treatment and diagnosis for PWIDs, even the sexual and reproductive services which are available in the country cannot easily be accessed by PWIDs. The fact that drug use is criminalised causes PWIDs to fear approaching medical service providers because they do not want to be reported to law enforcers. PWIDs have unique sexual and reproductive health needs. For example, women who use opiates often stop menstruating and may not be aware that they are pregnant.¹⁹ The use of opiates also impacts negatively on male sexual function.²⁰ These particular sexual and reproductive health needs are not attended to in the existing medical service structures. PWIDs are also alienated from accessing HIV prevention

14 Section 27.

15 Section 47.

16 Human Rights Awareness and Promotion Forum *The Narcotic Drugs and Psychotropic Substances (Control) Act, 2015 and the Legal Regulation of Drug Use in Uganda: Analysing the tension between criminal law, public health and human rights* (2016) 56.

17 As above.

18 As above.

19 International Network of People Who Use Drugs (INPUD) and Global Network of People Living With HIV (GNP+) *Advancing the Sexual and Reproductive Health and Human Rights of Injecting Drug Users living with HIV: A policy briefing* (2010) 6.

20 As above.

and care services.

To take the impact of this criminalisation a step further: when PWIDs are placed in prisons on the basis of this Act, access to medical services which address their needs in terms of sexual and reproductive rights and HIV prevention and care would be even more difficult to access. People in prison are also vulnerable to sexual assault by other inmates, which increases their vulnerability to HIV infection.²¹ The criminalisation of drug use reduces economic opportunities of PWIDs and renders them even more vulnerable as a key population group.

The Act also has a provision that medical practitioners are required to make a register of the names of persons who come to see them and who are addicted to drugs.²² This list must be made available to the Minister responsible for health on an annual basis. This provision has the effect of further discouraging PWIDs from accessing healthcare services because it means that they will be listed as a 'drug addict' by the medical practitioner who helps them and their names will be forwarded to the Minister, which could render them vulnerable to a future targeted arrest.

The Act makes it an offence to 'frequent any place used for smoking opium or Indian hemp'.²³ While the smoking of opium or Indian hemp would not qualify as 'injecting drugs', usually the same locations are used for taking both injecting and non-injecting drugs and this provision justifies the arrest of PWIDs even where they were not using drugs or were not found to be in possession of any narcotic drug.

The provision makes it easy for the police to target PWIDs as a group and to round them up for arrest with little evidence apart from the fact that they were found in a place which is known to be used for taking certain drugs. Such a provision renders PWIDs more vulnerable to arbitrary arrest and extortion by the police and diminishes their sense of security and dignity. In turn, it would be more difficult for PWIDs to demand for the realisation of their rights to access healthcare services and to be empowered to advocate for the reform of laws which affect them.

21 UNAIDS and World Health Organization Inter-Agency Working Group on Key Populations *HIV and young people who inject drugs: A policy brief (2013)* 14.

22 Section 29.

23 Section 48.

Areas for advocacy

While this Act is still in force and presents a number of provisions which ought to be amended in order to ensure the realisation of rights of PWIDs, it would perhaps be best for PWIDs' rights activists to focus their efforts on the Act which has been adopted to replace the National Drug Authority and Policy Act. This replacement Act is called the Narcotic Drugs and Psychotropic Substances Control Act, 2015 and it will come into force as soon as the Minister issues the necessary instrument. The new Act, and areas for advocacy in respect of it, will be discussed next.

ii) ***Narcotic Drugs and Psychotropic Substances (Control) Act, 2015***

The Narcotic Drugs and Psychotropic Substances (Control) Act, 2015 was enacted in order to combine and change the existing laws relating to drug use and possession. The Act has as a particular aim to combat trafficking in drugs. It also regulates the growing of certain plants which yield drugs. The Act has not yet come into operation.²⁴

This Act also emphasises the criminal law approach to drug use in Uganda. It goes a step further in this approach and imposes heavy penalties for the use and possession of narcotic drugs. For an offence related to drugs listed in the Second Schedule to the Act, a fine of at least UGX 10,000,000 or three times the market value of the drug (whichever is greater) or imprisonment of between 10 and 25 years or both a fine and prison sentence can be imposed.²⁵ The Act also criminalises the 'use' of narcotic drugs and psychotropic substances, which would include injecting these drugs.²⁶ The effect of these provisions is that they intensify stigma against PWIDs. By drastically increasing the penalties for individual drug use and possession, the message is sent that PWIDs are criminals deserving of severe punishment.

The new Act contains provisions prohibiting the 'promotion' of drug use, which may place healthcare and harm reduction service providers in a position of compromise: they may be reluctant to

²⁴ Section 1 provides that the Act will come into operation on a date which the Minister will determine.

²⁵ Section 4.

²⁶ Section 6.

offer assistance to PWIDs out of fear of being viewed as ‘promoting’ an illegality.²⁷

The positive aspects of the law also unfortunately do not address the concerns of criminalisation as a model that is incompatible with HIV prevention and control. The Act provides for the establishment of rehabilitation centres for the provision of treatment, care and rehabilitation of persons addicted to narcotic drugs or psychotropic substances.²⁸ The Act provides that a person may be ‘committed’ to rehabilitation centres where a court has convicted him/her under a provision of the Act and the court is satisfied that the person is addicted to a narcotic drug or a psychotropic substance and possesses this drug for personal consumption only (and not for the purposes of drug trafficking). The fact that the availability of state sponsored rehabilitation care is only accessible through the criminal justice system is highly problematic, and PWIDs would instead keep away from these facilities for fear of being arrested, and this would worsen their vulnerability to HIV.

There is also a quick mention of treatment and care of PWIDs under section 66 of the Act which deals with government’s obligation to take measures for preventing drug abuse.

The section provides that the Government may take measures to prevent and combat the abuse of narcotic drugs which may include ‘identification, treatment, education, aftercare, rehabilitation and social integration of addicts’. This provision is almost an after-thought and it is very clear that the focus of the Act is on suppressing illegal trafficking in drugs.²⁹

Areas for advocacy

There is need to advocate for an amendment of the law to decriminalise individual drug use, as well as the possession of drugs for individual use in order to create an enabling environment for HIV prevention and treatment among drug users.

27 Section 6(d) of the Act provides that any person who ‘[r]ecruits or promotes the smoking, inhaling, sniffing or in any other manner promotes the use of cannabis, opium, khat, heroin, cocaine or any other narcotic drug or psychotropic substance’ commits an offence.

28 Section 52(2).

29 HRAPF, n16 above at 40-41.

There is also a need to advocate for the adoption of comprehensive and focused legislation and policies which will provide guidelines for harm reduction services to PWIDs, especially state sponsored rehabilitation services and opioid substitution therapy. These services should be made available to PWIDs without them having gone through the criminal justice system first. The policies should recognise that harm reduction measures are a priority for PWIDs and are central to HIV prevention and care within this group. There is also need for policies guiding the expansion of public healthcare facilities that provide specialised and non-discriminatory services to PWIDs to overcome the hurdle that stigma presents.

The law should furthermore be amended not to criminalise the ‘promotion’ of drug use. Alternatively, PWIDs can advocate that the law should be amended or regulations should be adopted to provide that the provision of legitimate services to PWIDs does not amount to the ‘promotion’ of drug use.

iii) ***The Penal Code Act, Cap 120***

The Penal Code Act provides for most crimes and offences recognised in Uganda and contains a number of provisions which have a serious impact on the SRHR as well as access to HIV prevention and care services of PWIDs.

Provisions criminalising sex work

Sections 136 to 139 of the Penal Code Act criminalise different aspects of sex work in Uganda. This criminalisation is troubling since sex work is a common source of income, and often a very last resort, for PWIDs. Since sex work is criminalised, sex workers generally face arbitrary arrests and mistreatment by the police.³⁰ The criminalisation of sex work worsens the stigma and discrimination which PWIDs already face and makes it even more difficult for them to approach healthcare centres where they will be able to get treatment. The criminalisation of sex work also makes PWIDs more vulnerable to HIV infection because it makes it more difficult to insist on the use of condoms during sex and also

³⁰ Human Rights Awareness and Promotion Forum *Legal regulation of sex work in Uganda: Exploring the current trends and their impact on human rights of sex workers* (2016) 43-45.

makes them likely victims of sexual assault by their clients, the police or prison inmates if they are arrested.

Provisions criminalising idle and disorderly conduct

Sections 167 and 168 of the Penal Code Act create the offences of ‘being an idle and disorderly person’ and ‘being a rogue and a vagabond’, respectively. These are overbroad and vague provisions which criminalise a very broad range of actions such as ‘being found wandering’ in a public place at such a time and under such circumstances as would ‘lead to the conclusion that such person is there for an illegal and disorderly purpose’. PWIDs are arrested under these provisions where police officers suspect that a person is a drug user, on the basis of their appearance or location, but do not have the necessary evidence to secure a conviction under the National Drug Policy and Authority Act.³¹

These provisions operate to unfairly target key populations and ought to be reviewed and revoked. They have the effect of further marginalising PWIDs and isolating them from healthcare services. The provisions also cause insecurity and humiliation to PWIDs and increase the internal stigma which they experience, disempowering them as agents in ensuring the realisation of their own sexual and reproductive health rights and services.

Areas for advocacy

There is need to challenge the Penal Code provisions in courts of law and to engage in advocacy to have them amended by Parliament as they fall short of constitutional requirements. Advocacy is also necessary to ensure that law enforcers respect the rights of arrested persons, especially when they belong to a marginalised group such as PWIDs.

iv) *The HIV Prevention and Control Act, 2014*

The purpose of this Act is to provide for the ‘protection, counselling, testing and care of persons living with and affected by HIV and AIDS’ in order to prevent HIV and AIDS. The Act has many provisions which affect PWIDs’ access to SRHR and access to HIV services. These are:

³¹ HRAPF, n16 above at 51-52.

Positive provisions

The Act has a number of positive provisions which make it easier for PWIDs to access HIV prevention and care. These include provision of counselling before and after someone is tested for HIV³² and prohibition of discrimination on the basis of HIV status in the workplace, schools, healthcare settings etc,³³ requiring of the State to provide ‘universal HIV treatment to all persons on a non-discriminatory basis,’³⁴ to make available free of charge Post Exposure Prophylaxis (PEP) to persons who had been exposed to HIV,³⁵ to promote the awareness of rights of persons living with HIV and to ensure their participation in government programmes.³⁶ These provisions are positive steps which address the stigma that people living with HIV face and it is important for all key population groups, PWIDs included, to know about these provisions and to insist on their enforcement where possible.

The Act requires of the state to ‘give priority to most at risk populations’ which it defines as ‘fishing communities, prisons, migrant populations or other areas as may be determined by the Minister from time to time’.³⁷ It seems that the Act had intentionally listed for priority most at risk population groups that are not controversial in Uganda, and left it to the Minister to define the others. No mention is made of PWIDs or other key population groups who face immense stigma from society. Even without specific mention of PWIDs, these positive provisions can still be used in support of advocating for the prioritisation of PWIDs since they have been identified and defined as a ‘key population’ by the UNAIDS as well as the Government of Uganda.³⁸

Problematic provisions

There are also provisions in the Act that negatively impact the access to HIV prevention and care services of PWIDs. These include forced HIV testing for persons charged with sexual offences,³⁹

32 Sections 3(1), 5 & 6.

33 Sections 32(1) & 33.

34 Section 24(1)(b).

35 Section 32(3)(b).

36 Section 24(1)(e) & (f).

37 Section 24(1)(k) & 24(2).

38 UNAIDS UNAIDS *Terminology Guidelines* (2015) 8; Republic of Uganda Ministry of Health *Addendum to the National Antiretroviral Treatment Guidelines* (2013) 18.

39 Section 12.

criminalisation of actual and attempted transmission of HIV⁴⁰ and disclosure of patient information.⁴¹ Criminalisation of transmission of HIV will discourage testing as prior knowledge of one's HIV status would be evidence that they are guilty of this offence as they knew that they could transmit HIV. The criminalisation of attempted transmission is very broad as an attempt is not defined and can be used to 'witch-hunt' groups of persons that are considered both unwanted and very likely to be HIV positive. The fact that the Act allows for the disclosure of HIV test results, especially without consent under some circumstances, will discourage testing as it will create a sense of insecurity within stigmatised populations like PWIDs. All of these provisions hinder PWIDs from accessing HIV prevention and care services.

Areas for Advocacy

A case was filed in Uganda's Constitutional Court challenging the constitutionality of the problematic provisions of this Act. PWIDs are encouraged to support this case as it unfolds in order to ensure that the law is amended and the problematic provisions removed.⁴² There is also need for advocacy to ensure that the positive provisions are implemented in favour of PWIDs.

v) *The Non-governmental Organisation Act, 2016*

A new Non-Governmental Organisations Act came into force in March 2016 to regulate NGOs in Uganda and their operations. The Act contains two provisions that pose a threat to the future existence and work of organisations which provide services to PWIDs. These are:

Provisions placing 'special obligations' on organisations and providing for the refusal to register organisations whose objectives contravene the law

These provisions prohibit organisations from engaging in activities that are prejudicial to the 'security and laws of Uganda', and to

40 Sections 41 & 43.

41 Section 18.

42 Constitutional Petition No. 24 of 2016 instituted on 14 July 2016 by UGANET, ICWEA and Prof. Ben Twinomugisha, with the support of over 60 civil society organisations.

the ‘interests of Uganda and to dignity of Ugandans’.⁴³ The NGO Bureau is also empowered to refuse to register an organisation whose objectives are regarded as being in contravention of the laws of Uganda.⁴⁴ The provision of services to a group that is considered to engage in criminal conduct by using and possessing drugs can be interpreted as being contrary to the laws of Uganda and the interests of Ugandans. This means that the NGO Act could have the effect of stopping the operation of organisations which provide sexual and reproductive health services, HIV prevention and care and harm reduction services to PWIDs as well as organisations which advocate for the rights of this group and empowers its members to advocate for their rights themselves.

Areas for advocacy

There is need to advocate for the amendment of this Act to remove these two provisions. Alternatively, the provisions should be challenged in the Constitutional Court. There is also need for advocacy and engagement with the NGO Bureau, the Ministry of Health and the Uganda AIDS Commission (UAC) to ensure that the provisions are not used to target key populations like PWIDs.

vi) *Equal Opportunities Commission Act, 2007*

The World Health Organization encourages countries to implement laws that prohibit discrimination against key population groups as part of the fight against the spread of HIV/AIDS.⁴⁵ Uganda has enacted the Equal Opportunities Commission Act, 2007 (EOC Act), which is purposed to combat discrimination and inequalities against any group of persons on grounds such as sex, age, tribe or health status and to take affirmative action in favour of these groups.

The EOC is given the power to investigate complaints of plans, policies or actions which seemingly amount to discrimination and to examine laws and policies which are likely to have the effect of preventing equal opportunities.⁴⁶ In order to carry out its mandate, the EOC is also empowered to investigate complaints brought before it concerning discrimination and marginalisation,⁴⁷

43 Section 44(d) and (f).

44 Section 30(1)(a).

45 WHO, n2 above at 10.

46 Section 14(2).

47 Section 15.

and to monitor state entities to ensure that they adhere to non-discrimination principles and equal opportunities.

Initially, minorities associated with criminal conduct, such as PWIDs, could not access the Commission due to section 15(6)(d) which prohibited handling of issues that were considered immoral and socially unacceptable. However, the Constitutional Court held that that provision was unconstitutional in the case of *Jjuuko Adrian v Attorney General*⁴⁸ and that all persons should have access to the Commission.

Areas for Advocacy

Since the Court has made it clear that all persons, including PWIDs, can access the Commission, it is important to make use of the Equal Opportunities Commission to enforce the rights of PWIDs. PWIDs should also engage in advocacy to ensure that the EOC Act is implemented to their advantage, to reduce the inequalities and denial of services they face in the health sector.

c) *Subsidiary legislation, common law and equity*

There are no specific rules or regulations made under the authority of Parliament, or common law or equity rules that specifically affect PWIDs in Uganda.

d) *Customary law*

Customary law is derived from the customs and practices of the communities in Uganda. Customary law has never addressed drug use or possession. The first regulation of drug use in Uganda was introduced by the British through the 1902 Order-in-Council which made British laws to apply in Uganda.⁴⁹ The fact that the regulation and criminalisation of drug use is not recognised in customary laws serves as support for their decriminalisation.

2.3 Which policies affect the SRHR as well access to HIV prevention and care of PWIDs?

48 Constitutional Petition No. 1 of 2009.

49 The United Kingdom Dangerous Drugs Act of 1920 and the United Kingdom Pharmacy and Poisons Act of 1933 became part of Ugandan law after their enactment on the strength of the 1902 Order-in-Council. See HRAPF, n16 above at 32.

A number of policies affect the SRHR of PWIDs as well as their access to HIV prevention and care and these are:

- i) ***The Second National Health Policy: Promoting Peoples' Health to Enhance Socio-Economic Development (2010).***⁵⁰

The National Health Policy has the objectives of strengthening the organisation and management of health systems and improving the quality of access to health services in order to achieve the goal of 'a good standard of health for all people in Uganda' which will promote healthy and productive lives'.

According to the policy, Uganda intends on 'reducing health inequities through action on the social determinants of health' in order to reach the government's targets on combatting AIDS.⁵¹ One of these 'determinants of health' that the policy recognises is 'social behaviours'.⁵² Social behaviours are crucial in the forming of key population groups such as PWIDs. The policy does not go into any detail about how the existence of marginalised groups is often rooted in social behaviours and does not offer solutions on how their exclusion from the healthcare system can be addressed. Two groups which are recognised by name however, are women and People With Disabilities (PWD).

Areas for advocacy

Advocacy is needed to encourage the inclusion of PWIDs in this policy as a vulnerable group in need of specified health interventions.

- ii) ***The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (2012).***

This policy provides a framework for planning, promoting and providing services in respect of sexual and reproductive rights and reflect the objectives and priorities of the National HIV Strategic Plan and the Health Sector Investment Plan. This policy, which serves to increase access to SRHR and HIV prevention and care is a positive stride toward making these services accessible

⁵⁰ The Republic of Uganda Ministry of Health *The Second National Health Policy: Promoting Peoples' Health to Enhance Socio-Economic Development (2010)*.

⁵¹ As above at 10.

⁵² As above.

to all. However, considering that PWIDs are a key population group with specific needs in respect of their sexual and reproductive health, policy and programming which focuses on this group in particular would be needed and should be the subject of advocacy.

The policy lists people who can get services for the termination of pregnancy to include pregnant women who suffer from a severe maternal illness which threatens their health and HIV positive women.⁵³ A pregnancy can also be terminated where the unborn child suffers from severe abnormalities which would make it impossible to survive outside of the womb. Considering that PWIDs are particularly vulnerable to HIV infection as well as the fact that injecting drugs takes a serious toll on a person's body and could affect the normal development of a foetus, a female PWIDs who falls pregnant could likely need to make use of this exception to the prohibition against abortion.

Another positive aspect of the policy is that it encourages the provision of sexual and reproductive healthcare on the one hand, and HIV/AIDS prevention and care on the other, in a manner which integrates the two.⁵⁴ What this would mean, practically, is that someone who visits a health centre for a pap smear or a pregnancy test would also be offered an HIV test; or if someone visits a health centre to get anti-retroviral treatment the healthcare provider would also enquire into the sexual or reproductive health needs of the patient.

Areas for advocacy

PWIDs are encouraged to advocate for a policy that is more inclusive and that addresses their needs and concerns.

- iii) ***National HIV and AIDS Strategic Plan 2015/2016 - 2019/2020 (2015)⁵⁵ and the National HIV and AIDS Priority Action Plan 2015/2016 - 2017/2018.***

The National HIV and AIDS Strategic Plan (NSP) guides the implementation of the national response to HIV in alignment with

53 As above at 47.

54 As above at 64.

55 Uganda AIDS Commission *An AIDS Free Uganda: My responsibility! National HIV and AIDS Strategic Plan 2015/2016 - 2019/2020 (2015).*

interventions aimed at the key drivers of the epidemic.⁵⁶ The National HIV and AIDS Priority Action Plan is part of the NSP and sets out the priorities of the NSP which will be attended to during the first three years of its implementation.

The NSP acknowledges the high HIV prevalence among key populations groups. These groups are stated to include sex workers, Men who have Sex with Men and boda boda drivers.⁵⁷ The plan also recognises the role that socio-economic factors and norms play in HIV infection rates.⁵⁸ The NSP makes mention of the harmful effects of the HIV Prevention and Control Act on the HIV response since some of its provisions enforce HIV-related discrimination and stigma.

A positive aspect of the NSP is that it targets key populations in HIV prevention interventions.⁵⁹ The NSP aims at scaling-up comprehensive interventions targeting Most At Risk Populations (MARPs).⁶⁰ These interventions include increased HCT and comprehensive social support for vulnerable groups as well as eliminating stigma and discrimination against these groups.⁶¹

The objectives and action points of the NSP can be used in advocating for targeted interventions for PWIDs. It is regrettable that the NSP fails to make specific mention of PWIDs as a key population group.

Areas for advocacy

PWIDs could engage the Ministry of Health in order to ensure that they are also expressly included in this policy.

- iv) ***Uganda HIV Testing and Counseling Policy, 3rd edition (2010).***⁶²

This policy has the goal of reducing HIV transmission by putting the structures in place to allow people to know their HIV status and to improve their quality of life by linking them to prevention,

56 As above at 1.

57 As above at 5.

58 As above at 9.

59 As above at 21.

60 As above at 22.

61 As above.

62 The Republic of Uganda Ministry of Health *Uganda HIV Testing and Counselling Policy 3rd edition* (2010).

care, treatment and support services.⁶³

The policy covers a number of elements such as service delivery, health systems and questions of human rights, stigma and special groups.⁶⁴

The policy encourages a ‘human rights-based approach’ to HIV Counselling and Testing (HCT) by reducing stigma and discrimination during HCT service delivery.⁶⁵

The policy provides that HCT services should be designed to address the needs of ‘special groups’.⁶⁶ Even though this is not expressly stated, PWIDs can be considered to be included under these ‘special groups’ in that Most At Risk Populations (MARPs) in general are mentioned.

Areas for advocacy

While the HCT policy does generally comply with international guidelines and standards,⁶⁷ there is room for advocacy for HCT guidelines which address the needs of PWIDs in particular. It is also necessary to ensure and demand that this policy is implemented.

- v) ***The National Policy Guidelines for Post Exposure Prophylaxis for HIV, Hepatitis B and Hepatitis C (2007).***⁶⁸

After a person has been exposed to the HIV virus by coming into contact with the blood or other body fluids of a person who is HIV positive, there is a window period of between 48 and 72 hours in which infection with the disease can still be prevented. HIV Post Exposure Prophylaxis (PEP) is emergency treatment which can reduce the likelihood of HIV infection if it is taken before the window period ends.⁶⁹

63 As above at 7.

64 As above at 8.

65 As above.

66 As above at 10.

67 UNAIDS 90-90-90 *An ambitious treatment target to help end the HIV epidemic* (2015) 16.

68 The Republic of Uganda Ministry of Health *The National Policy Guidelines for Post Exposure Prophylaxis for HIV, Hepatitis B and Hepatitis C* (2007).

69 As above at vii.

The National Policy Guidelines on PEP are instructive in preventing infection with HIV and Hepatitis B and C after such exposure to these viruses.⁷⁰ The guidelines are targeted at healthcare workers, barbershop attendants, victims of sexual offence and police officers.⁷¹ The policy does not recognise key populations as groups which would be in particular need of PEP and therefore does not suggest particular programming and considerations to serve these groups. Under the heading of ‘non-occupational exposure’ only sexual assault is discussed, and exposure through the use of injecting drugs is not considered at all.

Areas for advocacy

There is need to advocate for the explicit inclusion of PWIDs in this policy as they require PEP services due to their vulnerability.

vi) Policy on HIV treatment

Uganda has integrated its guidelines on ART⁷² with policies on child feeding and prevention of mother-to-child HIV transmission in a single document.⁷³ This policy offers guidance to health workers on providing comprehensive treatment to HIV patients. In 2013, an addendum was added to this document in order to scale up Uganda’s response to the HIV epidemic.⁷⁴ The addendum created a new requirement of initiating ART to MARPS, which is explicitly stated to include PWIDs in the discussion on providing ART to adolescents.⁷⁵

In December 2016, President Museveni launched a new set of test and treat guidelines which would ensure that those who test positive for HIV would start treatment immediately and free of charge.

70 As above at 4.

71 As above at 4-5.

72 Republic of Uganda Ministry of Health National Antiretroviral Treatment Guidelines for Adults, Children and Adolescents (2009).

73 Republic of Uganda Ministry of Health *The Integrated National Guidelines on Antiretroviral Therapy, Prevention of Mother to Child Transmission of HIV and Infant & Young Child Feeding* (2011).

74 N30 above.

75 As above at 18.

The guidelines also provide that all individuals who are HIV positive will be eligible for treatment.⁷⁶

This step by the President is a positive move toward ensuring that PWIDs are also included in the scaled-up provision of HIV testing and treatment.

Areas for advocacy

PWIDs are encouraged to take action to ensure that in practice, PWIDs benefit from these inclusive policies and that they are also able to access treatment immediately after diagnosis.

vii) ***Medical and Dental Practitioners: Code of Professional Ethics (2013).***

The purpose of the Code of Professional Ethics is to promote the highest standard of ethical behavior of medical practitioners. Medical practitioners are required to respect the constitutional rights of their patients.⁷⁷

In particular, medical practitioners are required to ensure that they do not discriminate against their patients on the basis of gender, race, religion, disability HIV status or any other vulnerability.⁷⁸ PWIDs should be encouraged to approach healthcare centres since medical practitioners are not supposed to discriminate against them on any basis. However, there is also a provision which may cause PWIDs to be reluctant to go to healthcare service providers. This provision requires of doctors to protect the confidentiality and privacy of their patients and to refrain from disclosing information of the patient without his or her consent except where such disclosure would 'protect the public or advance greater good of the community'. A medical practitioner may consider it necessary to report the illegal drug use of one of her patients to law enforcement agents in order to 'protect the public'. PWID are not guaranteed that they will be treated with patient confidentiality and it is understandable that it would be difficult to seek healthcare for as long as drug use remains

76 H Lutaaya 'Uganda rolls out free HIV testing and treatment for all' The Sunrise 1 December 2016 available at <http://www.sunrise.ug/news/201612/uganda-rolls-out-free-hiv-aids-testing-and-treatment-for-all.html> (accessed 27 January 2017).

77 Section 4.

78 Section 5.

illegal.

Areas for advocacy

There is a need for awareness raising of the rights of PWIDs among healthcare providers and a human rights-based interpretation of this requirement should be encouraged.

3

WHAT DOES INTERNATIONAL LAW SAY ABOUT PWIDS AND HOW DOES IT AFFECT THEIR SRHR AND ACCESS TO HIV PREVENTION AND CARE?

International human rights law makes it clear that all human beings are equal in worth and have the same basic rights. The Universal Declaration of Human Rights states that ‘all human beings are born free and equal in dignity and rights’.⁷⁹ It also provides that all are equal before the law⁸⁰ and that everyone is entitled to all the rights and freedoms guaranteed in the declaration.⁸¹ These rights also appear in the International Covenant on Civil and Political Rights⁸², the International Covenant on Economic, Social and Cultural Rights⁸³, the Convention on the Elimination of all forms of Discrimination Against Women⁸⁴ and the African Charter on Human and Peoples’ Rights.⁸⁵

The fact that PWIDs use drugs, which is illegal in some countries including Uganda, does not make any difference to their inherent dignity as human being and rights bearers. If international and regional human rights law is followed, PWIDs should be able to access healthcare services on an equal footing with other people and should not be discriminated against.

Sexual and reproductive health rights are part of the right to health.⁸⁶ The right to health is recognised in the Universal Declaration of Human Rights,⁸⁷ the African Charter on Human and Peoples’ Rights⁸⁸ and the International Covenant on Social, Economic and Cultural Rights which makes provision for ‘the highest

79 Article 1.

80 Article 7.

81 Article 2.

82 Article 26.

83 Article 2(2).

84 Article 1.

85 Article 2.

86 Principle 17 of the Yogyakarta Principles on the Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity.

87 Article 25(1).

88 Article 12.

attainable standard of physical and mental health'.⁸⁹ In as far as female PWIDs are concerned, the Convention on the Elimination of All forms of Discrimination Against Women protects women's right to health⁹⁰ and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa protect the 'health and reproductive rights' of women.⁹¹

Under international and regional law, the SRHR of PWIDs are protected in the guarantees of the right to health and they are entitled to access the services which make the enjoyment of these rights possible.

89 Article 12.
90 Article 12.
91 Article 14.

4

**ILLUSTRATIONS OF THE EFFECTS OF LAWS
AND POLICIES AFFECTING THE SRHR AND
ACCESS TO HIV PREVENTION AND TREATMENT
OF PWIDs****Example 1**

Noor is a 23-year old woman who has been using cocaine for the past three years. Noor is not employed and depends on her boyfriend, who owns a small shop in Mbale town, to sustain her. Noor and her boyfriend are part of a circle of friends who regularly get together and use cocaine. Noor suspects that she is pregnant since she has not had a menstrual period for the past two months. Noor knows that her boyfriend does not earn enough to sustain a child and they were not planning on having children. They have not been using condoms because they have been reluctant to approach the local clinic where condoms are distributed. She has gone there to collect condoms once or twice, but was discouraged to return because the nurses were rude to her. Noor also fears for the health of her baby. She knows that her cocaine use will influence its development. She has tried to stop using cocaine a number of times, but has found it impossible to break the habit. She also fears that she might have contracted HIV through sharing needles with her friends. She does not want to have a baby that has been infected with HIV. Noor has not had a medical check-up since she started using cocaine.

The idea of going to a clinic regularly and asking for treatment that would prevent HIV from being transmitted to her child scares her. One of their friends were arrested from the waiting room after the medical assistant observed the scars from injections on her arms. Noor feels she has no option but to end the pregnancy. She decides to take OMO and JIK from her boyfriend's shop and to make a 'cocktail' which will end her pregnancy. She decides that if the cocktail is not effective, she will remove the pregnancy by using the spoke of an old bicycle ...

Discussion

The criminalisation of drug use, along with limited access sexual and reproductive healthcare services, has placed the PWID in the example in a position of compromise. She does not have unfettered access to harm reduction services; family planning; maternal health services; HIV prevention and care services or safe abortion services. Even where these services are available, stigma and discrimination prevents her from accessing them. She is forced into a position where she has to undergo an unsafe abortion and which places her life in immediate danger.

Example 2

Timothy is a 34-year old man from Mbarara who has been using drugs since he was 26. Initially, he only used weed and brown sugar, but over time he has also started injecting heroin. For the past few months, Timothy has struggled to get an erection and this has affected his personal life and confidence. What he finds particularly painful is that this situation may mean that he would never be able to have children of his own. Timothy thinks that doctors may be able to assist him with this but he does not see himself going to a hospital. The last time he received any medical care was four years ago when he had overdosed and was rushed to hospital by his uncle. He remembers the way that the doctor outrightly told him that he deserved to die because he is stupid enough to use drugs. He also felt that the nurses handled him harshly after deliberately neglecting to provide care for him for many hours. During his stay at the hospital he was afraid that the police would come and arrest him at any moment. Timothy feels embarrassed to talk about his problem with anyone, let alone doctors and nurses who already judge him for his lifestyle.

Discussion

This example illustrates the struggle of PWIDs to have their sexual and reproductive health rights and needs met. Injecting drug use has severe consequences on the reproductive systems of PWIDs, yet no attention is paid to the right of this group to have sex lives which are both safe and fulfilling. The criminalisation of drug use, along with the absence of policies to ensure the realisation of SRHR of PWIDs, means that sexual and reproductive health is out of reach for PWIDs in Uganda.

5

CONCLUSION

This booklet has shown that there are a number of laws and policies which impact on the rights of PWIDs. The greatest obstacle in the way of PWIDs to access sexual and reproductive health services and HIV prevention and care are the laws which criminalise drug use and possession.

PWIDs are affected by the absence of policies which properly address their needs in terms of harm reduction services. Even though there are policies which deal with SRHR and HIV prevention and treatment services for people in general, the specific sexual and reproductive needs of PWIDs are not addressed or even mentioned in any of the policies. The only programme which focuses on HIV prevention and care for key population groups in particular, namely MARPI-Mulago, is a non-governmental initiative which is limited in its reach and funds.

Leaders among PWIDs, especially the Uganda Harm Reduction Network (UHRN), are encouraged to advocate for the decriminalisation of individual drug use and possession and for the adoption of policies and programming which address the harm reduction, sexual and reproductive health as well as HIV prevention and care needs of PWIDs.

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ABOUT HRAPF

Background:

Human Rights Awareness and Promotion Forum (HRAPF) is an independent, nonpartisan, Non-Governmental human rights organisation that is duly registered under the laws of Uganda. HRAPF was founded in 2008. HRAPF prides itself in promoting access to justice, raising awareness on human rights among the most marginalised groups in Uganda and advocating for an enabling legal and policy framework for the promotion of rights of marginalised groups.

HRAPF's Vision:

A society where the human rights of all persons including marginalised groups are valued and respected.

HRAPF's Mission:

To promote respect and observance of human rights of marginalised groups through legal and legislative advocacy, research and documentation, legal and human rights awareness, capacity building and partnerships.

HRAPF's Slogan:

'Taking Human Rights to all'

HRAPF's Objectives:

1. To sensitise Ugandans on the international and national human rights regime in order to promote a culture of respect for human rights of marginalised groups.
2. To undertake research and document human rights abuses suffered by marginalised groups for appropriate remedial action.
3. To influence legal and policy developments in Uganda to ensure compliance with human rights principles.

4. To offer legal assistance to marginalised groups in order to enhance access to justice.
5. To share information and best practices on the rights of marginalised groups in order to strengthen the human rights movement in Uganda.
6. To network and collaborate with key strategic partners, government, communities and individuals at a national, regional and international level.
7. To build a strong and vibrant human rights organisation.

HRAPF's Values:

1. Non -discrimination
2. Equal opportunity
3. Justice
4. Practical Approach
5. Team work

HRAPF'S PROGRAMMES

Under the strategic plan 2013-2017, HRAPF has three broad programmes:

ACCESS TO JUSTICE PROGRAMME

This programme aims at promoting sustainable access to justice for marginalised groups in Uganda. The programme mainly focuses on criminal justice, family justice and sexual and gender based violence. It targets sexual minorities, women and children living with HIV/AIDS, indigent men and women and the elderly with land problems.

LEGISLATIVE ADVOCACY AND NETWORKING PROGRAMME

The objective of this programme is to work with likeminded organisations and institutions to advocate and influence the adoption of policies and legislation that promotes equality and non-discrimination in order to prevent discrimination of marginalised groups.

ORGANISATIONAL DEVELOPMENT AND CAPACITY BUILDING PROGRAMME

The objective of this programme is to create the appropriate institutional structures and organisational framework for the efficient and effective implementation of the Programme activities and realisation of the Programme Goal.

HRAPF'S GOVERNANCE AND LEADERSHIP STRUCTURE

HRAPF's governance and leadership structure is composed of four organs: The General Assembly, the Trustees, the Board of Directors and the Secretariat.

The General Assembly

This is the supreme policy-making body of the organisation. It is made up of all members. Currently HRAPF has 53 members. Membership is open to all persons interested in promotion, protection and creation of awareness of human rights to the most marginalised Ugandans.

The Trustees

The Trustees are the custodians of the organisation's Memorandum and Articles of Association.

The Board of Directors

The BOD is responsible for guiding the Secretariat to perform day-to-day running of the organisation. The BOD is composed of seven members: the Chairperson, the Vice Chairperson, the Secretary General, the Treasurer, two other members, and the Executive Director as ex-officio. The BOD meets once every quarter.

The Secretariat

This is the implementing body of the Organisation. It is headed by the Executive Director and is currently made up of 33 staff members. HRAPF regularly hosts interns and volunteers.

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