CHINA’S HEALTH AID TO AFRICA

An Evaluation of China's Health Aid to Africa using a Case Study of Chinese Medicine and Medical Practice in Tanzania

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Abstract

Sino-Africa relations involve China’s foreign aid to African countries. There are many questions surrounding China’s foreign aid, such as its scope, its impact, and whether it is altruistic or opportunistic. This thesis provides an analysis of China’s health aid to Sub-Saharan Africa, drawing in part on research I conducted in Dar es Salaam, Tanzania, on China’s health services. This paper begins with an analysis of the history of the relationship between China and Africa, while taking into account colonialism. This history is important in understanding the complexity of China’s engagement in African countries. This paper then focuses on two components of China’s health aid: Traditional Chinese Medicine (TCM) and the relationship between Chinese doctors and the African communities they work in. Results suggest that TCM offers an affordable alternative form of medicine to most Africans in low-income countries. However, there is still uncertainty about whether the provision of free TCM by the Chinese government is altruistic or a strategy to promote Chinese products in the African market. Additionally, the research shows that there is a lack of interaction between Chinese doctors and the African local communities. The thesis concludes that, regardless of China’s motivations, foreign aid alone does not result in the development of a country. There is a need for African governments and societies to take an active role in the allocation of health aid to their people so that it best serves communities. Thus, instead of indulging in the debate on whether health aid is altruistic or not, African countries should focus on finding ways to use aid to advance their own best interests.
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My sincere thanks also go to my family and friends who have been a great source of support in writing this thesis and my life in general. Without the precious support, it would not be possible to conduct this research.

Last but not least, I would like to thank God for always holding me and lifting me up. Without him, nothing would have been possible.
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Preface

I was born and raised in Tanzania, where I lived until the age of nineteen, and most of what I knew about China’s involvement in my country and other African countries had to do with economic interactions. I saw an increasing number of Chinese people coming to Tanzania to work in construction sites and open big shops with goods from China. I also knew about the growing number of Tanzanians traveling to China to buy goods in bulk to resell them in Tanzania. Initially, most of the foreigners I saw were Western tourists, volunteers, and businessmen and women. Then I began noticing more Chinese in Tanzania, and the trend piqued my interest and curiosity.

During my junior year as a student at Duke University, I took a class titled Global Health Systems and Policy from Dr. David Toole. In this class, we learned about how various health systems are affected by globalization as well as various political economies of health care. This class caused me to begin asking questions about the global stakeholders and players in Africa in terms of health care and health systems. Following this class, I took another course titled the History of Chinese Medicine from Dr. Nicole Barnes, which broadened my understanding of Chinese medicine and practice both within and outside of China, including in Africa. This class made me realize that China is a significant player in the African health sector. Although a lot of studies are being done about China’s economic and political involvement in the continent, not much is written about China’s health aid to Africa, the history and impact of such aid, and the
sustainability of the aid. Thus, I decided to investigate and learn more about China’s health aid to Africa, which motivated me to write this thesis. My main goal for the thesis is to provide readers with a brief historical overview and an analysis of the current framework of China’s health aid to Africa, using a case study of Chinese medicine and medical practice in Tanzania. I will also propose mechanisms for African involvement and engagement to fully benefit from such aid.

**Introduction**

*China’s Second Continent* is the title of Howard French’s book, which talks about the presence of China in Africa and the complex relationships between Chinese immigrants and African communities. Although China describes its relationship with African countries as a “win-win friendship,” the dynamics of the benefits gained by each party are still vague, mostly due to lack of research in the area. First and foremost, the economic differences between China and most Sub-Saharan countries create complex power dynamics in the relationship between the two parties. In the 2017 fiscal year, the World Bank categorized China as an upper-middle-income economy with a GNI per capita between $4,036 and $12,475, while most Sub-Saharan African countries are still ranked as low-income economies with GNI per capita of $1,025 or

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As China continues to grow and expand economically, there have been major criticisms about its involvement in the African continent as a form of neo-colonialism.

One of the main components of Sino-African relations is China’s foreign aid (CFA) to African countries, of which health aid is, according to Wenjie Liang and colleagues, “an important aspect.” China’s aid to Africa has raised many questions and concerns: Will Chinese aid discourage needed economic and political reforms in African countries? Will it burden poor countries with debt—a burden from which many countries have only just escaped with the debt cancellation policies adopted by many development banks?” This thesis attempts to assess some of these questions and concerns by focusing on one component of China’s aid to Africa: health aid.

I have divided this thesis into three parts. In part I, I provide a brief history of the early contact between China and Africa during the Ming dynasty through admiral Zheng He’s fleets, although this exchange was not continuous. I then follow up with a discussion of how colonialism affected China and Africa differently, which in turn had a considerable influence on how they each progressed economically, socially, and politically.

In part II, I present a brief history of aid on the African continent, initially led by European nations but later followed by China. I then focus on analyzing China’s Health Aid (CHA) to Africa and provide an overview of the scope of the aid, its reported effectiveness, and

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5 Wenjie Liang et al., China’s Approach in the Blooming South-South Health Cooperation: Chances, Challenges and the Way Forward, report, China National Health Development Research Center, National Health and Family Planning Commission of the P.R. China.1.

the governance mechanisms that guide the conceptualization and implementation of such efforts. In this section of the thesis, I discuss how although both Western health aid and China’s health aid have claimed an altruistic intent to support the development of African nations, shortcomings in approach and impact demonstrate a need for a reformed strategy that involves Africans themselves in the process.

In part III, I discuss a case study of research I conducted in Dar es Salaam, Tanzania, to investigate the services provided by Chinese health workers in Tanzania, the challenges faced by Chinese health workers in Tanzania, and the integration of these health workers in the Tanzanian community. The research I conducted was brief (three weeks during a winter break) and involved only a small sample size, so I will draw no definitive conclusions or generalizations from my findings. However, this case study does serve as a primary source that illuminates findings I report from secondary sources in part I and part II.

At the end of this thesis I discuss the need for African leaders who are passionate about positive change and who represent African communities. These leaders need to be actively and fairly involved in the determination and rigorous evaluation of the various elements of China’s health aid to African countries. This leadership, I argue, will enable all parties involved to gain a deeper understanding of the implementation and effectiveness of health aid, and how it fits within a specific African country’s health strategies.

Part I: Historical Review

China - Africa Early Contacts

Most people today believe that people from the West were the first explorers to different parts of the world. However, the Chinese admiral Zheng He made seven epic journeys to various parts of the world, including Asia and Africa, between 1405 and 1433, a few decades before the
Portuguese arrived in the West of Africa around 1441. His fleet reached the East coast of Africa (what are now Somalia and Kenya) during his fourth voyage, which left China in 1413. In Zheng He’s fifth (1417-19), sixth (1421) and, seventh voyage or final voyage (1431), he continued to visit the coast of East Africa, the Persian Gulf, and other parts of Southeast Asia and India. It is believed that this early contact established Chinese trading relationships with regions of Southeast Asia, India, Arabia, and Africa. For example, one of the famous gifts given to Zheng He included two giraffes from Malindi [see picture 1 on appendix].

Although Zheng He initiated trading contacts between Africa and China, soon after the death of Emperor Yongle in 1424, the succeeding emperors did not support the voyages, and China returned to an isolationist policy. Thus, the contacts between China and Africa came to a halt, while those of the West continued. Scholar Walter Rodney points out that “Europeans used the superiority of their ships and cannon to gain control of all the world’s waterways, starting with the western Mediterranean and the Atlantic coast of North Africa,” which was the beginning of the conquest and colonialization of the African continent and other parts of the world.

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11 Although Walter Rodney credits European ships for their “superiority”, Dreyer who wrote the book titled, Zheng He: China and the Oceans in the Early Ming Dynasty, 1405-1433 by Edward Dreyer, writes in his conclusion that Zheng He’s ships were probably the largest wooden vessels ever constructed. Edward Dreyer, "Conclusion," in Zheng He: China and the Oceans in the Early Ming Dynasty, 1405-1433, 1st ed. (New York: Pearson Longman, 2007).
Colonialism - The Roadblock to Development

One of the common features between Africa and China is that they both have a history of control and dominance by imperialist nations, though in the case of China the majority of its territory remained under local control even during the height of imperialism. However, the political, economic, and social impacts of colonialism in China and Africa vary greatly due to the differences in the intensity and magnitude of colonial invasion. The development of industrial, mining, and settler economies transformed many regions in Asia, including China, while most colonized countries in Africa were neglected and the economies developed were mainly export-oriented and unsustainable.\(^\text{12}\) It is beyond the scope of this thesis to compare the colonial history of China and the countries in Africa, but certainly the experience was different enough to have allowed China to become a rising world power, while the countries of Africa seem to remain bound to their colonial histories.

Between 1870s to late 1900s, Africa faced conquest and colonization by European imperialists. The reasons for colonization included increased demand for raw materials to feed the growing industries in Europe, demand for cheap labor, and the search for guaranteed markets. Other factors involved inter-European power struggles and competition for preeminence.\(^\text{13}\) Countries such as Germany, Britain, Portugal, France, and Spain were competing for power within European power politics. One of the ways these European powers could demonstrate national supremacy was through the acquisition of territories around the world,  


including Africa. Other reasons for the scramble for land by European nations in Africa and other parts of the world include increasing social problems such as unemployment, poverty, and homelessness in Europe because of industrialization. One of the solutions for these problems was to establish settler-colonies in African countries such as Algeria, Tunisia, and South Africa to export the “surplus population” from Europe.

Considering these reasons for the European colonization of Africa, it is not surprising that many people claim that China’s re-entrance and engagement in Africa, which highly resembles that of the West, is a form of neo-colonialism. Stephen Marks writes that “China’s race for Africa is certainly due in large part to the same causes as Europe’s 19th century scramble.”

Given China’s own history of colonialism, it is ironic that China is now being accused of duplicating Europe’s nineteenth-century scramble for the African continent. Consider this political cartoon from the 1890s, which depicts Britain, Germany, Russia, France, and Japan carving up China like a melon.

A famous French Political Cartoon from the 1890s showing a pie that represents China being divided between UK, Germany, Russia, France and Japan

14 Ibid, 144.
15 Ibid, 216.
18 Le Petit Journal, "Famous French political cartoon from the late 1890s. A pie represents "Chine" (French for China) and is being divided between UK, Germany, Russia, France and Japan," digital image, Gallica, January 16, 1898, accessed April 24, 2017, http://gallica.bnf.fr/ark:/12148/bpt6k716261c/f8/.
From my perspective as an African who became curious about China’s involvement in Africa, learning of China’s own history with colonialism, even in a cursory way, presented me with something of a puzzle. Why has China escaped its colonial past in a way that most African countries have not? Again, this thesis is not the place to give that question the treatment it requires, but it is worth highlighting the source of the irony built into China’s aid to Africa.

The trade between Britain and the Chinese Qing Empire around the nineteenth century increased demand for silk and porcelain in the British market. However, Britain had insufficient silver for the barter trade and thus began using Indian opium to obtain porcelain and silk from the Qing Empire. The exponential growth of opium in China between 1790 and 1832 resulted in an increase of social instability and addiction, which led to conflicts between Britain and China. Eventually, the conflicts broke into the Opium war (1839-1842), in which China was defeated and Britain took over the island of Hong Kong, as well as gained trading access to the ports of Ningbo, Amoy (Xiamen), Fuzhou and Shanghai.\(^{19}\) Several unfair treaties were signed thereafter, beginning with the Nanjing treaty in 1842, with the result that there was a nineteenth-century

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scramble for China that somewhat resembles the scramble for Africa. And yet, today China is ranked as an upper-middle-income country, while many countries in Africa flounder. Even more, many of the countries where China is most involved (for reasons that mimic nineteenth-century colonialism: the need for raw materials to feed growing industries, markets for the export goods, and global dominance) are those least developed and most bound to their colonial past, like the Democratic Republic of Congo (DRC).

When the DRC was the Belgian Congo (1908-1960), Belgian colonials demanded each village to deliver a certain amount of rubber for export, and failure to do so resulted in the women being taken as hostages, and troops being sent to villages to kill some of the men. For each cartridge used, the militants had to show proof of an amputated hand from the African victim. It is undoubtedly not an overstatement when Edem Kodjo, the author of Africa Tomorrow, writes that the African has been “torn away from his past” and “the African … is today the deformed image of others.” The continent of Africa has suffered from horrible genocides “at the hands of the architects of slavery and colonialism.” For example, in 1904, the Herero people in Namibia, who resisted German colonialism, were driven to the desert and left to die from dehydration and hunger. This genocide killed at least seventy percent of the Herero population. Not every African country experienced colonialism in a form as extreme as that


present in Congo and Namibia. Nonetheless, such events do remind us that the history of colonialism in Africa extended over generations and was often brutal.

Not surprisingly, therefore, colonialism led to significant disruption and disintegration of the existing local political, social, and economic structures. Colonialism left many African countries impotent and dependent. Professor Walter Rodney argues that in addition to hindering development in Africa, colonialism also led to a cultural and psychological crisis of most Africans also known as the inferiority complex. This means that most Africans themselves have internalized and accepted—at least partially—the idea of being underdeveloped and with limited opportunities to transform and develop their natural environment. Recognizing this fact is important for understanding the dynamics of China’s increasing involvement with the continent. With this background in mind, let me turn specifically to China’s health aid to Africa.

Part II: China’s Health Aid to Africa

Chinese foreign health assistance began during the Cold War when China dispatched its first medical team to Algeria following the country’s war against French colonialism and the flight of much of the country’s trained medical personnel in April 1963. Up until 1975, China continued to send medical teams to various parts of Africa, using the system of one Chinese province being responsible for one or more African countries.


Figure 1: The table below shows some of the provinces in China with their respective countries in Africa

<table>
<thead>
<tr>
<th>Country</th>
<th>Dispatching Province</th>
<th>Start Date</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Algeria</td>
<td>Hubel</td>
<td>Apr. 1963</td>
<td>Withdrew in Feb. 1995 due to war, re-dispatched in 1997</td>
</tr>
<tr>
<td>Zanzibar</td>
<td>Jiangsu</td>
<td>Aug. 1964</td>
<td></td>
</tr>
<tr>
<td>Somalia</td>
<td>Jilin</td>
<td>June 1965</td>
<td>Withdrew in 1991 due to civil war.</td>
</tr>
<tr>
<td>Mali</td>
<td>Zhejiang</td>
<td>Feb. 1968</td>
<td></td>
</tr>
<tr>
<td>Tanganyika (Tanzania)</td>
<td>Shandong</td>
<td>Mar. 1968</td>
<td></td>
</tr>
</tbody>
</table>

However, starting in 1975 and up to the launch of economic reform in 1978, China shifted its focus on “domestic economic construction and diplomatic work carried around the economic construction,” which significantly reduced China’s foreign aid, including health aid to Africa. For example, Shandong province used to send over 200 medical teams to hospitals in different parts of Tanzania, but this number of government-sent doctors was decreased to two to four teams. However, things took a turn after China launched its “going-out” strategy, which aimed to drive Chinese enterprises into the international market. Research shows that China’s health aid was also a channel “to pave [the] way for Chinese enterprises to enter the recipient pharmaceutical market.” By the end of 2009, China had built pharmaceutical factories in


30 Wenjie Liang et al., China’s Approach in the Blooming South-South Health Cooperation: Chances, Challenges and the Way Forward, report, China National Health Development Research Center, National Health and Family Planning Commission of the P.R. China.


32 Wenjie Liang et al., China’s Approach in the Blooming South-South Health Cooperation: Chances, Challenges and the Way Forward, report, China National Health Development Research Center, National Health and Family Planning Commission of the P.R. China.
Tanzania, Mali, and Ethiopia.\textsuperscript{33} Furthermore, China continued to dispatch medical teams (CMT), sending 43 CMT to 42 African countries in 2014. One of the major drawbacks of China’s aid, as Lancaster points out, is that there are a lot of unknowns such as “how large the aid is, how fast it is growing; how decisions are made on how much aid is provided every year; which countries receive it and how much they get, how the aid is managed within the Chinese government and how it is evaluated.”\textsuperscript{34}

In 2011, China published a white paper on the government website with information about the forms, distribution, and management of its foreign aid. This report says that the financial resources for foreign aid provided by China fall mainly into three categories: grants (aid gratis), interest-free loans, and concessional loans. The report emphasizes that China’s aid is grounded on the Eight Principles for Economic Aid and Technical Assistance (EPEATA) to other countries. The five main features of EPEATA include: 1. Unremittingly helping recipient countries build up their self-development capacity; 2. Imposing no political conditions; 3. Adhering to equality, mutual benefit, and common development; 4. Remaining realistic while striving for the best; 5. Keeping pace with the times and paying attention to reform and innovation.\textsuperscript{35} China’s health aid to Africa has continued to grow, and based on the 2006

\textsuperscript{33} Charles Freeman and Xiaoqing Boynton, “\textit{China's Emerging Global Health Aid and Foreign Engagement in Africa}”, report, Center for Strategic and International Studies.\textsuperscript{4}


document entitled “China’s African Policy,” China will continue to provide health assistance to Sub-Saharan African countries.36

It is worth noting that on the face of it China’s approach to aid is different from that of the West. The West’s approach to aid includes conditionality and selectivity, which assumes that aid works best in well-governed countries where corruption is not a great problem; therefore, poorly governed countries are often denied aid. The problem with such an approach is that the countries that fail to fulfill these conditions are the ones most in need of assistance; thus, aid fails to serve its purpose.37 In contrast, China’s aid to Africa is unconditional with “no-ties,” which means that China does not impose any political or economic conditions or expectations for the recipient countries.38 Whether China’s aid is as free of ties as it proclaims is one of the questions in play, but the white paper makes the case that it is.

China’s health aid to Africa includes free provision of Traditional Chinese Medicine (TCM), infrastructural improvement, human resource development cooperation, emergency humanitarian aid, and volunteer programs.39 The white paper mentions that China has assisted African countries in construction of about eighty medical facilities, including general hospitals, mobile hospitals, health centers, specialist clinics, and traditional Chinese medicine centers. In terms of medical equipment, China has provided African countries with “about 120 batches of


38 Ibid.

39 Wenjie Liang et al., China’s Approach in the Blooming South-South Health Cooperation: Chances, Challenges and the Way Forward, report, China National Health Development Research Center, National Health and Family Planning Commission of the P.R. China.10.
medical equipment and medicine, including color Doppler ultrasound machines, CT scanners, automatic biochemical analyzers, ICU monitors, MRI scanners,” and so forth. From 2004 to 2009, China provided a total of $37.49 billion in aid to foreign countries, of which $15.54 billion was for grants.40 The chart below shows the geographical distribution of China’s foreign aid.

Geographical Distribution of China’s Foreign Aid Funds in 2009 as shown in China’s White Paper of 2011

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The figures of foreign aid written in the white paper report by the Chinese government may seem like a lot, but in comparison to other donors, China’s foreign aid is still very low. As can be seen in the comparison chart below, China’s development assistance as share of GNI was less than 0.1%.
Countries with gross development co-operation > $500 million and % GNI (World Bank).

Countries not members of the OECD Development Assistance Committee indicated with grey bars, as seen in the case of China.

China’s health aid to Africa falls in the category of grants because this is the type of foreign aid that is mainly used to help recipient countries build hospitals, schools, and other medium and small projects for social welfare. Most of Chinese foreign aid is allocated to transport and storage, and energy generation and supply as can be seen in the chart below.

It is important to note that China is considered a “graduate” of foreign health aid programs because of its history of initially relying on foreign aid, such as the 1981 World Bank
loan for Rural Health and Medical Education.\textsuperscript{42} Liang argues that China’s experience as a donor recipient allows it to use the “lessons learnt as the recipient country to help other developing countries.”\textsuperscript{43} But the question that many people are battling with today is whether China’s aid (including health aid) to Africa is altruistic or opportunistic. Is China, as a former recipient of aid and as a country that has its own history of colonialism, now stepping in simply to help its African brothers and sisters, or does it have other motives?

The Chinese media plays a huge role in portraying China’s health aid to African countries as a “selfless help to recipient,” but it seems political and economic motivations are also in play.\textsuperscript{44} Consider this positive portrayal of China’s aid (emphasis mine):

By 1973, China's foreign aid reached a record high, "the highest when the state's fiscal expenditure of 6% to 7%. China's selfless assistance did bring some political effect. In 1971, the 26th session of the United Nations General Assembly adopted the overwhelming majority of votes by the Albanian and Algerian countries to restore all the legitimate rights of the People's Republic of China in the United Nations and the deportation of all United Nations agencies. Of the 76 countries that voted in favor of this proposal, 51 were the third world countries of Asia, Africa and Latin America, the vast majority of which were Chinese foreign aid recipients, which triggered comments such as: “we were carried out by black friends.”\textsuperscript{45}

\textsuperscript{42} Wenjie Liang et al., \textit{China’s Approach in the Blooming South-South Health Cooperation: Chances, Challenges and the Way Forward}, report, China National Health Development Research Center, National Health and Family Planning Commission of the P.R. China.6.

\textsuperscript{43} Ibid.6.

\textsuperscript{44} Wenjie Liang et al., \textit{China’s Approach in the Blooming South-South Health Cooperation}.2.

This author describes China’s foreign aid, which includes health aid, as “selfless assistance,” but he also describes how China benefited from the political favors received from its donors in the United Nations. In other words, China’s selfless assistance somehow favorably leads to political favors or gains (or at least it has in the past). To explore the current motivations of China’s health aid to Africa, let me narrow my focus and consider two forms of China’s health aid to Africa, with a focus on how these forms of aid operate in my home country of Tanzania: Traditional Chinese Medicine and Chinese doctors.

**Traditional Chinese Medicine: Altruistic or Economical Strategy?**

Traditional Chinese Medicine (TCM) in Tanzania traces its roots back in the 1970s when Chinese doctors accompanied migrant workers and laborers who were working in the construction sites of Tazara Railway. In addition to these doctors, the Chinese government sent medical doctors to work in hospitals across Tanzania, some of whom decided to settle down and open medical clinics in Dar es Salaam and other urban areas. Hsu’s research shows that trust in the Chinese doctors and their health services began during the socialist period in Tanzania, as one of her interviewees said, “We trusted them [referring to the Chinese doctors] more than our local doctors at that time.” TCM is often perceived as “a rapidly effective ‘advanced’ ‘traditional’ medicine; its ready-made patent formulas, which make it look ‘scientific’ and ‘modern,’ are easy to consume; and its entrepreneurial set-up has several advantages over the bureaucratic structures of ‘hospital medicine.’”

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Research also shows that Tanzanians’ perception of what constitutes “modern” mostly implies better and/or advanced, which demonstrates that the inferiority complex, which occurred as a result of colonialism, has continued to affect people’s consumption habits, whereby they express a preference to lean towards what is considered “modern.” In the research study I conducted in Tanzania, which I will discuss in more detail in part III, one of the Chinese doctors said, “I prescribe Western medicine more of course.” Another study done in Tanzania showed that “Tanzanian consumers were consistently reported to prefer Western foreign goods over equivalent regional imports, with home-produced goods faring least well of all.”

The Tanzanian government has also played a huge role in fueling TCM to Tanzania both as aid and an import product for sale. The standardization and scientizing of TCM by the Chinese government has largely affected its acceptance in African countries such as Tanzania, where the government insists on distinguishing between traditional and modern medicine, with a preference for the latter. Furthermore, in addition to colonialism, it is the lack of committed efforts by the Tanzanian government to invest in the indigenous medical system that has also resulted in further hindering it from development and improvement. TCM’s are competitive in the local markets because they are cheap and are perceived to be more efficient than Tanzanian traditional medicine; thus for most Tanzanians, TCM’s are a good deal. And consequently, the

49 Robert O. Rugimbana et al., "The Impact of “Consumer Cringe on Developing Regional Trade Blocks,” Journal of African Business 1, no. 2 (2000), doi:10.1300/j156v01n02_06. One of the limitations of this study is that although it discusses people’s preference, it does not discuss people’s consumption patterns. One may prefer Western medicine because they assume it is the best, but they may consume Chinese medicine because it is what they can afford; thus, it is important to be able to differentiate preference and consumption patterns. Additionally, it is crucial to investigate the differences in preference and consumption between different social-economic groups of people.


acceptance of TCM in the Tanzanian market has influenced the increase of its supply through health aid as well as economic trade.

Traditional Chinese medicines are mass-produced from pharmaceutical factories in China, and in many cases TCM is not only cheap but free.\(^5^2\) However, China’s donation of TCM may not be altruistic, given the increasing volumes of TCM exported to Africa for sale. China’s provision of TCM as aid appears to be an economical strategy to promote Chinese products, which in turn influences consumers’ choice on their next purchase. In business terms, the cost incurred by China in supplying free TCM to Sub-Saharan African countries can be categorized as sales expense, which generates future revenue once the product has attained consumers’ trust and increased demand. For example, one of the reasons that TCM was formally introduced and incorporated into South Africa’s health care system in 2011 was the sufficient demand from the population to do so.\(^5^3\)

China earns significant revenue from the production and sales of TCM products worldwide, but especially from malaria endemic countries like Tanzania, where the prevalence of malaria has created a continuous demand for medication like Artemisinin.\(^5^4\) Tanzania still faces an immense burden of malaria with limited resources to control its spread, which in turn creates a large demand for antimalarial drugs.\(^5^5\) The hospitals and antimalarial centers that are


built by the Chinese in Tanzania through bilateral cooperation and as part of China’s health assistance since 2006 are the main hubs of selling Chinese antimalarial drugs.56

There is no doubt that financial constraints influence the consumption of TCM in Tanzania. For example, most lower – and middle – income people in Tanzania prefer TCM to Western forms of medicine and local traditional medicine because TCM is more affordable compared to Western forms of medicine, and local traditional medicine is not well developed.57

Some research suggests, however, that the success of TCM may be due to the perceived failure or limitations of the alternatives (Western biomedicine and local indigenous medicine) to manage the health needs of the population.58 For example, some patients use TCM after other forms of medicine have failed to treat their conditions or illness.59 Prior to colonialism and the introduction of biomedicine, millions of Africans used to rely on their own traditional medicine, also known as ethno-medicine.60 For some patients, faced with a mistrust of the current state of these traditional forms of healing but still harboring traditional views of health and they body. Colonialism was a setback to the progress of most traditional forms of healing. Thus, TCM has become a popular alternative to many Africans not only because it is cheaper than Western medicine, but because “a user is not called upon to abandon traditional definitions of the body or


59 Ibid, 470.

of notions of illness in utilizing a new healing tradition. Local beliefs can, indeed do, happily and constructively coexist with alternative imported systems.”

The popularity of TCM in Tanzania is high and is underscored by the fact that in Swahili it is referred to as dawa ya Kichina. Research shows that some Tanzanians perceive Chinese products as non-durable and of low quality. Thus the Swahili word mchina, which literally means a Chinese person, has been extended to name all Chinese products that are of low quality. Interestingly, even though TCM medicines are also Chinese products, they have so far been widely accepted by Tanzanians. Hsu’s research on factors that contribute to Tanzanians trusting TCM shows that unlike the connotation of the word mchina, the phrase dawa ya Kichina, “allows patients to transfer their positive experiences with Chinese biomedical doctors during the period of socialist orientation onto the current, entrepreneurial TCM doctors.”

Relationship of Chinese doctors with Tanzanian local communities

As part of its health aid assistance to Sub-Saharan Africa, China sends medical teams to different parts of the continent. Some of these doctors decide to settle down in the African countries and open their own medical centers. There is also a growing number of private Chinese medical practitioners in Sub-Saharan Africa, including Tanzania. These are practitioners who come not as part of a government program but on their own. China claims to send medical teams to other low-income countries in Africa as part of humanitarian aid and to strengthen the South-

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South co-operation to achieve economic development. The altruistic motive in sending medical teams to Africa is in question when one discovers that China is facing a problem of social and civil unrest within its own health sector, because doctors are low wages or fail to find good jobs. “Doctors in China have long been a group of people whose low financial incomes and social positions are distinctively in contrast to their high training costs, academic degrees … and professional risks.” It is possible that one of the ways the Chinese government resolves this problem is by sending some professional medical personnel to Africa as an “opportunity” to advance their careers. If so, this situation is similar to the colonizing strategy I discussed in part I, whereby European colonizers in Africa created settler economies to reduce the unemployment and social unrest in Europe.

Regardless of what brings Chinese doctors to Tanzania, research done in Tanzania’s island of Zanzibar shows that Chinese doctors do not interact much with the locals and they do not make efforts to learn the local language, Swahili: Chinese medical doctors “were also known for not mixing with the local population … outside working hours. They lived in a house, cooked their [own] food and had their own leisure activities such as table tennis.” Moreover, in the research study I conducted in Dar es Salaam, Tanzania, discussed in part III of this paper, I found out that none of the participants spoke Swahili, including those who had been in the country for more than two years. Even worse, none of these Chinese doctors were learning Swahili.

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65 It is important to note that none of the Chinese doctors in my research study discussed in part III expressed poor working conditions in China being a motive for their relocation to Tanzania, but the questionnaire was open-ended, the question was very broad, and the sample size was very small, so it impossible to draw any conclusions.

Interestingly, the Tanzanians who worked with or for these Chinese doctors spoke fluent Chinese (Mandarin).

The pattern of Chinese doctors not interacting with locals is not unique to Tanzania but present in other African countries to which China provides health aid. In Cameroon, Pokam’s research also shows that the Chinese doctors are not interested in learning the local language even though their Cameroonian coworkers and employees learn Chinese. Additionally, Pokam mentions that the “Chinese doctors migrate to Africa with their own cooks,” which means they also do not make any effort to integrate or adapt to the local people’s food.\(^\text{67}\) Hsu argues that the lack of interaction between Chinese doctors and Tanzanians may be due to existing power differentials (related to both authority and money) between the doctors and the locals.\(^\text{68}\) But whatever the reason, the lack of interaction between Chinese doctors and local communities is concerning because it suggests a certain disinterest on the part of Chinese doctors to be involved in the African communities. The disinterest of Chinese doctors to integrate with local communities may suggest that the Chinese doctors are first and foremost passionate, not about using their medical expertise to help the local people, but rather about using the opportunity to work in an African country to further develop their own career goals.

I should also note, however, that the relationship between Chinese doctors and African communities may well be driven in part by the government contract for the Chinese doctors. Hsu’s research shows that the contract Chinese medical doctors sign before being sent abroad advises them to spend evening indoors and not mix with the local population outside working


One wonders whether these instructions represent racist attitudes. The lack of interaction may also be indicative of Chinese racism towards black people. Most studies have focused on racism faced by Africans in China, but not much on the inter-relations between Chinese abroad and the communities they live in. Studies of racism in China certainly suggest that this may be a significant issue. Although dated, one study recounts events in the 1970s and 1980s in which, in one case, African students were called “black devils” (hei gui) after complaints that they played loud music at night. African students were beaten and severely injured from this incident. In another case, Africans who had sexual relationships with Chinese women were arrested and deported, although the same fate did not meet whites who had Chinese girlfriends. When interviewed in the 1990s, some Chinese students claimed to view “Africans as peasants because the Chinese media only showed Africans as poor recipients of aid from China.” Whether these sorts of attitudes persist in China and whether they accompany the Chinese doctors who immigrate to Africa is an issue in need of more research, particularly by African scholars who are still underrepresented in scholarly works. Nonetheless, it seems likely that racial attitudes towards black people may well be one reason for the disinterest of Chinese doctors toward African communities.

The failure of Chinese doctors to adapt to their new environments raises the following question: how is the treatment of Chinese doctors effective without an understanding of the local

69 Elisabeth Hsu, “Zanzibar and its Chinese Communities,” *Population, Space and Place* (2007); doi: 10.1002/psp.429. Due to the limitation of time in this study, I have not been able to find the Chinese doctors’ contract to Africa in order to be able to analyze the reasons for such a regulation.


72 Ibid, 417.

73 Ibid, 417.
culture and ways of life that play a role in manifestation of illnesses? I am curious how Chinese doctors manage to offer treatment to Tanzanians if they do not understand the locals’ lifestyles, culture, and language, since one of the advantages of Chinese medicine is supposed to be that it has a holistic approach that takes into account all the factors in the patient’s life and the environment that may lead to illness. There has not been research done to determine whether Chinese doctors in Tanzania practice the traditional Chinese healing in this way; and it is important to note that “not all forms of “Chinese medicine (zhongyi) practiced in the PRC [People’s Republic of China], and outside it, can claim to be derived from TCM. The modernized (xiandaihua), scientised (kexuehua), systematized (xitonghua) and standardized (guifanhua) form of Chinese medicine of the PRC … is only one form among others that are practiced in the PRC, in Taiwan and elsewhere.” Nevertheless, the lack of interaction and integration between Chinese doctors in Africa and their communities remains a problem.

An understanding of TCM and the relationship between Chinese doctors and the local communities is crucial in improving the effectiveness of health aid to Sub-Saharan African countries. TCM offers an affordable alternative form of medication to most low-income African families, and thus helps to bridge the health gaps in the existing health systems. Additionally, the interaction between Chinese doctors and the local communities in which they work is of paramount importance because it allows the doctors to become familiar with the environment,

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74 Ted J. Kaptchuk, “The Web That Has No Weaver: Understanding Chinese Medicine” (New York: Congdon & Weed, 1983). Kaptchuk, a scholar and practitioner of Chinese medicine in Boston, writes: “the Chinese method is based on the idea that no single part can be understood except in its relation to the whole.” Fellow scholar-practitioner Volker Scheid, based in London, adds that Chinese practitioners make “a conscious choice ... to grasp how this unique and ultimately singular presentation [referring to an illness] embodies both the coherence of the body/person and its integration into the world around it; and to develop strategies for effectively acting on this relationship ... through gaining a clear conception of it.” Volker Scheid, "Integrating East Asian Medicine into Contemporary Healthcare,”, doi:10.1136/acupmed-2012-010154.

culture and traditions of the people they are treating. In delivering health care, it is important for medical personnel to be fully aware and engaged with the communities and the environment in which their patients live. Health and environment are interconnected, and failure to understand the environment may lead to failure to control diseases and vice-versa.

The next section of this paper is a research study to investigate the health services of Chinese doctors in Dar es Salaam, Tanzania, in comparison to the literature review discussed in part I and II.

**Part III: Chinese Health Services in Tanzania**

Given what I found in secondary sources about China’s Health Aid, as discussed in part I and II of this paper, I developed a modest research project to investigate the services provided by Chinese health workers in Tanzania, and the integration of the Chinese health workers in the Tanzanian community. The main questions I aimed to answer included: What types of health services are provided by Chinese health care workers in Dar es Salaam, Tanzania? How do these health services serve the health needs of the local population? What are the challenges facing Chinese health workers in Tanzania in providing their services to the local population? What are the perceptions of the Chinese health workers about Tanzanian traditional medicine and medicine from the West? How have the Chinese health workers in Dar es Salaam integrated with the local community? With these questions in mind, I developed a survey instrument and consent forms (see appendix) and then travelled to Tanzania in December 2016 to conduct my research.

**Study Context**
The study area of the case study was Dar es Salaam city, Tanzania. Dar es Salaam is one of the major cities in Tanzania. The population of people in Dar es Salaam is still growing because of huge migrations of people from rural areas seeking economic opportunities in the metropolis. One of the biggest hospitals in Tanzania, Muhimbili National Hospital, is found in Dar es Salaam, and thus people travel from different parts of the region to receive health services at this hospital, since it has more specialists and resources.

**Methodology**

I conducted the research for this case study for three weeks, from mid-December 2016 through the beginning of January 2017. The methods used to collect data include observation and questionnaires given to Chinese health care workers. I collected a total of six questionnaires from Chinese health workers from three different hospitals and a home-based center. The questionnaires were written in both Chinese and English, and the Chinese health workers were instructed to respond to the open-ended questions in the language that they were most comfortable in. All the respondents except one responded in Chinese. All the questionnaire responses that were written in Chinese were translated into English in the Health Humanities Lab by Dr. Nicole Barnes, and Grant Wen, who is a sophomore Chinese heritage undergraduate student at Duke University.

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76 The population of Tanzania in 2015 was about 5.116 million people according to the World Factbook.
Limitations

Most Chinese health workers were very skeptical about my goals and motives for the case study, and some did not want to participate in my research as soon as they heard I am a student in a university in United States. It took a lot of explaining both in Chinese (Mandarin) and English to get the Chinese health workers to answer the questionnaires. It came to a point that I felt I had reached a dead-end, and thus, I decided to switch gears and pretended to be a patient in need of acupuncture services because my back was giving me problems. I asked one of the Chinese doctors who agreed to participate in my survey for a referral. He was at first skeptical, but I managed to convince him, and he gave me the phone number of another Chinese doctor who provides health care services at her home. I managed to reach the Chinese woman doctor over the phone and arranged a visit to her home. Upon arrival, I was shocked to see that she had turned her room into a clinic full of different tools for acupuncture, cupping and massage. I learned that she and her friend were both not certified workers in Tanzania, but they provided these services through Chinese hospital referrals like mine. One of them claimed to be a Chinese doctor in a big hospital in China, while the other said she was only experienced in providing such services. Both women also said they were only in Tanzania for a vacation. At the end of the cupping, I told her about my thesis research and she and her friend both agreed to fill out my questionnaires. These were my last two participants, which made a total of six from three different Chinese hospitals and the one home-based “clinic/center”.

77 I failed to secure Duke IRB approval for this research before I started, but I did follow all the IRB requirements throughout my research, including providing all my participants with a consent form, asking no personal questions, and protecting subject’s identity and personal information during data collection. Instead of names, all my participants were given numbers in the questionnaires they filled out, and I did not take any pictures of the participants. Due to these circumstances, the Duke IRB team allowed me to use my data in my thesis work, but if aiming to further use my data for publication, I will need to get an IRB approval from all required institutions.
Three weeks are not enough to conduct an extensive qualitative research to understand the types of health services provided by Chinese health workers, the challenges they face, and the way they integrate in the community. Due to the time limitation, I was not able to get many participants in my study especially because most of them worked only on certain days of the week, most left the hospitals early, and, more importantly, I had no time to build trust; thus, the most I could get from one hospital was one or two participants.

Although I consider myself to have professional working proficiency in Chinese/Mandarin, I have not practiced speaking the language since I came back from my study abroad at Duke Kunshan University. Hence, I was not feeling very confident to approach the Chinese health workers in Chinese, and since most had low fluency in English and almost none in Swahili, I relied on the Tanzanians (who spoke fluent Chinese) working in these hospitals to translate for me. This created another barrier in getting information since I wasn’t able to express my objectives clearly and I wasn’t sure what got lost through translation.

**Data Analysis**

Demographics:

- Age: (<20, <30, <40, <50, <60, >60)
- Sex: (male, female, other)

The responses indicate that all the participants were 20-40 years old; and based on my observation and calculations of the time it takes for medical training, those who were <30 years were likely in their late twenties. Four of the participants who work in the hospitals/clinics were male. The two Chinese health workers who provide services at their own home were female.

- Occupation/Profession
This question was not translated into Chinese because I thought it should be straightforward. However, I think for future research, it would be better to translate everything to assist participants who are not fluent in English. The respondent’s answers on this question after translation included: – doctor, manager, self-employed, trade school (professional), and one nonresponse. These responses are very interesting because I was expecting that the answer to this question from most participants should be doctor/nurse/technician, but this does not seem to be the way they identify themselves. One of the reasons could be failure to understand the term “occupation/profession” as written in English. Another possible reason is that individuals who provide services such as acupuncture and cupping may not necessarily identify themselves as doctors because they did not go through medical school and get certified. This is alarming because without proper regulation even non-certified and non-qualified individuals can provide health services, which consequently risks the lives of the population receiving the health services. For example, among the two women in Tanzania who provide health services from their apartment, only one claims to be a certified doctor. The other uses her experience to deliver health services, which is posing risk to patients. Such cases bring attention to the need of government regulation in health care services in their countries to protect the health and lives of their citizens.

- Original Province in China
- Education level
- Work experience (in years) in China, Tanzania and other parts of the world
- Sector (government, private, both)

Three participants in the case study came from Henan province, one came from Sichuan, another from Liaoning, and one participant did not respond to this question. Also, all participants had
college levels of education and higher. One participant had a bachelor degree in engineering, but this participant was not directly involved in delivering health care. This specific participant identified themselves as “manager”. Additionally, all participants had an average of about twelve years of work experience in China and a range of six months to two years of work experience in Tanzania. The two women who claimed to be on vacation yet provided services at their home did not respond to the how much time they have worked in Tanzania, but one of them wrote that she has worked for five years in China.

**Health services provided by Chinese health care workers in Dar es Salaam, Tanzania**

The Chinese hospitals or clinics varied in size and resources available. One of the hospitals I visited is only specialized in providing MRI, CT and X-ray services. This hospital does not provide any patient consultation, and thus most patients are sent by their hospitals to this Chinese hospital to get a test and then the patients head back to their hospitals with their results. Most of the workers in this hospital including technicians, were Tanzanians; however, the hospital is managed by the Chinese.

The Sino-Tanzania Friendship hospital, which is one of the biggest Chinese hospitals in Tanzania, offers various services, including surgery, obstetrics and gynecology, pediatrics, dermatology, pain management, and acupuncture. The two women who provided health services at their apartment said they offered Chinese herbal medicine and traditional Chinese treatment. One of the women wrote, “We are a clinic, a place to maintain your health.” These two women also said they treat fatigue and back pain issues.

One of the questions in the questionnaire were: *What type of Chinese medicine do you practice? If you prescribe drugs, what type of drugs do you prescribe to people?* One of the Chinese workers responded, “I learned western medicine in school, I also learned Chinese
medicine. I prescribe Western medicine more of course.” Ending the sentence with “of course” may be an indication of the perception of Western medicine as superior compared to other forms of medication, as discussed earlier in this paper. The same participant also claimed to have never heard of the perception of Chinese medicine as fake. Another participant said, “I take care of the self-care aspect, I don’t prescribe medicine,” while another one simply wrote, “I manage acupuncture.”

In part II of this paper, I discussed the relationship between Chinese doctors and the local African communities. One of the major findings from the secondary sources was a lack of interactions between Chinese doctors in Africa and the local people in the respective countries. My own findings from the research study support this conclusion.

**Reasons/Motives of Chinese medical personnel to travel Tanzania for work**

Not all participants in this study were not sent by the government; thus, it is quite interesting to hear the reasons these Chinese health workers came to Tanzania. In the questionnaire, I asked, *What made you come to Tanzania?* Below I include some of the interesting responses I came across while analyzing the data:

- “To experience a different life” – Manager
- “This is a beautiful country. I was invited by a friend. I am experience a different culture” – Doctor
- “I like the people of Tanzania. I like the air, the beaches. I hope to bring Chinese medicine and self-care to Tanzania to help more Tanzanians.” – Cupping woman 1
- “For trip” – Cupping woman 2

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78 cupping woman 1 and 2 are the two women who provide health services in their apartment.
These findings suggest a sincere desire and interest of the Chinese to travel to Tanzania to experience a different life, culture and so forth. None of the participants mentioned that they moved to Tanzania because they were dissatisfied with their salaries and working conditions in China.

**Language**

Surprisingly, none of the participants in the study spoke any Swahili, including those who had been in Tanzania for more than a year. Most of them only spoke Chinese, and three of them spoke some English. This finding is similar to Hsu’s and Hilaire’s research, which found that most Chinese do not make efforts to learn the local language of the people in the communities they work in, which is another factor that hinders the interaction between the two groups. I would expect and recommend that the Chinese and African governments make learning the local language a requisite for the Chinese doctors sent on a medical mission to African countries because only then will the doctors be able to fully integrate and understand the complexity of the inter-relationship between health, poverty, gender and power. One cannot understand or solve the problem of health in the low-income communities without an understanding of all the other factors.

**Involvement and Integration in the local community**

One of the questions in the research was, “*After work, where do you usually hang out? (please list some of the activities you do after work, e.g. Watching football at the local club.*)”

<table>
<thead>
<tr>
<th>Level of integration</th>
<th>Doesn’t integrate with locals</th>
<th>Somewhat integrates with locals</th>
<th>Integrates with locals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cupping woman 2</td>
<td>Watch TV with my family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Manager</td>
<td></td>
<td></td>
<td>I go out to have local food at a local bar</td>
</tr>
<tr>
<td>Participant 02 and 01</td>
<td>reading</td>
<td>Walking, exercise, drinking tea</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>---------</td>
<td>---------------------------------</td>
<td></td>
</tr>
<tr>
<td>Participant 04</td>
<td></td>
<td>Hang out at the beach, exercise</td>
<td></td>
</tr>
<tr>
<td>Cupping woman 1</td>
<td>Resting at home, watching TV, listening to music</td>
<td>Going to the beach</td>
<td>Going to local bars</td>
</tr>
</tbody>
</table>

The table above shows the responses of the six participants in the case study and the level of integration in the community based on the type of activity the participants described. The first category involves activities that do not lead to any form of contact with the local population such as watching TV or listening to music. The second category involves some sort of integration between the participants and the local people although it may not necessarily reflect interactions between the two groups. The integration considered in this category may simply be participants learning about the local peoples’ culture and practices through observation. For example, walking or hanging out at the beach involves sharing common spaces with the locals, which is one way of integrating into a new environment. The third category involves activities that are highly likely to involve interaction with the locals, through which participants may be able to build friendships with the locals and learn about the locals’ culture in a bar. However, since all the participants in this case study mentioned that they do not speak Swahili, interaction with the locals might be very limited.

To try to gauge levels of integration in a different way, I asked another question: “On a scale of 1-10, 1 being the least and 10 being the most, how much do you know the local people’s culture, tradition, and way of living?” Out of the six participants, half of them ranked their understanding of the local culture, tradition, and lifestyle a 1, which is the lowest score. The highest rank on this scale was a 3 (out of 10), which interestingly was the Chinese health worker who had only stayed in Tanzania for only six months. One of the participants who did not rank...
their understanding wrote, “To be truthful, I don’t understand much. But from my coworkers and people around me, my sense of Tanzania’s culture is that it is very down to earth and easy to get along with.”

The answers to this question crystalize most of the points discussed in the earlier sections. First, the failure of the Chinese doctors to speak or learn the local language and to integrate in the local communities has resulted in their lack of understanding of the local community’s culture, traditions and ways of life. Moreover, the motives of the Chinese doctors to travel to Tanzania does not match with the way they behave or act in Tanzania. Most of them claimed to travel to Tanzania because it is a beautiful country and they want to experience a different life, but these same Chinese doctors have very low interactions with the local people and hardly understand the local traditions and culture. This may suggest that there is a need for further investigation of the motives of Chinese medical personnel in Tanzania and other Sub-Saharan African countries. Because failure to understand the local people’s culture may hinder effective delivery of health care services, the integration of Chinese doctors in these African countries is a component that needs to be addressed.

**Perceptions of Western medicine and Tanzanian traditional medicine by Chinese health workers in Tanzania**

In analyzing this category, I decided to use a table that summarizes the responses of the participants to the question of: “What is your perception of western medicine and Tanzanian traditional medicine?” in comparison to the time they have spent in Tanzania and their level of understanding the local people’s culture and traditions. I used two summary tables to give more room to the responses for the participants, and participants were randomly assigned between the two summary tables.

**Summary Table 1:**
<table>
<thead>
<tr>
<th>Participant</th>
<th>01</th>
<th>02</th>
<th>03</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of years in Tanzania</td>
<td>1 year</td>
<td>6 months</td>
<td>More than 1 year</td>
</tr>
<tr>
<td>Rank of knowledge and understanding of local culture</td>
<td>2/10</td>
<td>3/10</td>
<td>1/10</td>
</tr>
<tr>
<td>Perception of Western medicine &amp; traditional</td>
<td>“In regards to Tanzanian traditional medicine, I don’t have much of an understanding”</td>
<td>“I don’t really understand Tanzanian traditional medicine. Tanzanian traditional medicine and western medicine both have their own advantages”</td>
<td>- No response-</td>
</tr>
<tr>
<td>Chinese products are generally perceived by Tanzanians as fake, have you also experienced this in your practice and if so, how do you overcome this challenge?</td>
<td>“I don’t know”</td>
<td>“I haven’t heard of this before”</td>
<td>“We don’t sell drugs etc.”</td>
</tr>
<tr>
<td>What are the challenges you are facing in your practice?</td>
<td>- (lost in translation)</td>
<td>“Time. I don’t have much time to see patients”</td>
<td>- No response</td>
</tr>
</tbody>
</table>

Summary Table 2:

<table>
<thead>
<tr>
<th>Participant</th>
<th>04</th>
<th>05 (cupping woman 1)</th>
<th>06 (cupping woman 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of years in Tanzania</td>
<td>2 years</td>
<td>1 year</td>
<td>- no response -</td>
</tr>
<tr>
<td>Rank of knowledge and understanding of local culture</td>
<td>“to be truthful, I don’t understand much. But from my coworkers and people around me, my sense of Tanzania culture is that it is very down to earth and easy to get along with,”</td>
<td>1/10</td>
<td>1/10</td>
</tr>
<tr>
<td>Perception of western medicine &amp; traditional</td>
<td>“Traditional (old) things can be of use today. Western (foreign) things can be of use for China. Each thing has its benefits; we can take advantage of the good thing, and not worry too much about the downsides for mutually beneficial outcomes”</td>
<td>“Western and Chinese medicine each have their advantage. Tanzanian traditional medicine is also very unique/special”</td>
<td>“I’m not very clear about this. I don’t understand either much”</td>
</tr>
<tr>
<td>Chinese products are generally perceived by Tanzanians as fake,</td>
<td>“of course, this can happen”</td>
<td>“No, China has a lot of high quality products. We will allow them to experience and feel them”</td>
<td>“Locals have not told me about this”</td>
</tr>
</tbody>
</table>
Based on summary table 1 and 2, we can see that the participants who had a low understanding of the local people’s culture also had a low or no understanding of Tanzanian traditional medicine. Additionally, there seems to be a lack of awareness about the negative perceptions of Chinese products by the locals. This may also be due to the lack of understanding of the local language, which is a sign of failure to communicate with the locals and understand their views and perceptions. Interestingly, the participants did not have any strong views on either of the two forms of medicine (Western medicine and Tanzanian traditional medicine).

Discussion

The major objectives for conducting the research study in Dar es Salaam, Tanzania, were to investigate the services provided by Chinese health workers, and the integration of the Chinese health workers in the Tanzanian community. The findings indicate that the Chinese medical personnel in Tanzania provide a variety of health services such as X-ray imaging, CT/MRI scans, physical therapy, consultation, acupuncture, cupping and so forth. Although most of these services are provided in a hospital setting, some are provided in home settings.

Dar es Salaam is among the major growing cities in East Africa, which attracts people from rural areas of the country to the city in search for work and to improve their living
Most of these people get employed to do physical labor because they are illiterate and/or due to scarcity of job opportunities. One of the questions I aimed to answer was: How do Chinese health services serve the health needs of the local population in Dar es Salaam? The results of the research show that the services provided by the Chinese such as acupuncture, massage, and cupping would be helpful to the people who are engaged in hard physical labor and most likely living in poverty. However, there is a need for further research to investigate whether the Chinese services are being used by the locals or not, and whether the Chinese services are affordable to the local Tanzanians. Traditional Chinese Medicine is usually an affordable and reliable option compared to biomedicine from the West, which is expensive, and to the poorly developed traditional medicine from Tanzania. However, this may not be the case for Chinese health services. When I went to visit the Chinese home-based clinic, I paid $50 for the cupping, which is equivalent to about Tshs. 100,000. This amount is the approximate monthly minimum wage for someone working in the agricultural sector in Tanzania. Therefore, the question of whether the Chinese services serve the needs for the local population still needs further investigation.

The challenges faced by Chinese health workers in Tanzania identified during this research include communication and cultural difference, requirement for further studies and limited time to see patients. An effort by the Chinese health workers to learn the local language will help to resolve the communication challenge. Participants reported that they had limited time to see patients, but it is unclear what that means, because most the clinics I visited looked

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empty. It is possible that the Chinese doctors receive many patients and that I arrived on a slow day. It is also possible that the Chinese health workers are engaged in other activities beyond health care delivery, and for that reason do not have enough time to see patients. Or maybe they are misreporting, perhaps out of embarrassment that their hospitals and clinics are so empty.

The findings of this research study also show that most Chinese health workers do not understand Tanzanian traditional medicine. Most of the participants said that they believe there are advantages and disadvantages in both Tanzanian indigenous medicine and Western forms of medicine, and that the two can learn from each other. My hypothesis was that the Chinese health workers would be critical about the other forms of medicine, because they would see them as competitors, but this hypothesis seems to be mistaken. Instead, my findings confirm research that suggests “healing within Tanzania – within Africa – consists of these multiple agents: coexisting and competing systems all granted legitimacy through use.”

Conclusion

Success of China’s Health Aid

Even though the motives of China’s health aid may be economically and profit-driven, Tanzania also benefits largely from this aid. The first advantage of China’s health aid to Tanzania is the increase in availability of specialist health services to Tanzanians. All the CMTs sent to African countries are professional experts mostly in their mid-career, as can be seen from the findings of the research study I conducted in Dar es Salaam. In addition, China has offered assistance in building a number of health centers in Tanzania, trained Tanzanian medical

personnel, and provided free services and medication to a majority of Tanzanians.\footnote{Pál Nyíri, \textit{"China into Africa: Trade, Aid, and Influence"}. Robert I. Rotberg, The China Journal 62 (2009), doi:10.1086/tcj.62.20648163.} The China-Tanzania cooperation has contributed largely to the improvement of public health systems, which still faces a critical shortage of resources due to lack of funding.\footnote{Wenjie Liang et al., \textit{China’s Approach in the Blooming South-South Health Cooperation: Chances, Challenges and the Way Forward}, report, China National Health Development Research Center, National Health and Family Planning Commission of the P.R. China.12.} Moreover, China has assisted Tanzania in fighting against malaria, a disease that mostly kills children under the age of five and pregnant women. The various forms of China’s health aid reach people from all social economic classes, compared to other forms of aid, which only end up in government bank accounts. At an individual level, China’s health aid gives opportunities to the poor to access professional doctors and receive affordable medication. On the White paper report, China describes the distribution of its foreign aid as follows: “China sets great store by people’s living conditions and economic development of recipient countries, making great efforts to ensure its aid benefits as many needy people as possible.”\footnote{“China’s Foreign Aid: Information Office of the State Council The People’s Republic of China April 2011, Beijing," China’s Foreign Aid (2011), 2011, , accessed April 18, 2017, http://english.gov.cn/archive/white_paper/2014/09/09/content_281474986284620.htm.} At a national level, China’s health aid assists African governments in the health sector and thus gives the governments an opportunity to focus in other development projects such as education.

**Challenges of China’s Health Aid**

Despite the numerous advantages of CHA in Tanzania, there are still major challenges facing its implementation and regulation. One of the main challenges of CHA is the rise of a
black market producing fake TCMs. The availability of fake TCMs in Tanzania is also largely due to lack of proper regulation of the TCMs by the Tanzanian government and by the Chinese government before they are exported. In 2001, Tanzanian health officials toured the Chinese medical clinics and confiscated all medicines that were not well packaged or labeled. Although the Tanzanian government took an important step in trying to regulate Chinese medicine, the approach of using packaging standards rather than testing for efficacy and safety is also contributing to an increase in fake medicines in the market because packaging is all it takes for the medicine to be approved. The Chinese practitioners complained about this intervention as negatively affecting trade, and that the “packaging was not indicative of the medicine’s exotic provenance.” Brigitte Read who conducted research in Uganda, a country north of Tanzania, discovered that good packaging of TCMs with Chinese characters might sometimes be used to deceive Ugandans into buying fake medicine. The major concern with fake medicines is that they disrupt the trust that the locals have of TCMs and consequently affects Tanzanian’s perception of CHA as a whole.

Unfortunately, there is a paucity of information regarding the scale, scope, and impact of Chinese health aid to Africa. Irrespective of the nature of the assistance, there is a need for a systematic and rigorous evaluation of the various approaches and investments. Such assessments


could be critical in informing future investments and consequently serving to advance the health of the target populations.90

Finally, there is a need for African leaders, who are passionate for positive change and who represent African communities, to be actively and fairly involved in the determination and rigorous evaluation of the various elements of China’s health aid to African countries. This, I argue, will enable all parties involved to gain a deeper understanding of how priorities and allocations for health aid are determined, how such aid fits within the specific African country’s health strategies and finding efficient means to assess the terms, implementation and effectiveness of such aid. Additionally, African countries need to understand that aid is not effective if not sustainable, and sustainable aid must stimulate the efforts for development. It is time for African countries to invest heavily in education and training, diversifying the economy, and strengthening governance systems – to be able to stimulate development in the continent.91 From what I see, there is no point in arguing whether aid is altruistic or not. It is time for African governments and communities to also prioritize their own needs. It takes a strong will and great bravery to break the existing power differentials in decision making, but everything that’s great comes with its own sacrifice.

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Bibliography


"Famous French political cartoon from the late 1890s. A pie represents "Chine" (French for China) and is being divided between UK, Germany, Russia, France and Japan." Digital


Appendix:

Picture 1: A drawing of Zheng He and the giraffe gift from Malindi

A drawing of Zheng He and one of the giraffes that he was given as a gift from the ruler of Malindi, one of several trading centers on the African coast.
By Ojibwa,

Consent Form:

Informed Consent Form for participant number:

This informed consent form is for the senior thesis research project of Ms. Florence Tesha majoring in Global Health and Chinese at Duke University, in the United States. Ms. Florence Tesha is conducting research to analyze China’s health aid in Tanzania by understanding Chinese health services and products in Tanzania.

Name of Principle Investigator: Dr. David Toole
This Informed Consent Form has two parts:
  • Information Sheet (to share information about the study with you)
  • Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Introduction
Briefly state who you are and that you are inviting them to participate in research which you are doing. Inform them that they may talk to anyone they feel comfortable talking with about the research and that they can take time to reflect on whether they want to participate or not. Assure the participant that if they do not understand some of the words or concepts, that you will take time to explain them as you go along and that they can ask questions at any time.

I am Florence Tesha, a senior student at Duke University majoring in Global Health and Chinese. In this research project, I am investigating China’s health aid to Tanzania. I am going to give you information and invite you to be part of this research. You do not have to decide today whether you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me or of another researcher.

Purpose of the research
China’s health aid to Africa began out of Cold War in April 1963 when the first Chinese Medical Team (CMT) was sent to Algeria following the end of Algeria’s war against French colonialism and flight of much of the country’s trained medical personnel. Since 1963, China has sent medical teams to various parts of Africa using the system of one Chinese province is responsible for one or more African countries. Tanzania is one of the countries that has benefited from China’s health aid for many years. Recently, there has been an increase of private doctors from China to Tanzania to offer medical services. In this research, I want to understand the challenges faced by Chinese medical personnel in Tanzania when it comes to adjusting to the local culture and traditions, as well as the perceptions of the local people on Chinese services and products. I also want to understand the perceptions of Chinese medical personnel on local traditional medicine and western medicine. This project also involves understanding the type of healing/treatment provided by Chinese medical personnel.

Type of Research Intervention
This research will involve your participation that will take about one hour interview.

Participant Selection
You are being invited to take part in this research because we feel that your experience as Chinese medical personnel can contribute much to our understanding and knowledge of China’s health aid and/or Chinese medical practices in Tanzania.

**Voluntary Participation**
Your participation in this research is entirely voluntary. It is your choice whether to participate or not. The choice that you make will have no bearing on your job or on any work-related evaluations or reports. You may change your mind later and stop participating even if you agreed earlier 😊

**Procedures**
We are asking you to help us learn more about Chinese medical practices in Tanzania. We are inviting you to take part in this research project. You have a choice of selecting an interview or questionnaire format. You can use a language of your choice for both the interviews and questionnaires. If you accept, you will be asked:

**Interviews:**
During the interview, I will sit down with you in a comfortable place of your choice. If it is better for you, the interview can take place in your home or a friend's home. If you do not wish to answer any of the questions during the interview, you may say so and I will move on to the next question. No one else but me will be present unless you would like someone else to be there. The information recorded is confidential, and no one else except Dr. David Toole and the research mentors mentioned above will access the information documented during your interview. The entire interview will be tape-recorded, but no-one will be identified by name on the tape. The tape will be kept safely and encrypted. The information recorded is confidential, and no one else except the interviewer and research mentors mentioned above will have access to the tapes. The tapes will be destroyed after April 2017 when the research project is over.

**Questionnaire:**
In this research project, you also have a choice to fill out a questionnaire, which will be provided by Ms. Florence Tesha and collected by Ms. Florence Tesha OR You may answer the questionnaire yourself, or it can be read to you and you can say out loud the answer you want me to write down.
If you do not wish to answer any of the questions included in the survey, you may skip them and move on to the next question. The information recorded is confidential, your name is not being included on the forms, only a number will identify you, and no one else except the researcher and her mentors mentioned above.

**Risks**
Is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish for this to happen. You do not have to answer any question or take part in the survey if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

**Benefits**
There will be no direct benefit to you, but your participation is likely to help us find out more about Chinese health services in Tanzania.
Reimbursements
You will not be provided any incentive to take part in the research.

Confidentiality
We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. Only the researchers will know what your number is and we will lock that information up with a lock and key. It will not be shared with anyone.

Sharing the Results
Nothing that you tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name. The knowledge that we get from this research will be shared with you before it is made widely available to the public.

Who to Contact
If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact any of the following:

   Principal Investigator Name: Dr. David Toole
   Email: david.toole@duke.edu
   Phone: +1 919 660 3475

   Researcher: Ms. Florence Tesha
   Email: fet3@duke.edu
   Phone: +1 919 597 1577

You can ask me any more questions about any part of the research study, if you wish to. Do you have any questions?

Part II: Certificate of Consent

I have been invited to participate in a research about China’s health practices in Tanzania.

(This section is mandatory)
I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant__________________
Signature of Participant ___________________
Date ___________________________
   Day/month/year
If illiterate

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness____________ Thumb print of participant 
Signature of witness _____________
Date __________________________
   Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the research project and its objectives. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent________________________

Signature of Researcher /person taking the consent________________________
Date __________________________
   Day/month/year

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92 A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.
Questionnaire Sample

Participant Number:

Basic Questions (Please circle the correct answer)
Age:
   a. <20
   b. <30
   c. <40
   d. <50
   e. <60
   f. >60
Sex:
   a. Male
   b. Female
   c. Other

Occupation/ Profession:

Original Province in China:

Education level:

Work Experience (in years)
   • Tanzania
   • China
   • Other parts of the world (please mention) ………………

Sector:
   a. government-sent
   b. Private
   c. Both

Questionnaire/Survey (You can respond both in Chinese or English)
1. How long have you worked in Tanzania?
   您在坦桑尼亚工作了多久？

2. What made you come to Tanzania?
   您为什么选择来坦桑尼亚？

3. What type of Chinese medicine do you practice? If you prescribe drugs, what type of drugs do you prescribe to people?
   您的专科是哪种中医？如果您也开药，请问您开的是哪种药？

4. What are the health services available at this clinic/center?
   这家诊所提供哪些医疗服务？

5. How many people do you see per week?
   您每周会诊多少个病人？

6. What type of diseases do you treat?
   您治疗哪些疾病？

7. How do the local people know about your services or clinic?
   当地人如何了解到您的服务/诊所？

8. Apart from offering medical services, are you also engaged in other economic activities?
   除了提供医疗服务，您还参与其他的经济活动吗？

9. How many languages do you speak, and what is your fluency in those languages? If you speak Swahili, where did you learn it?
   您会几种语言？分别都是什么水平？如果您会说斯瓦希里语，是在哪里学会的？

10. Chinese products are generally perceived by Tanzanians as fake, have you also experienced this in your practice and if so, how do you overcome this challenge?
    坦桑尼亚人通常认为中国的制品是假货。有当地人对您这样说过吗？如果有，您是如何克服这个困难的？

11. What is your perception of western medicine and Tanzanian traditional medicine?
    您对西医和坦桑尼亚传统医学怎么看？

12. What are the challenges you are facing in your practice?
    您在行医中面对怎样的挑战？

13. How cheap or expensive are your services and/or medicine compared to western medicine and Tanzanian traditional medicine? (please list price examples if possible)
    对比西医和坦桑尼亚传统医学，您的服务有多贵/便宜？请尽可能列举价格。
14. After work, where do you usually hang out? (please list some of the activities you do after work eg. Watching football at the local club.)

15. Are you in Tanzania with your family? If not, how often do you visit your family?

16. How long do you plan to be in Tanzania?

17. What is your next career goal?

18. On a scale of 1-10, 1 being the least and 10 being the most, how much do you know the local people’s culture, tradition and way of living?