Practising Acupuncture in the Developing World

Sarah Watkins

Summary

Historically a GP, Dr Sarah Watkins took up acupuncture relatively late in her career, but has taken it a long way since then. In this article she presents a vivid picture of what it is like to introduce acupuncture to remote rural populations in parts of the developing world. She describes the rapidly growing demand of the local populations following just word-of-mouth spread that a new treatment was available; the different needle length requirements of the impoverished locals compared with the average well-fed westerner; and the simple, safe and effective treatment regimes that she developed and introduced to the local trained nurses, in order to cope with the numbers of patients and to provide continuity of care after her departure. Sarah also comments on the emerging pattern of response that she has observed amongst her patients, and enters into a brief discussion of why this might be so. Early influences on her technique include Felix Mann, Chan Gunn, and a period of study at the Nanjing College of TCM in China. Whilst in the United Kingdom Sarah divides her time between private practice and working as a police surgeon, but is planning return trips to both Bangladesh and Ethiopia, plus fresh pastures in Vietnam and Kerala in south west India.

Keywords

Acupuncture, rural populations, developing world.

Introduction

At the ICMART Meeting in Edinburgh in May 2002 I presented a free paper about my personal experience of working in Bangladesh, using acupuncture in remote rural communities that have access to only minimal healthcare.

A scientific journal is not usually the place for personal anecdotes, but my experiences in developing countries have been so exciting that I hope some readers may be interested to hear about what can be achieved. The medical need is vast. Over here we have so much; there, they have nothing. I am no Christian, but the Catholic Sisters in each of the countries I visited welcomed and looked after me and facilitated what I was trying to do in a most marvellous way.

My career as a GP spanned 20 years before I took early retirement in 1996 due to ill-health. In 1994 I saw Felix Mann at work. I also spent two months as a mature foreign student in China at the College of Traditional Chinese Medicine in Nanjing. By then I had already begun treating patients, using Mann’s minimal technique. Although I never chose to needle in the Chinese manner, exposure to the Chinese system allowed me to appreciate what a wide range of conditions could be treated with needles. General Practice provided a constant stream of patients willing to be treated, and as time went on, I developed my own style of needling. I have been influenced by Chan Gunn, and have also been impressed by the generally enhanced benefit that periosteal stimulation produces. I now work as a private practitioner and also as a police surgeon – contrasting environments that nevertheless provide frequent opportunities to use acupuncture.

By 1999, my health much improved, I was in a position to take up a challenge working overseas offered to me by a French doctor, Edith Lesprit. Edith has spent a lifetime using Chinese acupuncture in developing countries, working on behalf of the poor people of Vietnam, Kampuchea, Bangladesh, India, Pakistan, Ethiopia and Cuba. She is inspirational and, vitally, has contacts with...
many different Orders of Catholic Sisters in all of these countries. She herself is Buddhist.

In a medical sense, the prospect of going to work in unknown territory created some anxiety. This soon dissipated under the combined effect of my many years worth of experience of general practice, some visits to the Wellcome Institute at Euston Road to work with interactive CD-ROMs for brushing up on tropical disease, and the words of Edith telling me, “You are very lucky to be going to such a beautiful place.” It is extraordinary to be in a position of such confidence that acupuncture will help so many people. Even when apparently nothing could be done (and there were some really tragic cases) I was able in addition to utilise Reiki, a form of healing with which some readers may already be familiar.

My first experience, then, began in Bangladesh in January 2000, with a Catholic order of nuns, the Salesian Sisters of Mary Immaculate. Initially I had no sure idea of what I might be able to offer, or how practicable an application acupuncture would prove to be. It became obvious during my first visit, however, that, aside from treating some hundreds of patients myself, if I could teach some basic safe simple acupuncture techniques to a few of the Nursing Sisters, then treatment could be made available to many more patients.

I returned to Bangladesh in February 2001, more convinced than ever that my time would be well spent concentrating on enabling these Sisters to acquire some acupuncture skills. Subsequently four Sisters became proficient, two in particular becoming outstanding. They demonstrated good handling of the needles, good focus on the patients, and good ‘mind intent’.

I went to Ethiopia next, in November 2002, spending a month with a different Order of nuns, the Daughters of Charity of St Vincent de Paul. As in Bangladesh, these dedicated women offer basic healthcare to a grossly impoverished population (and in the case of Ethiopia, a population also grossly traumatised from the recent civil war with Eritrea). I introduced acupuncture here in the same way as I had done in Bangladesh, and as a consequence, four more Sisters are now competent needlers.

On my recent visit to Ethiopia my intention from the outset was to get the Sisters needling very quickly. A few lectures, a number of demonstrations, a lot of encouragement and an emphasis on a limited repertoire of safe, accessible, effective points, and we were in business. Exclusion of gross pathology was always necessary – TB, HIV/AIDS, polio etc. clearly do not respond to acupuncture, but when one sees the many musculoskeletal problems that...
are so common out there, then being able to ‘do something’ is really exciting.

Treatment Plans
Two different treatment plans comprising safe and apparently effective points were developed. A five-point plan for the upper quadrant and a three-point plan for the lower quadrant. These are detailed below.

Five-Point Treatment Plan
The points used were as follows:
1. Along the nuchal line, in the area of the traditional GB20 point.
2. At C7/T1 level, either obliquely in the midline, down towards the spinous processes, or about an inch laterally, with the needle going obliquely downwards into the muscle.
3. Picking up the muscular bundle of the trapezius and doing a ‘Chan Gunn’ directly into the bundle, horizontal to the clavicle, i.e. in a transverse plane.
4. Vertically above the mid-scapular spine, down onto bone.
5. Horizontally below the mid-scapular spine, until bone is hit.

In addition to these regular points for upper limb problems, a combination of soft tissue needling was used at the traditional point LI4 or between the knuckles (Bafeng), together with an approximation of LU7, and HT7, to treat much arm and hand pain.

I supply all the needles, taking thousands with me in my luggage, or sending them by post. I use only one needle for each patient, although I clearly use more than one point per patient. I do not leave the needle in, but when hitting bone I peck at the periosteum three or four times. I do not seek to elicit the ‘de qi’ sensation. I use mainly 30mm length needles. Occasionally, in grossly malnourished patients, a 15mm needle is all that is necessary (my western patients, by contrast, need 40 or 50mm needles, or in the pelvic area often 75mm needles!) I use no moxa, cupping, or electroacupuncture. The need for safe disposal of needles has to be emphasised, and to that end I take a number of safety-boxes out with me. Even a small box can hold many hundreds of used needles. These can then be buried in a deep pit, or incinerated.
Low back, pelvic, hip & leg pain - Three-point Treatment Plan

The points used were as follows:

1. Into the line marking the sacroiliac joint, through the muscle & connective tissue down to bone, on each side

2. Below the posterior superior iliac crest, directly down to the bone of the ilium (in western patients, obesity makes this a much less accessible area.)

3. Directly onto the greater trochanter. (In western patients access to the greater trochanter is similarly less easy. If the patients lie on their side the bony prominence of the greater trochanter is usually palpable.)

Most of the patients are treated simply sitting on a stool. Good access to skin and surface anatomy is vital but difficult, given the many layers of clothing worn and the modesty displayed by both men and women towards exposing any part of themselves.

I demonstrated other points such as LR3, SP9 and SP6 (or rough approximations thereof) for lower leg problems. A point midway between the medial malleolus and the point of the heel, with the needle angled towards the heel to touch the bone of the calcaneum was very useful for plantar fasciitis – a common problem. Needling around the knee joint was also useful for much trauma and osteoarthritis or rheumatoid arthritis or rheumatic joint swellings.

These safe accessible points constituted the basis of the simple treatment plans the Nursing Sisters were able to use. I made no attempt to make these Nursing Sisters into ‘global’ acupuncture practitioners. I wanted them to feel able to manage and treat frequently occurring musculoskeletal problems with confidence and elegance, using a simple and reliable repertoire of points.

Response

A trickle of patients quickly became a flood. People walked many miles, and sometimes for days, seeking treatment. This clearly presented less than ideal, indeed, unusually adverse circumstances for treatment. Nevertheless, they still kept coming! Time constraints meant that I could usually only see patients once or twice. (Actually, even in the UK I like getting most people ‘better’ with two or three treatments – beyond that I do not think a patient will respond).

By the end of my visit we were treating up to 80 patients daily - at one stage 100 patients arrived in a single day. In Ethiopia there had been no prior notice to the villages that I was coming. In Bangladesh, however, more than 100 patients were waiting even on the first day!

Discussion

I recognise the great variability of response that is exhibited by patients. One of the most fascinating features of using needles is to try to determine the nature of the interaction of the three components of acupuncture – the patient, the dose, and the practitioner. However, in the conditions in which I was working there was no room for such niceties as individualised treatment – we had to concentrate on developing a fairly standard procedure for the three-point and five-point treatment plans. The plans and the standardisation seemed effective.

My experience has been that with acupuncture, almost regardless of the techniques used, a certain pattern of response emerges – 20% ‘miracles’, 20% ‘failures’ and 60% ‘in-betweens’. This pattern is also achieved by Dr Wu, a Master
of Tai Qi and TCM, working in Guiyang in Guizhou province in South China. I met this wonderful physician through briefly studying Tai Qi with him. Dr Wu ascribes his ‘failures’ to the patients’ own lack of qi! I venture to suggest that this response pattern may be similar to that experienced by many practitioners who do not follow the Chinese ‘qi’ theory. Perhaps it is part of the characteristic of acupuncture itself.

What other treatment modes have such an extraordinarily positive benefit? It is not surprising that I am very happy to be able to share knowledge and skills with people who minister to very deprived populations, so that they too may share this benefit.

I plan to return to Bangladesh in October 2003, and after that, perhaps go to Vietnam, then Kerala in India, before returning to Ethiopia. Time, health and wealth permitting (I cover my own costs but am inevitably drawn into many different projects which need funding!) I hope to travel and teach acupuncture for a month each year. One Sister wrote to me, “Surely you will be happy to hear that many patients are coming for treatment with the magic needle.” Indeed I am.
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