In Spring 2006 Gina had a phone call out of the blue from Sally Watkins, a medical acupuncturist whom she had first met in 1980 while doing her GP training. Sally had seen from the lists in The Point (a BMAS newsletter) that Gina had gained her Certificate of Basic Competence (CoBC) from the British Medical Acupuncture Society, and wanted to invite her to join in a ‘life-enhancing experience’.

Sally has previously explained, in an article in this journal, how she developed simple regimes of minimal Western medical acupuncture which were effective, safe and suitable to be taught quickly to nurses. She had previously had success in training nurses in Bangladesh in these regimes, and had made one previous trip to Ethiopia for this purpose. She was planning to return to consolidate her work.

Gina had never visited Africa before, and her mental picture of Ethiopia mainly consisted of those harrowing images of famine which had dominated television screens back in the 1970s. Advance background reading reminded her about the Ark of the Covenant, Lucy the pre-hominid, Hailie Selassie and the Olympic runners. She organised her travel vaccinations and packed her case with hot-weather clothes, then repacked it after consulting the Internet and realising that in Addis and in the west of the country it would be cool at night and pleasantly warm by day.

Sally had previously worked through a Catholic organisation called the Sisters of Charity, which had several bases in Ethiopia where the nuns ran schools, clinics and income generation projects. We stayed as guests of the Sisters, living within their small compounds. We spent the first few days in Addis Ababa, adjusting to the altitude (2400m, the third highest capital in the world) and the abject poverty of most of the six million people who live there. We visited the famous Fistula Hospital, and were very impressed by the love and care shown to the frightened incontinent young women who were brought there daily.

Ethiopia is a mountainous country and has a poorly developed road and railway system, perhaps because it is one of the few countries in Africa which was never colonised. The average Ethiopian lives two days’ walk from the nearest road. Our destination was the small town of Dembi Dollo, 400 miles to the west of Addis. It would have been two days’ journey by car, and Gina’s experience of the quality of the roads in Addis soon convinced her of the wisdom of Sally’s decision to travel across the country by plane. Our small DH6 bush plane was noisy, but had no problems in landing in the field which comprised the runway at Dembi Dollo.

We were overcome by the beauty of this remote place (Figure 1). The rainy season had just ended and the vegetation was lush and tropical, with exotic coloured birds and spectacular flowers. The Sisters welcomed us with warm hospitality. They had arranged a programme for us to visit their five outposts (Sakko, Karro, Alacu, Addo and Danka) which lay within a 15km radius of Dembi Dollo. The roads were mud tracks, and the short journeys between the clinics were slow and hazardous.

Three or four of the Sisters lived in each outpost, often in primitive conditions without a telephone or reliable electricity. Usually there was a nurse, a teacher and a social worker. The main problem faced by the local people was of overwhelming poverty. The average income was only £50 per person per year, and 60% of the population are illiterate. There were few opportunities for work other than subsistence farming, yet many families had been forced to sell their land and labourers earned only 24p per day. The Sisters were trying to address this problem by setting up women’s co-operatives and teaching skills such as soap-making and weaving.

We saw many patients with elephantiasis (Figure 2), a painful condition caused by blocked lymphatic drainage of the legs, which leads to gross swelling. Infection is a frequent complication, and sometimes amputation is necessary. It can be caused by a
parasite, but in this region the high silica content of
the soil was thought to be responsible. Many people
did not own shoes, and those who did were reluctant
to wear them in the rainy season when the roads and
paths turned to mud.

Goitre was endemic, due to the low iodine
content of the volcanic soil (Figure 3). Some patients
had gross thyroid swelling. A team of Dutch
epidemiologists had been visiting the area for several
years, and had brought (at their own expense)
supplies of iodine capsules. In the year before our
visit they had finally persuaded the Ethiopian
government to permit the supply of iodised salt: the
clinics contained large sacks of this which the women
weighed out into small packets to be sold for a few
pence.

The health clinics were generally in poor repair,
without a reliable electricity supply. There was a
hospital in Dembi Dollo, but all investigations and
medication had to be paid for and people simply
could not afford to attend. The clinics were run by
experienced nurses who were able to prescribe basic
medicines. Gina was shocked to find that all opiate

Figure 1 Lush vegetation surrounding the spectacular Qeta Falls, West Wollega.

Figure 2 Elephantiasis, shown in this picture, is one of the commonest conditions seen in this region of Ethiopia.
Travel report

Drugs were simply unavailable in Ethiopia; we were told that the government had banned them to prevent drug dependency. Diclofenac was the only analgesic that we saw in use.

In the West, acupuncture is beginning to be accepted as an adjunct or alternative to analgesic treatment. Here, where there was little else that could be offered for severe pain, it had a vital role. Sally had trained three nurses on her previous visit; as well as encouraging and updating these, we trained another five (Figure 4). We had brought many packs of needles with us, hoping that they would escape the eagle eye of Airport Security (in the event, they were much more interested in our aurisscopes). So we were able to leave these with the nurses, equipping them to treat many people after we had left, particularly since one needle could be re-used several times on the same patient.

Sally had already set up regular donations to support the work of the Sisters. The scale of the achievements of these devoted women in the midst of such poverty was humbling. Through the generosity of the staff and patients of Gina’s GP practice, and through other fundraising events, we were also able to provide some practical help. This included buying livestock such as sheep, donkeys and oxen for the poorest families. We were reassured that the Sisters would monitor the welfare of these animals, and the families undertook to return either the first lambs or other income into the scheme. It was very satisfying to know that our money was going directly to those in need.

Gina returned with such a multitude of new images in her mind that it has taken some time to adjust. She has learned that simple acupuncture is easy to teach, and can provide valuable pain relief in a poor area with few resources. She has discovered the warmth and dedication of some amazing people who choose to live their lives amongst the poorest of the poor. And we have both experienced a spectacularly beautiful country, struggling with unimaginable poverty, which still seems to be living in the Dark Ages.

A video of the authors’ journey is available on www.youtube.com using the keywords ‘acupuncture’ and ‘Ethiopia’.

Reference list

Needles for Ethiopia

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