'Miracle' cures from early times

By John Masaba

The whole thing reeks of forgery and deception on a large scale. For what is in mere soil and water to cure AIDS? Nothing." That was what the *Weekly Topic*, in its October 26, 1989 editorial, described the purported soil cure for HIV, which was ravaging the country and spreading panic among communities.

Six years earlier, in 1982, the first two cases of the disease in Uganda had been recorded in Rakai on the shores of Lake Victoria. This was followed by 17 more cases, a year later — before the virus was confirmed as an epidemic in Uganda in 1984.

The symptoms of the disease on those affected included extreme wasting away of the body. The victims would often die a few weeks or months later, hence the name *slim*. But just how were the people going to deal with this strange sickness which left sufferers severely battered?

In the absence of a solution in the form of a cure (or treatment like antiretroviral drugs) , even the most ridiculous of remedies to the disease were welcome, despite the media warning the public against using them.

So when Yowania Nanyonga, a peasant elderly woman, came out and said she had on the night of September 8, 1988 been visited and instructed by God's spiritual voice to cure illnesses by merely feeding them the blessed soil from her garden, many people believed her.

Genesis

The soil miracle cure narrative started with Nanyonga's niece, Margaret Nazziwa, who she had allegedly recovered from the disease.

Nazziwa had reportedly been at the brink of death, before she fully recovered after taking the concoction of soil and water from Nanyonga's backyard. Before the 'cure', Nazziwa had reportedly been treated at a hospital in Kampala, where she had failed to respond, but improved after drinking the concoction.

Of course, the cure was not genuine and Nazziwa reportedly succumbed to the disease weeks later.

Despite that, however, Nanyonga continued to receive patients in droves, including civil servants, members of the church and government officials.

It was said Nanyonga never sold her soil and prescribed that it should be mixed with cold water for it to be effective.

David Blumenkrantz, a blogger, in his November 1989 article, Thirty Tons of Soil: Nanyonga's Divine Panacea, described the lines of those seeking Nanyonga's miracle concoction as stretching more than two kilometres.

"People were apparently willing to wait several days for their turn," he wrote, adding that those seeking 'the blessed dirt' came not only from within Uganda, but also from neighbouring countries such as Rwanda and Zaire.

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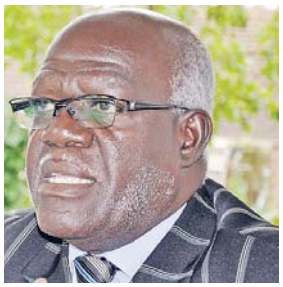
Elvis Basudde, a journalist and HIV/AIDS activist, who was away in the US at the time and only read about the stories from Uganda, told *New Vision* that it did not surprise him. "HIV at the time did not have a name; they called it a "strange sickness" brought about by witchcraft. And Africans are superstitious people," he said.

Major Rubaramira Ruranga, an activist and person living with HIV, who admits taking Nanyonga's 'miracle' cure, said it tasted 'horrible' and gave him a stomach upset.

Hot iron therapy

The story does not end with Nanyonga's soil cure. Rubaramira says there were many others. This, he explained, owed to some canny people using the panic precipitated by the HIV/AIDS epidemic to cash in for self-enrichment.



Major Rubaramira

"Some people were able to reach us (people living with HIV) through some important people in Uganda Aids Commission," he explained.

The treatment involved the practitioner using a red hot iron on the person living with HIV, allegedly to heal them.

"They would put a wet cloth on you and then place a hot iron," he said.

In essence, this act was to 'kill' the virus in your blood, but it instead left the patient with a lot of pain from burn wounds; some people ended up being hospitalised, while others died from their injuries.

Kemron

Then there was Kemron. It was spearheaded by the Kenya Medical Research Institute under its then director, Davy Koech and lead researcher Prof Arthur Obel.

The drug was even launched during a public ceremony by Kenya's President Daniel Arap Moi and had many people seeking it, including US prominent basketball player, Magic Johnson, who had declared that he was HIV-positive. However, it turned out to be a fake.

The drug, which cost sh1.5m per month, was out of reach for many patients. Later, a WHO-sponsored study carried out in five African countries revealed that the drug was nothing more than appetizer.

Bombo crazy

Scientifically known as Mormodica foetida, *bombo*, a common herb in Uganda that has been widely used to treat people with unpleasant body odour, did not miss out on the list.

"I was advised to crush the leaves and drink the liquid three times every day," Rubaramira says.

But as it turned out, the *bombo* was no more herb to treat simple ailments.

"People living with HIV virus tend to develop skin infections and stomach problems, so it was somewhat helpful. However, it was nothing special," he said.

Stigma and discrimination is a major barrier to HIV response

Community Health Alliance Uganda (CHAU) is the linking organization of International HIV/AIDS Alliance-IHAA) since 2010. CHAU's portfolio of work spans technical and organizational capacity building of civil society organizations, policy and advocacy, community systems strengthening, HIV and SRHR programming started as a country office in 2005.

CHAU is positioned as an organization of choice in linking community organisations to provide quality health services particularly to marginalized and key populations in Uganda with high organizational effectiveness and efficiency.

CHAU Vision: "A Uganda where no person dies of preventable diseases". '*Winning together with integrity*' is its culture.

CHAU Mission: To empower communities to live healthy and productive lives.

CHAU'S strategic objectives

CHAU is committed to achieving the four strategic results below:

- Enabling environment and ability of citizens to influence national health and HIV/AIDS related legislation, policies and programmes.
- Increased adoption of safer sexual behaviors and reduction in risky practices among the youths and adults.
- Improved access and utilization of quality, inclusive and integrated SRH, HIV/AIDS and TB services by the target populations.
- Improved institutional development of community Health Alliance Uganda to deliver its mandate.

This year's World AIDS Day Theme is **"know your status"**. The theme reinforces HIV prevention, treatment, care and support initiatives. The theme is indeed timely. It embraces HIV counselling and testing in light of the '90-90-90' UNAIDS global targets.

Despite the continuous efforts of Uganda AIDS Commission and Ministry of Health; and their partners, HIV remains a public health problem. Currently, Uganda has 1.32 million people living with HIV. The prevalence varies by sex, geographical area, key and vulnerable populations. For instance, population estimation and rapid assessment studies CHAU conducted in 2017 on harm reduction and HIV prevention among people who inject drugs show that HIV prevalence is 6-7 times higher among PWID than in the general population. Other surveys indicate similar trend among MSM (13%), sex workers (31.3%) and persons with multiple sexual partners (25%).

Community Health Alliance Uganda implements different projects these include; Sexual Reproductive Health and Rights Umbrella (SRHR-U) that aim at increasing access to quality HIV services, adoption of safer sexual behaviors and reduction in risky practices among the youths and adults. Through the projects 15,000 target population continues to receive and benefit from stigma and discrimination free and quality HIV testing services including services to key and or priority populations.

10,000 young, priority and vulnerable populations have been provided with information and services on HIV prevention, testing and treatment services and 650,000 condoms have been distributed.

It's worth noting that even with unceasing efforts to eradicate the HIV epidemic by both Government and civil society, there are many hidden populations who don't know their HIV status in the community. This is usually due to lack of information about the existence of such services or fear to access HIV testing services due to stigma and discrimination. Punitive laws, prejudices and stigmatizing attitudes towards key population has meant that these groups most vulnerable to infection are far less likely to engage with HIV services. Prejudices and social discrimination are some of the leading causes for certain groups of Uganda's population, such as sex workers, injecting drug users and men who have sex with men, to avoid seeking health care or HIV testing. For example continuous application of the HIV criminal law unjustly has a negative impact on up-take of health services including HIV/SRHR services which in the long run will negatively impact on the global reach target of 90-90-90 but also fuels criminalization, discrimination, stigmatization of people already living with the HIV virus.

The parliament of Uganda enacted HIV and AIDS Prevention and Control Act in 2014. The Act criminalizes people living with HIV in particular section 21(e) that allows a medical practitioner to reveal HIV results to a third party (partner notification) including family members and any other sexual partner deemed at risk. It should be noted that sections 39 (attempted transmission of HIV) and section 41 (intentional transmission of HIV) are stigmatizing and discriminatory in nature. These particular sections in the HIV Act in question have negatively affected HIV Testing Services because of fear to be caught on the bad side of the law. This is indeed a setback for Uganda because HIV testing is a clear entry for access of HIV related treatment but also HIV prevention when one is found negative. This ultimately doesn't help the epidemic and in particular impacts on yet the global reach target of 90-90-90 for Uganda

The Dutch Ministry of Foreign Affairs funded Partnership to Inspire, Transform and Connect HIV response (PITCH) partners (11 implementing partners) have increasingly engaged policy makers to discuss human rights including health rights of key populations, the laws and policies (Homosexuality Act 2014 and the HIV Prevention and Control Act of 2014 among other unjust laws and policies) that negatively impact on Key population HIV/SRHR programming in Uganda. PITCH equally interrogates the possibilities of policy and law reform (as well as reform in law enforcement practices) to support access to HIV and SRHR services for key populations, determines barriers to access to SRHR and HIV prevention and care services for all key populations but most importantly engages with policy makers and suggests suitable and all-encompassing policies and guidelines to bridge the identified gaps in key populations HIV national programming. PITCH commits to significantly contribute to living no one behind by ensuring equal access (free from stigma and any form of discrimination) to HIV related services, equal and quality access to sexual and reproductive health and rights for those most affected by HIV, equal and full rights for key populations and adolescent girls and young women (AGYW), but also commits to capacity building of civil society organisations to become strong and successful HIV and SRHR advocates in Uganda by December 2020 when it officially shuts down.

Health worker providing HIV testing services to a client during an outreach in Kajjansi.

According to the crane survey 2, key populations have been highlighted as the main drivers of the HIV epidemic and in order to reach the 90-90-90 global targets, specific and targeted interventions and strategies have to be designed to attract key population communities to key population friendly services in order to access HIV stigma free testing services.

As we commemorate 30 years of World of AIDS day, let's re-think our key population programming strategy. Uganda should embrace targeted prevention strategies especially if it is to achieve the 90-90-90 global targets. There should be deliberate effort to enact all-inclusive HIV/SRHR laws that do not criminalize, stigmatize and discriminate against Key populations as guided by research and science.

Ending all forms of discrimination is not only about respecting the basic human rights of individuals; it also has a multiplier effect across all other development areas.

Gracie Nakazzi Lubega (Program specialist BCC and community engagements- CHAU). Atwiine Gracias (Country Coordinator PITCH - Uganda)

Together we can End Stigma and Discrimination and contribute to the HIV response in Uganda!