

## Moxafrica | investigating the use of moxibustion therapy for the treatment of tuberculosis

How do you decide in retrospect when a wild seed really gets sown or when one germinates?

There are so many possible "beginnings" to Moxafrica, proving perhaps that no tree has a single root, even if somewhere amongst the tangle of roots lies the husky remains of one tiny seed. Jenny growing up in Africa, for instance, is one; Merlin encountering the extraordinary work of Paul Farmer with DR-TB and learning how an epidemic of drug resistant TB was emerging is another; both of us hearing somewhere in some past workshops that direct rice-grain moxa had been used to treat and cure TB in Japan in the 1930's....

All we can really say is that a penny dropped in the American Bar in Amsterdam in November 2007 over some rather expensive single malt whisky. This penny boldly asked us, "Why couldn't moxa help treat TB today when the drugs are in short supply or when they just don't work because of resistance? When it's a treatment that is so easy to teach, and so stupidly low-tech? When no-one can capitalise or profiteer off it from patents?"

Could it really help? The penny wanted an answer, and just wouldn't fit back in its purse no matter how hard we tried to put it there.

And then why pick Africa? A lot of people have asked us that. Initially it was because Jenny was personally determined to set up some sort of project in Africa related to acupuncture. She'd grown up there, and it's self-evident that Africa can get deep beneath your skin. But the more we've investigated the global state of TB and particularly the allocated African resource to combat drug resistance, the more we realised that moxa just might be made for the continent, for fighting TB exactly where TB most successfully flourishes and where resources are so desperately short.

We did everything we could to set about this task systematically. We burrowed around in the available literature in the subject in English. (Not that much...). Then we went in search of the more relevant stuff in Japanese. It took a long time for us to realise that the tradition which existed in Japan in the 1930s literally hasn't survived the specialists who were doing it at the time. Why should it have? Japan is an affluent country now, and affluent countries make less than welcome homes for the tubercle bacillus, particularly when drugs and diagnostics are available as well. We realised that we were going to have to attempt to re-cut the pathway afresh for ourselves, using every credible sign we could find to help us do so.

So next we did our own primary research on the temperatures at the base of moxa cones of different types and sizes so we could talk with some better authority on the self-evident risks from blistering.

And because we knew that we would consistently encounter cases of TB co-infection with HIV/AIDS in Africa, we began looking at what happens to CD4 count with daily moxa on existing HIV+ patients on ARV drugs in the UK. A small sample, unfortunately, but there were clear responses and, almost unbelievably they were positive. Could moxa possibly even help with co-infected cases? This obviously wasn't a combination of diseases that the guys in Japan had to confront in the 30s, and it had seemed improbable that they might be treatable together with moxa. In truth, it had looked highly unlikely but now it really looked like it was a possibility. And in Africa this might be key. It's the home of the dreadful double-whammy of co-infection, and everything about treating both diseases pharmaceutically is fraught with difficulties.

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There's something about moxa. Doctor Shimetaro Hara, an enigmatic figure who slowly materialised to us from the early twentieth century literature described it in 1933 as a peoples' medicine, the only resort for those Japanese living in poverty who were deprived of access to any decent form of health care. These people were exactly those most vulnerable to TB of course, and they emerged from his accounts as an uncanny reflection of the vast ocean of people in Africa who are so threatened today by the same disease. Moxa seems to have then been a kind of Robin Hood therapy, something which seems to make many uncomfortable not only in the biomedical world today but also in the modern world of acupuncture. But, God, how badly the continent needs a Robin Hood, whoever's sensibilities it upsets.

But we still have one enormous question to answer: how true really were those accounts from the 1930's?

We got our first chance to answer this last December when we were invited to treat a dying man in a rural hospital in Uganda. His name was Frank and he was desperately sick, co-infected with TB-HIV, unable to eat, and unable to keep down the medicines his sister was vainly trying to administer.

One thing we'd learnt from the Japanese documentation we'd uncovered was that dosage is key - the worse the patient's condition the smaller the dosage. So we used a single cone on a single point bilaterally. Just that, and nothing else. It felt like a joke treatment. The poor guy was so sick. How could such a tiny treatment make any difference? But an effect was almost instantaneously apparent: he seemed to wake up a little, and become more aware of his surroundings. Two days later, with two days' more treatment he was walking in the ward, and eating and keeping down his food. We had taught his sister the most simple of protocols, left her some moxa and had to leave to catch the bus back to Kampala and get the flight home.

If only it had been a happier ending though. We know he left the hospital, so the treatment should have continued. But we now know that he's since died. Nothing else.

Despite this sad news, it was now clear to us that those accounts from the 30's had some substance. Our task is to establish exactly how much, and how easily this ancient East Asian treatment can adapt to a modern East African epidemic - or South African. (We have an invitation to start a parallel study in Capetown which we'd start tomorrow if we had the funds.) Or West African, come to that. We have some contacts now in both Cameroon and Senegal.

Currently we have over a hundred patients enrolled on a treatment programme in Kampala, Uganda, many of whom are drug resistant. The programme is in the hands of two extraordinary Ugandan women, and will last for a year. The answer to our question as to what is provided to Ugandan patients who fail in first line TB drug treatment was chilling.

"Nothing", we were told, "we have nothing else for them and we have to leave them to die." This is the terrible reality that exists.

In honesty we can't pretend that there's not still a mountain to climb, but our determination is strengthening. It's going to be as much about the amount of money we can raise as anything else, we realise.

The story of TB in the second half of the twentieth century is frankly a stain upon our right to call ourselves human - and a shameful example of our capacity to literally look away. The statistics (and there are so many of them) tell the most dreadful story. The last drug to treat TB is over 45 years old, and drug resistance has been known about for 44 of them. The vaccine (which doesn't generally work today) is nearly twice as old. If one estimates the massive total of people who

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have been struck down by this disease in the last fifty years (the vast proportion of whom were in the developing world) it really adds up to what might be best described as genocide-by-neglect.

Desmond Tutu (who recovered from TB himself) talks about a specifically African human quality called Ubuntu. "One of the sayings in our country", he writes, "is Ubuntu - the essence of being human. Ubuntu speaks particularly about the fact that you can't exist as a human being in isolation. It speaks about our interconnectedness. You can't be human all by yourself."

There's a telling exchange that occurs between two minor characters in a play of Shakespeare's. "Master!", the 3rd Fisherman says, "I marvel how the fishes live in the sea." The 1st Fisherman replies, "Why, as men do a-land - the great ones eat up the little ones"

We live today in a global world, with horrendous inequalities between peoples predicated by globalised economics, monopolies and unfair trading practices, where fish eat fish, dogs eat dogs, and unforgivably the richer man still feeds off the poorer. Maybe, in exchange for a little low-tech medicine, Africa might show us in both East and West what we finally need to have the right in Bishop Tutu's terms to truly call ourselves human beings.

Sounds like a fair trade.

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