

Moxafrica Goes to North Korea

by Ulick Burke

Summary

Since 2016, Moxafrica has been working in North Korea to assist the Korean Red Cross Foundation in their local struggle with the global health emergency that is tuberculosis. There have so far been two trips, in October 2016 and March 2017, during which about 80 practitioners have been trained in the Dr Hara moxibustion protocol (direct small cone moxa on ST-36 and the Dr Hara 'loin points') and the fundamentals of Dr Mukaino's M-Test. We have received generous moxa donations from several sources in Japan including Tokyo Eisei Gakuen College, Sennenkyu (Senepha), Morinomiya University of Medical Sciences and Koshiishi Sensei, and about 3kg of high-quality Japanese golden moxa has been passed on to the Korean Red Cross Foundation.

The North Korean Ministry of Public Health (MoPH) has started an eight-month, 200-patient study of the Dr Hara protocol as an adjunctive treatment for people with either drug-susceptible or drug-resistant tuberculosis. Another study is underway that seeks to compare daily direct moxa on ST-36 with isoniazid (an anti-tuberculosis antibiotic) preventative therapy, to measure which is the more effective prophylactic for people most at risk of contracting tuberculosis. Moxafrica is also in talks with the Korean Red Cross Foundation about including the moxa protocol and M-Test in a new syllabus for rural community health workers which makes for an incredibly exciting opportunity that we had hoped to see developed in Uganda but so far have not seen materialize. We are also in talks with the Ministry of Public Health to make the moxa protocol the national standard, although this will ultimately depend upon the study results.

Why North Korea?

The last 400 years have been particularly traumatic for the people who live in North Korea. In 1639, the Manchus invaded for a second time and Korea was a tributary state of the Qing Dynasty until 1894. The Japanese occupation of the Korean peninsula started in 1916 and lasted until the end of World War Two. In 1945, Korea was granted independence, only to be immediately carved in half along the 38 parallel. The Soviets took the North and the Americans occupied the South. During the Korean War, 1950-53, the US Air Force carpet bombed the

North for three years with no concern for civilian life, killing one in five of the general population. The Korean War ended in an armistice and peace has never been declared.

In the 1990s severe famine killed about one million North Koreans (4-5% of the total population) and although there is no longer a food crisis, both stunting and malnourishment are still common. This is especially relevant to our work because there is a consistent log linear relationship between BMI and TB,¹ which is also unfortunately extremely common.² Furthermore, as a direct result of WHO mismanagement in the 1990s, drug-resistant tuberculosis is now a major problem.³ In 2015, out of 4,600 estimated cases of multi-drug resistant tuberculosis (and the true number is probably higher unfortunately), only 125 were given treatment.⁴ That's at best less than 3% of cases for an airborne infectious disease that has a mortality rate of about 50%.

Direct small cone moxibustion is a particularly suitable protocol for North Korea because it is cheap and effective, and because, since a very similar technique already exists, there are minimal cultural barriers to overcome. What Moxafrica is offering is the exact Dr Hara protocol and refined high-grade Japanese moxa. Why is it important that high-grade moxa is used? High-grade moxa contains a greater proportion of essential oils that may be important in the immunomodulatory mechanism. Also, compared to low-quality moxa, with smouldering high-quality moxa the heat sensation perceived by the patient is lower because it burns faster.

First Visit

In October 2016 I spent one week in North Korea representing Moxafrica. The most significant training was at a Pyongyang hospital where national technical standards are set. About 20 senior doctors attended the two-day workshop, as well as a few MoPH staff and the deputy director for TB control. I am told the attendees were surprised and skeptical when they first received the invitation, but became intrigued when they read Merlin Young and Jenny Craig's essays on the possible mechanisms behind the immunomodulatory effect of direct moxibustion⁵ and the preliminary trial data from Uganda. Actually, direct moxa is common in North Korea but is generally reviled by patients because the low-quality moxa used (green) burns slowly and is painful. It took multiple demonstrations



Moxibustion Practice

(proving direct moxa didn't have to be painful) to convince the North Korean practitioners to try it on themselves and that their patients could be persuaded to self treat for a minimum six months. Two days were scheduled to teach the full moxa immunomodulation protocol (ST-36 and Dr Hara's loin points) but by lunchtime on the first day we had already finished. All the attendees, whether Koryo or biomedical specialists, were familiar with direct moxibustion and although the grade of moxa material was novel (and somewhat of a distraction because there were numerous side discussions about refinement) the protocol itself was picked up quickly. This was a good thing. I was already very confident that the attendees would have no problem teaching Dr Hara's protocol but it did leave me in a bit of a pickle. What to do?

Fortunately, I always have an M-Test finding sheet in my bag. We had plenty of moxa in lieu of press tacks, so we decided to hold an impromptu M-Test demonstration. I explained the background to Professor Mukaino's method and led the group through some neck and whole body movements, hoping to find a suitable volunteer to demonstrate on. The Director of the Meridian Research Department was enthusiastic, had a positive finding on M 27 (backbend/anterior extension), and seemed like a good candidate for me to demonstrate on. Unfortunately, his condition was such that neither mother-son points, large muscle groups, or stimulation of the ear gave any significant relief so, after promising to return to him later, I asked for another volunteer.

The deputy director of the Paediatric TB unit had very severe pain when he rotated his neck to the left. This time I was in luck and the first point I tested, right LU-9, gave him great relief. With the addition of LU-9's combination point, ipsilateral SP-5, he was completely free of pain. The doctor was surprised and tentatively repeated the movement. Disbelief soon followed, and his neck movements became first rapid and then violent.

I asked him to move gently, to enjoy the relief and not seek out the pain that had previously accompanied such movement. This response is not very uncommon, especially with male patients. After this demonstration the attendees were eager to learn more and, given the simplicity of the protocol, quickly picked up the basics.

This Year's Trip

Due to the success of the impromptu M-Test demonstration in 2016, the Korean Red Cross Foundation and Moxafrica planned more seminars for the March trip in 2017. About 80 medical practitioners learned the basic protocol and it made a great impact upon the attendees. There was continual surprise that merely touching a point with a finger could significantly impact the quality of movement as experienced by the patient.

While infectious, most people on treatment for TB are housed in sanatoriums. Inadequately designed and ventilated sanatoriums are less than ideal places to treat tuberculosis because they fuel multiple strain infections and often amplify existing resistance patterns. At one such tuberculosis sanatorium on the edge of Pyongyang I was able to use the M-test to treat people living with TB. These patients were already enrolled in the Dr Hara protocol and reported less coughing, less joint pain, and more regular bowel movements, all very encouraging. They liked the moxa protocol but they also responded well to the M-Test. Moxafrica is now in discussion with the Ministry of Public Health to extend M-Test training to include drug-resistant tuberculosis patients, who are often resident in the sanatorium for years and suffer from, in addition to everything else, boredom and depression. Training long-term patients would give those that wanted it a skill, a job, and it would help relieve the burden upon the already stretched medical system.

Looking to the Future

According to all that we have learned so far, the Dr. Hara protocol is a powerful standardised form of immunomodulation. Meanwhile the M-Test is a standardised method that uses patient feedback through movement to guide the practitioner in personalising the treatment. Since movement is the feedback loop utilized in the M-Test, there is a minimal gap between treatment and meaningful changes to daily life practices. Both protocols place a minimal burden of skill on the practitioner and can be learned to a useful degree in a very short period of time – a weekend. Another way to make this point is that both protocols use ‘levers’ that compensate for lack of experience or skill. With



M-Test demonstration

direct moxibustion, the tool, moxa, is incredibly forgiving and novices can get meaningful results with limited skills. With the M-Test, the movement feedback loop elevates the patient from a largely passive recipient of care to an active partner. This also reduces the burden on the practitioner. The M-Test and direct moxibustion are therefore highly compatible and eminently suitable for use in public health especially where other resources are limited. We have high hopes for their further deployment.

The Ministry of Public Health moxibustion study will conclude in October 2017 and by November we should know if the protocol will become part of the national standard of treating TB and MDR-TB. Naturally we are working to help see any of these happen, but at the same time we also foresee a significant logistical problem that could present itself. *Artemisia argyi* is common in North Korea (I've seen it growing on the roadside) but the expertise and technology to refine it to the quality we believe necessary for it to be both safe and effective in TB treatment is absent. Moxafrica has always cherished a core belief in the importance of encouraging independent development and of fostering what we call ‘indigenisation’ of moxa therapy at every opportunity. We have a stock of good moxa that we know we can supply, but we know it could be exhausted very quickly and having us supplying the moxa should never be the answer anyway. There were over 120,000 new TB patients in the country in 2015 – there could easily have been 10,000 drug-resistant ones (no-one really wants to estimate that one) – and they may be needing a lot of moxa. In anticipation of this we realise that we have to look immediately

at how we might best help facilitate in-country manufacturing to foster a sustainable treatment program. This is a new challenge for us but is one we welcome because it could mean that many lives will be saved. We welcome any advice or help from NAJOM readers on this matter, because we know that they will be as excited and engaged in the import of these challenges as we are.

I would like to finish by thanking Mizutani Sensei, NAJOM and its readers, Professor Yoshito Mukaino Sensei, Professor Tadashi Hisamistu Sensei, Mrs. Matsue Koshiishi Sensei and her clinic, and Takeshi Kitagawa Sensei for their herculean support and guidance for Moxafrica over the years. This list is far from exhaustive and please forgive me if I have omitted your name (I expecting a scolding from the other trustees but the deadline is upon me!) Thank you all.

Notes

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5. NAJOM. 2011. Part 1: 18. No. 51 (March): 3-6. Part 2: 18. No 52 (July): 3-6.
6. NAJOM. 2016. 22, No. 66 (March): 28-29.

Ulick Burke, Moxafrica trustee, was an apprentice at Dr Lee Zheng Yu’s clinic in Taipei, Taiwan, from 2008-2011 where he studied herbal medicine and acupuncture. He later studied the M-Test with Dr Mukaino in Fukuoka. He is interested in simple and effective protocols that can be taught to public health professionals in a short amount of time, anti-microbial resistance, and trauma.