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THE HUMAN RIGHTS ADVOCATE

SIXTH ISSUE - JUNE 2019

Why punish patients?

Reflections on the impact of the Narcotic Drugs and Psychotropic Substances Control Act, 2016 on **People Who Use and Inject Drugs** in Uganda

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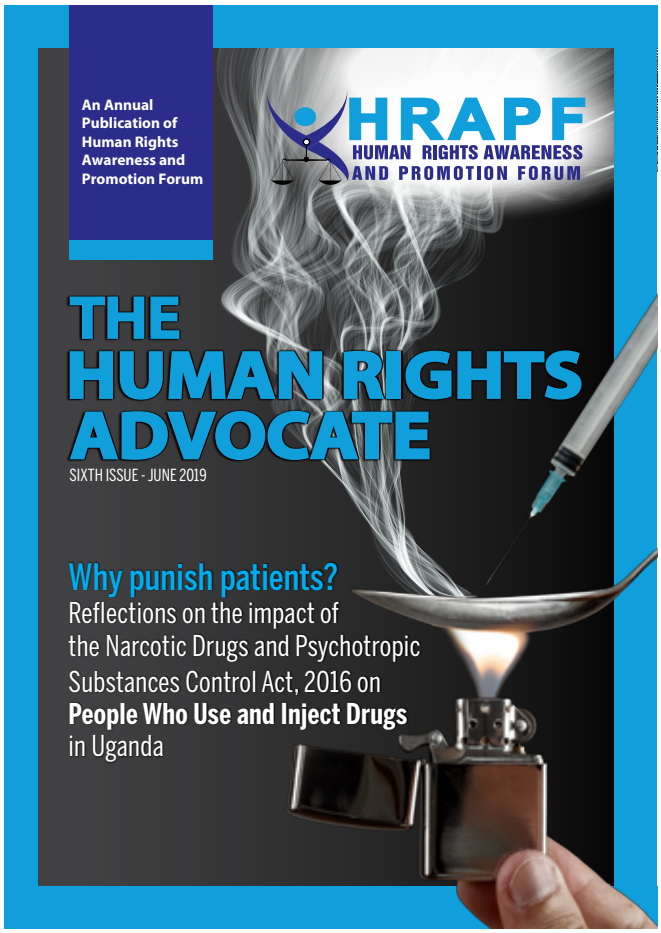

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EDITOR'S NOTE

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Dr. Adrian Jjuuko

Editor

It is my pleasure to present to you the sixth issue of *The Human Rights Advocate* magazine. Human Rights Awareness and Promotion Forum publishes this magazine on an annual basis. It is the focus of this magazine to consider how particular laws and bills affect the human rights of Ugandans, and marginalised groups in particular. In every issue of the magazine, a particular law or bill is analysed from various viewpoints.

HRAPF is an independent, not-for-profit, non-partisan and non-governmental organisation, which aims to raise awareness and defend the rights of marginalised groups in Uganda. HRAPF works for the promotion, realisation, protection and enforcement of human rights through human rights awareness, research, advocacy and legal aid service provision. The vision of HRAPF is a society where the human rights of all persons including marginalised persons and Most at Risk Populations are valued, respected and protected.

One of the groups which HRAPF targets in its work is People Who Use and Inject Drugs (PWUIDs). This group faces severe marginalisation due to the criminalisation of drug use and possession and the stigma associated with the use of drugs.

This sixth issue of the magazine is dedicated to the Narcotic Drugs and Psychotropic Substances Control Act, 2016 (NDPSCA). This law was enacted in response to the increased cases of drugs trafficking in Uganda.

While it is commendable that steps are being taken to address the crisis of drug trafficking in the country, HRAPF is concerned about this Act due to its current effect as well as potential effect on PWUIDs. PWUIDs are a vulnerable and stigmatised group within Ugandan society. Very little is offered to them in terms of state-sponsored treatment and support. In HRAPF's view, the Act does not contemplate holistic strategies for addressing drug use at an individual level, but rather deals with individual drug users in the same harsh manner that drug traffickers are treated.

HRAPF decided to dedicate this issue of the *Human Rights Advocate* magazine to exploring the effect of the NDPSCA on the human rights of PWUIDs from the viewpoint of various stakeholders. The magazine features articles from civil society members advocating for the rights of PWUIDs; academia; law enforcement agencies; the National Referral Mental Hospital as well as a paralegal who works with PWUIDs. Brian Kibirango, a programme officer at Makerere University's Human Rights and Peace Centre (HURIPEC) places the NDPSCA within its historical context. This is followed by a research brief on HRAPF's 2016 study on the NDPSCA as well as the legal regulatory framework of drug use in Uganda developed by HRAPF's Research Officer, Linette du Toit. The magazine shares the views on the NDSPCA of Dr. Brian Mutamba, a psychiatrist in the Alcohol and Drug Unit at Butabika National Referral Mental Hospital as well as those of Mr. Wamala Twaibu, the Executive Director of Uganda Harm Reduction Network. A view on the Act is furthermore shared from the enforcers' side by the Acting Commissioner, Anti-Narcotics in the Uganda Police Force. Opinions about the NDPSCA are also shared by Mr. Lubowa Bull, a paralegal who works with PWUIDs in Kampala as well as with Mr. Gracias Atwiine, the country focal person for the Project to Inspire, Transform and Connect the HIV response (PITCH). Finally, the magazine contains an issue brief on harm reduction that was commissioned by HRAPF. HRAPF has also developed a draft Harm Reduction Bill which puts forth suggestions for how elements of harm reduction can be incorporated into Uganda's legal regime.

HRAPF is also pleased to be able to strengthen the voices of PWUIDs themselves in the pages of this magazine through digital storytelling. A number of photos which were taken and captioned by Ugandan activists who advocate for the rights of PWUIDs are published in this magazine – products of a PhotoVoice project among the partner organisations in Uganda implementing the PITCH project.

We hope that you will find this issue of the magazine informative and that the articles will enlighten the various aspects of concern regarding the NDPSCA and the human rights of PWUIDs. We also hope that this magazine will be used as a tool to advocate against the criminal justice approach to drug use in Uganda.

EDITORIAL

A law punishing patients cannot be tolerated

People Who Use and Inject Drugs (PWUIDs) are a marginalised group that suffers discrimination and stigma in Ugandan society.[1] The group is offered very little support in terms of rehabilitation from drugs on which they have become dependent.[2] Furthermore, PWUIDs are also one of the Key Population groups most vulnerable to HIV infection and are globally 28 times more likely to be living with HIV than the general population.[3]

Across the globe, various countries take the 'war on drugs' approach to deal with both the issues of drug trafficking and individual drug use and possession – a war of which PWUIDs are the casualties.[4] This approach aims to deal with individual drug use and possession through the criminal justice system and to clamp down on PWUIDs with heavy penalties.[5] Sight is lost of the fact that once a person is addicted to a substance, it is no longer a case of merely exercising their will and deciding not to engage in drug use, possession and related criminal activity. The criminal justice approach also ignores the vulnerability of PWUIDs to HIV infection: PWUIDs ought to be given care, support and various rehabilitative options. Instead, they are viewed as criminals and villains to be locked up and punished for their crimes.

In contrast with the criminal justice 'war on drugs' approach to drug use, is the approach which places focus on the health and human rights of PWUIDs. This public health approach supports the adoption of harm reduction measures for the sake of treating PWUIDs and minimising the harmful impact of drug addiction on the PWUIDs themselves as well as society at large.[6] These measures include preventive education, community development, overdose prevention using naloxone, needle and syringe exchange programmes, medically assisted treatment for drug dependence and testing and treatment for HIV.[7] The implementation of the harm reduction model effectively addresses the spread of HIV among PWUIDs.[8]

Uganda's Narcotic Drugs and Psychotropic Substances Control Act, 2016 (NDPSCA) came into force in February 2016. The purpose of this Act, according to its long title is to:

> *amend the law relating to narcotic drugs and psychotropic substances with respect to the control of the possession of, and trafficking in narcotic drugs and psychotropic substances and the cultivation of certain plants; to provide for the forfeiture of property derived from or used in illicit traffic in narcotic drugs and psychotropic substances; to*

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1 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) 16.

2 Apart from the 40 bed Alcohol and Drug Unit within the Butabika National Referral Mental Hospital, there is no other state-sponsored rehabilitation for drug users available in Uganda, as above at 17.

3 UNAIDS(a) *Harm reduction saves lives* (2017) 2.

4 UNAIDS(b) *Health, rights and drugs: Harm reduction, decriminalization and zero discrimination for people who use drugs* (2019) 2.

5 HRAPF (n 1 above) 18.

6 UNAIDS(a) (n 3 above) 4.

7 UNAIDS(b) (n 4 above) 2.

8 As above.

implement the provisions of international conventions on narcotic drugs and psychotropic substances; and for other related matters.

It is commendable that Parliament has taken a firm step to address the issue of drug trafficking in Uganda. This is a necessary step as Uganda is a transit route for drugs.[9] At the same time, however, the NDPSCA targets the drug lords and traffickers less, and instead focuses on individual drug users, as it subjects individual drug use and possession to severe penalties and does not prioritise public health considerations. The Act prescribes heavy penalties for drug possession, such as a fine of Ugx 10,000,000 or three times the market value of the drug, or imprisonment for a minimum period of ten years for certain classes of drugs.[10] The NDPSCA also criminalises acts associated with narcotic drugs such as possession of any pipe or utensil for the illicit use of drugs as well as 'promoting' the use of such substances.[11] The Act furthermore criminalises the owning, occupying or being 'concerned in the management' of any premises used for the cultivation, sale or manufacture of such substances.[12]

The criminal provisions of the Act have come into force and are currently applied to harshly punish individual PWUIDs, accused of transgressing the provisions of the Act as HRAPF has observed. This has drastically changed the way in which PWUIDs are treated within the criminal justice system. After arrest on allegation of possession or use of a narcotic drug or psychotropic substance, bail is set at exorbitant amounts due to the heavy sentences that these offences carry, which means that an accused person is likely to spend an average of 3 to 5 months on pre-trial remand.[13] Plea bargains are also no longer an option as they had been under the National Drug Policy and Authority Act, Cap 206, which regulated illegal drug use and possession prior to the enactment of the NDPSCA. Magistrates are prevented from negotiating lighter sentences if a person accused of drug possession pleads guilty since the offence of possession of a prohibited narcotic carries a minimum offence of 5 years imprisonment: the Act does not allow for light sentences.[14]

"The NDPSCA also criminalises acts associated with narcotic drugs such as possession of any pipe or utensil for the illicit use of drugs as well as 'promoting' the use of such substances."

Part V of the Act, titled 'Rehabilitation' has a number of provisions which envision the treatment of PWUIDs who have become entangled in the criminal justice system. These provisions still raise many question marks

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9 'Police recover illicit drugs worth Shs3.2b at Entebbe Airport' *Daily Monitor* 16th May 2019. Available at https://www.monitor.co.ug/News/National/Police-recover-illicit-drugs-worth-Shs3-2b-Entebbe-Airport/688334-5115542-75d86nz/index.html (accessed 14th October 2019).

10 Sec 4(2).

11 Sec 6(c) & (d).

12 Sec 6(b).

13 As above.

14 As above.

around the feasibility of their enforcement.[15] The Minister of Health is empowered to establish rehabilitation centres in order to provide 'care, treatment and rehabilitation of persons addicted to narcotics and psychotropic substances'.[16] Under this part of the Act a Rehabilitation Fund and a Board to manage this Fund are also established.[17] The Minister is furthermore empowered to establish an 'Advisory Committee for the Rehabilitation of Narcotic Addicts'.[18] The Act makes it clear that the provision of rehabilitation and any other harm reduction measure is placed squarely within the criminal justice system. Section 58 of the Act provides as follows:

> ***58. Committal of persons to centres***
>
> *(1) A court which convicts any person for an offence under this Act may, if it is satisfied that that persons is addicted to a narcotic drug or psychotropic substance and that he or she is in possession of a narcotic drug or psychotropic substance only for his or her personal consumption, order that a part of the period of imprisonment imposed on him or her be spent in a centre specified by the court.*
>
> *(2) The court may, on the application of the Attorney General or the convicted person, vary or revoke the order, made under subsection (1).*
>
> *(3) Where, on the report of the officer in charge of a centre to which a convicted person is committed under subsection (1), the court which committed him or her to the centre is satisfied that the convicted person has successfully undergone the treatment and rehabilitation program of the centre and that he or she is no longer an addict, the court may, having regard to all circumstances of the case, grant remission of the whole or part of the remaining period of imprisonment imposed on a convicted person.*

This section means that rehabilitation only becomes available once a PWUID has gone all the way through the criminal justice system, has awaited trial on remand if they were not able to meet the bail terms and has been found guilty of an offence under the Act and adjudged to be an 'addict'. The provision furthermore provides no choice to the PWUID involved on whether or not they consent to undergoing treatment, care and rehabilitation, they can simply be ordered by the court to undergo rehabilitation. The Act does not empower Police Officers to refer PWUIDs for treatment or rehabilitative care following a medical assessment. Instead, people who may be suffering severe withdrawal symptoms are held in police custody and can find themselves in detention for multiple month as they await their trial. A PWUID is punished for suspected drug use or possession even before standing trial, which is a severely inhumane way to treat a person in need of care, treatment and support. State-sponsored rehabilitation cannot be limited to a court order upon conviction on a drug-related offence.

There is need to amend the NDPSCA to distinguish between drug traffickers and people who possess prohibited substances for personal use. There is need to create separate offences relating to these two categories of possession and to impose lighter minimum sentences where possession is for personal use and not for purposes of trafficking. There is furthermore need to ensure care, treatment and rehabilitation to PWUIDs who are not part of the criminal justice system. Care, treatment and rehabilitation ought to be considered as a form of diversion that would avoid conviction on drug-related charges. PWUIDs ought to be treated in a manner which protects their dignity and vulnerability as patients, instead of vilifying them and minimising prospects of dignified rehabilitation. The appropriate amendments to the NDPSCA could make this possible.

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[15] See article by Dr. Brian Mutamba below.

[16] Sec 52.

[17] Secs 53 & 54.

[18] Sec 56.

ARTICLE:

Historising Uganda's Narcotic Drugs and Psychotropic Substances (Control) Act 2016

By Brian Kibirango*

1. Introduction

The Narcotic Drugs and Psychotropic Substances (Control) Act (NDPSCA) of Uganda has variously been criticised on the basis that instead of causing an improvement in the situation of persons who use drugs (PWUDs), it introduces stringent and punitive measures which further worsen the operating environment for enjoyment of human rights by PWUDs. For example, many PWUDs find it hard to access vital health-related information and services which increases their vulnerability to risks such as HIV infection. This article presents the origin and purpose of Uganda's Narcotic Drugs and Psychotropic Substances (Control) Act 2016 with a view to provide a bit of a context for the arguably extreme measures it introduces.

2. Background and purpose of the NDPSCA

The NDPSCA was signed into law in 2016; following almost a decade of pushing for a law that would decisively regulate illicit drug usage and related acts.[1] The enactment of this law was necessitated by the perceived weaknesses of the then applicable legal regime including the National Drug Policy and Authority Act (NDPA) and the Penal code Act which, it was felt, could not address the country's 'drug problem.'[2] Indeed, both the long title and a number of provisions of the NDPSCA were coached in such terms as to religiously reflect the strong determination of the authorities to 'decisively' deal with the problem of illicit drug use.

On its part, the long title states that the objective of the Act is to:

> *consolidate and amend the law relating to narcotic drugs and psychotropic substances with respect to the control of the possession of, and trafficking in narcotic drugs and psychotropic substances and the cultivation of certain plants; to provide for the forfeiture of property derived from or used in illicit traffic in narcotic drugs and psychotropic substances; to implement the provisions of international conventions on narcotic drugs and psychotropic substances; and for other related matters.*

* Brian Kibirango holds a Bachelor of Laws Degree from Makerere University. He currently works with the Human Rights and Peace Centre (HURIPEC) at the School of Law, Makerere University as a Programme Officer. He previously worked as a Legal Associate at MS Development Law Associates during which engagement he participated as a researcher in HRAPF's 2016 study on *The Narcotic Drugs and Psychotropic Substances (Control) Act, 2015 and the legal regulation of drug use in Uganda* (2016) available at https://hrapf.org/index.php/resources/research-reports/44-finalhrapfreportoflegalregulationofdruguseinuganda2016-1/file.

1 The first draft of the Bill was introduced in 2007.

2 See, for example, O Nakatudde 'Parliament Passes Narcotic Drugs and Psychotropic Substances Bill' 20th November 2014, *Uganda Radio Network*, available at https://ugandaradionetwork.com/story/parliament-passes-narcotic-drugs-and-psychotropic-substances-bill (accessed on 28th May 2019) .

> **It is noteworthy that the issue of escalating human rights violations associated with drug policies remain a big concern for the global community.**

This statement of objective is a finer version of the objective statement as compared to the 2007 Memorandum of the Bill which had boldly included, as one of its policy objectives, that it was 'intended to make provision for a mechanism to generate resources for law enforcement agencies through the confiscation of money and properties obtained from illicit trading in drugs.'[3]

The mechanisms through which the objectives of the Act are set out to be achieved are spread across the ninety two sections and four schedules comprising the Act. Of specific mention, the Act contains a number of punitive provisions such as: section 4 prescribing the applicable fines and/or prison sentences to be slapped against those found liable for unauthorised possession of a narcotic drug or psychotropic substance listed either under any of the Schedules of the Act; section 5 prescribing the fine and/or penalty that awaits a person liable for trafficking in the said drugs or substances; section 6 which widens the liability for drug offences to include direct/actual users of the prohibited drugs and substances and/or being in possession of utensils that is used in drug use, or is in the habit of recruiting others or promoting the illicit consumption of drugs on the one hand and those who in some way may be connected to the process for example as an owner, occupier or manager of premises used for drug consumption, sale, cultivation or even manufacture of drugs on the other hand; section 7 which prohibits medical practitioners and veterinary surgeons from prescribing, administering or supplying such drugs or substances save for where this is required for medical or veterinary treatment respectively,[4] among others.

On a good note, the Act also contains some progressive provisions mirroring some form of consideration for the welfare of persons who use drugs.[5] In this regard, sections 51-58 (Part V) of the Act make provision for the committal, treatment and rehabilitation of persons addicted to drugs.[6] It has been observed, however, that the mechanics for accessing these services and the language adopted in these otherwise progressive provisions still largely reflect the negative attitude of the authorities toward drug use.[7]

It is noteworthy that the issue of escalating human rights violations associated with drug policies remain a big concern for the global community. Key among these is the 'increasing use of laws focused on punishment, policing, prisons and even the military as core tools of drug enforcement'.[8] Out of such concerns, for example, the International Guidelines on Human Rights and Drug Policy[9] have been developed to guide States on the measures they should take, or refrain from taking, in order to ensure respect both for their human rights obligations under the traditional human

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3 This Bill is accessible at http://parliamentwatch.ug/wp-content/uploads/2015/03/240057586-The-Narcotic-Drugs-Psychotropic-Substances-Control-Bill.pdf

4 Under Section 8, a medical practitioner, dentist or veterinary surgeon who contravenes this provision is liable to have their name scrapped off the professional register of practitioners in the respective field.

5 Human Rights Awareness and Promotional Forum (HRAPF) *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).

6 The proposed interventions thereunder include establishment of rehabilitation centres, a rehabilitation fund as well as an Advisory Committee to guide on different matters incidental to rehabilitation.

7 For a broader discussion of this issue, see HRAPF (n 5 above) 39.

8 'The Conversation' New UN guidelines to mainstream human rights in the global drugs debate, 15th March 2019 available at http://theconversation.com/new-un-guidelines-to-mainstream-human-rights-in-the-global-drugs-debate-113221 (accessed 28th May 2019).

9 UNAIDS, UNDP & WHO 'The International Guidelines on Human Rights and Drug Policy' (2019), available at https://www.undp.org/content/dam/undp/library/HIV-AIDS/HRDP%20Guidelines%202019_FINAL.PDF (accessed 28th May 2019).

rights instruments as well as their concurrent obligations under the international drug control conventions.

Such concerns only tend to show that human rights insensitive drug policy is not a Uganda-specific approach but rather a later example of an unjustified paranoia characterising most of the drug policies as the following discussion shows.

3. Origin of the NDPSCA: A brief

The existing literature on the history of drug regulation in Uganda generally notes that criminalisation of drug use is not a making of Uganda.[10] Rather, the trend is part of 'an internationalised system that regards drug use as dangerous and which is willing to suppress it using all means and more so the law."[11]

HRAPF's study on the analysis of the laws in Uganda traces this history to the holy Quran which cautioned its followers against certain evils, including the use of intoxicants, which it portrayed as carefully crafted plans of Satan to 'hamper' them 'from the remembrance of Allah and from prayer'.[12] This study further observes that the later regulatory environments were largely linked to political or economic power dynamics.[13] For example, Britain, which colonised Uganda for over a period of 68 years since 1894, held drug dealership in very high regard given its economic rewards.[14] Evidence of this is visible in her forceful scrapping of otherwise 'long-standing prohibitions' of drugs for example in Burma in order to pave way for British businessmen to sell drugs in India.[15]

In an interesting turn of events, the liberal approach to drug regulation was later replaced by domestic prohibitions which were again based on power relations.[16] In most parts of the world-Europe, Canada, Australia among others, the prohibitions were attributed to the fear of potential harm caused by the increased access to drugs such as opium by the hitherto oppressed members of the lower class such as workers and immigrants.[17] It was feared that access to drugs would influence revenge by the oppressed against their oppressors.[18] Accordingly, a number of domestic laws were passed in most of these countries restricting drug use to authorised medical prescription. The domestic prohibitions were swiftly accompanied by international efforts as early as 1909 which culminated into multilateral efforts such as: enactment of the 1912 International Opium Convention; establishment of the Opium Advisory Committee (OAC) in 1920 to supervise the implementation of the Opium Convention of 1912; enactment of the 1936 Geneva Convention for the Suppression of the Illicit Traffic in Dangerous Drugs; as well as the UN's efforts in the form of enactment of the 1953 Opium Protocol, the Single Convention on Narcotic Drugs, 1961 (subsequently amended by a Protocol in 1972); the Convention on Psychotropic Substances of 1971 and the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances in addition to a rather broad institutional framework to facilitate the enforcement of the legal framework.[19]

However, it has been observed that this international (both normative and institutional) regime does less to reduce

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[10] E Muhwezi 'Uganda's Narcotic Drugs and Psychotropic Substances (Control) Act and how it impacts on Public Health and Human Rights' accessed at Policies for Equitable Access to Health (PEAH) website http://www.peah.it/2017/05/4082/. See also HRAPF, n 5 above.

[11] Muhwezi, as above.

[12] HRAPF (n 5 above) 25.

[13] As above.

[14] As above.

[15] HRAPF, as above citing J Windle 'How the East influenced drug prohibition' (2013) 35(3) *The International History Review* 9 (pre-publication copy).

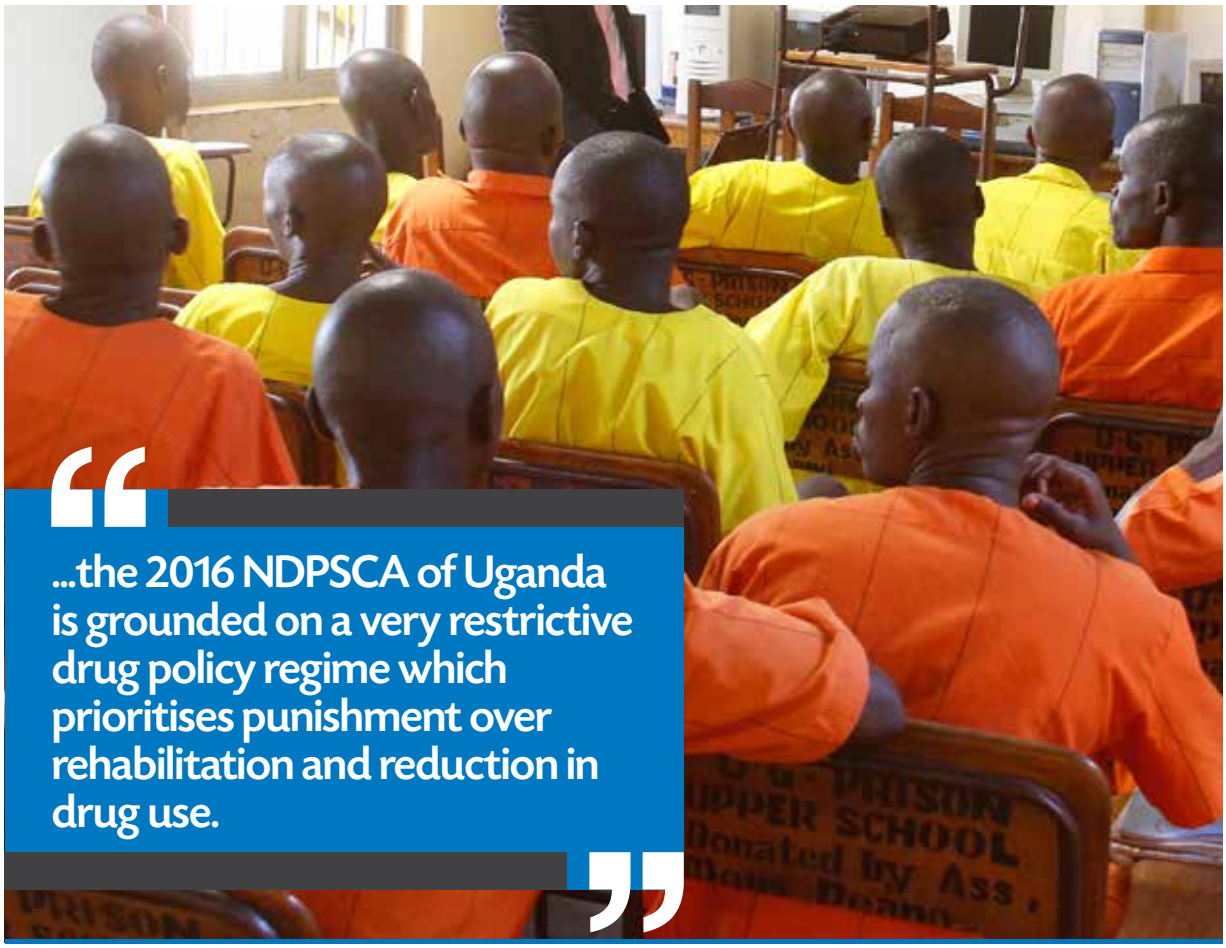
[16] HRAPF above, 26-27.

[17] As above, 27

[18] As above, 27.

[19] For a more detailed listing of these initiatives, see HRAPF (n 5 above) 29-30.

Source: Lama Photography



> ...the 2016 NDPSCA of Uganda is grounded on a very restrictive drug policy regime which prioritises punishment over rehabilitation and reduction in drug use.

demand for drugs or to mitigate the related negative effects upon PWUDs as much as it does seek to ensure drug control and prohibition.[20] Unfortunately, the objective statement of the NDPSCA to the effect that the Act seeks to among others... implement the provisions of international conventions on narcotic drugs and psychotropic substances' suggests that the NDPSCA adopts the approach of the criminal justice-focused international regime in full throttle. This intention is even more evident in the statement of the objective of the NDPSC Bill which was 'the adoption of measures to criminalise drug-related offences under domestic law in conformity with Article 3 of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances and other international conventions'[21]

[20] HRAPF (n 5 above) 30-31.

[21] Bill No. 25 (2007), accessed at http://parliamentwatch.ug/wp-content/uploads/2015/03/240057586-The-Narcotic-Drugs-Psychotropic-Substances-Control-Bill.pdf.

4. Conclusion

The foregoing discussion has shown that the 2016 NDPSCA of Uganda is grounded on a very restrictive drug policy regime which prioritises punishment over rehabilitation and reduction in drug use. This approach has lasting human rights implications for PWUDs. However, latest developments indicate that the international community is gradually becoming concerned about the abuse of human rights associated with drug policy enforcement as seen in the recent adoption of the International Guidelines on Human Rights and Drug Policy.[22] As such, at no point should a state front her obligations under the international drug conventions as a justification for violating obligations under other international human rights instruments. In view of such developments, it is incumbent upon the state of Uganda to think more carefully on how to implement her concurrent obligations to regulate drug use as well as observe human rights.

[22] n 9 above.

RESEARCH BRIEF:

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*

*By Linette du Toit**

Source: HRAPF photo

1. Introduction

In 2016, Human Rights Awareness and Promotion Forum extended its legal aid services to People Who Use and Inject Drugs for the first time. In the same year, a study was undertaken in order to determine the effects of the legal regime on the rights of PWUDs in Uganda. This study was lead by Dr. Busingye Kabumba and was published under the titled: *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*. This Research Brief summarises the study, its findings and recommendations.

2. Background to study

People who use drugs (PWUDs) are a vulnerable and stigmatised group in Ugandan society. They are usually sidelined in and pushed to the margins of society and are offered very little support in terms of rehabilitation and treatment.[1] Research suggests that the use of drugs in Uganda is on the increase, even in rural areas.[2] There is widespread use of 'khat' or 'mira' in Uganda, as well as locally grown cannabis in various forms.[3] Cocaine is widely available and heroin is cheap enough to be used daily even by those who earn a very

* Linette du Toit is a Research Officer at HRAPF and was one of the research assistants in the 2016 HRAPF study.

1 G Atwiine & W Twaibu 'Targeting people using and injecting drugs will contribute to reduced HIV prevalence rate in Uganda' *Daily Monitor* 29 April 2016.

2 LH Tugume 'The dynamics of intoxicant/drug consumption in contemporary Uganda: A case study of urban Kampala' (2015) 4 *International Journal of Development Societies* 109; Uganda Harm Reduction Network 'UHRN press statement on the drug use situation for people who inject drugs in Uganda' 15 April 2016 available at https://stoptheharm.org/press/uhrn-press-statement-on-the-drug-use-situation-for-people-who-inject-drugs-in-uganda (accessed 24 October 2016).

3 As above at 110-112; R Kalumba 'How big is Uganda's drug problem?' *Daily Monitor* 26 June 2010 http://www.monitor.co.ug/News/National/688334-946518-item-01-yasc83z/index.html (accessed 24 October 2016).

low income.[4] As an expected symptom of marginalisation, little public attention has been paid to the plight of drug users and the medical and social needs of this fast-expanding, yet invisible, group. The growing drug problem among individuals in Uganda seem to only make headlines on the rare occasion that well-known personalities are involved or when Ugandans are arrested for drug trafficking in other countries.[5] The emergence of a drug trafficking crisis in Uganda, with Entebbe airport as a major transit route, has furthermore overshadowed contemplation of the state's relationship with individual drug users.[6] As a result, Uganda's response to a multifaceted drug problem has not been focused on the urgent need to come up with holistic strategies which contemplate the causes and consequences of individual drug use and provides sustainable solutions to PWUDs.[7]

The emerging consensus at the global level is that dependence on drugs is best approached as a public health and human rights issue.[8] In terms of such an approach, the focus is on the health rights and needs of PWUDs. It has been shown that where public health options are made available, there have been dramatic declines in drug dependence, mortality and overdose along with a measure of prevention of the transmission of HIV.[9] Contrary to treating drug addiction as a public health issue is the approach that emphasises the criminal justice system as a means of controlling drug use. This approach, which adopts a so-called 'war on drugs', seeks to address the challenge of drug use through the fear and force of the law.[10] Globally, however, it has been demonstrated that the criminalisation of drug use has the effect of creating a massive illicit drug market; increasing the spread of HIV and diminishing the opportunities for drug users to be rehabilitated.[11]

The issue of regulation of drug use made headlines with the recent enactment of the Narcotic Drugs and Psychotropic Substances (Control) Act of 2016 (NDPSCA) in Uganda. This Act introduces a much more rigorous criminal law-based legal regime governing drug use and clearly domesticates the international 'war on drugs'. It is feared that this intensified criminalisation of individual drug use will increase the vulnerability of this group to numerous negative socio-economic outcomes, including a severely heightened risk of HIV infection. Furthermore, the adoption of the NDPSCA proceeded largely without rigorous consideration of the probable human rights implications that this Act could have on PWUDs.

HRAPF provides legal aid services to the most marginalised persons including

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4 M Sibiloni 'Uganda's thriving drug scene' *Al Jazeera*, 5 November 2014 available at http://www.aljazeera.com/indepth/inpictures/2014/10/pictures-uganda-thriving-drug-20141031101312851406.html (accessed 24 October 2016); S Roosbald 'Heroin, cocaine use increase in Uganda' 20 October 2015 *VOA News*, available at http://learningenglish.voanews.com/a/heroin-and-cocaine-use-increase-in-uganda/3014915.html (accessed 14 October 2016) and '45% of Ugandan youths take drugs and alcohol' *New Vision* 7 March 2013, available at http://www.newvision.co.ug/new_vision/news/1315230/-ugandan-youth-drugs-alcohol (accessed 24 October 2016) .

5 S Zinunula 'Inside Jackie Chandiru's drug addictions story' *Chimpreports* 26 February 2016 http://chimpreports.com/entertainment/exclusive-inside-jackie-chandirus-drug-addiction-tale/ (accessed 24 October 2016); 'Ugandans on death row in China named; parents weep' *New Vision* 7 July 2014 available at http://www.newvision.co.ug/new_vision/news/1342385/ugandans-death-row-china-named-parents-weep (accessed 24 October 2016).

6 Uganda's response to a growing drug problem has been to enact highly punitive legislation which would serve as a greater deterrent to drug traffickers and possessors than the existing regime managed to accomplish. Colectivo de Estudios Drogas y Derecho (CEDD) 'In search of rights: Drug users and state responses in Latin America' (2014) 9.

7 Over the past decade, as evidence of Uganda's multi-faceted drug issues emerged, the suggested 'catch-all' solution has been to enact legislation which will forcefully deal with trafficking, in the first place, and individual possession and use of drugs, as secondary matters. See UHRN n2 above and Sibiloni n4 above.

8 United Nations Office on Drugs and Crime 'From coercion to cohesion: Treating drug dependence through health care, not punishment' (2010) 1-4.

9 As above.

10 E Wood et al 'The war on drugs: A devastating public-policy disaster (2009) 373 *The Lancet* 989.

11 Wood et al (n 4 above) and Atwiine and Twaibu (n 1 above). See also the United Nations Office on Drugs and Crime '2005 World Drug Report' (2005).

Uganda Police officers brutally arresting a youth in Kampala after finding him in possession of narcotics.

Source: Lama Photography

persons who use drugs. Through its work, HRAPF has come across cases where members of this group are subjected to discrimination in as far as social recognition, service provision and the protection of fundamental rights are concerned. The legal environment is viewed as both a contributing cause as well as reinforcing factor of this stigma. Furthermore, despite the scale of drug use and the imperative public health and human rights issues which its criminalisation presents, almost no previous research has been done on the legal and policy environment relating to PWUDs in Uganda.

It is upon this background that HRAPF decided to conduct a study into the enforcement of laws affecting PWUDs in Uganda. This is a research brief of the study which analysed the NDPSCA and the other laws currently in place as part of the legal regulation of drug use in Uganda. The study was done through assessing both the compliance of the regime to relevant domestic, regional and international law, as well the impact that it creates upon the rights and welfare of PWUDs. The study specifically interrogated the NDPSCA in light of Uganda's human rights obligations and the existing regulatory climate. The ultimate question posed and answered by the study is whether an appropriate balance has been struck between the State objective to reduce crime and the human rights and public health imperatives implicated by drug use.

3. Methodology

The study is a critical, human rights-based assessment of the NDPSCA and other laws affecting PWUDs. The study was executed using largely qualitative methods, involving both a review of secondary literature but also in-depth interviews with critical actors. A case-study research design, focusing on Kampala, was adopted in order to assess the implications of the current regulatory framework for drug use upon key individuals, groups and other actors.

This study method involved in-depth interviews with PWUDs, organisations working on issues which affect PWUDs, law enforcement agencies and officials, public and private health care providers as well as officials representing the Ministry of Health.

The research was conducted in the Kampala District and the researchers were guided and assisted by Uganda Harm Reduction Network (UHRN) in terms of accessing PWUDs and interacting with them. Other stakeholders who were engaged were also drawn from Kampala, which is the capital city of Uganda and the centre of the country's commercial, political, social and economic life. It is believed that although geographically limited, the insights thus generated are

broadly reflective of the bigger country's picture, and that the reforms indicated are similarly scalable.

4. Findings

The criminalisation of the use of drugs is not unique to Uganda. It is part of an internationalised system that regards drug use as dangerous and which is willing to suppress it using all means, particularly the law. Although States initially had a much more relaxed approach towards drugs, they later started looking at drug use through the lenses of race and immigration, and after the first world war, undertook international commitments to fight drug use. This has resulted into today's 'war on drugs' with all its negative effects especially on the individuals who use drugs. Uganda started criminalising drug use following this international trend and with the enactment of the NDPSCA, has made strides towards being part of this global movement to suppress the use of drugs.

4.1 Analysis of regulatory regime governing drug use in Uganda

4.1.1 The National Drug Policy and Authority Act, 2006

The NDPSCA came into force in February 2016 and replaced criminal provisions relating to the possession and usage of drugs as well as the cultivation of certain plants in the National Drug Policy and Authority Act, Cap 206 (NDPA). The study finds that the NDPA is viewed by law enforcement officials and a number of other stakeholders as largely inadequate in responding to issues of large scale drug trafficking in Uganda. The perceived weaknesses of the NDPA prompted the enactment of the NDPSCA, which deals specifically with narcotic drugs and psychotropic substances.

4.1.2 The Narcotic Drugs and Psychotropic Substances (Control) Act, 2016

The NDPSCA has a decided penal focus and does not prioritise the welfare of persons who use drugs. One of the primary aims of the Act is to give effect to punitive international conventions. Along with the criminalisation of trafficking in narcotic drugs and psychotropic substances, the Act also criminalises the possession of these drugs and prescribes heavy penalties such as a fine of Ugx 10,000,000 (approx. USD 3,000) or three times the market value of the drug, whichever is greater, or imprisonment of a minimum of ten years or both such a fine and imprisonment. The Act also criminalises acts associated with narcotic drugs such as possession of any pipe or utensil for the illicit use of such drugs; 'recruiting' or 'promoting' the smoking, inhaling, sniffing or other use of such substances and owning, occupying or being 'concerned in the management' of any premises used for the cultivation, sale or manufacture of such substances.

> **The essence of the Act is to treat PWUDs as criminals who need to be locked up instead of viewing them as human beings in need of assistance.**

The Act makes a measure of provision for the welfare of PWUDs by empowering the Minister of Health to establish 'rehabilitation centers' aimed at providing 'care, treatment and rehabilitation of persons addicted to narcotic drugs or psychotropic substances'. The Minister is also empowered to appoint an 'Advisory Committee for the Rehabilitation of Narcotic Addicts' in order to advise the Minister on matters relating to the administration of the centers and the 'care, treatment and rehabilitation of drug addicts'. The Act furthermore provides that a person may be committed to spend a part of their period of imprisonment in such a rehabilitation centre upon conviction of an offence under the Act.

Despite these seemingly progressive provisions, the mechanism for 'rehabilitation' contemplated under the Act can only be accessed after one has been convicted and sentenced. Since the time spent in the 'center' is considered as part of

one's custodial sentence, it is feared that the provision may have the direct and adverse effect of triggering custodial sentences where fines would otherwise have been imposed. The fact that the envisioned Advisory Committee' membership does not provide for participation or inclusion of PWUDs is also viewed as problematic. Overall, the NDPSCA conflates support for PWUDs with the criminal law and even the limited health services provided under such a framework are rendered meaningless and effectively inaccessible. It also leaves the judicial officer with broad and unqualified power to determine which PWUDs access treatment and who does not, which severely undermines not only the agency and autonomy of such persons but also their rights to health and, ultimately, to life. The essence of the Act is to treat PWUDs as criminals who need to be locked up instead of viewing them as human beings in need of assistance.

4.1.3 The Penal Code Act

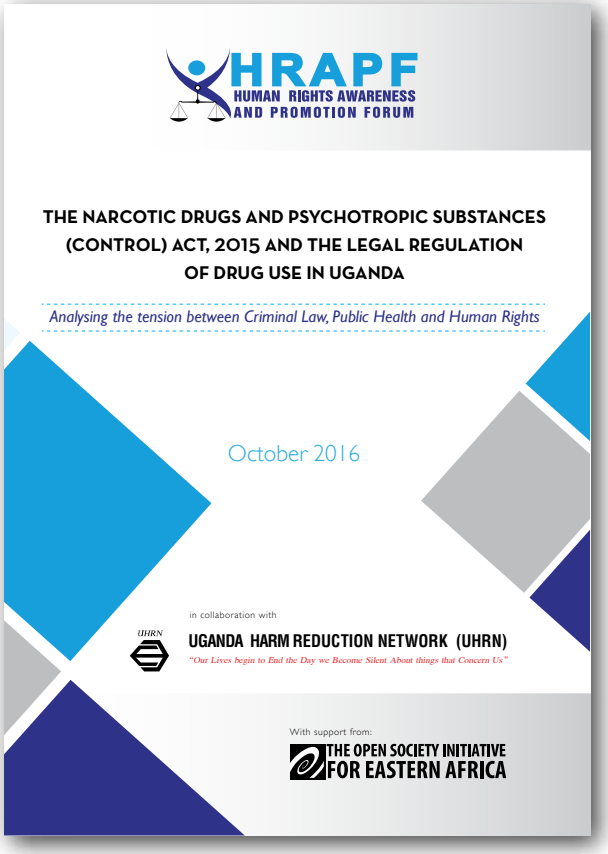
The Penal Code Act, Cap 120 does not contain any provisions directly related to drug use in Uganda. However, it would appear that, in practice, some of its provisions, particularly those relating to vagrancy, are being employed in this respect. Section 167 and 168 of the Act respectively criminalises 'being idle and disorderly' and 'being a rogue and vagabond'. Interviews with PWUDs revealed that, more often than not, these, rather than the provisions of the NDPA, were the offences under which they were arrested, charged and remanded.

4.2 Impact of the regulatory regime on the human rights, health and general welfare of PWUDs in Uganda

4.2.1 Violations of human rights

a) The right to health

The criminalisation of drug use has had the effect of limiting the range of medical interventions available and accessible to PWUDs in both private and public facilities. There is no comprehensive facility for the provision of public health services to PWUDs. There is also no treatment available within Uganda for people who overdose on drugs and need critical and urgent medical attention.



Source: HRAPF photo

The emphasis on criminal approaches to drug use has discouraged many PWUDs from seeking even those medical services which might be available in the public and private health systems. This is because of the way they are treated by medical professionals and the threat of being taken to court to answer charges related to their drug use upon their recovery. The study finds a direct link between the criminalisation of drug use and HIV and AIDS. This is so because the criminalisation of drug-use makes it less likely for PWUDs to be offered information and services in relation to needle-sharing, which increases transmission of HIV among injecting drug users in particular.

b) The right to liberty

The study finds that another consequence of criminalisation of drug use has been that the police and other law enforcement agencies make use of a whole range of legal provisions; even beyond those provisions which have a direct link to drug prohibition; to harass, intimidate, blackmail and extort money from PWUDs. Laws most frequently used in this respect are offences under the Penal Code including 'being a common nuisance'; 'being idle and disorderly'; 'being a rogue and vagabond';

and carrying on offensive trades. The police often round up groups of youth who are known or suspected PWUDs under the guise that they have committed these offences, as a means of extorting money from them. Some PWUDs report being arrested under these provisions countless times. Cases were also recorded where PWUDs were charged with offences they have not committed, such as murder, for the purpose of having them remanded for extended periods, only for them to be released months later after it had been established by the public prosecutor that there is no reasonable prospects of the alleged offence being successfully prosecuted. Additionally, on occasion, the police have deliberately fabricated evidence against PWUDs in order to ensure their successful prosecution and incarceration.

c) Right to freedom from torture, inhuman and degrading treatment

The study found that, in almost all cases, whether arrests were in terms of the NDPA offences or Penal Code offences, they were usually brutal and dehumanising. Patterns of physical violence, intimidation and harassment were also recorded in the incarceration process.

d) The right to equality and non-discrimination

An analysis of the current enforcement of the regulatory framework revealed that the drug laws are discriminatory in effect, since lower income individuals disproportionately face arrests, prosecution and conviction when compared to upper or middle class persons who use drugs. From the PWUDs interviewed, all who were from underprivileged backgrounds had been arrested by the police at some point and some of them suffered long periods of remand after being charged. On the other hand, not a single one of the upper or middle class PWUDs interviewed had ever been the subject of law enforcement. It is clear that the criminalisation of drug use is used to target 'undesirable' classes of society, leaving untouched members of the middle and upper classes engaging in the same conduct. As with those jurisdictions, while the law in Uganda has been facially neutral, this study reveals that, in effect it has had a markedly disparate application, being decidedly biased against low income and underprivileged persons.

e) The right to freedom of association and civic participation

The study finds that due to the regulatory climate, organisations which have sought to work with PWUDs have faced delays in registration and have also faced deregistration and threats of deregistration, constituting a violation of the right to freedom of association of PWUDs.

4.2.2 Other violations and consequences

The social stigma created in large part by the criminal approach to drug use has further entrenched the isolation and related suffering and depression of PWUDs. Criminalisation of drug use is found to cause social stigma and related socio-economic consequences for PWUDs who have been convicted and imprisoned or who have even just been arrested and detained. They face disruptions in their family lives and education as well as the loss of employment and decreased chances of obtaining employment. An indirect consequence of the criminalisation of drug use is that, when incarcerated, PWUDs are often exposed to a wider range of drug use. The PWUDs interviewed recounted suffering both physical and psychological trauma as a result of incarceration. Furthermore, the criminalisation and incarceration of PWUDs has been found to cause them to transform into actual criminals through exposure to criminals, such as elite drug traffickers, or due to the denial of opportunities for gainful employment which they face following incarceration.

4.3 Harm reduction as an alternative approach

The adverse impacts of the current regulatory climate make it clear that an alternative approach is required if a rational response to drug use in Uganda is to be achieved. The harm reduction approach, according to one conceptualisation, is an approach which accepts that licit and illicit drug use is part of our world and chooses to work to minimise its harmful effects rather than simply ignore or condemn them. The approach acknowledges drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviour from severe abuse to total abstinence and establishes quality of

individual and community life and well-being, as opposed to cessation of all drug use, as the criteria for successful interventions and policies. The harm reduction approach calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.

The study found that there is strong support for turning to the harm reduction approach from a number of key informants and other stakeholders. Those in support of adopting and implementing this approach also emphasises that increased government funding would be needed in order to support the legal and public health needs of PWUDs.

5. Conclusion

The NDPSCA substantially changes the law on drugs in Uganda, although it retains the criminalisation model. The NDPSCA is seen as the avenue to comprehensively address drug use and supply in Uganda. Law enforcement officials particularly commend the stiffer penalties for both drug use and drug supply as well as the fact that it deals with trafficking of drugs, and interstate trafficking in particular. On the whole, the legal regime in Uganda appears to have adopted a mainly criminal stance towards PWUDs. Although there is some provision for rehabilitation and support under the NDPSCA, which was not present under the NDPA, the envisaged intervention is extremely limited and problematic insofar as it can only be triggered in the context of the criminal law, and can only be accessed by a PWUD upon conviction by a Court.

The criminal approach adopted with regard to drug use does not bode well, in particular for the right to health of PWUDs in Uganda since it creates a legal environment in which they are further marginalised and pushed to the periphery in terms of both health programming and actual clinical care. The use of general and vague legal provisions, such as vagrancy laws under the Penal Code Act, also has implications for legality and the rights of PWUDs to justice, to a fair trial and to all the human rights that attach to interactions between the citizen and the criminal justice process.

In considering the overall effect of criminalisation of drug use, it becomes apparent that any regulation of drug use should not involve a direct or indirect violation of the rights to life and health of persons who use drugs. The principle of 'harm reduction' should be embraced in order to reduce the negative consequences associated with drug use. Uganda is in need of the adoption of a nation-wide harm reduction policy which would create an enabling legal environment for PWUDs to access health services relevant for them to enjoy the highest attainable standard of physical and mental health; and would also involve increased state funding to support the legal and public health needs of the PWUDs.

6. Key recommendations

To the Ministry of Health

- Adopt a harm reduction approach to drug use in Uganda and increase budget support for such efforts.
- Ensure that the harm reduction effort involves the provision of a minimum service package for harm reduction, consistent with World Health Organization (WHO) standards, and that this package is integrated into the national public health interventions, including the National HIV programme.
- Devote a specific budget to the support and rehabilitation of PWUDs in Uganda, as opposed to focusing more on law enforcement.
- Consider establishing regional mental health hospital services, which deal with drug addiction.
- Allocate a medical officer in-charge of PWUD's health services at every district.
- Consider establishing specific treatment facilities for PWUDs in all public health facilities to enhance access by PWUDs to health service.
- Create a statutory body charged with the responsibility of overseeing drug-related issues, fashioned along the lines of the Uganda AIDS Commission (UAC).

- Fund a major epidemiological study on the implications of drug use on the disease burden in Uganda, as a basis for drastic public health interventions for PWUDs.
- Sensitise the police, public health officials, communities and other key stakeholders as to the realities of drug use and the need for a public health rather than criminal law approach to drug use in Uganda.

To Parliament

- Decriminalise small-scale, individual drug use.
- Review the NDPSCA in as far is it links the provision of rehabilitation and health services to PWUDs to the criminal process.
- Repeal overbroad and ambiguous offences, such as the 'Idle and disorderly' laws, which are used to harass, intimidate and extort money from PWUDs.

To the Judiciary

- Discourage and dismiss vague charges, which are clear attempts to use overbroad offences in the law to harass, intimidate and extort money from PWUDs.
- In cases where a conviction under the current regime is preferred, favour non-custodial sentences in order to avoid the great adverse and multiplier effects of imprisonment on the health and lives of PWUDs.
- Train judges and magistrates to be able to handle cases involving PWUDs with sensitivity and mindfulness of the advantages of a public health approach to drug use.

To the Uganda Law Reform Commission

- Conduct further research into the impact of the criminalisation of drug use as opposed to other best practices such as harm reduction, and make appropriate proposals to Parliament for reform of the law.

To the DPP

- Refuse to sanction vague charges which are clear attempts to use overbroad offences to harass, intimidate and extort money from PWUDs.

To the Uganda Police Force

- Desist from misusing overbroad offences to harass, intimidate and extort money from PWUDs.

To Persons Who Use Drugs and Civil Society Organisations working with PWUDs

- Undertake further studies regarding the general circumstances of PWUDs in Uganda.
- Sensitise the police, public health officials, communities and other key stakeholders as to the realities of drug use and the need for a public health rather than criminal law approach in Uganda.
- Lobby Parliament to decriminalise drug use in Uganda and to focus instead on the harm reduction approach.

To Public and private health facilities

- Adopt a more welcoming and more sensitive approach to PWUDs who seek health care services.
- Consider creating units dedicated to addressing the particular health needs of PWUDs.

To the Academia

- Undertake further studies aimed at comprehensively mapping the situation of PWUDs in Uganda.
- Conduct a major epidemiological study on the implications of drug use on the disease burden in Uganda which can serve as a basis for urgent public health interventions for PWUDs.

OPINION:

The impact of restrictive drug laws on HIV prevention and treatment in Uganda

*By Gracias Atwiine**

Source: HRAPF photo

There is need for a stronger focus on the health needs and rights of people who use drugs, especially injecting drug users. Uganda recently passed a stringent Narcotic Drugs and Psychotropic Substances Control Act, 2016. This new law has replaced the more relaxed, less repressive and less punitive National Drug Authority and Policy Act, Cap 206. The new law introduces heavier penalties for drug use and possession.

It is important to realise and appreciate that the war on drugs has failed and subsequently does not help countries to curb down drug use but rather pushes drug users into hiding and reinforces poor health seeking behaviors among the drug user community. Statistics show that the more the US invested in drug control, the more the drug use practice increased. The figures for the first war on drugs, early 1971, in the US tell us that there were 500,000 drug users in the US in 1971 with two Federal Agencies doing drug law enforcement with an annual budget of $ 100 million budget compared to 5,000,000 drug users with 55 Federal and Military Agencies doing drug control and law enforcement with an annual budget of $ 20 billion in 2012.[1] Research conducted by Harm Reduction International (HRI) shows that about $100bn is spent on the war on drugs annually.[2] If 7.5% of the global drug control funding were to be redirected to scaling-up harm reduction by 2020, there would be 94% fewer new HIV infections among people who inject drugs by 2030, and 93% fewer HIV-related deaths.[3]

Drug use is predicted to rise by 25% by 2050 with most of the increase in developing countries. The drug use practice is increasing in Uganda according to the research study conducted in 2017.[4] The study findings indicate that there are over 3,100 drug users in Uganda and that this number is expected to increase over time.[5] Drug users in Uganda like in many other countries are a hidden population that is usually unable to access social services like health, education among other services due to fear of being arrested under the existing harsh, repressive and punitive drug-related laws.

*Gracias Atwiine is the Country Focal Person for Uganda in the Project to Inspire, Transform and Connect the HIV/AIDS response (PITCH).

1 Drug Policy Alliance 'The Federal Drug Control Budget: new rhetoric, same failed drug war' (2015) 1.

2 C Cook et al 'The case for a Harm Reduction decade: progress, potential and paradigm shifts' (2016) *Harm Reduction International* 5.

3 As above.

4 D Muhangi et al *Population Estimation and Rapid Assessment on Harm Reduction and HIV prevention among people who inject drugs in Kampala City and Mbale Town, Uganda* (2017).

5 As above.

Source: © Rich Gang, 2018 | PhotoVoice | international HIV/AIDS Alliance | PITCH | Uganda

"When the police raided the den, officers surrounded me and one knocked me to the ground by hitting me with the butt of his rifle. I was arrested and put in a cell. There was no evidence or proper charge but my daughter was alone at home without care, and after 3 days in there, I was forced to pay for my release."

This story is not uncommon. People who use drugs are Criminals. They fear arrest so go into hiding. In hiding, there are no health services available to these individuals, many of whom are extremely vulnerable to HIV.

Services need to be brought to these communities to meet their health needs.

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Uganda continues to take a punitive approach to HIV and drugs, using arrests, incarceration, forced HIV testing and disclosure of KPs upon arrest, criminal penalties and compulsory detention to criminalise and punish users.[6]

Addiction to drugs is a health concern that requires medical attention. Criminalising drug use, which is a public health issue, creates more harm than good. It affects health-seeking practices and behaviors of key affected populations. In turn this affects the HIV level of transmission in such communities especially injecting drug users. The drug user population rarely accesses social and health services in settings where they will be identified and documented due to fear of stigma and of being arrested by the police. As a result of poor health seeking behaviors, the prevalence rate of HIV is estimated at 17.5% among drug users, compared to 7.3% in the general population in Uganda.[7] The Ugandan repressive drug laws (that push PWUIDs into hiding) coupled with wrongly targeted HIV prevention approaches and interventions are responsible for the increase of HIV prevalence rate from 6.3% to 7.3%.[8] The HIV prevention strategies for Uganda are silent on HIV/harm reduction interventions and how to engage and work with PWUIDs with a goal of improving their health-seeking behaviours and demand for health services.

Key studies and research in Uganda have shown that key populations have a high HIV prevalence.[9] There is need to target people who use and inject drugs (PWUIDs) to

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6 Human Rights Awareness and Promotion Forum *The Narcotic Drugs and Psychotropic Substances (Control) Act, 2015 and the legal regulation of drug use in Uganda* (2016) 18.

7 Ministry of Health *Uganda AIDS Indicator Survey* (2011).

8 As above.

9 Uganda Harm Reduction Network *Cumulative service users statistics (from March 10 2013 to December 16 2016) in 13 districts in Uganda* (2016).

reduce new HIV infections since the highest number of new HIV infections in Uganda are among key populations including PWUIDs. For example the HIV prevalence is 35% among Sex Workers, 14% among Men who have Sex with Men and 17.5% among PWUIDs due to poor health seeking behaviors exacerbated by the fear of being arrested further sending them into hiding.[10]

The outcome document of the United Nations General Assembly Special Session high level meeting, held in New York from 19th to 21st April 2016, recognised drug use as a public health issue and not a criminal issue.[11] The AU in its Common African Position on drug use equally recognises that drug use is a public health issue and not a criminal issue as all African countries put their voices behind this submission to UNGASS 2016.[12] There is therefore a need to harmonise Ugandan domestic laws with this pronouncement to ensure drug users' rights are respected and upheld, including access to health with targeted specific harm reduction interventions.

All United Nations Agencies that deal with health and human rights have called for a health-based approach to drug use. The current Narcotic Drugs and Psychotropic Substances Control Act reinforces an approach of dealing with use and possession of drugs by using the criminal justice system. It is believed that fear and force of the law will prevent the forming of drug-using habits. Global research has shown that on the contrary, the criminal justice approach rather drives drug use practice underground with the risk of increasing the spread of HIV, HBV and HCV among the drug using communities. In Uganda, harsh criminal laws on drug use are coupled with an absence of state-sponsored rehabilitation services such as needle exchange and opioid substitution programmes and programming aiming at reducing the spread of HIV among drug users. A single Act dealing with the crime of drug trafficking on the one hand and drug use, possession and forced rehabilitation of individuals on the other strongly enforces this criminal justice approach. Draconian laws instil fear of the hard-hand of the law on PWUIDs. This fear increases stigma surrounding drug use, closes down conversation and communication and isolates PWUIDs from support, health care and HIV services including rehabilitation.

There is growing evidence which indicates that drug treatment and counseling programs are far more effective in reducing drug addiction and abuse compared to incarceration.[13] Opioid Substitution Treatment, like Methadone or Nalexone, saves from accidental overdoses and are recommended for persons who are addicted to heroin.[14] When these public health options are made available, studies show dramatic decline in drug dependence, mortality and overdose.[15]

There is therefore a need for a stronger focus on the health needs and rights of people who use drugs, especially those who inject drugs.

There is therefore a need for a stronger focus on the health needs and rights of people who use drugs, especially those who inject drugs. There is a gap in service provision for PWUIDs in Uganda where no attention is given to those who need drug dependence treatment services besides the existing repressive drug law.

The current anti-narcotic law is a blow to public health.

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10 MUSPH *Crane Survey Report: Population Size Estimates* (2018) Unpublished data; PLACE *Sixe Estimation of Key Populations in Uganda* (2018) Unpublished data.

11 UNGASS 2016 United Nations General Assembly Special Session on the World Drug Problem 'Outcome document' available at https://www.unodc.org/ungass2016/en/index/main-content1.html (Accessed on 23rd September 2019).

12 As above.

13 Harm Reduction International 'Global state of harm reduction 2018' (2019) 13.

14 As above.

15 As above.

It penalises possession of illicit drugs with 10 to 25 years in prison. It goes as far as levying a five-year prison sentence for failure to disclose prior prescriptions for narcotic drugs or psychotropic substances.[16] Such punitive laws further push people who inject drugs who are at higher risks of HIV, Hepatitis and other blood pathogen transmissions away from accessing prevention information, health and social services that are vital to managing drug dependence, preventing transmission of HIV, and supporting people to live full and productive lives.

It's therefore important to promote and embrace drug use as a public health issue rather than a criminal justice issue but also to advocate emphatically for core harm reduction specific prevention and treatment interventions.[17] With Uganda's new HIV infection rate that stands at 300 people per day,[18] there is a need for HIV prevention measures and improved treatment among people who use and inject drugs. Uganda can no longer ignore the causal relationships between sex, needles, syringes and the HIV epidemic especially with the glaring evidence of high HIV prevalence rate among people who use and inject drugs.

There is need to embrace and include harm reduction interventions in our national health (prevention and treatment) policies and guidelines. Like one Senior Research Analyst at Harm Reduction International, Catherine Cook says:[19]

> The world has come a long way in providing harm reduction services to people who use drugs. But this journey has been a slow one, and there is much further still to go if there is to be any hope of putting a stop to the countless avoidable deaths and health-related harms of people who use drugs every year by overdose, HIV/AIDS, and viral hepatitis, there needs to be a significant scale-up of harm reduction provision the world over.

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16 Sec 9.

17 n 13 above.

18 UNODC, UNAIDS and World Bank *Report on World Drug Problem* (2015).

19 Harm Reduction Coalition 'We can end AIDS among people who inject drugs' available at https://harmreduction.org/blog/endaids/ (Accessed on 23rd September 2019).

INTERVIEW:

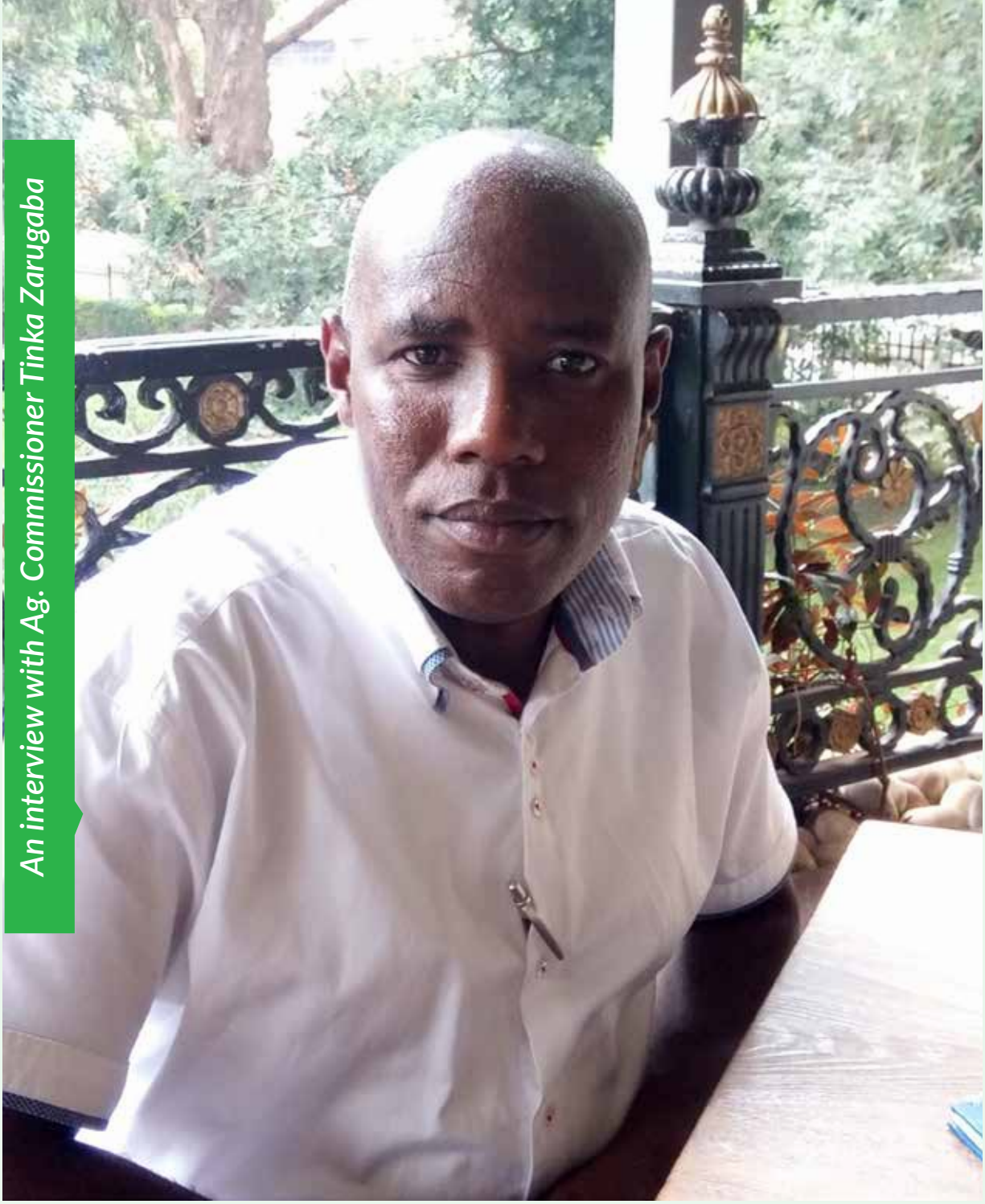
A perspective on the NDPSCA from the Uganda Police Force's Anti-Narcotics Department

1. *Human Rights Advocate magazine (HRA):* *What is your current position within the Uganda Police Force?*

Ag. Commissioner Tinka Zarugaba (TZ): I am the Acting Commissioner and Head of the Anti-Narcotics Department, which is under the CID Directorate of the Uganda Police Force.

2. *HRA:* *What is your experience in dealing with drug control?*

TZ: I have been working in drug control for 11 years. I started my career in drug-related issues as an investigator at Entebbe International Airport. I rose to Head, Criminal Investigations; Deputy Head of Department, Anti-Narcotics to Head of Department, Anti-Narcotics. Our role as anti-narcotics officers is that we are supposed to fight narcotics abuse. That means we are supposed to arrest and prosecute people who use and trade in drugs: traffickers, growers and people who help them as well as users. Our mandate is to arrest all people who promote drug abuse in the country. The experience I have is that we have not been quite



Source: HRAPF photo

successful. The traffickers we arrest are the low-level traffickers: the pushers. The king-pins are either not in Uganda and if they are, they are very powerful, dangerous, rich and influential and very difficult to arrest. Our investigation methods are not able to reach there. We end up arresting low-level traffickers and users. The users are often victims who are addicted, they need rehabilitation and treatment and we are calling them criminals. Our method is not so effective in controlling drug use in Uganda.

3. HRA: *Is the Narcotic Drugs and Psychotropic Substances Control Act currently being enforced?*

TZ: The Narcotics Act came into force in February 2016. We are enforcing it. However, not all provisions are enforceable. Some provisions require the Minister of Internal Affairs to make regulations. Some provisions require the Narcotics Coordinating Committee and Advisory Board to have been formed. We are enforcing what we can while waiting for the Ministry to enact the necessary Regulations to enforce the remaining provisions. The law mandates the Minister of Internal Affairs to form this Committee and Advisory Board. I cannot explain why this has not yet

been done. My mandate is to implement what I have been given. Civil society has space to undertake advocacy to ensure that the Regulations take shape. Civil society could call meetings with the Permanent Secretary or the Minister of Internal Affairs himself in order to ascertain why the Act has not yet been fully operationalised.

4. ***HRA:*** *What is your view on the NDPSCA as a law enforcer?*

TZ: Even though we are not implementing the Act fully, we are observing that the Act has some issues. We should call for its amendment as soon as it is fully enforced. The Act is not balanced. It focuses on eliminating trafficking in drugs. It is not looking at the consequences of drug usage. People who are addicted need to first be tried and it is the trial magistrate who has to take the decision. It takes long and it does not consider the health aspects of the addict. We would want to see an Act that has a balance: an Act that allows law enforcers to do the work of enforcing but also gives the option of exercising some discretion. When I meet someone who is sick or who is an addict what do I do as a law enforcer? If I get somebody who is a trafficker but he has related problems like HIV and TB what do I do? If I get a suspect who has TB, do I incarcerate him? You can be a trafficker but also a victim of another associated disease. Those are the issues that the Act needs to address. I need to know where to begin. Do I first attend to health issues or do I focus on the criminal aspects? The Act is not so clear on these issues for the law enforcer.

5. ***HRA:*** *Are you satisfied with the part of the NDPSCA that provides more stringent drug control? Do you think that, when it is fully enforced, it is likely to address drug trafficking effectively?*

TZ: It would be effective if we had the means and the capacity to deal with drug lords. For now, the stringent control makes the vulnerable population who are peddlars even more vulnerable. Though the Act is stringent it does not bring the desired results. Due to a lack of resources, we are focusing on the facilitators of business and not the businesses owners. The business owners simply replace the facilitators if they get taken out, so we are in an endless battle. Unless the government makes a deliberate effort to empower law enforcement with machinery, money and tools to look for the kingpin, we are fighting a losing battle. The stringent Act does not solve the problem.

6. ***HRA:*** *What suggestions would you make for amendment of the Act to make it more balanced?*

TZ: The Act does make provision for rehabilitation, but this is only at the very end of the trial. Any abrupt withdrawal brings health complications for a PWUID. My suggestion would be that the Act would allow police officers to make diversions. At the time of arrest, I should be given powers to do screening, so that I can determine whether you are a trafficker or a user in need of treatment. At present, law enforcement officials are not allowed to make diversions. The trial magistrate, toward the end of trial after the suspect had spent many months on remand, is the first person allowed to make a diversion.

7. ***HRA:*** *Are there any recommendations you could make to civil society about the role it could play to support a balanced enforcement of the Act?*

TZ: There should be a close collaboration between civil society and law enforcement officers on drug control. Civil society should also engage government to ensure that the Act is fully operationalised, because it is only after operationalising the Act that we can challenge the Act because we know how it works. Civil society should also study the Act critically vís-a-vís the health aspect of the victims and see how we can create a balance between the criminal enforcement of the Act but also treatment and rehabilitation.

HRA: *Thank you very much for your time and for sharing your views.*

OPINION:

"The NDPSCA is not a solution for us"

*By Wamala Twaibu**

Source: UHRN photo

Uganda Harm Reduction Network is a network of people who use and inject drugs. It works across the country. So far we have 36 member organisations who are groups of PWUDs. The vision of UHRN is 'A society where People Who Use Drug are empowered to make informed decisions on the effects of drugs and substance use and live a life that gives them hope'. We have a number of programmes targeted toward reaching our vision. These programmes are: Research and Knowledge Management; Access to Justice; Institutional Development and Capacity Enhancement as well as Policy and Advocacy. Our paralegals working under the Access to Justice programme are trained by HRAPF. They work within the communities and share information on arrests of PWUIDs who had come into conflict with the law.

In Uganda we face a serious shortage of treatment for PWUIDs. We have the National Referral Centre at Butabika Hospital. This Centre is mostly focused on issues of people using tobacco and marijuana; for hard drugs we have no treatment centre in the country. Of recent the government in starting to get to terms that the problem of drug use needs to be addressed with the right approaches. Conversations are going to roll out a Methadone Clinic at the National Referral Centre in Butabika and this will be the first of its kind in Uganda. The Centres for Disease Control and Prevention (CDC) under PEPFAR has allocated funding to pilot the Methadone treatment. We remain hopeful that this gap in rehabilitation will be dealt with. Extensive medical machinery and equipment is needed in order to provide such treatment.

At present, PWUIDs who have families who support them are transferred to Kenya or Tanzania for rehabilitation from drugs. Organisations in other countries are willing to give treatment to Ugandan patients for free; as if they were a citizen of that country, provided they could cover their own transport and accommodation. There are some private centres for the treatment of substance abuse such as alcohol and tobacco here in Uganda, but even the private facilities are not equipped to provide rehabilitation for drug users. These centres are also very expensive - up to Ugx80,0000 per night.

In my view, the NDPSCA has both good and bad provisions. It was not adopted with input from all stakeholders and left out PWUIDs. It seems that the Act as it is does not allow PWUIDs to access rehabilitation without moving through the criminal justice system first. These are the things we want to see amended. The Act also has provisions which penalise owners of premises who are aware that drugs are taken by persons on this premises and do not report them. It becomes very hard for a PWUID to go and seek medical treatment because they fear that the tests carried out can be used as evidence against them.

The law does not differentiate between who is a user and who is none user. The law did not consider the use of children to transport drugs. The law does not provide guidance on how child drug mules ought to be treated.

*Wamala Twaibu is the Executive Director of Uganda Harm Reduction Network.

A person who is arrested in possession of drugs is liable to a very heavy fine. The law did not consider persons from the community. In our view, taking PWUIDs to prison would not be a solution. Rehabilitation is what is needed and this should also go hand-on-hand with skills development to ensure that people are able to take care of themselves once they have been rehabilitated successfully.

The law also provides that 'addicts' should be committed to treatment centres, but these treatment centres do not exist yet, nor are there guidelines for their operation. The Rehabilitation Fund is a good initiative, but it appears to only support government centres. It is not clear whether private rehabilitation centres will be supported.

Bringing the law is not a solution to us. It is not a friendly law as it did not look at the human rights approach but only focused on the criminal justice approach. It is even harder on the community who do not even know what is in the law. What we want is, if a person has been found with, for example, one stick of marijuana, that they would be sentenced to do community service, rather than being taken to prison. Drug addiction is a disease that requires treatment and cannot be resolved by imprisonment. Drug users have also been able to access drugs while in prison which put them at a much higher risk especially in cases where they have to share needles.

Police officers also misuse the law by extorting PWUIDs for bribes, since it is easier to pay a high bribe than to handle the heavy sanctions which the law create. The new Act provides that any person who works to support or who helps, like we do with the Needle Exchange Programme, can be arrested. We may appear to be supporting drug use and the needles could be used as evidence.

In Uganda, the government does not view drug users as people who need treatment as support, but rather as possible criminals. Whenever there is a crime committed drug users are suspected. We have been working very hard to sensitise government, policymakers and civil society to help them to understand what is 'harm reduction'. The government is not looking at the cause but rather at the effect. If you do not sit with people and understand their problems, it becomes very hard to come up with solutions. Advocacy and engagement has been very fruitful though. We have reached a level where we can be given audience by policymakers and the Uganda Police Force to listen to our issues. We are ably working with the Anti-Narcotics Department of the UPF. Through advocacy we are creating good relationships, but this is only in Kamapala and it needs to be scaled up in almost 130 districts in Uganda.

I call upon the government to treat drug use as public health issue and not as a criminal justice matter because today I am a victim and tomorrow your son or your daughter may be a victim. ¤

The Ugandan Harm Reduction Network has finally achieved a breakthrough, with the Ministry of Health giving us the green light to pilot a Needle and Syringe Exchange Programme (NSP), where people who inject drugs now have the chance to access clean needles and syringes. This will largely reduce the risks associated with sharing needles such as the transmission of HIV and Hepatitis. Wider adoption of NSP Programmes across the country has the potential to save hundreds of thousands of lives and contribute greatly to controlling the HIV epidemic.

Access to health and life saving interventions must be recognized as a constitutional right.

Embrace NSP and Save Lives.

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The HIV prevalence in people who inject drugs is almost 3 times higher than the general population, but most people who use drugs (PUDs) boycott public HIV and health facilities through fear of arrest, stigma and discrimination.

The extension of HIV services to drug hotspots and dens has the power to increase uptake of HIV services across PUD communities in Uganda.

Make HIV services affordable and accessible to all - Support don't Punish.

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Something as basic as clean water is hard to find in drug hotspots. Injecting drug users are forced to mix heroin with blood or dirty water before injecting, increasing their exposure to HIV and other diseases.

Needle and Syringe Programme (NSP) kits provide steralised water along with clean needles and syringes to these communities.

The Government must embrace NSP programmes to reduce HIV transmission and save lives.

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"We want to get off of drugs, but don't even know how to start. If we go to rehabilitation centers, there is no treatment and we suffer badly from 'tickes' (withdrawal symptoms). Often we are put away with people who have mental illnesses. So we are forced to go back to the drug dens, where we continue using."

Opioid Substitution Treatment (OST) is an effective intervention for drug dependence and HIV prevention.

The Government must see drug dependency as a health issue and equip health facilities with OST and methadone programmes to support people who use drugs to recover, lead normal lives and contribute to society.

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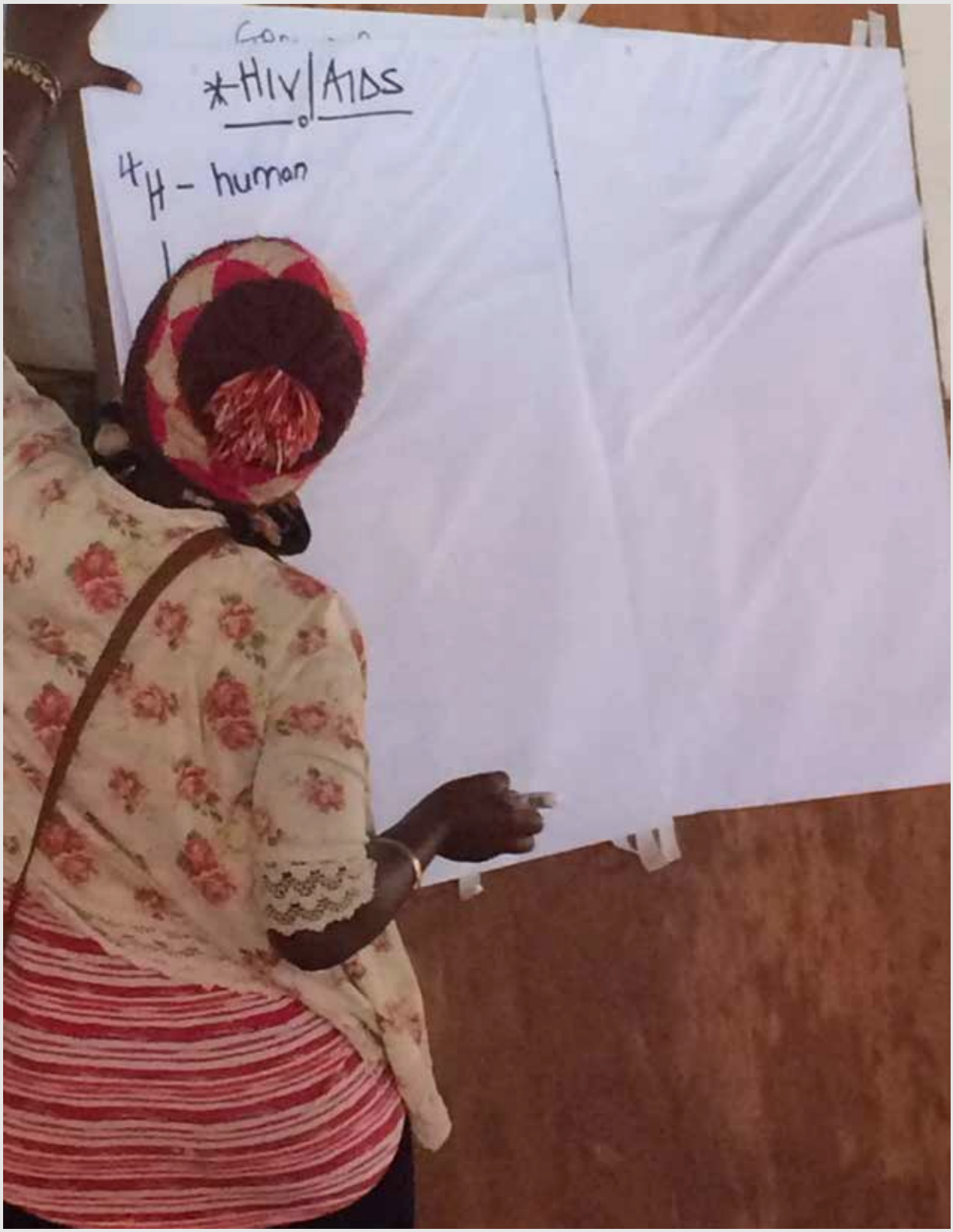

People who use drugs (PUDs) are still the missing piece in effective HIV awareness programming. In drug hotspots, many are not even aware of the existing HIV prevention options.

Condoms, Prep and SRHR and HIV information and testing cans save lives but PUDs are ignored and dying in silence.

We call for a deeper engagement with PUDs to scale up access and uptake of HIV prevention interventions in drug using communities in Uganda.

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ARTICLE:

A glance at care and treatment offered to People Who Use and Inject Drugs at Butabika National Referral Mental Hospital

*By Dr. Byamah Brian Mutamba**

Butabika Hospital is the National Mental Referral Hospital in Uganda and is tasked with the provision of specialised mental health services. In keeping with the World Health Organization (WHO) guidelines, we provide services for a wide range of mental, neurological and substance use disorders. The hospital is witnessing a growing population of patients and about 30% to 40% of patients admitted with mental illness come in with co-existing alcohol and substance use problems. The Alcohol and Drug Unit (ADU) is a sub-specialist unit within the hospital which offers specialised treatment services for people with alcohol and drug use problems, mostly focusing on in-patient rehabilitation. The Unit cannot cater for every patient who needs this service because of limited capacity.

Overall, acute and emergency care as well as basic alcohol and substance use treatment services are provided in any part of the hospital. After addressing the initial emergency and acute care, inpatient rehabilitation is the next phase of care and this is provided by the ADU. The ADU mostly provides psychological treatments to empower and support individuals who have come to an understanding that they have an alcohol and substance use problem, and to start on a journey of recovery. They may or may not have medication which support them in this case. Patients may be on medication to treat co-occurring mental and physical health problems, however, the focus is on them being in an in-patient facility where they are in a safe space from the outside world that allows them to focus on their recovery. According to the WHO guidelines, an average in-patient rehabilitation phase lasts about three to four months, although it can be shorter or longer, depending on the needs of the patient.

"Overall, acute and emergency care as well as basic alcohol and substance use treatment services are provided in any part of the hospital."

For a long time, the ADU was a twenty bed unit, but the bed capacity has more than doubled and unlike previously when it could only cater for male patients, it is now able to accommodate both male and female patients.

There are a few people who voluntarily come in for rehabilitation, but many more come in through the usual hospital system where they are admitted on different wards because of acute conditions for which they receive care up to the point when they are referred to the

* Consultant Psychiatrist, Alcohol and Drug Unit, Butabika National Referral Mental Hospital.

> **We have not had any referrals as an alternative to a criminal sentence.**

ADU. Considering that the inpatient rehabilitation phase takes about three months, we have greater need than capacity. We facilitate liaison services for patients admitted to other wards in the hospital so they can also benefit from group and individual psychotherapy, even without being admitted to the ADU.

Butabika is fully funded by government. We rarely get referrals from the criminal justice system apart from some referrals by police. A significant number of referrals are from the education system: people who are in high school or tertiary education. We have not had any referrals as an alternative to a criminal sentence.

Most of our admitted patients come in involuntarily with serious mental and physical health needs, and social consequences of mental and substance use disorders so we have to work with their acute needs. The police may bring in people from the street who are mentally unwell, and their admission to hospital helps to protect and care for the patient as well as to protect society against the patients in a few instances. We do not admit many patients to the ADU involuntarily though there are cases when, because of the severity of the patient's condition, this happens. When admission is involuntary, there is continuous engagement with the patient and their family so as to make a joint decision about whether or not the persons should undergo rehabilitation.

> **The police may bring in people from the street who are mentally unwell, and their admission to hospital helps to protect and care for the patient as well as to protect society against the patients in a few instances.**

The new Mental Treatment Act has some provisions for supporting persons with alcohol and substance use problems. We had an obsolete Mental Health Act until this year which legislated against evidence-based methods and treatments for patients in need of mental health care. People could only be admitted to a mental hospital if a court decided that a person is fit for treatment. The old Act considered persons with mental health issues as sub-human and used derogatory language to describe them.

The passing of the Narcotic Drugs and Psychotropic Substances Control Act (NDSPCA) means that we now have a legal framework that we can refer to and that can guide us. Though there are concerns about the implementation and enforcement of the Act and the practicalities around that, even with its shortcomings, the adoption of the Act is a step forward for mental health and substance use services in Uganda. ¤

Source: https://www.butabikahospital.go.ug

Source: HRAPF photo

By Lubowa Bull

OPINION:

Before and after the NDPSCA era, the treatment of PWUIDs by authorities remain unchanged

I work as a Community Paralegal among PWUIDs. I used to be a drug user myself but I quit. So now I help people in the community. I help people to access services at hospital and also help PWUIDs who had been arrested. I am part of Uganda Harm Reduction Network and I was trained as a Community Paralegal by HRAPF.

I have been arrested so many times. In 2018 I was arrested because I was supplying syringes to my colleagues at hotspots. I was arrested during an operation because the police thought I was a drug dealer. I was with the police for two days. After that I was granted a police bond. I kept reporting and appearing in court and eventually the charges were dropped.

The charges that are usually used are possession of opium or possession of drugs. Since it is difficult to prove cases of possession of drugs or possession of opium, they would rather charge under the idle and disorderly provisions or even say that you are stealing something. Sometimes the cases will go all the way to court, I am working on two cases this year that are possession cases. I have tried to have PWUIDs committed to rehabilitation but we have been told that the person needs to go to court first. UHRN would then write a letter to the Officer in Charge to grant that the person can be taken to the rehabilitation centre but they refuse and say the person has to go to court first. So they send him to court and to prison first.

The only rehabilitation centre that is available is at Butabika. PWUIDs would often complain about this. They would say that Butabika is a hospital for mad people and they cannot go there. What happened to me at Butabika is that they gave me CPZ and I woke up feeling so cold. It would have been better if they could give me Methadone. I used to know all the procedures they used that side and I couldn't deal with their methods which were like cold turkey. I still refer people there but some of them come back and complain. That's the only option we have. At Serenity you have to pay money.

We have instances that PWUIDs who are arrested with drugs get caned. This happens at all police stations. The Local Defense Unit, that was recently redeployed, undertake night operations and they cane even kids who they find using drugs. We need to sensitise the police

and magistrates. We need to sit down and solve these issues.

The 2016 Act is being enforced and cases of possession of drugs and opium are charged under this Act. The treatment of PWUIDs in the 2016 Act era and before is unchanged. A drug user is a person who needs services like any other person. You need to treat them like other people. When you come to the government hospital, they cannot give you services. It prevents PWUIDs from seeking out healthcare. They need to be treated like any other Ugandan.

In my view, drug use originates from families. Where people have not received love and care from their parents, the drug becomes their love. I grew up without my father. When I was 12 years old I ran away from home and started using drugs. Using drugs is like taking care of yourself; taking care of your own heart. I lost ten of my friends to drugs. I quit drugs in 2010 – I started in 2001. I was admitted to Butabika by my family. I use to even sell drugs in the hospital until I was arrested in Butabika. I used to have a cross-addiction: drinking and smoking opium. At some point, I just decided that I was not going to drink anymore and I was not going to use any drug. PWUIDs do fear quitting drugs, they think they may die if they just stop cold turkey. But you can, if you take care of yourself. For me, it was a miracle. I was a heavy junkie because I had used all *all* drugs: heroine, ecstacy, blue … I think solutions to the use of drugs start at a family level. These days you find that there are even kids in primary who are taking drugs. Children need to be taught about the dangers of drugs by their parents.¤

"The police cells are like torture chambers to us. The police hunt us down day and night. My friend is a drug user and sells sex to buy drugs. She was raped and tried to report it to the police. Instead of helping her, they mocked her and sent her away - they treated her as a criminal."

Many young female drug users have no choice but to turn to sex work to support their habit, exposing themselves to HIV, STIs and sexual violence.

Instead of criminalising drug use, it must been seen as a health issue. Only then will we reduce the transmission of HIV and win the fight against AIDS.

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ISSUE BRIEF

Harm reduction for drug users in Uganda: The limits of the law on narcotics and psychotropic substances and the case for reform*

1. Background

In October 2016, HRAPF and the Uganda Harm Reduction Network (UHRN) published a Report entitled: 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.[1] The study analysed the current legal framework on drugs, specifically focusing on the Narcotic Drugs and Psychotropic Substances (Control) Act (NDPSCA), and concluded that the approach taken towards drug use in Uganda is focused on criminalisation rather than harm reduction. HRAPF and UHRN thus called for an amendment of the law to include more harm reduction provisions. This Issue Brief was commissioned in order to show the gaps in the law and how they could be filled through amendment of the Act.

2. Introduction

This Issue Brief investigates the concept of harm reduction as a strategy to deal with the negative consequences of the use of narcotics and psychotropic substances. Although harm reduction strategies have proven to be an effective way of managing the negative consequences of drug use on individuals and the community, they are not widely applied. In the case of Uganda, the law has adopted a criminalisation approach to drug use and has not promoted harm reduction within and outside the criminal justice system. Indeed, the problem of drug use and trafficking has mainly been dealt with by introducing stiffer sentences, without either addressing root causes of drug use and trafficking or dealing with its negative consequences. In this Issue Brief, the case is made for the adoption of harm reduction in Uganda, both within and outside the criminal justice system. A case is made for law review to address the gaps in the recently promulgated Narcotics Drugs and Psychotropic Substances (Control) Act, 2016 (NDPSCA). It is acknowledged though that radical reforms that would promote the full range of harm reduction approaches may not be feasible in Uganda, based on the moral and legal condemnation of drug use and the entrenched commitment to criminalisation. The Issue Brief defines harm reduction and among others illustrates the connection between drug use and HIV/AIDS prevalence. Focusing particularly on how harm reduction could be used to manage HIV/AIDS prevalence among drug users and the rest of the population. The position of the law in Uganda is discussed, pointing out gaps that

[1] 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).

*This Issue Brief was commissioned by Human Rights Awareness and Promotion Forum and was researched and drafted in November 2017 by Dr. Christopher Mbazira. Dr. Mbazira is an Associate Professor and Principal of the School of Law, Makerere University. He is also the Coordinator of the Public Interest Law Clinic (PILAC) and a research consultant on human rights, public policy and governance issues.

compromise harm reduction and making suggestions for reform. At the end of the Issue Brief, a case is made for law reform, focusing particularly on amendments to the NDPSCA. A Draft Amendment Bill is elaborated as a starting point.

3. Understanding Harm Reduction

Traditionally, substance abuse treatment has placed most of its focus on reducing or eliminating drug use, neglecting the prevention of the adverse consequences of drug use. Evidence shows an increasing and constantly shifting approach in response to the drug problem. It is within this context that harm reduction strategies have been advocated for. Strategies such as supply reduction, community development, preventive education, treatment and rehabilitation may work in the long term to reduce substance use. The term 'harm reduction' has been used interchangeably with other terms such as 'damage limitation', 'casualty reduction', 'harm minimisation', 'risk management', or 'secondary intervention'.

It should be noted that the definition of the term 'harm reduction' has been evolving. To understand this evolution, one needs to capture some of the definitions which have been propounded in this regard. Newcombe in 1992 defined harm reduction as 'a social policy which priorities the aim of decreasing the negative effects of drug use'.[2] A similar definition was adopted in 1996 by The Youth Work Support Pack for Dealing With The Drugs Issue, describing harm reduction or harm minimisation as 'any activity which aims to reduce the harm caused by drug use. However, as is illustrated by Kiely and Egan, these definitions were somewhat broad.[3] For this reason, more concise definitions are preferred. According to Heather et.al., harm reduction as a strategy includes any activity which is directed at reducing the harm associated with drug use without necessarily reducing drug use itself.[4] Duncan et.al. assert that the strategy recognises the fact that people will use drugs and that harm reduction therefore 'attempts to minimise the potential hazards associated with drug use rather than the use itself.'[5]

Clements et al and Watson are even more elaborate. Clements et al define the strategy as an approach to education which aims to reduce the harm from drug use to the lowest level possible by providing accurate information about drug use and its risks; developing the skills of less dangerous drug use; developing coping and helping skills; and opposing discrimination against drug users. It is stated that the strategy encourages existing and would-be drug users to discover less dangerous ways of using and promotes helping and coping skills.[6] Similarly, Watson conceives the concept as the philosophical and practical development of strategies so that the outcomes of drug use are as safe as is situationally possible. According to Watson, harm reduction involves the provision of factual information, resources, education, skills and the development of attitude

> **Harm reduction is a practical approach that employs a range of different strategies with the goal of minimizing the negative consequences of drug use.**

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2 R Newcombe 'The reduction of drug related harm, a conceptual framework for theory, practice and research' in P 0' Hare et. al. (eds.) *The reduction of drug-related harm* (1992) 1.

3 E Kiely & E Egan 'Harm Reduction : The concept and practice' in E Kiely & E Egan (eds.) *Harm Reduction: An information and resource booklet for agencies engaged in drug education* (2000) 8 Department of Applied Social Studies, National University of Ireland, Cork.

4 N Heather, A Wodak, E Nadelmann, P 0' Hare (eds.) *Psychoactive drugs and harm -reduction: From faith to science* (1993) Whurr, London.

5 DF Duncan, T Nicholson, P Clifford, W Hawkins & R Petosa 'Harm Reduction: An emerging new paradigm for drug education' (1994) 24:4 *Journal of Drug Education* 287.

6 I Watson Clements, J Cohen & J Kay 'Taking drugs seriously: A manual of harm minimising education on drugs' (1996) Healthwise Helpline Limited, Liverpool 14.

change, in order that the consequences of drug use for the users, the community and the culture have minimal negative impact.[7]

The goal of harm reduction strategies and approaches is to reduce the negative consequences of drug abuse, and not to erase the use of licit or illicit drugs.[8] Harm reduction is a practical approach that employs a range of different strategies with the goal of minimising the negative consequences of drug use. The strategies may for instance include changing the way people consume drugs or ensuring that the environment in which they use drugs minimises the risks of negative consequences to their health. The consequences may include infections, overdose, legal problems, social and familial issues. The approaches taken may vary depending on the drug, the type of harm related to its consumption, and the individual who consumes the drugs.[9]

Research shows that harm reduction is not a new strategy. In the United Kingdom for instance, harm reduction approaches are traced to way back before the 1960s. During this time, those who promoted harm reduction looked at it more as a tool to deal with the individual consumer and addict. In the United States of America, harm reduction approaches used in relation to illegal drugs have been documented by Duncan.[10] The examples given is action taken in response to an epidemic of paint and solvent huffing which resulted in two deaths. Following these deaths, a local drug treatment centre decided to prioritise the prevention of deaths resulting from these incidents. Focus was put on describing ways of reducing the risks associated with huffing. In due course however, and by the 1970s, realisation that the problems associated with drug use were societal in nature and had a community wide impact resulted into individual harm reduction approaches being abandoned in preference for policies with a wider societal impact.[11]

The central reason that harm reduction approaches should be implemented is that these stratagems save lives and shrink the likelihood of drug use problems. This is for the benefit of the individual, their families, and the community at large. Roizen has categorised the adverse consequences of drug use by using the "4 Ls" model, or four areas of harm in the life of drug using individuals.[12] The "4Ls" stand for "liver", "lover", "livelihood" and "law". "Liver" is used to refer to the various liver related health complications arising out of drug use. These are identified to include cirrhosis; cancer; overdose; psychiatric, psychological, or emotional problems (amnesia, depression, paranoia, etc.); accidents or other injuries while intoxicated, among others. "Lover" related complications are those attributed to challenges in relationships, family, friends, intimate partners, and children. Yet, "livelihood" related consequences is in relation to harms related to the user's professional life such as lack of concentration at work or school and other non-professional activities such as hobbies. Lastly, "law" related consequences are legal problems related to illegal drug use, drug acquisition, and/or trafficking, including driving under the

"The central reason that harm reduction approaches should be implemented is that these stratagems save lives and shrink the likelihood of drug use problems."

7 As above.

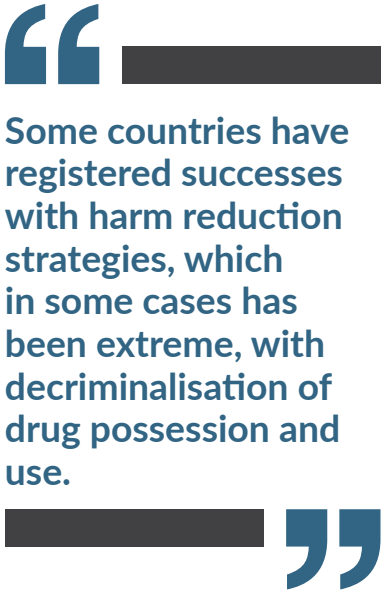
8 BA Hilton, R Thompson, L Moore-Dempsey & R.G. Janzen 'Harm reduction theories and strategies for control of human immunodefciency virus: A review of the literature' 33:3 *Journal of Advance Nursing* (2000) 357-370; D Addy & A Riter 'Clinical Treatment Guidelines for Alcohol and Drug Clinicians' No 4: Reducing harm for clients who continue to use (2000) Turning Point Alcohol and Drug Centre, Australia.

9 As above.

10 DF Duncan, T Nicholson, P Clifford, W Hawkins & R Petosa 'Harm Reduction: An Emerging New Paradigm for Drug Education' 24:4 *Journal of Drug Education* (1994) 281- 290.

11 See V Berridge *Histories of Harm Reduction: Illicit Drugs, Tobacco and Nicotine* (1999) 35 - 47.

12 R Roizen & C Weisner (1979) *Fragmentation in Alcoholism Treatment Services: An Exploratory Analysis*. Berkeley, CA, United States: Alcohol Research Group, University of California.



Some countries have registered successes with harm reduction strategies, which in some cases has been extreme, with decriminalisation of drug possession and use.

influence of drugs.

In addition to the previous classification of the consequences of drug use, other authors have classified the harms according to the drug using behavior: drug acquisition, drug use, and drug withdrawal. Each area is related to specific risks for the person who uses the drugs, his/her family and relationships, and for the surrounding community.[13] Acquisition could drain one's finances and even risk their life in some cases. The use comes with health and social problems and withdrawal may equally affect one's health and social life.

According to the United Nations Office on Drugs and Crime, harm minimisation strategies are directed towards reducing harm, in many cases by altering drug using behaviours and effects such as acquisition, drug use, and withdrawal.[14] The United Nations Drugs and Crime Office suggests that drug acquisition harms may be related to the risks of being exposed to high-risk situations, such as criminal behaviour which may either mean being exposed to or conducting criminal acts such as drug dealing and robbery, among others. Yet, drug use harms may be related to the drug used, the amount consumed, and the method of administration. Each drug and method has different pharmacological effects and consequences on the individual's health. The example is given of how injection drug use may lead to open wounds, vein problems, abscesses, skin breakdown, HIV and other infectious diseases arising mainly from sharing of needles and other paraphernalia.

It is added that the factors that influence overdose or intoxication-related harm include purity of the drug, dose, duration, and frequency of drug use; mode of administration; poly-drug use; physical state (nutrition, tolerance among others); and psychological factors (expectations). The United Nations adds that drug withdrawal harms are related to the effects of reducing or eliminating drug use that may impair the individual's work and social functioning. Withdrawal can also be related to a variety of problems such as physical and psychological issues, high-risk activities, and criminal behaviors.[15]

Some countries have registered successes with harm reduction strategies, which in some cases has been extreme, with decriminalisation of drug possession and use. The example is given of Portugal. The successes of Portugal are recorded by Alex Stevens, Heino Stover and Cinzia Brentari:

> From July 2001 people who are found by the Portuguese police to be in possession of fewer than ten days' personal supply of any drug have not been arrested, though the drug is still confiscated. They have instead been referred to regional drug dissuasion committees, which have the option of imposing warnings, fines, administrative sanctions (such as taking away driving or firearms licences), or — in the case of dependent users — referring them to treatment. Since decriminalisation, and the simultaneous expansion of prevention, treatment and harm reduction services, there have been dramatic reductions in drug-related deaths and HIV.[16]

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[13] As above; n 8 above.

[14] See United Nations Office on Drugs and Crime *Harm Reduction*, available at < https://www.unodc.org/ddt-training/treatment/VOLUME%20D/Topic%204/I.VolD_Topic4_Harm_Reduction.pdf> (accessed 8th October 2017).

[15] As above.

[16] A Stevens, H Stover & C Brentari *Criminal justice approaches to harm reduction in Europe* available at < file:///C:/Users/WINDOWS/Downloads/emcdda-harm%20red-mon-chl4-web.pdf > (accessed on 11th October 2017), at p 38.

In Africa, generally, emphasis has been put on criminalisation of drug use and harm reduction strategies have not been embraced. However, some countries have adopted some harm reduction strategies but only as part of treatment for addiction. In Mozambique for instance, medical protocols allow for the administration of methadone. This is the case in Uganda and Tanzania, but only to the extent that it is used in cases of withdrawal. Even then, methadone may not be readily available at facilities in some of these countries. However, other reduction strategies such as needle exchange remain illegal since they are considered to be promotion.

3.1 HIV/AIDS epidemic and harm reduction strategies

Despite the growing efforts to address the AIDS epidemic, HIV and other infectious diseases continue to widely spread, particularly among Injecting Drug Users (IDUs). Statistics show that the number of people living with HIV and also the number of deaths due to AIDS continues to increase. UNAIDS reports show that a total of 39.5 million people live with HIV and an estimated 4.3 million [3.6 million-6.6 million] adults and children were newly infected with HIV in 2006.[17] 2016 figures show that up to over 42,000,000 people are living with HIV.[18] Available data shows a high HIV prevalence rate among IDUs, in some countries averaging up to 48% as is the case in Estonia and over 28% in Philippines and Indonesia.[19] UNAIDS also captures data related to such viral infections as hepatitis among IDUs, which in Azerbaijan stands at 7.3%, almost being the same HIV prevalence of 8.5% for this group of people.

Hunt and Stevens have aptly captured the broad policy purposes of focusing harm reduction on the HIV/AIDS problems:

Public attention and resources may have been focused on HIV/AIDS because of concerns of its spread from drug users to the wider population ... However, the harm reduction policies that arose from this concern assumed that coercion was unlikely to change health behaviour. Instead of attempting to force drug injectors to stop sharing their equipment, for example, they were given the information and facilities necessary to do so, and enabled to take up these services voluntarily. With HIV/AIDS, injecting drug users were considered to be at risk of harm, with the indirect consequence of harm to non-drug users. As the concern shifts to crime, drug users are no longer seen as being harmed (there is very little attention given to the criminal victimisation of drug users), but as harming non-drug users.[20]

With HIV/AIDS, injecting drug users were considered to be at risk of harm, with the indirect consequence of harm to non-drug users.

Family Health International (FHI),[21] a non-profit public health organization that manages research and field activities in more than 70 countries, provides information on HIV prevention and treatment. One FHI publication is a compendium on assessment tools (Behavioral Surveillance Surveys) where one can find instruments that assess HIV behavioral risk and evaluate harm reduction programs focused on HIV prevention.[22] By 2000, in the United Kingdom, it was being reported that harm reduction strategies such as needle exchange and methadone maintenance had succeeded in reducing the transmission of infectious diseases, including HIV and

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17 United Nations Program on HIV/AIDS (UNAIDS) and the World Health Organization (WHO) (2006) AIDS Epidemic Update: December 2006. http://www.unaids.org/en/HIV_data/epi2006/default.asp.

18 See http://aidsinfo.unaids.org/.

19 As above.

20 N Hunt & A Stevens 'Whose Harm? Harm Reduction and the Shift to Coercion in UK Drug Policy' 3(4) *Social Policy and Society* (2004) 334 - 335.

21 FHI; http://www.fhi.org

22 See http://www.fhi.org/en/HIVAIDS/pub/guide/bssguidelines.htm.

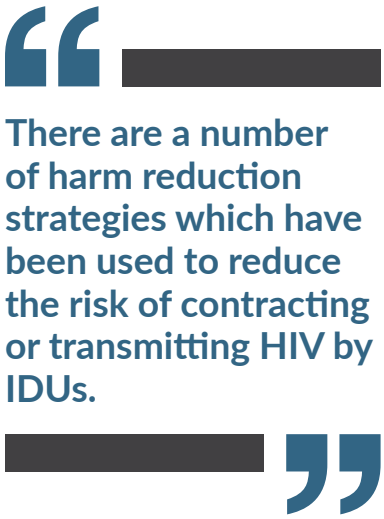
hepatitis C.[23] It was also reported that voluntary drug treatment, which included abstinence based as well as substitute prescribing has also reduced the criminality of the people who went through this treatment.[24]

Costigan, Crofts and Reid have given a list of some of the most effective principles for working with IDUs to prevent HIV infections.[25] These include the following:

- Have a non-judgmental attitude
- Emphasise the drug user's ability to care for himself or herself
- Use short-term pragmatic goals and a scale of behaviors to achieve the goals
- Provide information about the transmission of HIV, its prevention, and its connection with risk behaviors
- Focus on concrete risk behaviors and connect those with the individual's reality (his/her own risk behaviors)
- Provide different options to reduce the risk of infection
- Provide a supportive environment (professionals, family, peers among others)
- Have a team of experienced professionals involved in designing and implementing harm reduction programs and strategies.

There are a number of harm reduction strategies which have been used to reduce the risk of contracting or transmitting HIV by IDUs. These include drug substitution, needle and syringe programmes, and HIV counselling and testing.

Drug substitution has included substituting non-injecting drugs for the injected substance. This is in addition to switching users from "black market" drugs to legal drugs dispensed under the care of a health professional. The effect of this is that it reduces the risk of overdose and other medical complications. Drug substitution also helps to reduce crime and drug users' high-risk behaviours since it reduces the urgency of acquiring the drug. Yet, it allows health professionals to keep in contact with drug users, which aids in keeping them in treatment and thereby reduces relapse.



Needle and syringe exchange programmes include strategies to prevent the sharing of injecting equipment and strategies for the safe disposal of non-sterile injecting paraphernalia.[26] The following are some of the actions that could characterise the needle and syringe exchange strategies:

- Raising awareness and knowledge of the risk of contracting infectious diseases through injecting drug use
- Providing information and advice on the steps to inject safely
- Providing sterile injecting equipment, if possible
- Providing pragmatic information on how to disinfect needles, syringes, and other equipment
- Providing safe disposal for non-sterile injecting equipment or
- Providing pragmatic steps on how to dispose of non-sterile equipment

Voluntary HIV counselling and testing also plays are big role as part of harm reduction. Timely discovery of HIV infection is critical. This will help in the timely discovery of infections and ensuring that those found positive are put on antiretroviral drugs, which improves their quality of life and reduces the risks of transmission. Those found negative would be counselled

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23 Hunt & Stevens (n 20 above) at 335.

24 As above.

25 G Costigan, N Crofts & G Reid *Manual for Reducing Drug Related Harm in Asia. Melbourne, Victoria, Australia:* (2003). The Centre for Harm Reduction.

26 United Nations Office on Drugs and *Crime Harm Reduction*, n 14 above.

on how to stay negative. They could be educated on risk behaviours, including unsafe needle use and sharing, using condoms, reducing the number of sexual partners or being faithful to one partner, treating sexually transmitted diseases, and abstinence.

4. Harm Reduction and the Law in Uganda

In the HRAPF & UHRN Report,[27] the rationale for the Study that resulted into the Report was to interrogate the Narcotic Drugs and Psychotropic Substances (Control) Act (NDPSCA), in terms both of its provisions and the manner and extent to which they have been enforced thus far. This was done as a means of assessing the degree to which this Act and the broader regulatory regime for drug use in Uganda adequately takes into account the rights of persons who use drugs. One of the aims of the study was to make a preliminary assessment of the links between laws criminalising drug use and access to healthcare and rehabilitation services as well as the spread/prevention of HIV.

Among others, the Report of the Study puts in context the history of the regulation of drug use and how the regulatory movement and legal framework has evolved at a global level as well as in Uganda.[28] In the case of Uganda, concrete steps towards establishing a regulatory legal framework is traced to the 1971 Pharmacy and Drugs Act, which mainly dealt with manufacture, export, import, storage, supply and use of drugs and poisons for the pharmacy profession. The 1971 Act was repealed in 1993 and replaced with the *National Drug Policy and Authority Statute of 1993*.[29] It is indicated that the aim of this Act was "to ensure the availability, at all times, of essential, efficacious and cost-effective drugs to the entire population of Uganda, as a means of providing satisfactory health care and safeguarding the appropriate use of drugs".[30]

> **Timely discovery of HIV infection is critical. This will help in the timely discovery of infections and ensuring that those found positive are put on antiretroviral drugs, which improves their quality of life and reduces the risks of transmission.**

Although not clearly elaborated in the Report, it is clear from the laws above that the approach to narcotics and other psychotropic substances was to deal with them under the law regulating medicines and drugs generally and the pharmacy business and profession. For instance, under the 1993 Act, the subject of narcotics and psychotropic substances is dealt with under Part VI of the Act which contains only 3 lonely provisions. Section 47 prohibited the possession of any narcotic drug or psychotropic substance under international control. Section 48 criminalised the smoking of opium or Indian hemp. Section 49 prohibited the cultivation without authorisation from the Minister of any plant from which narcotics could be extracted. The punishment for these offences were prescribed in section 60, ranging from fines of up to UGX 2,000,000 to imprisonment of up to two years.

The conclusion drawn by the HRAPF and UHRN study is that:

It is evident, from this historical overview of the regulation of drug use in Uganda that, like many other punitive regimes in the country, the criminalization of drug use did not originally arise out of an organic or democratic process, but was rather initially imposed upon the peoples of Uganda by the United Kingdom, which colonised this territory. Nonetheless, at the very least since the passage of the 1971 Pharmacy and Drugs Act, the country ought to have taken stock of the best available evidence in crafting an appropriate legal and policy regime for addressing

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27 HRAPF, n 1 above.

28 HRAPF (n 1 above) 25-33.

29 Chapter 206, Laws of Uganda.

30 See Long Title to Act.

Source: freepik.com

> **... like many other punitive regimes in the country, the criminalisation of drug use did not originally arise out of an organic or democratic process, but was rather initially imposed upon the peoples of Uganda by the United Kingdom, which colonised this territory.**

the challenge of drug use while respecting the rights of PWUDs. In particular, the State ought to have been more critical, having regard to the antecedents of drug prohibitions in the United Kingdom and similar countries, to ensure that drug law and policy in Uganda did not unwittingly lead to the illegitimate marginalisation and criminalisation of a significant number of the country's citizens.[31]

The need to review the law relating to narcotics and psychotropic substances became apparent as drug abuse with all its negative consequences was perceived to be on the rise. In addition, Uganda was noticed to have become a transit route for smugglers of drugs from a number of countries especially Latin America, to such places as Europe. The opinion of law enforcement was that the regulatory framework was weak, characterised by penalties which were not punitive enough.[32] In 2014, the Director of the Criminal Investigations Directorate of the Uganda Police Force is quoted while referring to smugglers of narcotics that "[i]f our laws were like those of Kenya where they are fined thrice the market value of contraband, they would feel the pinch".[33] It is on account of sentiments like these that a specialised law to deal with narcotics and psychotropic substances was enacted in 2015 as the NDPSCA. The aim of the Act is as indicated in the Long Title:

> An Act to consolidate and amend the law relating to narcotic drugs and psychotropic substances in respect of the control of the possession of, trafficking in narcotic drugs and psychotropic substances and cultivation of certain plants; to provide for the forfeiture of property derived from or used in illicit traffic in narcotic drugs and psychotropic substances; to implement the provisions of international conventions on narcotic drugs and psychotropic substances; and for other related matters.

The architecture of the Act is as summarised in the HRAPF and UHRN Report. The Act has eight parts: i) Part 1 (with three sections) relates to preliminary matters; ii) Part 2 (with sixteen sections) deals with the prohibition of the possession of, and trafficking in, narcotic drugs and psychotropic substances and prohibition of cultivation of certain plants; iii) Part 3 (with

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[31] HRAPF (n 1 above) 32-33.

[32] See H Abdallah 'Uganda plans tough laws for drug traffickers' *The East African* 29th November 2014.

[33] A Bagala 'New law blocks narcotics route through Uganda' *Daily Monitor* 11th April 2017.

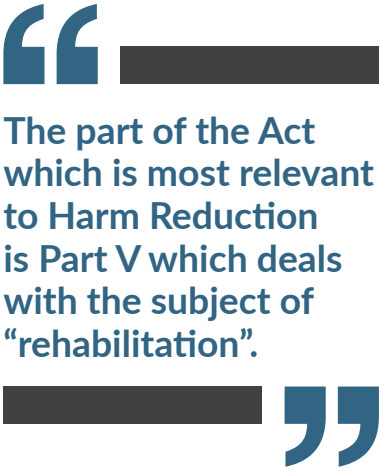
two sections) provides for the forfeiture of narcotic drugs, psychotropic substances, implements and conveyance; iv) Part 4 (with 29 sections) provides for restraint orders, forfeiture of property and proceeds of crime; v) Part 5 (with 8 sections) provides for rehabilitation; vi) Part 6 (with 6 sections) provides for international assistance in drug investigations and proceedings; vii) Part 7 (with 8 sections) establishes a National Coordination Committee for Drug Control and viii) Part 8 (with 21 sections) deals with miscellaneous matters.[34]

A reading of the 2015 Act shows that it cracks the whip, with stiffer penalties that make penalties under the 1993 Act a "big joke". The offences are expanded in elaborate provisions and the penalties for possession, use, cultivation and trafficking moving to UGX 10,000,000 and imprisonment in some cases up to 25 years. For offences of trafficking, fines could go to as far as three times the market value of the drug or substance. The powers of the courts are expanded in elaborate provisions to include among others forfeiture of property and restraint orders.[35] Part VIII is also extensive as far as creating offences is concerned, including offences committed by corporate bodies where there is evidence of consent or connivance by officials in the commission of an offence under the Act as well as neglect in this regard.[36]

[34] HRAPF (n 1 above) 37.

[35] Sections 22 - 50.

[36] Section 73.



The part of the Act which is most relevant to Harm Reduction is Part V which deals with the subject of "rehabilitation".

The part of the Act which is most relevant to Harm Reduction is Part V which deals with the subject of "rehabilitation". This Part in section 52 empowers the Minister to establish rehabilitation centres, whose functions are to provide care, treatment and rehabilitation of persons addicted to narcotics and psychotropic substances.[37] A Rehabilitation Fund is established,[38] as well as a Board to manage the Fund.[39] The Minister is also authorised to establish an Advisory Committee for the Rehabilitation of Narcotics Addicts.[40]

The biggest shortcoming with Part V of the Act is that it deals with the subject of harm reduction in a minimalist manner, yet it still places it within the criminal justice system. The benefit of rehabilitation is only available to those who have been convicted of an offence and adjudged to be addicts. Yet, the benefit is not available to those in respect of whom it is showed that possession of the drug or substance was not only for personal use.[41] The provisions on rehabilitation are worth quoting in *extenso*:

[37] Section 52(2).

[38] Section 53.

[39] Section 54.

[40] Section 56.

51. Interpretation

In this Part, unless the context otherwise requires —

'centre' means rehabilitation centre established under Section 52;

'Committee' means the Advisory Committee of the Rehabilitation of Narcotic Addicts

appointed under section 56;

'Fund' means the Rehabilitation Fund established under section 53;

'Minister' means Minister responsible for health

52. Rehabilitation centres

(1) The Minister may establish centres to be known as rehabilitation centres.

(2) The object of the centre is to provide care, treatment and rehabilitation of persons addicted to narcotic drugs and psychotropic substances.

58. Committal of persons to

[41] Section 58(1).

centres

(1) A court which convicts any person for an offence under this Act may, if it is satisfied that that person is addicted to a narcotic drug or psychotropic substance and that he or she is in possession of a narcotic drug or psychotic substance only for his or her personal consumption, order that a part of the period of imprisonment imposed on him or her be spend in a centre specified by the court.

(2) The court, may, on the application of the Attorney General or the convicted person, vary or revoke the order, made under subsection (1).

(3) Where, on the report of the officer in charge of a centre to which a convicted person is committed under subsection (1), the court which committed him or her to the centre is satisfied that the convicted person has successfully undergone the treatment and rehabilitation program of the centre and that he or she is no longer an addict, the court may, having regard to all circumstances of the case, grant remission of the whole or part of the remaining period of imprisonment imposed on a convicted person.

It is obvious that the provision is problematic from a number of perspectives. These could be summarised as below:

- The provisions exclude drug users who have not interacted with the criminal justice system. Yet, it could be the case that only a small proportion of drug users get the "chance" to interact with the criminal justice system. Indeed, all drug users would do whatever is within their powers to avoid falling into the cracks of the criminal justice system.
- The provision leaves out those who are not considered to be "addicted". Unfortunately, the provision does not give proper guidance on how "addiction" is determined. The Act itself does not give a satisfactory definition of "addiction". All that section 2 of the Act defines is "addict" to mean "a person addicted to any narcotic drug or psychotropic substance". This definition is not useful at all. Additionally, it is assumed that those who are not "addicts" may not require some form of assistance.
- The diversion to a rehabilitation centre is by order of court. There is no consent requirement on the part of the convict. The convict has no choice to decide whether or not to submit to the treatment or rehabilitation. From a point of ethics, it raises issues of consent to treatment. Yet, consent may have a big bearing on the success of the treatment of rehabilitation.
- The approach adopted by the provisions assumes that treatment and rehabilitation will be a success. What happens then when the treatment or rehabilitation fails and the sentence is over? What options exist to help the person and society? Based on section 58(1) and (2), does it mean that the person who is considered to still be an addict will continue in rehabilitation as long as they remain addicts? For how long would this be? What happens then in respect of the injurious conduct of the person to him/herself and society?
- The provisions do not define the terms "care", "treatment" and "rehabilitation". This gives rise to the question of what these entail exactly. A reading of the provision appears to suggest that purposes of the committal is ending the addiction. Yet, the use of the terms "care" and "treatment" could be conceptualised to include harm reduction strategies. The problem though is that harm reduction strategies may not necessarily end the addiction. As already seen, these strategies largely deal with minimising the adverse effects of drug use.

5. The proposed reforms

Based on the above, there is certainly need to review the law if harm reduction is to be promoted and the above shortfalls overcome. Specifically, the NDPSCA needs to be reviewed. In a broader manner, the approach adopted that the drug problem has to be dealt with through criminalisation across the board needs to be reviewed. It is on the basis of this that in their Report, HRAPF and UHRN propose law reforms that would focus among others on decriminalising drug use and de-linking rehabilitation and health services to PWUDs from the criminal process under the NDPSCA.[42]

It should be noted however that as much as decriminalisation is ideal and would create the right environment for the promotion of harm reduction, it may be hard to realise at this stage. This is because of the politics and the justifications that were advanced to adopt the NDPSCA, which focused mainly on promulgating stiffer penalties. Indeed, at the moment the global approach appears so much focused on criminalisation. For these reasons, decriminalisation requires a long term campaign and sustained advocacy that would only bear fruits after some time. However, in the short-term, efforts to urge government to de-link rehabilitation from the criminal process may not face so much resistance. The only challenge though is that it may be a tedious task to convince government and the legislature to amend the NDPSCA, an Act that is barely two years old. Indeed, even the proposals associated with rehabilitation have to be measured and kept to the minimum, to avoid appearing like one is proposing radical changes.

To achieve the object, the proposals for reform should focus on the following changes:

i. Ensure that care, treatment and rehabilitation is available even to those outside the criminal justice system. Yet, even for those already in the system, to consider care, treatment and rehabilitation as a form of *diversion* in ways which among others avoid a conviction and punishment.

ii. Define "care", "treatment" and "rehabilitation" in ways that embrace the different harm reduction strategies.

iii. Ensure that care, treatment and rehabilitation is based on consent and the full participation of the affected person.

To realise the above objectives of reform requires a review of Part V of the NDPSCA. The provisions of this part that need revision include:

Section 51: Interpretation - to include definitions of the terms "care", "treatment" and "rehabilitation" in ways that embrace the different approaches used in harm reduction.

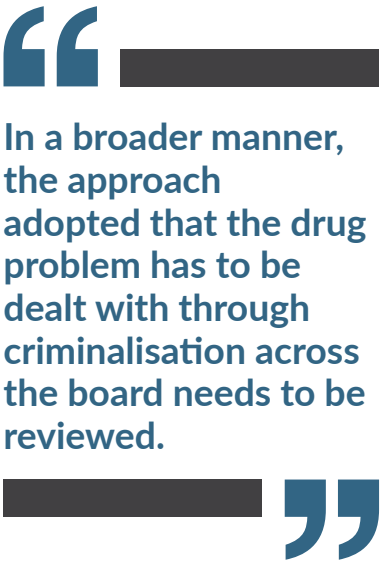
Section 52: Rehabilitation centres - to allow private actors licensed by the Minister to operate rehabilitation centres

Section 53(5): Rehabilitation Fund - to give private rehabilitation centres the right to benefit from the Fund

Section 58: Committal of persons to Centre - De-link care, treatment and rehabilitation from criminal justice system and allow those outside the system to benefit, while diverting those in system. This is in addition to including a requirement of consent to care, treatment and rehabilitation.

6. Conclusion

HRAPF calls upon the responsible ministries and members of Parliament to come up with an amendment to the Act that would reflect the changes above if the harm reduction model is to take root in Uganda.



[42] HRAPF (n 1 above) 77.

"My friends died as victims of HIV/AIDS which they contracted through sharing and re-using syringes and needles. Often we hide them to avoid others using them and police arrests from carrying them. We want clean needles and safer disposal of needles to save our lives - we are dying in silence."

Needles and Syringe Programmes (NSPs) reduces the risks of HIV transmission by providing clean needles and safe disposal to people who inject drugs.

The Government should embrace and roll out NSPs to end HIV/AIDS with us.

Embrace NSP

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"In the drug dens, sharing needles is common. We would buy X grams of heroin in a group of 3 or 4, prepare the needle then share it between us. The person who paid the most would inject first and so on. The last person might just be injecting blood. Since the Needle and Syringe Programme (NSP) came to the community, we now have clean needles and no longer have to share them. I have even been able to test for HIV and learn my status, which I didn't even know when I was sharing."

The sharing of needles between drug users is one of the biggest causes of HIV transmission amongst people who inject drugs.

Every clean needle and syringe provided through NSPs saves a life.

The Government must roll out NSPs nationally if we are to achieve their commitment to the 2019- 2020 goals of zero new HIV infections and zero new HIV/AIDS related deaths.

© Kenneth 2018 | PhotoVoice | International HIV/AIDS Alliance | PITCH | Uganda

HRAPF's PROPOSED BILL ON HARM REDUCTION

Narcotics Drugs and Psychotropic Substances (Amendment) Bill, 2017 As proposed by Human Rights Awareness and Promotion Forum (HRAPF)

14th November 2017

Drafted by Prof. Christopher Mbazira

Memorandum

1. The objective of this Bill is to reform the law relating to the care, treatment and rehabilitation of users of narcotic drugs and psychotropic substances with a view of dealing with the consequences of drug use to individuals and the community.

2. This Bill is a product of reviews of the Narcotic Drugs and Psychotropic Substances (Control) Act of 2015. The review, done by Human Rights Awareness and Promotion Forum and the Uganda Harm Reduction Network, revealed that the Act links care, treatment and rehabilitation of drug users to the criminal justice system by requiring that only those convicted of drug use could be committed to rehabilitation centres.

3. The implication of the approach taken by the Act in section 58 is that it excludes persons who are not going through the criminal justice system from accessing care, treatment and rehabilitation. The care, treatment and rehabilitation is only available to those who are convicted of personal drug use and adjudged "addicts". One problem though is that the Act does not adequately define who an addict is, as well as what constitutes care, treatment and rehabilitation.

4. This Bill is intended to promote strategies that deal with the problem of drug use by embracing approaches that decrease the negative effects of drug use on individuals and the community in general. One such effect of drug use is the impact on the health of users as well as the community. For instance, research shows that drug use is associated with the prevalence of HIV/AIDS and such infections as hepatitis are rising from unsafe use of injections and syringes by drug users through needle and syringe sharing. Drug users also engage in risky behaviours such as unsafe sex. Yet, prevalence among drug users automatically increases prevalence among the general population.

5. On the basis of the above, this Bill seeks to amend Part V of the Narcotic Drugs and Psychotropic Substances (Control) Act to promote care, treatment and rehabilitation.

6. Research shows that rehabilitation, care and treatment help stem the spread of infections by among others promoting safe use of injections, providing treatment and education to drug users.

7. In particular, the Bill seeks to amend the following sections of the Narcotic Drugs and Psychotropic Substances (Control) Act:

Section 51: Interpretation - to include definitions of the terms care, treatment and rehabilitation in ways that embrace the different approaches used in harm reduction.

Section 52: Rehabilitation centres - to allow private actors licensed by the Minister to operate rehabilitation centres

53(5): Rehabilitation Fund - to give private rehabilitation centres the right to benefit from the fund

58: Committal of persons to Centre - De-link care, treatment and rehabilitation from criminal justice system and allow those outside the system to benefit, while diverting those in the system. This is in addition to including a requirement of consent to care, treatment and rehabilitation.

A Bill for an Act ENTITLED

Narcotic Drugs and Psychotropic Substances (Control) Amendment Act

An Act to reform the law relating to narcotic drugs and psychotropic substances with a view of promoting the care, treatment and rehabilitation of drug users.

1. Commencement

This Act shall come into force upon publication in the Gazette.

2. Amendment of Section 51 of the Narcotic Drugs and Psychotropic Substances (Control) Act

Section 51 of the Narcotic Drugs and Psychotropic Substances (Control) Act is deleted and replaced with the following new section:

51. Interpretation

In this Part, unless the context otherwise requires —

'Care' means the range of measures taken to address the adverse effects arising from the use of narcotic drugs and psychotropic substances on users and helping users address, deal with and manage the health, psychological and social consequences of drug use.

'Centre' means rehabilitation centre established under Section 52;

'Committee' means the Advisory Committee of the Rehabilitation of Narcotic Addicts appointed under section 56;

'Fund' means the Rehabilitation Fund established under section 53; 'Minister' means Minister responsible for health

'Rehabilitation' means the processes of medical or psychotherapeutic treatment for dependency on psychoactive drugs and with the general intent of enabling the patient to cease substance abuse, in order to avoid the psychological, legal, financial, social, and physical consequences that can be caused by abuse.

'Treatment' means the range of medical and psychotherapeutic measures intended to address the health effects of drug use.

3. Amendment of section 52 of the Narcotic Drugs and Psychotropic Substances (Control) Act

Section 51 of the Narcotic Drugs and Psychotropic Substances (Control) Act is amended by adding subsections (3) and (4) in the following terms:

(3) With the exception of Government run centres, no person shall run a centre without a valid licence issued by the Minister.

(4) The Minister shall make regulations for the purpose of regulating the procedures of licensing and managing of private centres.

4. Amendment of section 53 of the Narcotic Drugs and Psychotropic Substances (Control) Act

Section 53 of the Narcotic Drugs and Psychotropic Substances (Control) Act is amended by replacing the phrase "current" in sub-section (5) with the term "recurrent" and adding subsections (6) and (7) in the following terms.

(6) Private centres shall have the right to access the Fund to meet their capital and recurrent expenditures.

(7) The Board as established under section 54 shall determine the modalities for private centres to access the Fund.

5. Amendment of section 58 of the Narcotic Drugs and Psychotropic Substances (Control) Act

Section 58 of the Narcotic Drugs and Psychotropic Substances (Control) Act is deleted and replaced with the following new section.

58. Access by persons to centres

(1) The centres shall be open to users of narcotic drugs or psychotropic substances in need of care, treatment or rehabilitation who will be admitted based on expression of interest and consent, taking into account the capacity and facilities at the centre.

(2) A court which tries a person for offences related to use of narcotic drugs or psychotropic substances may, on its own motion or upon application by the accused person, discontinue the trial and commit the accused person to a centre for care, treatment or rehabilitation. Such committal shall only proceed upon the consent of the accused person, in the absence of which the trial shall continue.

(3) Before committal to a centre of a person under subsection (2) above, the court shall satisfy itself that there is a centre willing to receive and prepared to care for, treat or rehabilitate the accused.

(4) The committal will be on such terms and conditions as the court may determine.

(5) The Police shall before charging any person arrested for use or possession of a narcotic drug or psychotropic substance take steps to determine the appropriateness of referring the persons so arrested to a centre for care, treatment or rehabilitation. Before making such referral, the Police will obtain a report from an officer in a charge of a centre indicating willingness to admit such person to a programme of care, treatment or rehabilitation. No person shall be admitted to a centre without their consent.

(6) Subsection (5) shall not apply to persons found in possession of a narcotic drug or substance for trafficking purposes.

(7) The Minister shall elaborate protocols for care, treatment and rehabilitation at the centres.

ABOUT HRAPF

Background

Human Rights Awareness and Promotion Forum is a voluntary, not for profit, and non-partisan Non-Governmental Organisation. HRAPF works for the promotion, realisation, protection and enforcement of human rights through human rights awareness, research, advocacy and legal aid service provision, with a particular focus on minorities and disadvantaged groups. It was established in 2008 with a vision of improving the observance of human rights of marginalised persons in Uganda.

Legal Status

HRAPF is incorporated under the laws of Uganda as a company limited by guarantee.

Vision

A society where the human rights of all persons including marginalised persons and Most at Risk Populations are valued, respected and protected.

Mission

To promote respect and protection of human rights of marginalised persons and Most at Risk Populations through enhanced access to justice, research and advocacy, legal and human rights awareness, capacity enhancement and strategic partnerships.

HRAPF's Objectives

1. To create awareness on the national, regional and international human rights regime.
2. To promote access to justice for marginalised persons and Most at Risk Population groups.
3. To undertake research and legal advocacy for the rights of marginalised persons and Most at Risk Population groups.
4. To network and collaborate with key strategic partners, government, communities and individuals at national, regional and international level.
5. To enhance the capacity of marginalised groups, Most at Risk Populations and key stakeholders to participate effectively in the promotion and respect of the rights of marginalised persons.
6. To maintain a strong and vibrant human rights organisation.

Our target constituencies

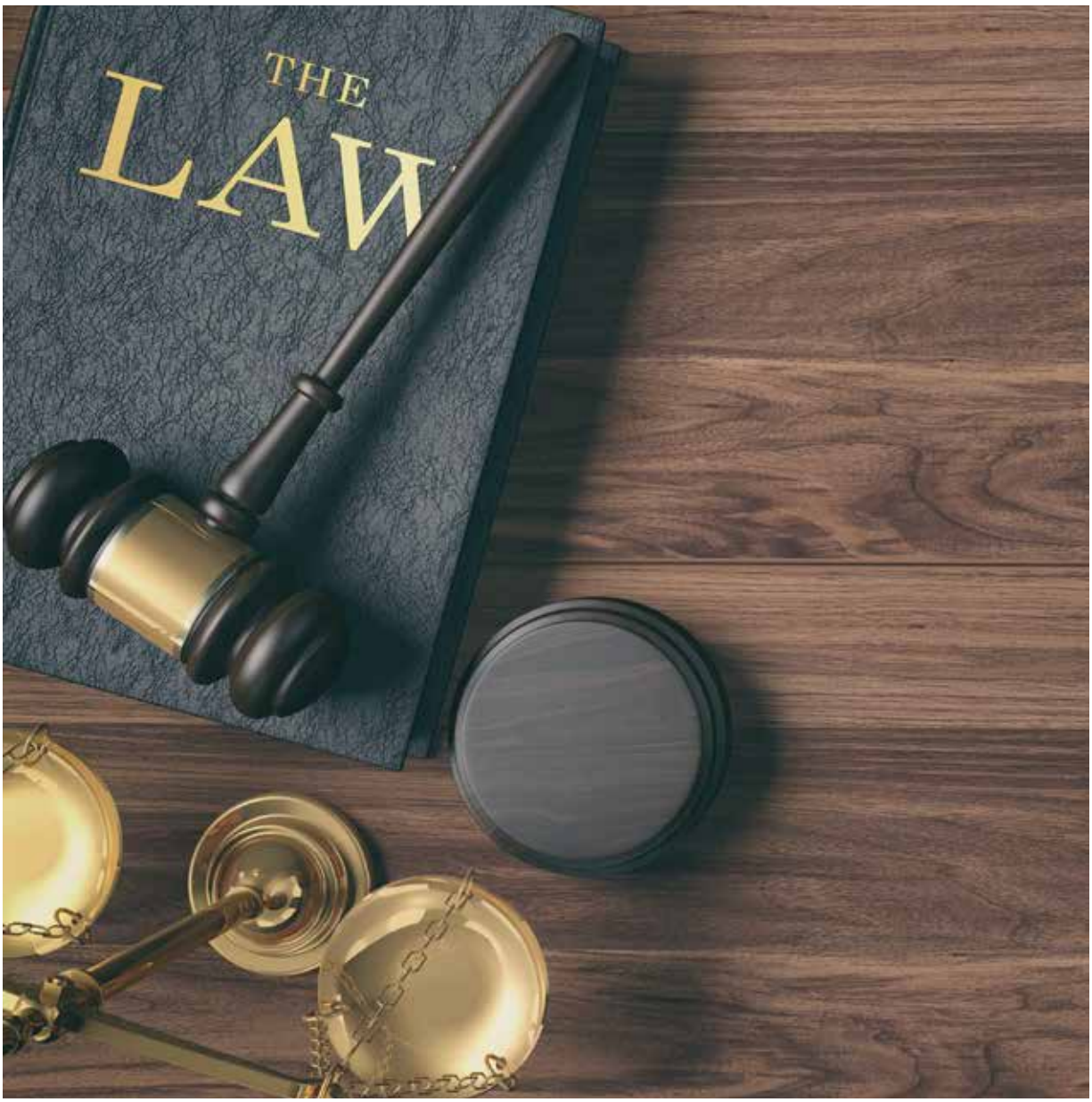
1. Lesbian, Gay, Bisexual and Transgender (LGBT) persons
2. Intersex Persons
3. Sex Workers
4. Women, girls and service providers in conflict with abortion laws
5. People who use drugs
6. People Living with HIV and TB (PLHIV/TB)
7. Poor women, children and the elderly with land justice issues

HRAPF Values

- Equality, Justice and Non-Discrimination
- Transparency, Integrity and Accountability
- Learning and Reflection
- Quality and Excellence
- Teamwork and Oneness
- Passion and Drive
- Networking and Collaboration

Slogan

Taking Human Rights to all



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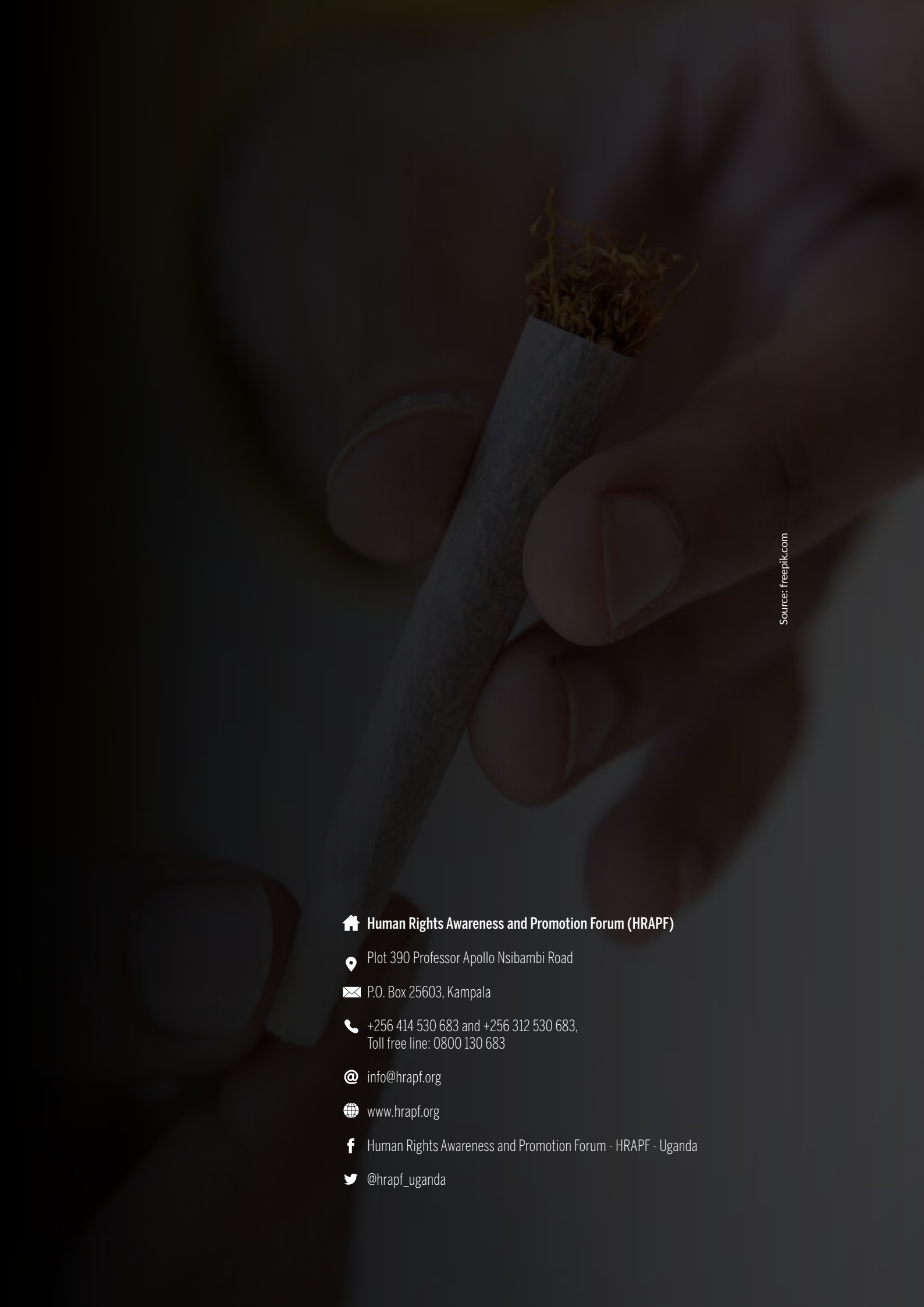

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