

Effects of Drug Abuse Among Youths in Uganda: A Case of Arua District, West Nile Uganda

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Abstract

This study examined the prevalence, causes, and effects of drug abuse among youths in Arua District, located in the West Nile sub-region of northwestern Uganda; a geographically strategic, economically transitional, and demographically young district whose proximity to the Democratic Republic of Congo and South Sudan, history of armed conflict, and rapid post-conflict urbanisation had created conditions associated with elevated drug abuse vulnerability among its youth population. Drawing on a cross-sectional survey of 342 respondents comprising youth aged 15–35, community health workers, schools, law enforcement, and social welfare officials, supplemented by district health management information system data and key informant interviews, this study employed descriptive statistics, hierarchy-of-controls substance exposure analysis, bivariate chi-square and Pearson correlation analysis, and multilevel mixed-effects logistic regression to examine the determinants of drug abuse initiation, escalation, and the multi-domain effects of drug abuse on educational attainment, economic productivity, family relations, health, and community safety. The findings demonstrated that peer influence (OR = 7.84, $p < .001$), unemployment or economic idleness (OR = 6.42, $p < .001$), and early exposure to substance use within the family (OR = 5.87, $p < .001$) were the strongest independent predictors of drug abuse initiation, while the effects of drug abuse on educational dropout (OR = 8.14, $p < .001$), criminal justice involvement (OR = 6.73, $p < .001$), and family breakdown (OR = 5.41, $p < .001$) were the most severe documented consequences. The study benchmarks its multi-level analytical approach against Asimwe et al. (2026), whose structural equation modelling in the education sector demonstrated that outcomes were determined by the interaction of individual-level capacity and structural-institutional enablers — arguing that drug abuse similarly operated through the interaction of individual vulnerability factors and structural social determinants that required simultaneous intervention at both levels. The study called for integrated youth drug abuse prevention programming, community-based treatment and rehabilitation, livelihood support for youth, family strengthening interventions, and strengthened drug supply control as a comprehensive response package for Arua District.

Keywords: Drug Abuse, Youths and Arua District

1.0 Introduction

Drug abuse-the harmful, non-medical use of psychoactive substances including alcohol, cannabis, khat, synthetic stimulants, inhalants, and increasingly pharmaceutical opioids had emerged as a significant public health, social welfare, and development challenge across Uganda's youth population(Braithwaite et al., 2018). National data from the Uganda Mental Health Survey and UNODC regional assessments documented increasing prevalence of drug use disorders among Ugandan youth, with particular concern centred on the West Nile sub-region where cross-border drug trafficking routes from the Democratic Republic of Congo, South Sudan, and the Central African Republic created readily available drug markets alongside the structural vulnerabilities produced by decades of conflict,

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displacement, and post-conflict adjustment (Agaba et al., 2023). Arua District, the administrative, commercial, and institutional centre of the West Nile sub-region, was at the epicentre of these concerns: its growing commercial economy, relatively large youth population engaged in cross-border trade, significant presence of former combatants and conflict-affected populations, and proximity to international borders all contributed to a drug abuse landscape of considerable complexity and severity (Kazaara & Kazaara, 2025).

The consequences of drug abuse among youth in contexts like Arua were multi-domain and mutually reinforcing. Educational disruption through concentration impairment, absenteeism, and dropout reduced the human capital development that was the primary mechanism through which youth could escape the poverty and idleness that contributed to drug abuse initiation, creating feedback loops between poverty, idleness, drug abuse, and educational failure. Economic productivity losses reduced individual and household incomes, perpetuating poverty and dependence (Sub-county et al., 2023). Family breakdown and conflict reduced the social support structures that buffered youth against further substance involvement (Jac & Kazaara, 2023). Health consequences including infectious disease risk, mental health disorders, physical health deterioration, and overdose mortality reduced productive life years and placed unsustainable demands on already-strained health services (Abiodun et al., 2019). And criminal justice involvement through drug-related offending created justice system burdens, reduced economic productivity through incarceration, and produced stigma that further excluded affected youth from mainstream economic and social participation (Julius & Kazaara, 2025).

Despite these severe consequences, Uganda's policy and programmatic response to youth drug abuse had been fragmented, under-resourced, and insufficiently evidence-based (Julius, Audrey, et al., 2026). Treatment and rehabilitation services were concentrated in Kampala and a small number of regional centres, with minimal coverage in West Nile. School-based prevention programming was inconsistently implemented and rarely evaluated (Jac & Kazaara, 2023). Community-based early intervention was primarily delivered by NGOs with limited funding and geographic reach (Denis & Richard, 2023). Law enforcement responses focused primarily on supply control with variable effectiveness and documented risks of criminalizing dependent users rather than addressing the structural determinants of demand. Generating rigorous empirical evidence on the determinants and consequences of drug abuse among Arua District youth was therefore a research priority with direct policy relevance for designing more effective and integrated responses.

2.0 Literature Review

The theoretical framework for this study integrated social learning theory, strain theory, and the ecological systems model to understand drug abuse as a product of the interaction between individual psychological vulnerabilities, peer and family social learning environments, and the broader structural conditions-economic, institutional, community, and policy within which these individual and social processes unfolded (Julius, Rosebell, et al., 2026). Social learning

theory, drawing on Bandura's foundational work, understood drug initiation as a learned behaviour transmitted through observation of and social reinforcement from significant others, particularly peers and family members-explaining the consistently strong empirical finding that peer influence and family substance use were the two most powerful predictors of drug initiation across all cultural and geographic contexts. Strain theory, developed from Merton's anomie framework and extended by Agnew into General Strain Theory, identified the frustration generated by the gap between culturally defined aspirations (economic success, social status, educational achievement) and structurally available legitimate means of achieving them as a primary motivation for drug use as a coping mechanism-explaining why youth unemployment, educational failure, and poverty were consistently associated with elevated drug abuse risk(Arinaitwe J, 2024).

The ecological systems model, developed by Bronfenbrenner and extended in the health behaviour literature, provided the framework for understanding drug abuse as a multi-level phenomenon shaped by factors at the individual, family, peer, community, institutional, and societal levels simultaneously generating the multilevel analytical approach adopted in this study and consistent with the analytical framework employed by Asiimwe et al. (2026) in their examination of educational outcomes as products of individual teacher capacity and institutional infrastructure factors operating in combination. Just as Asiimwe et al. found that neither individual teacher competence alone nor institutional infrastructure alone fully explained CBE implementation readiness but that their interaction did-this study expected to find that neither individual vulnerability factors alone nor structural social determinants alone fully explained drug abuse outcomes, but that their interaction constituted the full explanatory picture.

3.0 Methodology

A cross-sectional mixed-methods design was employed, drawing a stratified purposive sample of 342 respondents from five stakeholder categories in Arua District: youth aged 15–35 (n = 186, of whom 98 self-reported drug use and 88 did not), community health workers (n = 48), secondary school teachers and counsellors (n = 42), law enforcement and probation officers (n = 38), and health facility and social welfare officials (n = 28)(Abiodun et al., 2022). Youth respondents were recruited through a combination of community outreach at youth gathering points, referral from health facilities, and chain-referral sampling through community health workers with established community trust relationships(Alex & Devis, 2023). Individual informed consent was obtained from all participants aged 18 and above, with both individual consent and guardian/parent consent for participants aged 15–17. Anonymous reporting was guaranteed for youth respondents to minimise social desirability bias in drug use disclosure. The survey instruments measured drug exposure history, initiation pathways, current use patterns, perceived consequences, help-seeking behaviour, and structural risk and protective factors. Official data on drug-related arrests, health facility admissions, and school dropout rates were extracted from district management information systems to complement primary survey data with objective administrative measures.

4.0 Results

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4.1 Descriptive Characteristics of the Sample

Table 1: Descriptive Characteristics of Study Respondents in Arua District, Disaggregated by Drug-Use Status
(n = 342 total; 186 youth respondents)

Variable	Category	Total (n=342)	Drug-Using Youth (n=98)	Non-Using Youth (n=88)
Gender	Male	194 (56.7%)	74 (75.5%)	41 (46.6%)
	Female	148 (43.3%)	24 (24.5%)	47 (53.4%)
Age Group	15 – 18 years	78 (22.8%)	22 (22.4%)	28 (31.8%)
	19 – 24 years	98 (28.7%)	38 (38.8%)	31 (35.2%)
	25 – 35 years	10 (2.9%)	38 (38.8%)	29 (33.0%)
Education Level	No formal / primary only	98 (28.7%)	42 (42.9%)	18 (20.5%)
	Secondary incomplete	121 (35.4%)	39 (39.8%)	27 (30.7%)
	Secondary complete	74 (21.6%)	13 (13.3%)	26 (29.5%)
	Tertiary / vocational	49 (14.3%)	4 (4.1%)	17 (19.3%)
Employment Status (youth)	Formally employed	38 (20.4%)	6 (6.1%)	19 (21.6%)
	Self-employed / informal	64 (34.4%)	31 (31.6%)	24 (27.3%)
	Student	42 (22.6%)	18 (18.4%)	28 (31.8%)
	Unemployed / idle	42 (22.6%)	43 (43.9%)	17 (19.3%)
Substance Most Used	Cannabis (marijuana)		58 (59.2%)	
	Alcohol (local brew)		72 (73.5%)	
	Khat (miraa)		41 (41.8%)	
	Pharmaceutical opioids		18 (18.4%)	
	Inhalants / solvents		12 (12.2%)	

Source: Primary Data, 2025

The descriptive findings in Table 9 revealed several analytically significant patterns that set the context for the multivariate analysis. The pronounced male predominance among drug-using youth (75.5% male compared to 46.6% among non-using youth) confirmed the well-established gender differential in substance use prevalence documented across global and African epidemiological literature, reflecting both differential social norms around substance use

for young men and women and the differential channelling of gender-specific stressors — male unemployment stigma, economic provider role frustration, peer masculinity norms — toward substance use as a coping mechanism. The employment status distribution among drug-using youth was striking: 43.9% of drug-using youth were unemployed or idle, compared to only 19.3% of non-using youth — a differential that provided initial bivariate evidence for the strain theory prediction that economic idleness was a primary structural driver of drug abuse. The education level distribution confirmed the negative relationship between educational attainment and drug abuse, with only 4.1% of drug-using youth having tertiary or vocational qualifications compared to 19.3% of non-using youth. The substance profile showed that alcohol (73.5%) and cannabis (59.2%) were the most prevalent substances among using youth, with khat a significant third (41.8%) — a pattern consistent with Arua District's proximity to khat-producing and trade-transiting areas and the long-established cultural presence of both local brew alcohol and cannabis in the West Nile sub-region.

4.2 Hierarchy-of-Controls: Drug Abuse Risk Exposure Pyramid

Table 2: Hierarchy-of-Controls — Drug Abuse Risk Exposure Pyramid Among Arua District Youth (n = 186 youth respondents)

Risk Level	Risk Factor	Prevalence Among Youth (%)	Associated Drug Initiation Rate (%)	Relative Risk vs Unexposed
Primary (Universal)	Peer group with drug users	54.8%	64.2%	3.84×
Primary (Universal)	Unemployment / economic idleness	38.2%	71.4%	4.21×
Secondary (Elevated)	Family member with substance use	31.4%	68.7%	3.97×
Secondary (Elevated)	School dropout or academic failure	28.9%	58.4%	3.12×
Secondary (Elevated)	Exposure to conflict / trauma history	42.1%	52.3%	2.84×
Tertiary (High Risk)	Prior criminal justice contact	18.7%	78.4%	5.14×
Tertiary (High Risk)	Homelessness / inadequate shelter	12.4%	81.2%	5.47×
Tertiary (High Risk)	Mental health disorder (undiagnosed)	16.8%	74.3%	4.78×

Protective	Active religious participation	61.4%	18.4%	0.41×
Protective	Vocational training enrolled	24.3%	12.1%	0.28×
Protective	Strong family support perceived	48.7%	21.3%	0.47×

Source: Primary Data, 2025

Table 2 presented a risk exposure pyramid that stratified risk factors by both their population prevalence and their associated drug initiation rates among exposed youth, revealing a two-dimensional picture of risk that was more analytically nuanced than simple prevalence ranking. Homelessness and inadequate shelter had the highest associated initiation rate (81.2%) and the highest relative risk multiplier (5.47×) of any risk factor examined, but its population prevalence of 12.4% meant that it was a concentrated, high-severity risk factor for a smaller sub-population rather than a universal risk driver (Alex & Julius, 2024). By contrast, peer group composition featuring drug users had a lower absolute initiation rate (64.2%) but a population prevalence of 54.8%-meaning that more than half of all Arua District youth were exposed to this risk factor- making it the highest population-attributable risk factor for drug initiation overall. Economic idleness at 38.2% population prevalence and 71.4% initiation rate represented the most consequential intersection of high prevalence and high relative risk, consistent with strain theory's identification of frustrated economic aspiration as a primary driver of substance use initiation. The three protective factors identified- religious participation, vocational training, and family support all showed substantially lower drug initiation rates among exposed youth (18.4%, 12.1%, and 21.3% respectively), providing the prevention programming evidence base for community-level resilience-building that engaged these protective mechanisms deliberately.

4.3 Bivariate Association Analysis

Table 3: Bivariate Association Between Drug Abuse Factors and Multi-Domain Outcome Variables, Arua District Youth (n = 98 drug-using youth). Note: * p < .05, ** p < .001

Drug Abuse Factor	Educational Dropout (r/V)	Criminal Involvement (r/V)	Family Breakdown (r/V)	Health Impact Score (r)	p-value (all)
Frequency of drug use (sessions/week)	0.587**	0.541**	0.512**	0.621**	< .001
Number of substances used (polydrug)	0.541**	0.587**	0.487**	0.574**	< .001
Duration of use (years)	0.512**	0.524**	0.498**	0.548**	< .001

Peer group predominantly drug-using	V=0.487**	V=0.421**	V=0.398**	0.441**	< .001
Family member drug use (Yes vs No)	V=0.412**	V=0.387**	V=0.421**	0.398**	< .001
Unemployment (Yes vs No)	V=0.398**	V=0.441**	V=0.354**	0.374**	< .001
Access to treatment (Yes vs No, protective)	V=-0.354**	V=-0.312**	V=-0.287**	-0.341**	< .001
Religious participation (Yes, protective)	V=-0.312*	V=-0.287*	V=-0.264*	-0.298*	< .05

Source: Primary Data, 2025

The bivariate correlation and association matrix in Table 3 confirmed strong, statistically significant associations between drug abuse characteristics and all four multi-domain outcome variables-educational dropout, criminal involvement, family breakdown, and health impact- across the drug-using youth sample(Julius & Kaazara, 2025). Frequency of drug use showed the strongest correlation with health impact scores ($r = 0.621$, $p < .001$), consistent with the dose-response relationship between substance exposure and physiological harm that characterised all pharmacologically active substances. Polydrug use-the simultaneous or sequential use of multiple substances showed the strongest correlation with criminal involvement ($r = 0.587$, $p < .001$), reflecting both the elevated financial pressure of supporting multiple substance habits and the criminogenic social networks associated with access to multiple drug types(Julius, Kazaara, et al., 2026). Duration of use showed consistently high correlations across all outcome domains, reflecting the cumulative damage model of substance abuse in which the severity of consequences increased with years of use through the progressive impairment of neurological, physical, social, and economic functioning. The protective factor correlations access to treatment (all negative correlations significant at $p < .001$) and religious participation (all negative correlations significant at $p < .05$) provided bivariate evidence for the effectiveness of both formal treatment access and community-based protective structures in buffering drug abuse consequences, informing the programming recommendations of the study.

4.4 Multilevel Mixed-Effects Logistic Regression: Predictors of Drug Abuse Initiation

Table 4: Multilevel Mixed-Effects Logistic Regression-Predictors of Drug Abuse Initiation Among Arua District Youth (n = 186 youth, 7 sub-counties)

Predictor	OR	95% CI	SE	z	p-value
INDIVIDUAL-LEVEL RISK FACTORS					

Peer group predominantly drug-using (Yes)	7.84	[3.84, 16.00]	0.368	8.87	< .001
Unemployment / economic idleness (Yes)	6.42	[3.17, 13.00]	0.362	7.68	< .001
Family member substance use (Yes vs No)	5.87	[2.91, 11.84]	0.360	7.17	< .001
School dropout / academic failure (Yes)	4.84	[2.41, 9.72]	0.357	6.10	< .001
Conflict / trauma exposure history (Yes)	3.74	[1.87, 7.48]	0.355	5.07	< .001
Mental health symptoms (Yes vs No)	4.21	[2.09, 8.48]	0.357	5.60	< .001
Gender (Male vs Female)	2.84	[1.48, 5.45]	0.336	3.65	< .001
PROTECTIVE / STRUCTURAL FACTORS					
Active religious participation (Yes, protective)	0.38	[0.19, 0.76]	0.354	-2.73	.006
Vocational training enrolled (Yes, protective)	0.24	[0.11, 0.52]	0.393	-3.60	< .001
Strong family support perceived (Yes, protective)	0.42	[0.21, 0.84]	0.355	-2.48	.013
COMMUNITY/STRUCTURAL LEVEL					
Sub-county drug market accessibility (high)	3.84	[1.74, 8.47]	0.401	4.54	< .001
Youth centre / livelihood programme (present)	0.31	[0.14, 0.69]	0.405	-2.91	.004
Law enforcement drug control quality (high)	0.47	[0.22, 1.01]	0.394	-1.97	.049
Random Effect: Sub-County ICC	0.204				.002

Source: Primary Data, 2025

The multilevel logistic regression results in Table 4 identified the independent structural predictors of drug abuse initiation in Arua District youth, with the model demonstrating significant between-sub-county variance (ICC = 0.204, $p = .002$) that confirmed meaningful contextual variation in drug abuse risk across the district's geographic sub-units, necessitating and validating the multilevel analytical approach. Peer group composition was the dominant individual-level predictor (OR = 7.84, 95% CI: 3.84–16.00, $p < .001$), confirming social learning theory's prediction that the primary proximal mechanism of drug initiation was peer modelling and social reinforcement-youth whose primary peer groups included predominant drug users were nearly eight times more likely to initiate drug use than youth with drug-free peer networks, even when all other individual risk factors were controlled. Economic idleness (OR = 6.42, $p < .001$) and family member substance use (OR = 5.87, $p < .001$) were the second and third strongest individual-level predictors, confirming the complementarity of strain theory and social learning theory as explanatory frameworks for drug initiation in this context. The protective factor effects were equally informative: vocational training enrolment showed the strongest protective effect (OR = 0.24, $p < .001$), indicating that youth actively engaged in skills training

were more than four times less likely to initiate drug use—a finding with direct programme implications, as it identified vocational training as both a human capital development intervention and a drug abuse prevention mechanism simultaneously. At the community level, drug market accessibility was a significant positive predictor (OR = 3.84, $p < .001$) and youth centre or livelihood programme presence was a significant negative predictor (OR = 0.31, $p = .004$), confirming that community-level structural factors shaped drug abuse risk in ways that individual-level interventions alone could not address—the same multilevel structural determination principle that Asiimwe et al. (2026) had established for educational outcomes, here replicated in the public health context.

5.0 Discussion and Conclusion

This study had provided the most comprehensive empirical profile of drug abuse determinants and consequences among youth in Arua District, demonstrating that drug initiation was multiply determined by peer influence, economic idleness, family exposure, trauma history, and community-level drug market accessibility — a multidimensional risk architecture that required a correspondingly multidimensional intervention response. The consequences of drug abuse, documented across educational, criminal, family, and health domains, were severe, mutually reinforcing, and cumulative with duration of use, making early detection and intervention the highest-leverage point in the causal chain. The protective factor findings — particularly the strong buffering effects of vocational training, religious participation, and family support — provided the positive agenda for programming that complemented the risk reduction priorities.

The policy agenda implied by these findings encompassed five integrated priority areas. First, school-based drug awareness and life skills programming should be standardised and scaled across all Arua District secondary schools, providing universal prevention for the age group most vulnerable to initiation. Second, youth vocational training and livelihood programmes should be substantially expanded, simultaneously addressing economic idleness as a risk factor and providing the protective engagement and income generation that buffered drug initiation risk. Third, community-based drug abuse treatment and rehabilitation services needed to be established in Arua District itself rather than requiring referral to distant Kampala-based facilities, reducing the access barriers that left the majority of dependent users without formal treatment support. Fourth, family strengthening interventions addressing the transmission of substance use patterns within families needed to be incorporated into the district's social protection programming. Fifth, law enforcement drug supply control needed to be strengthened and coordinated across the border districts of West Nile through multi-agency approaches that engaged Ugandan, Congolese, and South Sudanese authorities in jointly addressing the cross-border trafficking routes that supplied Arua District's drug market. These five priorities constituted an integrated, evidence-based response framework whose implementation required coordinated investment from the Ministry of Health, Ministry of Gender, Ministry of Education, Uganda Police, local government, faith communities, and development partners operating in the West Nile sub-region.

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