

Beyond “Revolutionary Humanitarianism”: Chinese Doctors in South Sudan

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Dissertation submitted in partial fulfillment of
the requirements for the degree of Doctor
of Philosophy in the Department of
Cultural Anthropology in the Graduate School
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ABSTRACT

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Abstract

The transnational movement of medicines and medical professionals to post-war settings has given rise to various forms of caregiving, expertise and ethics. However, little is known about the broad range of actors and agents from the Global South engaging health and the body, beyond the spectacle of international NGOs such as Médecins Sans Frontières. My dissertation, entitled “Beyond ‘Revolutionary Humanitarianism’: Chinese Doctors in South Sudan,” analyzes the historical formation and contemporary reconfiguration of China’s longstanding medical programs in South Sudan. Through extended participant observation, semi-structured interviews, and archival research, I explore the role of medicine from China in South Sudan, a hybrid system that integrates aid and business. I argue that China’s medical interventions in conflict zones represent an assemblage of “regimes of living,” not only opening up possibilities for sustained care beyond global health agencies’ provision of emergency food and transitory medical campaigns, but also bringing about disparities in quality of life. Rooted in technological advancement rather than Christian tradition, China’s medical programs in Africa are producing a new form of everyday ethics, open to interrogation and debate on the ground. My research is in dialogue with literature on humanitarianism, biopolitics, and the anthropology of life. Focusing on bodily experience and medical expertise in a volatile setting, my work explores the new biopolitical landscape of present-day Africa, offering an alternative to the widely accepted logic and values of medical humanitarianism in places marked by “crisis” or “conflict.”

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1. Introduction

It was a glaring hot day in Juba, just before the arrival of the rainy season. I was sitting in the consultation room of People's Hospital, when a South Sudanese official brought in his uncle for treatment of diabetes with Dr. Li, a country doctor from central China's Kaifeng County, who made it to South Sudan after the new country declared independence. After the patient left, Dr. Li was sipping on a cup of tea, when he said to me, "We are representing China. South Sudanese will not associate you with Kaifeng or whatever place in China. They will only say that you are Chinese doctors. As doctors from a great nation treating patients in a foreign country, you cannot afford to lose face (*diu lian*) of China."

I heard a similar expression at Juba Teaching Hospital. Dr. Yao, head of a Chinese medical team on a one-year mission in South Sudan explained to me, "We are promoting the national image of China." Coming from a first-rate hospital in southern China's Anhui Province, Dr. Yao was leading a 15-member medical team supporting the public health sector in South Sudan.

Dr. Li and Dr. Yao came from different backgrounds and worked in different places. Dr. Li served in a private hospital run by the Chinese, while Dr. Yao and his team worked as foreign experts in the largest public hospital in South Sudan. But both of them

thought that they were among the goodwill messengers from China, delivering quality care to Africans.

1.1 Revolutionary Heritages

Hearing these words, I was reminded of Mao's vision of "revolutionary humanitarianism," a thought conceived in the years before China's liberation and later adopted as the guiding principle of China's medical missions in Africa and beyond. From the 1960s onwards, China began to send doctors abroad in support of international unity of the proletariat. This mode of assistance was built on the belief that the poor should help the poor, with the goal of bringing accessible medical service to the Third World. Beginning in the 1980s, "revolutionary humanitarianism" largely faded away, with China's shifted focus to a market economy. However, China has maintained this medical assistance program in Africa. In the past decade, China again picked up the discourse of humanitarianism in promoting its medical service to Africa; however, "revolutionary humanitarianism" was replaced with "international humanitarianism," reflecting integration with the discourse of the international humanitarian community.

Beginning in the 1990s, low-ranking doctors from China started to transplant themselves to Africa, resembling barefoot doctors (country doctors with limited training in Traditional Chinese Medicine and biomedicine), another program laid out by Mao in the mid-20th century. In the 1970s, barefoot doctors played a significant role in China's

medical service in Africa; many of them were selected to join the medical teams and their performance was highlighted by Chinese media. Unlike their predecessors, the newer generation of “barefoot doctors” in Africa are employed by private clinics and hospitals, but they still believe that what they are doing is more than earning money.

Joined together, the two types of medical professionals from China suggest a different transnational care regime, in contrast to the colonial and neoliberal order that has put Africa in the center of globalization (Ferguson 2006, Comaroff 1993). These developments also complicate the scholarship on China-Africa relations.

China’s engagement with Africa over the last two decades has attracted increasing academic attention (Alden 2007, Bodomo 2012, Brautigam 2009, French 2014, Monson 2009, Lee 2018). An unprecedented exchange of personnel, materiel, and technology has taken place between the two continents. The most recent manifestation is China’s ambitious infrastructure project extending to East Africa: the One Belt and One Road initiative. Over the last two decades, China has also started to enhance its international peacekeeping and security role in African countries, including Liberia, Sudan and South Sudan.

At the same time, Africa is more often than not depicted as the source of “crisis” awaiting medical humanitarian intervention (Abramowitz and Panter-Brick 2015, Bornstein and Redfield 2011, De Waal 1998, Fassin and Pandolfi 2010, Malkki 2015) guided by “humanitarian reason,” (Fassin 2012), or the compassion to save lives. South

Sudan is a case in point. Five years after the outbreak of conflict in December 2013, millions of people are still in need of humanitarian assistance across the country as a result of the armed conflict, intercommunal violence, economic crisis and outbreaks of disease. In the context of humanitarian aid, “crisis” is understood as tantamount to the production of “suffering subjects” (Robbins 2013).

As these two threads of Africa’s history unspool simultaneously, I delve into the repercussions of China’s medical programs in South Sudan. Locating Chinese medical professionals within the landscape of medical humanitarianism organized by the international community in Africa, my study questions the dominant assumption of biopolitics -- that crises produce suffering subjects waiting to be saved. The doctrine of “salvation” remains a powerful principle underlying biomedical and global health programs, constructing two uneven fields between those with power and those without. Moving away from this model, I explore the making of a biopolitics that connects expertise, techniques and ethics at a time of crisis, offering an alternative to the widely accepted logic of medical humanitarianism in places of conflict.

I join recent discussions surrounding China-Africa relations in challenging a single agenda describing this dynamic development (Chan 2013). In her study on Chinese-run copper mines and construction sites in Zambia, for example, Ching Kwan Lee (2017) argues that Chinese capital is bringing both potential and risk to Africa. In the same vein, I resist a single narrative in pinning down China’s medical programs in

South Sudan. Instead, I reveal the multiplicity of actors and biopolitical implications. I ask the following questions: Is Chinese medical assistance and business offering a different type of biopolitics in conflict and post-conflict areas? What insights do these developments offer into the geopolitics of care and the future of China- Africa relations?

Medicine is playing a critical role in deepening China's ties with Africa, as the former joins the "transnational medicine, mobile experts" movement in African countries (Dilger, Kane, and Langwick 2012). Medicine from China in South Sudan is a hybrid system, integrating aid and business, the practices and experience of "barefoot doctors," and the international friendship that once bound China and Africa together. Rooted in technical advancement rather than Christian doctrine, China's medical programs in Africa are producing a new form of "everyday ethics" (Keane 2016, Lambek 2010). Probing the phenomenology of illness and medical expertise (Barrett and Jenkins 2004, Das 2007, Throop 2010), I take a critical look at global health and transnational humanitarian programs in places identified as experiencing "crisis". The constant promotion of "suffering" is key to the maintenance of humanitarian campaigns. Following the recent conflicts in South Sudan in 2013 and 2016, many humanitarian aid organizations have cut back their programs, maintaining "minimal biopolitics" (Redfield 2013) to secure the "bare life" (Agamben 1998) of the temporarily stateless at a time of crisis.

Against the backdrop of China's arrival in South Sudan I trace the development of a new biopolitics. China's medical intervention in South Sudan has occurred in two waves, bringing highly specialized medical teams and "barefoot doctors" into remote territory. This represents both a resumption and a transformation of China's medical aid programs in southern Sudan in the 1970s and 1980s. In the first case, medicine from China took on a "revolutionary" aspect (Fang 2012, Taylor 2005, Zhan 2009) as it traveled across the world. This momentum is continuing. China is still configuring South Sudan – another "countryside" – as a major testing ground for the technical advancement of this longstanding medical ideology and practice, but the latest development has new actors and new implications.

1.2 Technical Assemblages

Although Chinese doctors in Africa work with endangered and precarious bodies, their approach to the provision of medical services is sustained, as is evident from the number of private hospitals and medical teams bolstering South Sudan's fragile medical infrastructure. "Barefoot doctors" have joined these medical teams as communicators of new knowledge, pharmaceuticals, and healing techniques in remote areas. Emphasizing the "technical," China's medical programs in South Sudan have wider implications within and beyond the medical sphere.

Lacking a history of Christianity or colonialism, Chinese medicine in South Sudan is charting a different path of development, contributing to a new understanding of the black body (Comaroff 1993, Crozier 2007, Hunt 2016, Vaughan 1991, Wall 2015) against a contingent background. Beginning with value-neutral, technological solutions, China's medical agents in Africa not only respond to emergencies, they also create new technical assemblages (Collier and Ong 2005). In a post-war country like South Sudan, practical technical solutions are not necessarily generated by a Christian moral imperative, and thus form an ethics of their own. Considering the immense infrastructure projects that China is currently developing in East Africa (including South Sudan), I regard "being technical" as suggesting a future (Mrázek 2002, Sneath, Holbraad, and Pedersen 2009). In accessing medical techniques and medical professionals from China, the South Sudanese are moving away from the label of "suffering bodies" under the rubric of humanitarianism .

This emerging medical ethics stands in contrast to the doctrine of salvation left by missionary medical endeavors and persisting to the present day, wherein the discourse of suffering defines the human condition (Good 1994). The term "transnational humanitarianism" is insufficient to capture the historical moment, which points to possibilities for future care that exceed the mere provision of food and temporary medical campaigns by global health agencies in places of crisis.

China's medical programs are yet to be fully accepted on the ground in South Sudan. In the first instance, they are not part of the humanitarian umbrella that covers NGOs dedicated to international health. In the public sector, Chinese doctors are working within an administrative system over which they do not have much maneuvering ability. Further, the emphasis of Chinese doctors on technical knowledge does not necessarily entitle them to a position of authority (Beinart, Brown, and Gilfoyle 2009). Most Chinese doctors feel that they are sidelined in the system. They position themselves as technical experts and feel uncomfortable interfering in the business of their South Sudanese colleagues. Their participation and contribution in the public sector is therefore limited in scope and effect. In the private sector, most of the South Sudanese patients in Chinese hospitals are officials, middle-class businessmen, and rich men who can afford the high cost.

In critiquing Foucault's understanding of biopolitics as normalizing governmentality, Fassin (2009) argues that the intervention in lives reflects a production of inequalities. Who have the right to health and who have not becomes apparent in conflict and post-conflict areas. Unlike colonial medicine and global health programs, China's medical activities are not a systematically designed apparatus with a clear-cut goal of governing the bodies. Nonetheless, an ethos of non-interference commonly observed among the Chinese doctors makes one wonder about its biopolitical

implications. To a certain extent, China's medical programs in South Sudan result in the inequality of lives in South Sudan.

1.3 Methods

I have carried out participant observation, semi-structured interviews, oral history interviews, archival research and historical document analysis. The cornerstones of my research are multi-sited ethnography (Falzon 2009, Marcus 1995), comparative analysis and historical analysis. To examine the interrelationships of conflict and health, I use mainly ethnographic materials, such as life stories, with complementary data analysis. To evaluate providers of humanitarian aid relative to China's performance, I draw on the findings of interviews and comparative analysis. To contemplate China-African relations, I turn to interviews and historical/archival materials.

From 2016 to 2017, I conducted 14 months' ethnographic, historical and archival fieldwork in six cities in South Sudan and China, looking at a hybrid form of medicine and medical practice that emerged in Africa with China's reentry into the continent. I investigated Juba, Wau, Kuajok, Torit in South Sudan and Kaifeng and Xi'an in China. I spent ten months working in South Sudan and four months in China. In Juba, I reached out to Chinese doctors and nurses, pharmaceutical sales representatives, African medical professionals, officials at national and state ministries of health and patients and their families. I travelled with Chinese medical teams to Torit, Wau and Kuajok for medical

consultations and surgeries. I tapped into the life of society beyond the medical sphere, availing myself of social occasions such as funerals, initiations, and marriages. In doing so, I situated myself within the South Sudanese landscape of life and death, a central concern of my research project, and inhabited the lived experiences of my interviewees, making use of the concept of “self” as ethnographer (Collins and Gallinat 2013). In China, I returned to the barefoot doctors’ point of departure/origin in Kaifeng to examine the local medical system and its impact on their service in South Sudan. In Xi’an, China, I interviewed a dozen senior doctors who had been sent to southern Sudan in the 1970s and 1980s on medical missions.

I visited a number of humanitarian aid organizations and interviewed key figures in religious organizations operating in South Sudan, such as the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), Samaritans’ Purse, Médecins Sans Frontiers, Real Medicine Foundation, WAHA International, the Comboni Missionaries and the Episcopal Church of Sudan and South Sudan, to pin down the roles of these religious and international medical aid and global health organizations and their impact on South Sudan’s socioeconomic structure and the everyday lives of the South Sudanese. I followed their medical programs and read through their mission statements to facilitate a detailed comparison with China’s medical activities in the region.

Following Ingold (2013), I take the processes of production as generators of new social theory. I devoted a bulk of my fieldwork to Chinese hospitals/clinics in Juba and

Wau and Chinese medical teams in Juba Teaching Hospital to learn how they practiced their medical expertise. In this way, I explored the formation of medical spaces and the enactment of biomedicine and Traditional Chinese Medicine (TCM) by a variety of actors, from translators to technicians, using a variety of materials, such as endoscopic machines, anesthetics and painkillers. I paid special attention to China's construction of new medical facilities, hospitals and wards, and how these infrastructural projects map on to national health policies in a post-war setting.

Life histories are crucial to ethnographic research. Life stories, presented from manifold sites and sides by diverse actors (Peacock and Holland 1993), offer multi-layered insights into this evolving medical presence. I followed a number of patients at Chinese clinics receiving orthopedic and fracture treatment, which are among the most common forms of treatment for physical complaints in South Sudan. Through these case studies and life stories, my research reveals South Sudanese people's conceptions of the body, pain and health, and their interest in and engagement with medicine from China. I was also interested in collecting the Chinese doctors' embodied understanding of and engagement with biomedicine through their day-to-day training and operations. During the interviews, I paid particular attention to gaps in the narratives that opened up directions for anthropological interpretation.

Archival research and historical analysis are significant components of my research. In South Sudan, I worked with two archivists at the South Sudan National

Archives to retrieve archives documenting China's earlier medical presence in southern Sudan (Southern Sudan Autonomous Region 1972-1983). I also went over *Nile Mirror*, the leading newspaper published in the south at that time, to collect stories reflecting this particular history. Medical officers' vivid descriptions of their work environment and detailed documentation of the engagement of Western aid organizations contributed to my understanding of 'doing medicine' in southern Sudan. These materials also showcased South Sudanese perceptions of China's medical activities at that time, helping me to grasp the production and negotiation of the discourse of "China-African friendship" discourse. In China, I retrieved historical materials from the Shaanxi Provincial Archives documenting earlier Chinese activities in Africa. I also referred to the comprehensive set of directives, regulations, manuals and policies guiding the Rural Cooperative Medical Systems in the 1960s, which laid the foundation for the emergence of "barefoot doctors."

My research methods are not solely qualitative. I have spent some time checking the databases and yearbooks of the national, state and municipal ministries of health to keep track of disease patterns, health systems, international cooperation and changes in aid priorities.

1.4 Structure of the Dissertation

My dissertation is composed of five chapters.

Chapter 1 gives a panoramic view of China's medical presence in southern Sudan by focusing on its historical dimensions. I explore the origin of "revolutionary humanitarianism," its transplantation to southern Sudan in the 1970s and the waning of this medical legacy in the 1980s. Then, I tell the story of the arrival of China's private capital into the health sector at the time of South Sudan's independence, highlighting the significance of contemporary "barefoot doctors" in the African countryside. Although they work in different socio-medical spaces, both "barefoot doctors" and medical teams are regarded by South Sudanese as signifiers of new knowledge and expertise. Revolution shaped China's medical programs in Africa, but different than France, the Chinese version revolution was not informed by the Enlightenment. Compassion politics is not a core component of China's international programs. However, the post-Maoist period does not necessarily mean the demise of such a powerful thought in modern times.

To be followed, I discuss Chinese doctors' everyday medical encounters with South Sudanese patients by focusing on their expertise in treating two types of illness.

In Chapter 2, I focus on firearm wounds, concentrating on the nature of Chinese doctors' orthopedic surgery and its biopolitical implications. A vulnerable and warring state like South Sudan cannot provide its citizens with adequate resources or attention. In the post-war context, who has the right to health and who does not have become immediate concerns. Chinese surgeons in both the public and the private sector work mostly with patients from more or less affluent backgrounds. The body is broken down

into “more valuable” and “less valuable” parts, and Chinese doctors in the public sector are left with the less valuable work, because more valuable parts (such as the arms and legs) gain even more value when South Sudanese doctors refer patients to private clinics for profit-making treatment. In the current political economy of South Sudan, Chinese surgeons are also practicing a limited form of biopolitics.

Chapter 3 delineates pain-related complaints and Chinese doctors’ approaches to “pain management.” In particular, I track the reconfiguration of traditional Chinese medicine in South Sudan, discussing its adoption as a fast-track method dealing with *waja* (pain). Chinese medicine and acupuncture may have nothing to do with “high power”, but they are practiced in a way that suggests the implications of magic and religion. In this way, TCM (including acupuncture) goes beyond its initial design as simplified and accessible medical dexterity for the masses to be practiced with a hint of “miracle cure” in South Sudan. But “miraculous treatment” can hardly address a South Sudanese’ experience of pain in full. Painkillers or pain management are perhaps effective in the short term, but they do not address the root causes of social pain in South Sudan.

Chapter 4 examines *yizhen*, China’s approach to medical campaigns. The alleviation of poverty and economic/social development are the two dimensions of the campaigns of Chinese medical teams. Humanitarian reason has not been enlisted as a powerful discourse in China’s medical campaigns in South Sudan and Africa at large.

Moreover, the Chinese medical team's campaigns have so far not followed the discourse of global surgery, or a "surgical epidemiology."

Chapter 5 discusses Chinese medical professionals' encounter with religion in South Sudan, and their ambivalent acceptance and dismissal of South Sudanese views of life and death. Suffering remains an influential religious and ethical category in South Sudan. An understanding of the human body and health care in South Sudan is expected to start from an insight into suffering and suffering bodies. The Chinese doctors are more focused on "good work" in a professional sense than "care" in a religious sense. In doing so, they are charting a new "regime of living" that defies the religious view of suffering in a post-war country.

2. China's Medical Internationalism and Globalization

In the fight for complete liberation the oppressed people rely first of all on their own struggle and then, and only then, on international assistance. The people who have triumphed in their own revolution should help those still struggling for liberation. This is our internationalist duty.

— Mao Zedong, “Talk with African friends” (August 8, 1963).

Sitting in the Shaanxi Provincial National Archives, I was surfing the archives documenting the activities of Chinese medical teams in southern Sudan in the 1970s-80s , when Mao's words popped up now and then on the papers. It was a transformative period, which witnessed international alliances involving Asia and Africa. Mao's vision was put into action, and many Chinese professionals were assigned a new cause. Like Cuban doctors practicing a mission of internationalism in Latin America (Brotherton 2013), Chinese doctors found a new mission overseas, in Africa, where they were tasked with “saving the dying and treating the wounded, practicing revolutionary humanitarianism,” an ethic prescribed by Mao in the revolutionary period.

Fifty years later, a new chapter unfolded. In April 2018, at the National People's Congress, China unveiled its International Development Cooperation Agency (IDCA). It was a milestone in China's history of foreign aid, having sent its first medical team to Algeria in 1963. The move will “better serve the country's overall diplomatic structure and the efforts to jointly build the One Belt and One Road Initiative,” according to a

press release by Xinhua News Agency¹. No concrete plans have been rolled out regarding the future of IDCA, but it is believed that it will coordinate existing aid programs undertaken by other departments, including the Ministry of Commerce and National Health Commission.

This move challenges the perception that China is interested only in exploiting natural resources and building roads, dams and stadiums in Africa and elsewhere in the developing world. China's inroads in Africa present mixed messages (Alden 2007, Brautigam 2009).

2.1 South Sudan through a Historical Lens

After gaining its independence from Britain on January 1, 1956, the southern Sudan region remained united with the north of the Sudan. The gradual imposition of Sharia law by the north resulted in two wars, from 1955-2005, with a short and fragile "peace" from 1973 to 1983. – One of the longest wars in the world ended with agreements signed in Nairobi in 2005. The result of these years of war was more than 2.5 million people dead and the region of the South completely devastated, impoverished, and without services and infrastructure.

¹ Xinhua News Agency (April 18, 2018). http://www.xinhuanet.com/english/2018-04/18/c_137120544.htm Accessed Oct 20, 2018.

In 2011, there was a referendum in favor of secession – 98.83 % of the citizens voted for independence. South Sudan obtained its independence on July 9, 2011, becoming the 54th country in Africa and 193rd in the world. These epochal events, aiming to unite the people, have been completely undermined by the 2013 outbreak of a bloody interethnic war. The two major protagonists are the largest ethnic communities: the Dinka, the largest in numbers, and the Nuer. Tribal fractures and difficulties have increased in recent years.

Just before Christmas in 2017, in a last attempt to create stability and space for dialogue, the government of South Sudan and nine rebel factions, with the mediation of Intergovernmental Authority on Development (IGAD), the African Union (AU) and Troika, signed a new agreement for the cessation of hostilities. There have been more than a dozen agreements since the beginning of this bloody civil war. But a few days after Christmas, the agreement had already been violated more than a dozen times in several locations by different armed rebel groups and the government. Since July 2016, while there has been no more fighting in Juba, the capital, the rebellion has slowly spread throughout the country. Fearing more bloodshed, millions of people have fled to neighboring Uganda, Sudan and Ethiopia. In 2018, the warring sides reached a new agreement to end the civil war and share power.

2.2 China's Medical Presence in South Sudan

China's presence in South Sudan is an extension of its long-standing relationship with Khartoum. In 1959, Sudan was the first African country to recognize China, and has since become one of the leading destinations in Africa for investment from China. In 1995, Khartoum reached an oil agreement with China. In June 1997, the Greater Nile Petroleum Operating Company was established, with the China National Petroleum Corporation (CNPC) owning 40 percent and Malaysia's Petronas owning 30 percent. India owns 25 percent and the remaining 5 percent went to Sudan. Most of the oil fields were in the territory of the South. But independence did not bring exclusive benefits, as most of the refineries and shipping facilities were still controlled by the north. China has invested heavily in Sudan's oil infrastructure, including the pipeline to Port Sudan and several refineries in the north.

At the peak of its oil production, South Sudan produced up to 350,000 barrels of crude oil per year. However, the civil wars in 2013 and 2016 have reduced production capacity to 130,000 barrels of oil per day.

The volatile situation propelled the CNPC to decrease its investment in this insecure setting. In 2012, 29 Chinese road workers were kidnapped by armed groups in Sudan's South Kordofan State. In October 2018, 14 Chinese oil workers at a local oil company operating in South Sudan were killed, as the result of violent clashes between armed groups from the Dinka and Nuer tribes.

The Chinese have always had an easy relationship with the South Sudanese. In 2012, the head of Chinese oil company was expelled from South Sudan. In 2016, during the second civil war, the CNPC evacuated most of its employees from South Sudan, although it did resume operations the following year.

The prospect of high returns in a war-torn country is still irresistible. Waves of Chinese businessmen and miners have flocked to the new land. In 2017, two Chinese gold miners were shot and killed in an ambush by unknown gunmen, near Ngawuru in South Sudan's Kapoeta State. At that time, the Embassy of China kept the incident low-profile and no details were released to the public. However, the Chinese living in Juba talked privately that they could hardly count on the embassy when they run into trouble. Owners of private businesses feel that they are the stepsons or stepdaughters of the state. In contrast, employees at state-owned enterprises, medical teams, and peacekeepers are given priority when it comes to life-saving moments.

Compared with state-owned enterprises, small businesses from China are never large in scale, but they are an indispensable part of China's presence in South Sudan. If the oil fields are the arteries of China's state power, the small businesses are capillaries. Some of them provide fruits and vegetables to the Chinese workers in the oil fields in Unity State, while others run supermarkets close to the compound of the embassy.

At its peak, there were about 1,000-2,000 Chinese in Juba, scattered around the city. Some were transient settlers, who fled to Uganda after the war broke out in 2016,

but many chose to stay on, despite the turbulent political situation. Vegetable growers, curtain suppliers, drainage workers, mobile phone sellers --- make up a significant segment of low-wage Chinese labor in South Sudan.

The more affluent Chinese have purchased land for development along the Nile River . Among the best-known are Old Jiang's Farm and Happiness Farm, where Chinese are welcome to relax and celebrate holidays . They grow Chinese vegetables and sell them to Chinese companies and businesses. But these farms are also easy targets. The compounds are scenes for occasional robberies, and the owners have had to employ additional South Sudanese police, to improve security .

During my fieldwork, I lived in the compound of a Chinese engineering company, which was responsible for the construction of energy grids in Juba. A number of male engineers in their late twenties or early thirties, with experience working in East Africa or South Asia, were packed into prefab houses. Like many of the Chinese state-owned enterprises in South Sudan, they are seldom allowed to go outside on their own. If they are on a mission, they usually go in a group of two or three. They do not mix much with their South Sudanese colleagues, except for a high-ranking official and his soldiers living on the same property .

In Juba, China is regarded as one of the richest countries in the world. Many South Sudanese, interested in study or work programs, request that I connect them with Embassy officials in charge of scholarship programs and China National Petroleum

Corporation. For these people, China embodies the future, and hope for survival and even success, when the country undergoes political turmoil and economic collapse. Someone from Wau reached out to me, “Please, I am a student who are (sic) looking for scholarship for the master’s degree in law because I am a LLB graduate but I need China.”

China’s medical program in South Sudan is not new. As early as 1971, under Chairman Mao’s revolutionary medical program in and beyond China, China sent a medical team to Sudan (including southern Sudan). Medicine served as a base for spreading Mao’s revolutionary thought. Similar to China’s revolution in the 1930s, the medical doctors were “a manifesto, a propaganda force, a seeding machine” (Mao 1991). Back then, Sudan was a priority recipient of this robust foreign aid program, but assistance to southern Sudan came to a halt in 1985, at the height of the second Sudanese war (1983-2005).

A period of silence followed until China’s entry into the oil fields in 1993, opening other opportunities, including construction projects and small businesses. Chinese working in Juba say that the oil fields are the upper steams, without which their business will be unimaginable in a post-conflict country. The flow of business opportunities peaked between 2011 to 2014. After the signing of *The Comprehensive Peace Agreement* (CPA) between Sudan People’s Liberation Movement (SPLA) and the

Government of Sudan, the flow of business opportunities peaked between 2011 to 2014. Juba suddenly became a hotspot for Chinese business ventures in Africa.

I went on a field trip to Juba for the first time in the summer of 2013. Despite the unpaved roads, scattered mineral water bottles and newly erected bulletin boards, the Ministry Road, one of the major roads in Juba, was bustling, packed with vehicles passing the financial district in Juba Town. South Sudanese writer Nyuol Lueth Tong observes a booming Juba:

So, this was Juba, the nation's largest and oldest city, a swirl of congestion and commotion... the air was thick with cement dust from the construction sites that lined the streets, stirred up by workers digging foundations and expanding the thin dirt roads, the roar of countless motorcycles, and of the minibuses haphazardly collecting passengers. A random madness seemed to be the core energy of the city. No wonder the littered streets, mud huts, and stick-and-plastic-bag slums were bustling with young people from rural villages. They were barefoot and penniless, but buoyant with dreams of a larger world to be part of. We had heard news of East African entrepreneurs peddling loan schemes, insurance pyramids and housing projects, of NGOs with abundant resources and grand notions of salvation and development. The NGOs were convinced they could steer our nascent state away from corruption and nepotism... (Tong 2013)

Even to this day, the story goes that shrewd Chinese businessmen got rich overnight by renting out tents to fortune-seekers, adventurers and brokers at the astonishing price of \$200 per night. The exchange rate of South Sudanese Pounds against US dollars stood at 2: 1. The steady oil output was pumping up a new nation. Everything was in Juba's favor.

Juba was a land of promise for Chinese immigrants. Small traders and construction builders, as well as state-owned enterprises flocked to the capital and other major cities in South Sudan to work the land, build viewing stands, plant vegetables and open supermarkets. Medicine was virgin territory awaiting exploration and development. Chinese businessmen invested in a number of private hospitals and clinics, including Peace Hospital, Friendship Hospital, Beijing Clinic, and Evergreen Hospital, attracting patients from all walks of life.

The newcomers from China knew little about the history of southern Sudan. Like settlers in the 17th century who boarded the *Mayflower* for the new territory of North America, the Chinese were full of hopes and rosy imaginations when they reached the new land, transforming all opportunities into potential business. To many, the CPA signed in 2005 was equivalent to a guarantee of political stability, a key to China's economic miracle over the past four decades. This vision was shared by many doctors going to South Sudan.

Mrs. Zhuang, a gynecologist from southern China's Guangdong Province, took me for a businessman and asked whether I could introduce her to other "medical projects" in East Africa and the United States. But the hoped-for stability could not be sustained. The two civil wars in 2013 and 2016 wreaked havoc on the medical businesses. Some were forced to shut down, while others had to lay off personnel or replace some

Chinese doctors and nurses with South Sudanese labor. The Chinese underestimated the political complexity of a post-conflict country.

In addition to the business momentum driving the Chinese adventure in South Sudan, there is another narrative. In 2011, China and South Sudan counterpart signed a memorandum of understanding on medical assistance, resuming a long-standing medical mission involving China and Africa that dated back to the 1960s. As a major component of the technical assistance program, twelve doctors from southern China's Anhui Province would be dispatched on a one-year mission to staff Juba Teaching Hospital in South Sudan.

China's medical programs in southern Sudan are sending out mixed messages. While the Chinese medical team has a presence in Juba Teaching Hospital, some South Sudanese complain that they are denied access when they seek the services of Chinese doctors there. The guards at the main gate said the Chinese medical team is not available to everyone but only for staff who are able to enter the consultation rooms. "They are very jealous of others who approach the Chinese doctors," said my friend Anok. When South Sudan is struggling with a shaky public health system, the Chinese medical team is a great resource, but the Chinese doctors are not accessible to everyone.

Regarding the private hospitals run by the Chinese, Some South Sudanese believe that the private hospitals run by the Chinese offer much better care than the languishing Juba Teaching Hospital. Other Sudanese associate these private hospitals with

substandard care, a hallmark that often goes with Chinese exports in Africa (Chappatte 2014). “Are they real doctors?” Such a question resonates with South Sudanese constantly frustrated by *pacang* (fake) things in the country, whether a politician’s commitment to peace or products from neighboring Uganda.

In short, China has two types of medical programs in South Sudan, state-sponsored medical teams and hospitals/clinics run by private capital. In their analysis of China’s relationship with Africa, Sautman and Yan (2007) summarize it as a combination of “friends and interests,” but they do not capture the details of the connections between them.

In this chapter, I will sketch out China’s medical programs in southern/South Sudan and explore its transformation over the past decades and then discuss the implications of this particular strain of biopolitics. Doctors are bearers of and witnesses to different layers of meanings rendered by geopolitics, ethics and capitalism. The revolutionary imprint left by Mao may have faded away, but it has not died out altogether. In recent years, there has been a powerful return of this socialism-infused humanitarian ethic. After Chinese president Xi Jinping took power, he shifted his attention back to Africa, revitalizing the historical memory of the Bandung Conference connecting Asia and Africa (Lee 2010). In 2013, after Xi was sworn in as President, his first state visit took him to three African countries: Tanzania, DR Congo, and South Africa. In the past

five years, he has paid a number of official visits to other African countries, including Egypt, Senegal, and Rwanda.

China's entry into the medical landscape in Sudan, including southern Sudan, invites not only a revisit of historical memory, but also new thinking and reevaluating the dominant humanitarian image.

When the humanitarian organizations are engaging local politics on a level of "minimal biopolitics," how does China mediate the political and the apolitical in medical care? When "humanitarian reason" (Fassin 2012) becomes the norm driving Anglo-European humanitarian organizations, what is the political heritage of China?

Maoist "revolution" is still powerful thinking guiding China's transnational medical programs, manifest in different spaces and subjects. On the one hand, humanitarianism in this context invites an image of Asian-African solidarity, a historical linkage between the two continents, instead of an unbalanced and unequal relationship between donors and recipients. Global health practice is no longer solely in the hands of non-governmental organizations, which suggests possibilities for Africa's future (Goldstone and Obarrio 2016). In the meantime, there is another dimension to China's medical program. When the state is withdrawing from public sphere across Africa, private capital from China joins the neoliberal apparatus in privatizing medical care in African countries. Both forces are at work in health programs in South Sudan.

Transnational doctors from China represent two types of mobility. The first involves experts “going to the countryside” (*xiaxiang*), reminiscent of China’s public and international health initiatives in the 1960s. The second involves the contemporary movement of “barefoot doctors” or rural doctors, who are sent by global private capital into the cities in Africa. The driving force behind these two groups is different, but both have a global agenda that crosses national boundaries yet moves away from the spectrum of medical humanitarianism.

2.3 Two Versions of Humanitarianism

China’s medical service in South Sudan stands in contrast to humanitarian aid delivered by the international community. As a war-torn area, South Sudan is a priority beneficiary of medical humanitarianism. Out of the total budget for 2017 set by the United Nations Office for Humanitarian Affairs (UNOCHA), about 10 percent is allocated to the health sector (UNOCHA 2016). But China has not expressed an interest in joining the international consortium’s efforts in South Sudan, although it sends more than 1,000 peacekeepers to the area.

“Humanitarian reason”, in the phrase and book title of Didier Fassin, French anthropologist and sociologist (2012), is now recognized as the new world order. According to Fassin, it is a “politics of compassion,” nourishing ethics of care, extending values and practice from the West to distant places under the mandate of “suffering,

compassion, assistance and responsibility” (ibid.: 2). As a response to precarious life, the birth of “humanitarian reason” can be traced back to the 18th century, but its significance has been heightened since the end of the 20th century, when conflicts and crises started to capture the attention of the international community. National governments, international and national non-governmental organizations, regional organizations (such as the Intergovernmental Authority on Development, IGAD) have various assistance programs deployed in South Sudan. Under the UNOCHA umbrella, more than 160 partners are working across South Sudan. And “South Sudan’s humanitarian crisis” tops the headlines of international media outlets.

Despite China’s hesitation to partner with humanitarian organizations, the discourse of “humanitarianism” can be found in the discourse of its medical service to South Sudan. In January 2018, the Anhui Health and Family Planning Commission, the provincial administration in charge of public health, paid an official visit to Juba.

According to a press release at the time:

Over the past five years, China’s medical teams to South Sudan have kept in mind the great trust of their motherland, implemented *internationalism* and *humanitarianism*, overcome many difficulties in language, climate and life, worked closely with the local medical personnel, and wholeheartedly provided indispensable service to the local people. The medical teams have created one medical miracle after another (emphasis supplied)².

² *The Second People’s Hospital of Hefei*. <http://www.hfsey.com/article/275.html>
Accessed Oct 22, 2018.

This discourse is a combination of different political aims. If internationalism is reminiscent of Mao's policy of emphasizing an alliance with Asian and African countries, humanitarianism is a combination of historical memory and contemporary transformation. In 1940, China Medical University received encouragement from Mao, who wrote to the graduates: "Rescue the dying and heal the wounded; practice revolutionary humanitarianism" (*jiusifushang, zhibingjiuren, shixing geming de rendaozhuyi*), which has been enlisted as an ethic guiding Chinese doctors in their service in other countries.

But China has also embraced a more modern version of "humanitarianism," not through borrowing the Western concept, but through a transformation of China's own philosophical thinking.

A phrase widely used in news reports about Chinese medical teams is *da'aiwujiang*, literally meaning "great love without borders". One may ask what is the difference between China's mission and that of Médecins Sans Frontières (MSF), which is built on the conviction that doctors should travel across national borders serving those in need of medical care. If "humanitarian reason" refers to assistance to places far away this commitment also applies to China's medical programs but on a different register. It is claimed that the idiom *da'aiwujiang* comes from Chinese philosopher Lao-Tzu, matching another idiom *shangshanruoshui*, which means that "the best virtue comes from water."

But the word is not found in Lao-Tzu's works. It turns out that *da'aiwujiang* is an invented phrase; it was coined in 2008, after a major earthquake hit southwest China's Sichuan Province. Relief efforts by NGOs and assistance from other provinces were widely reported by the media. It was from this time that *da'aiwujiang* entered China's relief discourse.

2.4 Transnational Doctors as an Empire Project and Global Capital

When we situate the Chinese medical program in Africa, a historically comparative lens is needed. The two hallmarks are “colonial medicine” and “medical humanitarianism.”

In the 20th century, a white doctor working in black Africa was the image that comes to mind. In fact, an examination of medicine through the lens of imperial expansion provides insights into physicians and transnational medicine. The birth of transnational medicine – tropical medicine in particular – is closely connected with Europe's conquest of Asia, Africa and South America in the 19th and early 20th centuries. Instead of being perceived as something benign or neutral, medicine is a cultural product and represents cultural power. Regarded as a form of technology, medicine became “a tool of empire,” part of the political, commercial, and military expansion of imperial powers (MacLeod and Lewis 1988). According to these two authors, medical programs have an important role in the expansion and consolidation of political rules, particularly

through sanitary orders and civilizing missions introduced into the European colonies. Once transplanted into colonies, medicine can work as an effective authority to curb transmissible diseases – and peoples. From the perspective of imperial medicine, therefore, medicine has the power to travel to distant places and has the capacity to settle in as a form of social order.

In the same vein, Vaughan (1991) argues that British colonial medicine played an important part in constructing “the African” as an object of knowledge and practice, intrinsic to the operation of colonial powers. Colonial conquest brings medicine and doctors, which are used as a way of “winning support from a newly subject population, of balancing out the coercive features of colonial rule, and of establishing a wider imperial hegemony than could be derived from conquest alone” (Arnold 1988). Medicine was forced to accompany the entire colonial enterprise.

National pride, adventure and exoticism were some of the driving forces for colonial doctors who landed in remote places in Africa. To a certain extent, their missions inherited the distinction of David Livingstone, the British explorer who was a medical missionary by profession. In a recruiting advertisement, the British Colonial Service said:

The chief attractions of the Colonial Service to the type of man we needed were, and remain, *spiritual*: the challenge to *adventure*, the urge to prove himself in the face of hardship and risk to health, of loneliness often and not infrequent danger; the chance of dedicating himself to the service of his fellow men, and of responsibility at an early age on a scale which life

at home could scarcely even offer; the pride of belonging to a great service devoted to a mighty and beneficent task; the novelty of life in unfamiliar scenes and strange conditions. (emphasis in original) (Crozier 2007)

“The game was bigger, the skies wider and the people were different” (ibid.: 63).

No other words better encapsulate the aspirations of colonial doctors sent from England to East Africa in the early 20th century catering to the overseas expansion of the British Empire. Never before had physicians found their roles substantially reshaped by the transnational movement of peoples, technologies and ideologies from Europe to Africa and other peripheries in the world. Medicine, once regarded as a purely physiological matter, came to be implicated in a larger sociocultural world, engaging empires, geographic spheres, politics, governance of life and death. If medicine was used in Europe to manage populations and exercise state regulation in the 19th century, its function was now substantially extended. Medicine was on the move, at a speed beyond the imagination of doctors, who were pushed to join the international movement with an agenda. With an imperialist enterprise at its peak, modern doctors were eager to employ their medical discoveries and curative treatments on indigenous peoples. Medicine and doctors were believed to go beyond boundaries.

Colonial medicine is a hierarchical system following strict rules and order. In her groundbreaking history (1999) examining colonial medicine in the Anglo-Egyptian Sudan, Heather Bell details the ways in which medicine was incorporated into the British Empire. This grand project was realized through the acquisition of knowledge in tropical

diseases, through the ranking and segregation of British, Egyptian, Syrian, and Sudanese doctors, and through the establishment of physical boundaries, laboratories, and training programs in midwifery.

Similarly, Jean Comaroff observes the inseparability of medicine from the colonial project:

The two were in many senses inseparable. Both were driven by a global sense of man that had emerged out of the enlightenment. Both concerned the extension of ‘rational’ control over domains of nature that were vital and dangerous. Although ostensibly an autonomous field of knowledge and practice, medicine both informed and was informed by imperialism, in Africa and elsewhere. It gave the validity of science to the humanitarian claims of colonialism, while finding confirmation for its own authority in the living laboratories enclosed by expanding imperial frontiers (Comaroff and Comaroff 1992).

Two centuries later, medicine took another shift, spurred by the discourse and practices of global capitalism, structural adjustment, and international development. Liberalization and neoliberal reforms have a distinctive push--pull effect in many parts of the world, as evidenced , for instance, by medical professionals entering and exiting the African continent. Different from the colonial period, when the flow of doctors was characterized as unidirectional, the contemporary transnational and intercontinental mobility of medical doctors is multi-faceted.

For example, many Ghanaian doctors make a decent living in London, by working within their transnational therapy network (Krause 2008) and the “natives” are entering the center stage. Similarly, Chinese medical professionals and businessmen

engage in various forms of mobility in Kenya (Hsu 2012). Transnational doctors suddenly appear to have the capacity to move in globally compressed time and space (Harvey 1990) availing themselves of opportunities without constraints. Mobile subjects make globalization a perfect cause to be imagined and to be practiced. Transnational doctors arguably possess “specialized knowledge, altruistic service, thirst for power, and blatant self-interest” (Iliffe 1998); their subjectivities are a complicated composite, influenced by sociocultural and political ecologies. These qualities speak to different orientations, not necessarily matching each other in good manners. Unlike other transnational subjects, transnational doctors engage with bodies, which are “contingent formations of space, time and materiality” (Lock and Farquhar 2007).

2.5 Humanitarian Aid in Southern Sudan

Medical humanitarianism entered the international arena in the 19th century (Haskell 1985). Over the course of the 20th century, medical humanitarian organizations operating in crisis settings assumed a prominent role in global health and development programs (Barnett 2011, Bass 2008, Fox 2001, Nordstrom 2004). The literature on this subject is closely linked with that on violence, peacemaking and post-conflict management. However, it is noteworthy that time-limited and disease-targeted “medical campaigns,” which characterize the activities of medical humanitarian organizations, are accepted and practiced as the norm in places of insecurity and contingency (Berry 2014).

Aside from short-term relief actions, scant attention has been paid to the strengthening and reconstruction of health systems in these countries. (Rubenstein 2011). Meanwhile, religion and faith have profoundly shaped the missions of humanitarian organizations, stamping them with a “transcendental” and “otherworldly” quality (Barnett and Stein 2012). The constant promotion of “suffering” is key to the maintenance of humanitarian campaigns. Following the two conflicts in South Sudan in 2013 and 2016, many humanitarian aid organizations have retrenched and withdrawn to Kenya, maintaining a level of “minimal biopolitics” (Redfield 2013) to secure the “bare life” (Agamben 1998) of the temporarily stateless in a time of crisis.

The birth of contemporary humanitarianism is largely a political project. In her analysis of the French revolutionary left and humanitarianism, Davey (2015) points out a transformative shift from the revolutionary to a more modest mode. Drawing upon the case of Médecins Sans Frontières, she pays attention to a fundamental change, from Third-Worldism to crossing the borders, driving the organization. The spirit of revolution was replaced by a new emphasis: human rights became the core values of contemporary humanitarianism, dominating western countries. South Sudan is a case in point. Hundreds of NGOs are offering services to the country which has a fragile medical infrastructure.

Larry Minear (1991) offers an overview of the origin and principles of medical humanitarianism in southern Sudan. The international community’s collective

humanitarian involvement in southern Sudan started in 1988, when a major famine, brought about by the combined effects of drought and conflict, occurred in northern Bahr-el-Ghazal. The famine killed approximately 250,000 people. The resulting pressure forced the United Nations to act, and Perez de Cuellar, the then Secretary-General, appointed James Grant, executive director of UNICEF, as his Special Envoy for Sudan. Grant shuttled between Khartoum and the south and, after a number of meetings, managed to reach an unprecedented agreement: the UN could provide humanitarian assistance to both government and rebel-controlled areas, with the consent of the Government of Sudan and the SPLA. This agreement was a game changer.

Until this point, some NGOs had worked in south Sudan in areas controlled by the SPLA but without government authorization. This allowed the UN, with its humanitarian partners, to deliver aid without military assistance to all conflict-affected populations . It was against this background that Operation Lifeline Sudan was created in March 1989 as a short-term relief operation, offering food and other necessities to war-affected populations. UNICEF worked as the leading agency alongside WFP and some 40 international and Sudanese NGOs. In essence, the UN provides the overall legal, political, logistical and security framework, while the NGOs implement most of the programs with their counterparts in government and rebel-controlled areas. By 2018, more than 163 UN and NGOs had become partners of UNOCHA.

China is not part of this orbit of humanitarianism. No Chinese NGO works in South Sudan, with the exception of the China Foundation for Poverty Alleviation (CFPA). This non-governmental organization started work in Khartoum in 2009, through collaboration with Al-Birr & Al-Tawasul Organization, a local NGO serving the needs of women and children. In April 2018, CFPA collaborated with Mercy Corps, a European-based NGO, and establish a program in northern Uganda targeting the welfare of refugees from South Sudan.

2.6 Birth of “Revolutionary Humanitarianism”

Mao’s promotion of medical internationalism was inspired by Norman Bethune, a Canadian doctor who, as a member of the Communist Party of Canada, travelled to China in support of the Communist Party of China. In early 1938, he arrived in China and proceeded to Yan’an, the revolutionary base of the Chinese Communist Party. Mao commissioned him to organize a mobile operating unit in the interior of north China. During an operation, Bethune broke his finger and died of blood poisoning. After his death, Mao wrote an article in memory of him, which, together with two other articles, *Serve the People* and *Foolish Man Who Removed the Mountains*, became one of the classical texts orienting Chinese towards the “New Man” (Cheng 2009):

What kind of spirit is this that makes a foreigner selflessly adopt the cause of the Chinese people’s liberation as his own? It is the spirit of internationalism (my emphasis), the spirit of communism... This is our

internationalism, the internationalism with which we oppose both narrow nationalism and narrow patriotism. (Mao 1967)

Mao believes in the “malleability and perfectibility” (ibid.: 219) of human nature, for which purpose a large-scale social engineering project was initiated in the 1940s. This project was transformed and escalated after the People’s Republic of China was founded in 1949. According to Mao’s vision, the emphasis of New China would be on the countryside rather than urban areas. Intellectuals would be subordinate to farmers in terms of social class, and the former were required to learn from the latter. In the 1960s, Mao unveiled a series of nationwide projects supporting such a social movement, including *shangshanxiang*, literally meaning “Up to the Mountains and Down to the Villages,” aimed at reeducating urban youth and intellectuals in the countryside.

Cheng summarizes, “One goal of this new educational revolution was essentially associated with the creation of the new man: to bring up *practical-minded and pragmatically trained* laborers, and not intellectuals, bureaucrats, or technocrats, as had come to be emphasized in the Soviet Union” (emphasis supplied), (ibid.: 109). Under this scheme, intellectuals and expertise were secondary to peasants.

China’s medical programs were closely related to events in China. Mao based his success in revolution on the masses, or the people’s war. Throughout his political career, his focus was always on the countryside. After the People’s Republic of China was founded in 1949, Mao adopted the same strategy in governing the country. He ordered

the integration of Traditional Chinese Medicine with western medicine and also played a pivotal role in reconstructing the health system.

During the Great Leap Forward (1958-1962) , China started to enhance the delivery of medical services to the countryside, by setting up health centers at the basic social and economic unit, or the people's communes (Taylor 2005). On June 25, 1965, Mao criticized the Ministry of Health for reserving medical resources in the city, leaving few resources in the villages. Qian Xinzhong, the then Minister of Health, reported to Mao that, of the 1.4 million medical personnel nationwide, 70 percent were in the cities, 20 percent were in the counties, and only 10 percent were in the villages. Regarding medical spending, 25 percent went to the countryside, while 75 percent were in the cities. Mao flew into a rage. He issued a directive on public health, calling for medical workers to serve the vast rural population.

Following Mao's public health speech in 1965, the emphasis on health in China was shifted to the countryside and the barefoot program was unveiled. Shanghai was the first place in this program, and then the entire nation was modeled upon its experience. Under the new system, villagers were selected for a short period of medical training, in order to offer rudimentary medical services to their fellow countrymen. " Barefoot doctors" meant that these doctors, like their fellow villagers, tended the paddies when there was no work to do in the clinic. By 1975, the number of barefoot doctors exceeded 1.5 million nationwide (Li 2007).

Barefoot doctors trained on this model became important components of China's health infrastructure in rural areas and of China's medical revolution in the Third World. At the center of this program was a combination of acupuncture and basic biomedicine. The emphasis was on disease prevention rather than curative medicine (Fang 2012). A parallel program was the "mobile medical team", an outside support group that was formed to promote the development and consolidation of cooperative medicine. After 1949, mobile medical teams had been established to serve rural areas and ethnic minorities. After Mao's instructions in 1965, the Ministry of Health responded with immediate action. The core component of this national policy was organizing advanced medical personnel to provide medical care in rural areas and training grassroots health workers. .

Beijing and other large and medium-sized cities throughout the country implemented Mao's instructions, quickly organized medical teams and dispatched them to rural areas and mountain regions for medical treatment (Xia 2003). By mid-April 1965, 18,697 medical personnel had been organized into 1,521 medical teams nationwide. In the first half of 1965, more than 28,000 medical providers participated in the service. Most medical teams in the provinces and regions had first-rate experts, professors and famous practitioners of Chinese medicine. In the 1960s and 1970s, the Beijing medical teams visited the underdeveloped provinces, e.g., Gansu, Shaanxi, Yunnan, and Jiangxi, and Tibet, to prevent and treat disease. Shanghai, Liaoning, Jiangsu, Shandong, Henan,

Hunan, Hubei, Sichuan and other provinces and cities also sent medical teams to Tibet. All provinces, municipalities and autonomous regions have organized medical personnel to carry out medical and health work in remote rural areas. By 1975, more than 1.1 million medical workers from cities and the People's Liberation Army throughout the country had visited rural areas throughout the country to provide medical care (ibid).

Mao was not only interested in a political campaign across China; he was also determined to export his version of utopian socialism, which took the form of "China's African Revolution" (Hutchison 1976). Following the African Independence Movements, China began to compete with the Soviet Union and the United States and reached out to African countries. The withdrawal of French doctors plunged Algeria into a medical crisis. In 1962, China and Algeria reached an agreement for China to send a medical team to Algeria. In 1963, China sent its first medical team to Algeria, unveiling its long-standing mission of "revolutionary medicine" to the Third World and in particular Africa. Under this model, each province in China would be responsible for medical care in one African country: Shanghai is in charge of Morocco, Shaanxi is in charge of Sudan, Henan is in charge of Ethiopia, etc.

In 1964, the Ministry of Health decided to expand the medical teams to Africa as part of its commitment to "anti-colonialism, anti-imperialism, anti-hegemonism and anti-revisionism" (Ministry of Health 1964). Medical teams were regarded as a significant component of China's revolutionary diplomacy in Africa and beyond. By 1966, China

had sent medical teams, with a total of 60 medical doctors, to Zanzibar, Somalia and Algeria. The Cultural Revolution slowed this medical assistance program, but the 1970s regained momentum . Throughout the 1960s and 1970s, Chinese doctors in African countries were practicing medicine infused with the Chairman’s thought. The doctors were not just medical professionals, they were also missionaries transmitting Mao’s thought. By 1980, China had sent medical teams to 26 African countries.

Zhan (2009) argues that China reconstructed Africa as its target for political and physical intervention, by considering the African bodies as the global peasants. Chinese developed a common identity with Africans, based on the assumption that “we Africans stick together” against the “white race”. “In crafting a distinctive geopolitical niche for China, the Chinese state fashioned a world that was epitomized in the construction of ‘an international proletariat’, and it was this world that China strove to lead.” (ibid.: 37)

2.7 Medical Team in the Sudan

From 1971 to 1973, 48 doctors and nurses were selected from Shaanxi and sent to Sudan for two years’ service at locations including Omdurman in the north, and Juba, Aweil and Malakal in the south. Many of those sent had been doctors at the county or township level or barefoot doctors (Shaanxi Provincial Revolutionary Committee 1972).

The Shaanxi Provincial Revolutionary Committee summarized the medical team’s mission as follows:

Under the leadership of the Party Committee of the Embassy of the Sudan, the medical team of the foreign aid team has insisted on political leadership, carried out Chairman Mao's revolutionary diplomatic line, and actively defended the Sudanese people against diseases. Through propagating Chairman Mao's thinking through medical practice and expanding our country's influence, the friendship between our country and the Sudanese people has been enhanced and remarkable results have been achieved. It was praised by the Sudanese government and people. In October last year, the State Council approved the 'Report on Strengthening the Work of Medical Teams' issued by the Ministry of Foreign Affairs, the Ministry of Health, and the Ministry of Finance, stating: 'Medical teams abroad are an important force in implementing Mao Zedong's proletarian diplomatic line, playing an important role in supporting the Third World's struggle against colonialism, anti-imperialism and anti-hegemony. (Shaanxi Provincial Revolutionary Committee 1975)

From 1971 to 1985, more than 400 Chinese doctors, nurses and technicians were sent to Sudan and southern Sudan on a two-year mission. Every team was made up of 20 team members, including a translator and nurses. Archives document how the doctors practiced "revolutionary humanitarianism" in Sudan and southern Sudan. One example is successful surgery for a Sudanese woman.

In September 1971, a 50-year-old woman named Sayed from the countryside suffer from a large tumor in her abdomen. She was skinny, unable to move, and could not keep her horizontal in bed. She was suffering from illness for many years and was very painful. She had found many doctors seeking treatment, but they said that it was an 'incurable disease.' When she heard about the Chinese medical team, she went to the Chinese medical team from the countryside more than 200 kilometers away. After an examination by the medical team, the doctors diagnosed it as a large ovarian tumor and high blood pressure. It is difficult to perform surgery on a patient who is very weak. However, in accordance with Chairman Mao's great teaching of 'saving the wounded and rescuing the dying, practicing revolutionary humanitarianism', the doctors were

reported as using ‘collective wisdom’ to overcome the difficulties of poor equipment and conditions. After more than three hours’ operation, they took out 50 kilograms of ovarian cysts and uterus. Our comrades took care of the patient day and night, and the patient quickly recovered her health. The family and the patient repeatedly thanked Chairman Mao.” (Shaanxi Provincial Revolutionary Committee 1972)

By availing themselves of limited medical facilities, the Chinese doctors reached out to as many patients as possible.

In the operating room, we saw used gauzes and worn gloves, but the Sudanese friends threw them away. Our comrades follow the instructions of Chairman Mao and washed the bloody gauzes and worn gloves to save money for the Sudanese people...In order to meet the needs of the patients, our comrades in Juba reused bottles, made medical dressings by themselves, used a stretcher if an operating bed was absent, and started a large number of outpatient dressing, small injuries and even hernia repair surgeries were also carried out in the consultation rooms... The conditions in southern Sudan are very poor. The only hospital in the provincial capital is very crowded. A large ward could accommodate up to 30 patients. However, in order to allow more patients to get treatment, sometimes we allowed to accommodate forty or fifty patients...The ward has neither air-conditioner nor electric fans. It smells terrible and there are few medical staff. The Chinese doctors never think about this. They think that as long as they are able to treat the Sudanese people, they do not mind the work pressure. They work day and night... If there are no nurses available, they will do the injections by themselves... Some patients shed tears in their eyes when they are discharged from the hospital. They said, ‘In the past, imperialism did not treat we southerners as humans, but stamped their feet on us. Only Chinese doctors treat us as brothers. You not only do everything you can to cure our illness, but also care for us in all possible means” (ibid).

Following the instructions of Mao, they ended up practicing in a small hospital in the countryside.

On the issue of the selection of locations, there were two kinds of opinions: one opinion is that we should go to a large hospital with better equipment and it is easy to carry out work; but another opinion is that we should go to a small hospital close to the countryside. Although the hospital is small, the equipment is poor, and the technology is low, this is the place where we need to go. The hospital is small, but it is easy to work with the working people of Sudan.... Poor equipment can also facilitate collective wisdom...” (ibid).

Dr. Lado is one of the South Sudanese doctors who worked with Chinese medical personnel in the 1970s. We met in the ophthalmology department of Juba Teaching Hospital. Ophthalmology was a key area emphasized by Chinese medical teams. When the Chinese medical team arrived in Juba in 1973, Juba was a small town with a few hundred residents. After the First Sudanese War, it was a golden period for the development of the South Sudan Autonomous Region. The Chinese worked from 8 am to 5 pm , Monday to Saturday, which was also observed by Hutchinson:

I myself spent a day with one of the teams in Juba, southern Sudan, where they were working immediately after the conclusion of the civil war in early 1972. The area had not had proper medical attention for over fifteen years and health and sanitary conditions were appalling. The team, which consisted of nine men and two women, worked flat out from 7 a.m. until dusk. In the morning they performed an operation for constriction of some sort, in the afternoon they conducted a clinic attended by literally hundreds of patients. (Hutchinson 1976)

During my fieldwork in South Sudan, I tried to retrieve archives documenting the earlier activities of Chinese doctors in southern Sudan. I visited the Ministry of Culture, Youth and Sports, the National Ministry of Health, Jubek State Health Ministry and Juba Teaching Hospital. Unfortunately, people told me that the medical records left by the

Chinese in the 1970s to 1980s were destroyed by fire when the Ophthalmology Department relocated to Buluk Eye Center. However, in the National Archives, I found part of a report about the Chinese team published by the *Nile Mirror*. The journalist wrote:

The more we went around, the more we met different people above all, in race. This time, our encounter was with the Chinese doctors. These are, without exaggeration, the only people always on duty. The head of the team is Dr. Chao Hung Hsen. The team, in his own words, is happy to be a partner in the development of the Chinese-Sudanese bilateral relations and especially glad to foster that relationship in the southern part of the Sudan. “When we first arrived at the Region, we found difficulties in communications. But with time, this obstacle is now removed. In fact, we have been trained in many languages because we are friends of many people.” So said the leader of Chinese team. An important factor of the Chinese team is their equipment. They have the doctors, and the medicine they prescribe to the patients. They are always on alert and never bother much about the time you visit them either in the hospital or in their homes. (The Scene in Hospital, *Nile Mirror*, 1974)

The medical teams working in southern Sudan were interrupted by the Second Sudanese Civil War. Shaanxi Province withdrew its medical team from southern Sudan in 1985. Beginning in 1970, the Chinese government assigned Anhui Province to dispatch a medical team to South Yemen. In 2011, an escalating civil war interrupted their mission. The next year, they assumed responsibility in South Sudan. In 2013, after South Sudan gained independence, Anhui Province sent the first medical team. The first team was composed of two physicians, two pediatricians, two gynecologists, two surgeons, an anesthetist, a dermatologist, a translator and a cook. Compared with the

1970s, each team's mission was reduced from two years to one year. Instead of working the full day, as in the 1970s, the new team works three hours a day, from 9 am to 12 pm. In the second year, an orthopedist was added to the team. In 2016, an acupuncturist and a nurse were added, expanding the team to 15 members.

By this time, many doctors coming to serve in South Sudan had a different motive than their predecessors in the 1970s and 1980s. Not only are they entitled to a package of generous salary and benefits; after completing their service in South Sudan, they are also eligible for a three-month-exchange program in Germany.

For many, their incentive is driven less by a mission of "serving the people of the world" than by gaining a new and refreshing experience in Africa. Dr. Liu is a 53-year old orthopedist at the No. 3 People's Hospital in Hefei, the capital of Anhui Province. Dr. Jiang, an anesthetist, was promoted to Chief Physician at the No. 2 Hospital in Hefei. She said, "I am skilled in all expertise in my hospital. Everything in the procedure is repetitive. China is developing too fast, leaving little room for one to stay to him/herself. The best thing about Africa is I can spend some time of my own will." Dr. Jiang's favorite book is *Ten Years in Africa* by Liang Zi, a female photographer who has traveled extensively in Africa. Jiang also dreams of boarding the luxury Rovos Trail and travelling throughout Africa. For many doctors, "humanitarianism" is now a distant concept. One doctor asked me, "I earn much less here in Juba than in China. Isn't it a form of humanitarianism?"

However, the Chinese government still uses “humanitarianism” to characterize its medical teams. In a commemorative booklet recognizing the 50th anniversary of Chinese Medical Teams, the National Health and Family Planning Commission cited the endorsements of Chinese leaders, testimonials to the changing spirit of the Chinese Medical Team.

The people who have won the revolutionary liberation should assist the people who are fighting for liberation. This is our internationalist obligation. (Mao Zedong)

When we have really developed, we must devote a considerable amount of resources to assistance. China will not forget this even after its own success in development. (Deng Xiaoping)

We cannot forget our poor friends because of our own economic development, or because our economic development requires the capital and technology of developed countries. (Jiang Zemin)

We will do our best to support and assist other developing countries in accelerating development. China is willing to work together with other countries in the world. Make the 21st century truly a century for everyone to enjoy development. (Hu Jintao)

Over the past 50 years, the Chinese medical team has not only made outstanding achievements in serving the people of Africa, won the highest honor for the motherland and the people, but also used its own practical actions to create a lofty spirit of the Chinese medical team. They can be summarized as the following: to be not afraid of hardship, be willing to sacrifice, rescue the wounded, love without borders. The spirit of the Chinese medical team is not only a powerful spiritual force that inspires generations of medical team members to make unremitting efforts, but also a vivid portrayal of our national spirit. (Xi Jinping)

These kudos reflect the transformation of Chinese medical teams, which started as a revolutionary project spreading Maoism to the Third World. During the 1980s, when China bid farewell to Maoism, the emphasis of medical aid was shifted to development, as China embraced market-driven reform learned from the West. The Third World as a powerful political base and revolutionary frontier was sidelined. Development became the key word. Deng, Jiang and Hu, the successors to Mao, all stressed the importance of development. To reflect this change, the Chinese medical teams were under the joint supervision of the Ministry of Health and the Ministry of Foreign Economic Relations and Trade. Xi reduced the emphasis on development in favor of reviving key components of Maoist ideals, such as “serving the people” and “rescuing the wounded and rescuing the dying,” reminiscent of the time of revolution and a transnational ethic presented by Mao in the 1960s.

2.8 Medicine as Business

After China shifted from a planned economy to a market economy in the 1980s, Chinese doctors who had served as medical team members in Africa seized the opportunity and converted their experience on the African continent into personal assets. They returned to Africa to open private clinics, most often staffed by one or two doctors, or a couple. In most cases, they employ a local nurse to administer injections, while the Chinese doctors are in charge of consultations and pharmacies. Most clinics do not have

in-patient service. They offer out-patient service, consultations on common diseases and acupuncture, similar to what barefoot doctors did in the 1960s. These clinics are never large, occupying two or three rooms and a few beds. The newcomers also include those who had worked in enterprise-based hospitals in China but were laid off after state enterprises were privatized or sold off in the 1990s. In Dar es Salaam and Kampala, there are some *fuqidian* (a husband-and-wife shop) clinics, where the man works as a pharmaceutical representative and his wife opens a small clinic for those who can afford treatment in a private Chinese clinic.

In her works (Hsu 2008, 2012), Elisabeth Hsu documents the arrival in Tanzania and Kenya of Chinese doctors who practice Traditional Chinese Medicine. She observes that these doctors have limited training or formal education, some of whom are self-taught in themselves medicine after having changed their professions. In her accounts, these private clinics and transnational doctors operate mostly individual or family-based businesses. In Juba and other cities in South Sudan, there is a similar yet distinctively different mode of medical business run by the Chinese.

In addition to the individual and family-operated clinics, businessmen are looking for a more comprehensive medical service. Medicine as business is more ambitiously promoted. Some of the medical facilities even position themselves as an international medical group and look to expand their business in neighboring countries. In the midst of financial crisis in South Sudan, the manager of a Chinese hospital even traveled to Iraq

to check out the possibility of opening a hospital there. In 2016, this same hospital also established a new five-story hospital in Kampala, but was compelled to withdraw, after encountering a series of political and financial challenges. These attempts at expansion did not succeed, but their ambition shows a major difference compared to existing family-operated businesses.

South Sudanese associate Chinese with a practical mind. They say “The Chinese, they can live everywhere. They can stay in the city, or in the village.” Most of the Chinese medical facilities are in Juba, but there are also a few hospitals and clinics in other states like Wau and Aweil, hundreds of miles from Juba. The Chinese hospitals and clinics in Juba are located in busy streets like the Ministry Road, Airport Road, and Independence Road, but a few others choose modest places like Atlabara and become involved with the South Sudanese communities.

These medical clinics and hospitals take their names from the most common Chinese names like Beijing Hospital or People’s Hospital (*renmin yiyuan*), or they follow the discourse adopted by China to describe the relationship with Africa, like Friendship Hospital (*youyi yiyuan*), China Friendship Hospital (*huayi yiyuan*) Alternatively, they use Peace (*heping*), Evergreen (*changqing*), or Sunshine (*yangguang*) to express hope for an end to war in South Sudan, which will help to ensure the success of their business.

Most of the hospitals feature a straightforward layout and look like township hospitals or village clinics in China. Entering Friendship Hospital, one first sees the

operating theater on the left side, which suggests the importance of surgery for the hospital. At its peak, Friendship Hospital had four surgeons, including two orthopedists. The reception area is staffed by both a Chinese receptionist and a South Sudanese receptionist. Behind them is a pharmacy, with about 200 different types of drugs. A small dressing room is next to the pharmacy.

The nursing station is staffed by Mrs. Xiong, Mrs. Hu, Mrs. Liu, and two South Sudanese nurses. Mrs. Liu's brother works at another hospital in Juba. In 2016, he transferred to a different Chinese hospital in Aweil, but the owner of that hospital did not pay him for almost a year. It is quite common for Chinese doctors to shift from one hospital to another.

On the right side of the hospital are consultation rooms for internal medicine, surgery and orthopedics, as well as a room for acupuncture, and another for radiology. Between the reception and the consultation rooms, there is a courtyard, where patients and their families sit on blue-colored beam chairs, watching programs on Al Jazeera. On the walls, there are posters, documenting the history of the hospital, and photographs of different types of bone deformities. Most mornings are quiet, with few visitors; but there tend to be more visitors in the afternoon. There are ten ward beds, two of which are VIP suites, furnished with a rest room, an air conditioner, and a TV.

In 2014, Mr. Zhong purchased a plot of land and built a new commercial complex, which was rented to a few other Chinese companies. In 2015, the first floor of

the complex was converted into a diagnostic center that includes a testing room and a CT scan room.

The Chinese doctors come from different backgrounds, but they all considered South Sudan as an adventure. Everyone wants to dig the first barrel of gold.

Dr. Guo, who graduated from the Fourth Military Medical University in 1973, was one of the Chinese doctors sent to the countryside following Mao's supreme instructions of June 26th, 1965. After returning to Beijing, he worked at the China Academy of Chinese Medical Sciences Guang'anmen Hospital and the Ministry of Railway Hospital, before launching his own private clinic in Beijing. After the independence of South Sudan, Dr. Guo came to Juba, rented a house from a high-ranking South Sudanese official, and opened his clinic with nine beds. He and Gao, his wife, ran the clinic for six years, before moving back to China in late 2016.

Some doctors combine medicine with other projects. Dr. Lu, who graduated from Henan Medical University, had worked in Sudan as a doctor with a state-owned enterprise constructing a dam in Merowe, about 300 kilometers north of Khartoum. He later registered his own subcontracting engineering company and bid for construction projects. When he moved to South Sudan in 2011, he tried his luck and operated a hospital in Nimule, a border city, but the devalued South Sudanese pound forced him to close the hospital. He still hoped to collaborate with state hospitals in Torit and Kapoeta in the eastern part of South Sudan, where he could open his own clinic on the premises of

state hospitals and use his connections with the state governors to reap benefits. Medical business in this way is based on a collaborative model, where private clinics are collaborating with *zol kebir*, or “big men” in South Sudan.

One of the biggest Chinese hospitals is the Friendship Hospital, which hosted dozens of medical personnel from central China’s Henan Province. I first got to know them in 2013, on my preliminary field visit to Juba and Wau. At that time, Friendship Hospital in Juba was home to almost 40 doctors and nurses from Henan. These health care workers were different than medical team members many of whom held bachelor’s, master’s or even doctoral degrees. These lower-ranking medical personnel worked mainly in township or county hospitals in China, after a three-year training at secondary medical schools. A few of them obtained bachelor’s degrees from schools like Henan University of Traditional Chinese Medicine or the Medical School of Zhengzhou University, but they account for only a small number of the medical personnel.

The rapid urbanization of China poses many challenges to lower-level clinics. Hospitals in the cities are expanding rapidly, leaving little room for hospitals at the county or township level. This is true of many of the doctors from Henan Province. For example, the First Affiliated Hospital of Zhengzhou University in the provincial capital of Henan is a giant hospital. In 2017, the hospital treated 6.5 million patients and operated on 280,000 patients. With more than 7,000 beds, it is the largest hospital in Asia.

By comparison, New York-Presbyterian, the largest hospital in the United States according to Becker's Hospital Review, has only 2,478 beds.

In the 1950s, China established a county-township-village, three-tier health care system, which contributed to rural primary health care and set an example in primary health care for developing nations. In 1978, China's experience was adopted at the International Conference on Primary Health Care, held at Almaty in Kazakhstan (formerly Kazakh Soviet Socialist Republic), which requested all governments and the world community to protect and promote the health of all people. It was the first international declaration emphasizing the importance of primary health care.

In the 1980s, this system experienced transformations along with the changes of China's administrative system and economic policy. The transformations are characterized by the disintegration of the rural cooperative medical service, by official permission for private practice, and by the implementation of the personal responsibility system in health care institutions. As urban hospitals are becoming "Big MacDonald" and absorbing an astonishing number of patients, the hospitals and clinics in the countryside are gradually withering. Dr. He, a village doctor in Kaifeng, found the number of patients visiting the village clinic dwindling substantially over the years. "They even go to Zhengzhou for minor ailments. Who cares for a village clinic like us?" As the Chinese increasingly head for big cities to see the "best doctors" and seek "the best treatment," lower-level doctors are compelled to seek their fortunes elsewhere, including Africa.

This was the case for Dr. Li. He had worked as a radiology technician at a township hospital in Kaifeng, but his monthly salary was only \$300, making it difficult to support his family. Li's daughter is attending high school, and his son is in college. Their tuition fees and living expenses are a big burden on him and his wife, who also works in the hospital. Although the Chinese government has allowed doctors in public medical facilities to practice in private institutions, the mobility of lower-level doctors is restricted. Africa ended up being one of the practical options.

In 2001, Li's friend asked him to try his luck in Khartoum, because a Chinese businessman opened a private hospital there. He was afraid of losing his *tiefanwan* (secure job) at the hospital, but he decided to venture into Africa. He stayed in Khartoum for a few years and shifted to *Dongfangguke Yiyuan* (Oriental Orthopedics Hospital) run by Dr. Duan and his nephew, Mr. Zhong.

Dr. Duan had also worked as a physician at Xijiangzhai Township Hospital, not far from Dr. Li's hospital. As the eldest son in his family, he had to take care of his four siblings, including their dowries. In the early 2000's, he opened a private hospital in Kaifeng. In 2009, one of his friends invited him to run a business in Khartoum. So he went. His nephew, Ma, joined the business.

Before going to Africa, Mr. Zhong was a marketing manager in Shenzhen, one of the forerunners of China's policy of reform and opening up. He began as a regional sales manager with Mengniu, a large company which manufactures and distributes dairy

products. His talents for sales resulted in great success. In one year's time, his sales rose from a few million RMB to more than 1 billion RMB. Within a short time, large supermarkets in Guangzhou and Shenzhen were Zhong's key accounts. Others might have been content with these achievements, but Zhong said he was "restless and adventurous" from childhood on. His favorite game was playing with homemade guns in gang wars with other fellows in the village.

Throughout the history, a major theme running through Chinese society is stability. For thousands of years, the Chinese imperial court expected its citizens to behave themselves obediently, remain loyal to the emperor, run family-based small-scaled businesses and keep to themselves. You are seldom given the freedom for innovation, creation development.

Zhong is strongly against the idea of *shougongzuofang*, or individual or family-based workshops. His business philosophy is built on a belief of "high risk, high reward". It means that to maintain the success of a "modern" medical business, both the size and patient volume should be expanded.

From the beginning, medical business run by Zhong was oriented towards business. Sudan became the place for Zhong's experiment. A businessman from Zhejiang wanted to collaborate with Zhong and Duan. But they broke up over business interests and Zhong established his own hospital in Khartoum named *Dongfangguke*. However, the devalued currency and increasingly restrictive regulations in Sudan, after South Sudan declared its independence, forced them to leave Khartoum and head to Juba for a new hospital.

In the next few years, China Friendship Hospital opened two branches in Malakia and Gudele, recruiting dozens of doctors and nurses from China, making it one of the biggest medical facilities run by the Chinese anywhere in Africa. Apart from the Chinese doctors and nurses, the hospital also employed a few South Sudanese nurses, translators, and marketing managers. At lunchtime, a South Sudanese driver at the Tongping headquarters would deliver meals to the other two branch hospitals. At night, doctors at Malakia and Gudele would return to Tongping to sleep.

In 2015, the hospital updated the medical facility and installed two CT machines, making it one of the major testing centers in Juba. Sometimes, patients who could not get their examinations done at Juba Teaching Hospital, due to a lack of facilities, would go to the Friendship Hospital for checkups.

This mode of development is shared by other hospitals run by the Chinese, one of whom is Madam Yu. Like Mr. Zhong, she had a business in Khartoum and, after the independence of South Sudan, headed to Juba to seek opportunities. She was originally from northeast China, so the doctors she employed were mostly from her hometown. At first, she wanted to open a comprehensive hospital, covering all departments and specialties, but she invited James, an orthopedist from the Military Hospital of South Sudan to be a partner. The hospital was later named Peace Trauma and Orthopedics Hospital.

Thanks to this collaborative model, surgical cases at Peace Hospital are divided into two categories. Dr. John and his South Sudanese colleagues are responsible for orthopedic cases dealing with arms and legs, while the other cases are in the hands of Chinese doctors, including Dr. Lu. The economic crisis has put a lot of pressure on South Sudanese doctors, forcing them to practice medicine in private clinics. The Chinese hospitals and clinics have become one of the options attracting South Sudanese medical personnel. All the Chinese medical facilities have a close relationship with South Sudanese officials to guarantee success in their business. For example, many patients at Yilientang Hospital are officials working at government ministries. The private clinics also occasionally invite the Chinese medical team to treat these officials.

3. Guns at the Door

Guns, or in Juba Arabic, *silaa*, are commonplace in South Sudan. The country's independence in 2011 has not been translated into a long-awaited peace. Guns have never disappeared from the public memory. Guns are witnesses to conflict and factions, violence and death, injured bodies and medical responses. In South Sudan, guns not only have a historical presence, but also configure people's corporeal identities. As Antze and Lambek (1996) argue, "memories are never simply records of the past, but are interpretive reconstructions that bear the imprint of local narrative conventions, cultural assumptions, discursive formations and practices, and social contexts of recall and commemoration. When memories recall acts of violence against individuals or entire groups, they carry additional burdens—as indictments or confessions, or as emblems of a victimized identity."

South Sudan is in the center of arms supply in the Horn of Africa. With more 40 years of internal conflict, South Sudan has been home to a range of non-state actors actively seeking small arms and light weapons to fight for their causes. A number of countries, primarily within the Horn of Africa, have been eager to arm them. Over the past decades, for example, Ethiopia and Uganda provided material support to the SPLA. Many of these weapons ended up in the hands of rebel groups in South Sudan. In the past, the Sudanese government and Sudanese Armed Forces have also armed and supported

forces fighting the SPLA and the South Sudanese government, providing guns and munitions.

Based on UN Comtrade data (2007), at least 34 countries have exported small arms, light weapons and ammunition worth almost USD 70 million. Both Sudan and South Sudan acted as conduits for small arms from the rest of the world to other countries in Africa (Chad, DRC, and Uganda). Nimule, for example, was a major black-market trading center for weapons coming from Uganda, many of which seemed to have been picked up by civilians. More recently, there has been an increase in arms trafficking from Kenya and Somalia to Uganda – an indicator of the growing instability in the entire region. As of late 2009, an estimated 2.7 million weapons were in circulation in the Sudan, with just under 20 percent held by the Government of National Unity, less than 10 percent held by the then Government of Southern Sudan (GoSS), and the rest held by then current and former armed groups. From inventories taken in 2009, it is estimated that the SPLA may possess some 200,000 firearms (Gramizzi 2014). However, civilians and armed groups are believed to possess many more weapons than the Sudanese state security forces and the SPLA combined. At the time, it was estimated that average civilian holdings in the ten Southern states were twice those of the fifteen Northern states and that the weighted average of civilian holdings across the country were a little below five weapons per hundred persons. With some forty million inhabitants, civilian holdings at the time were placed at approximately 2 million weapons, with only a very small

percentage of these weapons registered with the authorities. As the rearmament of Southern nomadic herders in the wake of GoSS and SPLA arms recovery initiatives attests, weapons have remained in plentiful supply and continuing cycles of bloody clashes among ethnic groups in the South suggest that there is no shortage of weapons or ammunition (Small Arms Survey 2009).

Two types of weapons dominated the arms held by non-state actors across North and South Sudan – AK-type assault rifles and RPG-2 or RPG-7 rocket launchers, as well as RPK and ‘DshK’-type machine guns (ibid). Many of these are relatively old weapons, manufactured in several dozen countries in Eastern Europe, the Middle East, and East Asia and widely circulated within and between armed groups and communities across the region and beyond.

Until the signing of the Comprehensive Peace Agreement in 2005, South Sudan experienced decades of armed conflict, and still suffers from the consequences, including continuing armed conflict at the community level. The presence of small arms contributes to these conflicts and makes them deadlier. For example, violence between nomadic herders and crop farmers or among pastoralists over cattle rustling or grazing rights has historically occurred in South Sudan. Traditionally, these conflicts were fought with spears and sticks. However, this has changed due to the circulation of small arms during the civil war. Cattle raids with guns now lead to dozens or even hundreds of deaths. Traditional conflict resolution mechanisms, such as negotiations between community

elders, are also less effective, as power is now often wielded by well-armed young men (Leonardi 2013).

Firearm-related violence in South Sudan does not make front-page news like mass shootings in the United States, but it is characterized by “enduring corporal aftermaths and embodied memories” (McSorley 2013). Indeed, South Sudanese are exposed to guns every day. Security guards wield them in compounds, outside banks and in hotels. Soldiers of the SPLA carry guns while riding motorcycles in the western suburbs of Juba. Herdsmen use them to fend off cattle raiders. When businessmen and politicians travel within Juba or to other cities, they bring guards and guns to protect them. Guns are an indispensable means of providing security, but also a deadly way to claim lives. It is not uncommon for people with guns to break into houses and steal anything of value. At night, one hears gunshots here and there in urban areas, especially in western Juba, an infamous hotspot for conflict.

Guns have gained a material presence in the lives of South Sudanese and are one of the country’s leading causes of injury. The widespread use of guns, together with grenades, knives and sticks, has become an outstanding feature of social life in South Sudan, victimizing people from all classes and backgrounds: civilians, soldiers and cattlemen, young and old, men and women. The frequency of cases of gunshot wounds testifies to the security situation in South Sudan’s urban areas.

The conflict in 2013 turned out to have a lasting impact, particularly in Upper Nile state, where government and opposition forces fought bitterly over the right to the state's oil fields, leading to an increase in gunshot cases. In early February 2014, Médecins Sans Frontières and the International Red Cross treated more than 150 people—mostly for gunshot wounds—in and around Malakal. The conflict continued into the summer of 2014 in states such as Upper Nile, and riots started to have an impact on the capital, Juba. During my fieldwork in Juba that summer, there were reports that presidential guards had gone on a rampage in the city, robbing and terrorizing citizens. Residents of Juba said that soldiers from the Tiger Unit of the presidential guard constantly roamed the city in their official pickup trucks, terrorizing and looting at night with impunity. Gun violence was threatening people's lives. The soldiers demanded 500 SSP from every citizen they encountered. Some people were beaten for failing to supply this sum.

The number of gunshot cases in South Sudan has fluctuated over time, peaking after each of the two civil wars in 2013 and 2016. At those times, many soldiers were sent to the Chinese hospitals and clinics in Juba for treatment, because the Military Hospital and Police Hospital lacked capacity. In summer 2014, the Friendship Hospital was packed with soldiers awaiting surgery, making it almost indistinguishable from a military hospital. The Friendship Hospital received as many as 30 patients in one month, most of whom required orthopedic treatment.

Dr. Luo, a surgeon at the Friendship Hospital, recalled that, in 2014, gunshot wounds accounted for one-fourth or even one-third of the orthopedics cases in the hospital in 2014. The other two thirds were attributable to car accidents, construction accidents, falls, and some bone diseases. Following the civil war in 2016, gunshot cases again saw a huge increase, especially from July to October. Many soldiers came to the hospital for treatment, but they could not afford it because they did not have money. They had not received salaries from the government for a long time. Delay in treatment resulted in bone deformities, infection, and necrosis. In South Sudan, there are far more old fracture cases than fresh ones. “To treat old fractures, you must reopen them to create a fresh wound so that bone alignment is possible. This is definitely very challenging,” Bai said.

Nonetheless, wars and conflicts create new opportunities for the Chinese private hospitals. Over the past few years, the Friendship Hospital has operated on more than one thousand orthopedic cases. The years 2014 and 2015 witnessed a booming business . Patients from other states came for treatment. At that time, Dr. Luo performed various surgeries, e.g., liver and spleen injuries, Caesarean sections, hernias, appendices, and intestinal obstructions, but these cases are decreasing substantially. “Who can get ten thousand pounds for a surgical operation these days? Some treatments can be delayed, but some others cannot. In China, we race against the time to treat patients. If you miss the time, the patient will miss the best time for treatment. In China, if we take time, many

patients can be saved, but things are different here. If they have no money, they should borrow money. They are just waiting to die here.”

Public medical facilities receive even more gunshot cases. In early 2018, gunshot wounds overwhelmed Juba Teaching Hospital. In April, the hospital registered 15 cases of gunshot wounds; most of the people wounded were victims of armed robberies. Such incidents occurred in Gudele, Guray, Shirkat and Gumbo, neighborhoods on the outskirts of Juba. Most of the wounds were found in the arms and legs, indicating that the shootings had been intended to scare rather than kill. People say that members of the organized forces, including the SPLA, police and national security services, were involved in these violent robberies in Juba.

It is impossible to accurately predict the frequency of gunshot cases in South Sudan, as the situation is too volatile. Since 2013, political instability and economic crisis have resulted in a wide range of security issues. After the peace agreement was signed in 2011 and before war broke out in 2013, Juba experienced a golden time. The exchange rate of the SSP against the US dollar was 2:1, and everyone seemed to have a means of making a living. In 2013, when I arrived in Juba for the first time, I was able to walk around without fearing armed robbery. However, things changed dramatically after 2013 due to ongoing instability and the deteriorating economic situation. By the third time I visited Juba, in 2015, it had become obvious that taking a *boda-boda* with my wallet in my pocket could prove not merely dangerous but lethal. The increase in checkpoints and

night-time curfews has made it challenging to move around, but the government also uses these means to check for the illegal possession of guns.

Guns become a means to livelihood when hunger sneaks in. Sikos, a driver who lives in Gudele and works for a Chinese company said, “At night, they come with guns. You bring everything you have, you put it down. The robbers would say, ‘If you don’t have money, I will kill you’. Everyone is very hungry. They are fearful of the rich people: they have guns and soldiers. If you give them something, maybe they will kill you, maybe they will not.”

The most difficult time comes at the end of the month, when money runs out, which means more killings and more suffering are possible. “We fought for freedom, but after independence, we started to kill each other. For what? For 5,000 SSP, you go and shoot your brother,” Sikos said.

The shadow of gun violence also falls on the Chinese doctors. This was particularly true during the civil war in 2016. On July 8 of that year, a group of Chinese doctors from the Friendship Hospital returned to Tongping from the Gudele Branch, when they found the roads blocked by checkpoints. Emmanuel, the driver, told the soldiers that Chinese people were sitting in the car and the soldiers at the checkpoints let them pass. When they passed the Crown Hotel, the car stopped again. The Presidential palace was armed with guns on both sides. The moment the Chinese doctors passed the checkpoint, soldiers on both sides exchanged fire. The hospital stopped service for five

days. At that time, all the Chinese doctors went upstairs to sleep and to guard against looting.

Dr. Zheng saw some dead people in the hospital. On July 8, five people were sent to the hospital, whose intestines were hanging out. Two of them were injured in the leg.

Later, some Dinka soldiers rushed into the Chinese hospitals searching for Nuer. A Nuer translator who had studied in China for six years and worked at one of the Chinese hospitals became the target. He was confronted by the Dinka soldiers and lied that he was from Uganda. On hearing this, the Dinka soldiers asked for his passport, which he failed to present. They dragged him to the entrance of hospital. “Dr. Lu, please save me!” he begged, but this was beyond Dr. Lu’s capacity. The translator was shot on the spot. When his body found two days later, it was already unrecognizable.

This chapter sheds light on the temporalities of firearm-related violence, the lasting effects of injuries and post-injury treatment to reassess the conceptualization of “violence” in South Sudan. I explore how a culture of gun violence shapes everyday language, practice and bodily experience, then discuss the biopolitics of orthopedics and surgery as practiced by Chinese doctors in Juba and elsewhere in the country.

3.1 “We Go by the Jungle Way”

A random walk through Juba Teaching Hospital would make one shudder at the sight of people with crutches or in wheelchairs. Some patients have been in the hospital

for months, or even years, without receiving proper treatment. Isaac, a 10-year-old boy, has lived in Ward 2 for more than two years since falling off a roof. People say that Juba Teaching Hospital is virtually a trauma hospital.

Of all of the departments of Juba Teaching Hospital, the Department of Orthopedics has a particularly important position, not only because it has an advanced theater of its own, distinguishing it from other departments, but also because many medical students want to become orthopedic surgeons in the future.

The Department of Orthopedics is located across from the endoscopy room, which is overseen by a gastroenterologist from China. The endoscopy room is where the Chinese doctors get together during their morning hours at the hospital, but they seldom engage with their South Sudanese colleagues in the Department of Orthopedics.

The department is divided into two rooms. Dr. Wilsoneth, the clinical officer, is in charge of the surgical dressing room and medical interns. Medical officers and consultants receive patients in the inner consultation room on Tuesday mornings. Operations in the theater are scheduled for Thursdays. The consultation room is very spacious, with a big flip chart standing against the wall. The big table in the center is reserved for Dr. John, the medical consultant, and the side table for Dr. Samuel, a younger medical officer.

Dr. Wilsoneth is responsible for changing dressings and replacing them with new ones. From time to time, he complains about the shortage of bandages and other materials.

“Our main store is empty, even with the donations from foreign countries. I don’t know where they have gone. Thank God, there were bandages in the main store yesterday.” The shortage of materials is a problem confronting all the patients visiting Juba Teaching Hospital. Like many of his colleagues working in the public sector, Wilsoneth goes to a private clinic in the afternoons to make extra money.

When Dr. John finishes his outpatient sessions on Tuesdays, he offers instruction to students from the College of Medicine. He is heavily built, with an adenoidal voice. He pulls out X-rays and displays them on the screen. His students sit around the table, earnestly taking notes. Nobody dares to challenge his authority.

Prior to 2012, Juba Teaching Hospital had no orthopedic surgeons. The only orthopedist working in the referral hospital was from the International Committee of the Red Cross. In the whole of South Sudan, there are currently only two orthopedic consultants, both of whom work at Juba Teaching Hospital: Dr. John and Dr. Wilson. Dr. John was trained in Iraq, and Dr. Wilson in Norway. Dr. John worked in the Sudanese Army for 27 years before moving to Juba Teaching Hospital and Military Hospital. Besides Dr. John and Dr. Wilson, a few junior medical officers work in the Department of Orthopedics, including Dr. Morris, Dr. Samuel and Dr. Kumba. But the demand for orthopedic surgery is huge. Every Tuesday morning, patients swarm the department waiting for the doctors. They carry X-rays performed elsewhere, such as Juba Diagnostics, Juba Medical Complex or the Friendship Hospital. Juba Teaching Hospital

has an X-ray room. The Chinese government donated a moveable DR machine to the hospital in 2016, but so far it has remained idle in the X-ray room. Only a couple of patients have accessed the machine.

Machior Mabayin, a 33-year-old soldier from Bor, Jionglei state, comes to see Dr. John. He was shot in the leg in the morning of November 16, 2016, while standing on a hill close to Kajo-Kaje Road, about 90 miles south of Juba. “There is no support from the army. Nobody helps anyone. If you don’t have your parents, you will die,” he says.

Sometimes, the hospital receives no power until 10 am or 11 am, but the patients do not complain; they simply wait patiently outside the appointment rooms. If the power fails to arrive that day, doctors may not offer consultation, requiring patients to return to the hospital the next week. Patients are used to doctors’ absence at Juba Teaching Hospital. “What can I do? Life is like that,” Mabayin leaves without meeting with Dr. John.

Car accidents and gunshot cases are among the most commonly reported surgical cases. In Juba, except for Ministry Road and a few others, the roads are unpaved, resulting in many motorcycle accidents. When the injured people reach the hospital, almost nothing is for free. An orthopedic operation costs 2,000 to 3,000 SSP, and patients have to cover many of the associated expenses out of their own pockets.

Running the surgical department of Juba Teaching Hospital, according to surgeon Dr. Michael, is fairly chaotic. Although a hierarchical system of organization is in place,

senior doctors are absent from the process. They are rarely even found on the premises of the hospital. Intern doctors usually see patients in the outpatient department, but they do not make decisions on their own. “These people are just clinical assistants. They should not be allowed to touch the patients. They have limited knowledge. But the administration allows them to do that. How can interns understand complicated medical cases?”

From the outpatient department, patients are sent to Ward 5, where doctors prepare IV fluid and blood. Severe cases are put on a timetabled schedule. When scheduled, patients come to see consultants in the referral clinic on Monday. On arriving, they are sent to Ward 10. If everything is alright, the surgeons decide to bring them to the theater. After the operations, the patients are taken back to Ward 10. The consultants take over and decide who should go for operations, using elective lists. Operations are performed on Thursdays. If investigation is insufficient, the patients go to the private clinics to carry out investigation on their own initiative. If there is no power, patients are asked to provide fuel; otherwise, their operations have to be postponed.

Some doctors can handle complicated conditions, but the types of surgery that can be performed are limited. Complicated operations such as surgery for malignant tumors, radiotherapy, organ transplantation and plastic surgery cannot be performed at Juba Teaching Hospital. The intern doctors have seen them in textbooks but never performed

them in practice. In such cases, the patients are referred to Nairobi, Egypt, Sudan, India or Germany for treatment, but the traveling involved is beyond most people's means.

Dr. Michael says that the way in which the doctors at Juba Teaching Hospital practice surgery is known as the "jungle way," because it is similar to the provision of medicine in wartime. "It depends on what can be done to help the patients and what facilities are there. You do what you can in the interests of the patients. Sometimes, you send the patients to get [what's needed]. If IV fluids are available, you ask the patients to get them outside. If they are not available, cover the injury with gauze and let the patient go home. If the patient's status is severe, you can lose the patient, so you don't need to follow procedures."

Before 2013, the government supplied everything in the hospital. After 2013, things changed. Patients now have to cover a large portion of their medical expenses. The financial burden is too much for many patients. Sending a patient for medication and an X-ray can take one or two weeks, but this significantly delays the treatment process. Open fractures should be treated in 6 to 8 hours, but here it takes at least 24 hours. At Juba Teaching Hospital, it is quite common that gunshot wounds are left unattended for a few days.

Under these conditions, doctors are not motivated to practice service in the hospital. Dr. Michael says he is just gambling outside the system. "The system is corrupt—why should I bother?" he asks. Many doctors go and look out for themselves.

“You have to do it for yourself. People’s lives are limited. It’s beyond our capacity, not in terms of management but in terms of the management of human resources. Instead of making changes, they are suppressed. We cannot do anything. Doctors went on a strike. This happened two years ago. You don’t talk about it. You just go.”

Now and then, doctors and nurses at Juba Teaching Hospital stage strikes over allowance arrears. In April 2016, more than 60 doctors and nurses at Juba Teaching Hospital staged a strike that continued for almost a month over payment delayed since the beginning of 2016. They said that the Undersecretary of the Ministry of Health told the director of Juba Teaching Hospital officially that the Ministry is unable to pay doctors’ salaries, and asked them to continue working without payment, which the doctors refused.

By December 2017, Dr. Michael had left Juba Teaching Hospital for Comitato Collaboraziene Medica, an Italian medical organization operating in Marial Loul Hospital in Tonj state.

In the orthopedic department, surgeons practice only the most basic operations, which are performed primarily by junior doctors like Dr. Samuel and Dr. Morris. Although Dr. John come for weekly consultations, he never shows up in the theater. Neither does Dr. Wilson. When I asked him what it means to be an orthopedist working in South Sudan, Dr. John replies that they “work on the parts that the patients can afford.” By that, he means private hospitals and clinics such as the Peace Hospital.

The Peace Hospital was established through Dr. John's professional credentials, so its full name is the Peace Hospital for Orthopedic Trauma Surgery. Under an agreement reached between Dr. John and Madam Yu, South Sudanese doctors are responsible for limb fractures, while Chinese doctors are responsible for the other parts of the body.

3.2 The New Normalcy

It has become increasingly common for Chinese doctors to deal with gunshot cases or gun-related violence. To a certain extent, gunshot wounds are the new normalcy. One day, when I was talking with Dr. Zeng in the consultation room at the People's Hospital, a 28-year-old woman wearing a black T-shirt came in to see the doctor. At 3 am, a group of gangsters had broken into her house to ask for money and slammed her in the head with guns. A moment later, Dr. Yaon received a mother and son. The boy had also been beaten by an army of hooligans with guns. Dr. Yaon closed the wound with 5 stitches. "It's so common. We're used to it." Now and then, they can hear gunshots at night, but they are increasingly accustomed to their existence.

The Chinese doctors mostly regard gunshot wounds as a technical issue. Dr. Xi, a surgeon from the medical team said:

Although there are no gunshot injuries in China, such a surgery is not a big problem. It is no more than taking foreign matters out of the body. What makes things different is firearm injuries. This is done as an emergency surgery, and we won't wait for more than two days. In China, the prognosis is better, the chances of infection are lower, and the

treatment is more timely. Even so, it is a minor operation instead of a trauma surgery.

When it comes to gunshot surgeries, a major difference between the Chinese doctors and the South Sudanese doctors is the size of the wound. Dr. Liu said that, under normal circumstances, they prefer small incisions, as they are less painful for the patients. “In the place where the nails are placed, I will make a small incision first, before extending the incision so that the surface of the wound won’t be too big.” In contrast, the South Sudanese doctors prefer large incisions, which are easier to handle for the doctors for a shorter time, but this surgery is more painful for the patients.

Nonetheless, the Chinese doctors do not interfere in the techniques of South Sudanese doctors. On Tuesdays, Dr. Liu goes to the Orthopedic Department to facilitate the out-patient service, but he does not take the initiative to interfere. He partners with Dr. Samuel, a South Sudanese doctor in his early 30’s. “If they have questions, I will help. If he does something wrong during the operation, I will correct it directly. I don’t give them instructions. I just do it for you, and it’s better to avoid too many verbal instructions. I won’t say that this bone is not clean. Of course, the scars should be removed as much as possible during the operation to facilitate bone growth, but I don’t tell them in words but instead take the scraping and return the bone to him when I am done.”

3.3 Temporalities of Gun-related Violence

I meet Jigo James at the Peace Hospital run by the Chinese in the morning of November 22, 2016. He was sent there the night before, after a grenade exploded in his house in Jebel District of Juba. As a follow-up to this brutal act, someone shot a gun at him and disappeared into the darkness. His right leg is badly injured, but he survived the attack. Cani, his second wife, was visiting her parents on the other side of the River Nile when the accident happened, so Jigo was on his own. Jigo has no idea who the attacker was, but it seems that he knows Jigo and decided to kill him. He could be one of the “unidentifiable gunmen” regularly described by South Sudanese and the media. It is hard to identify who is who when accidents happen, and rumors are always in the air. The attacker may have been a member of the government forces, rebel groups or third parties that mushroomed following the wars in 2013 and 2016.

The former Minister of Agriculture Lam Akol resigned from the Sudan People’s Liberation Movement in September 2016 and formed a new rebel faction called the National Democratic Movement. In March 2017, Lieutenant-General Michael Cirillo Swaka also resigned from the government, accusing Kiir’s government of ethnic cleansing and obstructing the implementation of the peace agreement. Subsequently, Cirillo formed a new rebel group, declaring himself chairman and commander-in-chief of the National Salvation Front.

Jigo’s cousin John is the main caretaker at the Peace Hospital. When I meet him, Jigo is lying in a small bed in the surgical dressing room, bleeding. Surrounding him are

his relatives and officers from the US Embassy. Madam Yu, who owns the hospital, says to John, “There are five wounds on his body, and every wound will cost 25,000 SSP, so altogether the price will be 125,000 SSP. [If] no money is paid, you must go home.”

Jigo’s medical expenses were covered by his family and the US Embassy, where he works. “This is a lot of money. But money is nothing. You cannot get life on the market,” says John. I ask him why he didn’t send his cousin to Juba Teaching Hospital for treatment, and he says that Juba Teaching Hospital could manage the task, but it would take time. “They refer the patients outside; only minor issues can be tackled in Juba Teaching Hospital.”

Jigo’s operation is performed that afternoon by Dr. Lu and Dr. Yaon, assisted by nurse Liu. Lu worked as an orthopedic surgeon in a county hospital in central China’s Henan Province before venturing into Africa ten years ago. Lu worked as an orthopedist at a few hospitals in Sudan, including Abugesesa Hospital in Port Sudan, Merowe Hydropower Project Department Hospital and Roseires Dam Project Department Hospital. Later, he reached agreements with the medical administrations in Nimule and Torit in South Sudan and worked as a general practitioner at the Nimule Chinese Hospital and Eastern Equatoria State Hospital. Then he reached Juba and began work for the Peace Hospital. Sun, who comes from the same county as Lu, worked at a private Chinese hospital in Angola for two years, but the deteriorating economic situation in Angola forced him to leave the country and search for a new place to live.

During the operation, I work as an assistant, handing out tampons and dressings. The anesthetists Susan and Jean are both from Juba Teaching Hospital. They have not received salaries from the government for three months, so they are looking for opportunities elsewhere, including the private Chinese Peace Hospital.

Sixty-five fragments are found in Jigo's right thigh. Dr. Lu takes out six pieces, but the others are too deep to be removed. He says it is better to wait until the situation stabilizes before performing a second operation. By the time the operation is done, it is 8 pm. Ministry Road, the main road running through Juba, has been empty of pedestrians and traders since 5 pm. Nobody dares to risk their life when night creeps on Juba.

Jigo is a South Sudanese worker at the US Embassy, where he is responsible for managing the warehouse. Working at the Embassy is a good job for many, but it has also brought about more risk. The resentment of the South Sudanese against the US has grown over the last few years. They complain that the US is supporting the opposition leader, Riek Machar.

South Sudanese workers at the Embassy have fallen victim to this growing resentment. Before Jigo's accident, a group of gunmen pulled one of Jigo's coworkers out of a Catholic church in Juba and shot him to death on the spot. In 2016, another four of Jigo's South Sudanese colleagues lost their lives. One of them was gunned down at home, receiving eight bullets. When Jigo returns home from work, he has to remove

badges suggestive of his “US” identity, even though he is a South Sudanese citizen. Once, someone driving a car crashed into him in Gudele. Luckily, he survived.

This is not the first time that Jigo has had gunshot wounds. Ten years ago, when he was living in his hometown of Yei, he was shot in the leg in the woods. No effort was made to remove the bullet. Later, in 2012, while living in Custom, Jigo received another bullet. “Most of the time, it’s fine, but in the rainy season, I feel the pain and chill in my bones in the morning,” he says.

Yei used to be a peaceful place, but it has become a ghost town known for killings. From September to November 2016, about 2,000 houses were dismantled in central Equatoria. Yei, a strategic stronghold of the opposition, became a site of genocide. Pro-government forces, who are mostly Dinkas, were reportedly killing Equatorians. According to the UN human rights office, South Sudanese pro-government forces killed at least 114 civilians in and around Yei from July 2016 to January 2017. People have fled Yei, including Jigo’s brothers and sisters, but his parents have remained.

For Jigo, life is full of uncertainties. “You don’t know where to start and where to end,” he says, lying in bed covered by an embroidered sheet handmade by Cani. Fortunately, Cani is a nurse at Mona Clinic in Hai Soula, which has been of great assistance in difficult circumstances.

On the morning that I visit Jigo in the Peace Hospital, Deborah, Jigo's aunt on his father's side, and Mary, his elder sister's daughter, arrive with food. After Jigo's operation, they bring mangoes, avocado, beans, peanuts, rice and eggs.

Galanda, a medical officer from the Embassy, comes in. She asks Jigo a lot of questions, mostly centered on care in the Chinese hospital.

Galanda: How are you?

Jigo: Things are fairly OK.

Galanda: Your legs need to be up. They're very swollen. Stretch, stretch, if you don't exercise, elevate it as much as possible. When was your dressing last changed ?

Jigo: Yesterday.

Galanda: That's not good. I need the dressing to be changed every day. The chance of infection is very high. This is dripping through. Did the doctor come? We need to find out if there is a bullet inside.

Jigo: The doctor came this morning; he said no problem. Although the bullet is inside, there will be no problem. They have already made an X-ray.

Galanda: You need to stretch your legs. We need to get crutches. You have to keep them. You need to move. You need to start walking. Are they giving you IV? You need to have at least seven days' IV after the surgery. Learn to know what is put into the IV. Because this is *your body*. Learn to ask *a lot of questions*. We need someone to change the dressing every day.

Jigo: I told them to, but the doctor didn't do it. He changes it every other day.

Galanda: This is very bad. Do you know with whom I can talk about it?

Jigo: Dr. Lu. He came this morning. I talked with him about the blood.

Galanda: You don't want the blood to sit there, because of flies. We don't want them to sit there for 24 hours. We want to change the dressing, sometimes even twice a day, to keep it clean and remove the dead tissue. And you have to stretch your leg as much as you can.

Jigo: I asked them when they are going to remove the stitches, and they just said, "Not yet."

Galanda: How frustrating!

For Jigo, the Chinese doctors are "okay," but they do not check on him regularly. A week later, I return to Gudele to visit Jigo and his family. They live on the outskirts of Juba, close to the famous African Shop. I enter a big courtyard shared by Jigo's cousins, including Kalaba, his cousin on his mother's side, who attends to most of the chores in the hospital. They were sitting under the tree playing cards. Jigo's first wife Lena comes back from church, bringing home a box donated by Samaritans' Purse. Jigo takes out pencils, toys and candies. His daughter Candice reaches out for them. He cannot walk properly, but at least he can stagger with a crutch. But Jigo says that they may consider doing a further operation in Egypt.

3.4 Uncertainties Everywhere

Following the conflict in 2016, gunshot cases saw a steady rise, including ambushes on the road. In early August, heavily armed men ambushed a bus convoy on the Juba-Nimule highway, the main road linking Juba with the Ugandan border. At least four civilians were killed and 10 wounded in the attack.

In October, eight children and two women were sent to the Peace Hospital following an ambush that killed up to 21 people. A convoy of commercial vehicles carrying more than 200 passengers was stopped at gunpoint at Ganyi, between Lainya and Juba, forcing some of the passengers to flee into the bush for safety.

Not only South Sudanese but also foreigners are becoming targets. Abdullah, a Somali in charge of a petroleum transport company, explains that on May 5, 2017, when he and his cousin Ahmed were driving back from Yei to Juba, they were ambushed by armed men. “I couldn’t tell their exact number, but I saw a number of machine guns being erected 50 meters in front of our car.”

Ahmed was driving the car. The gunmen fired at them, and one of the car’s tires burst, but Ahmed carried on driving like crazy. “If you stop, you will be killed.”

The cousins managed to escape, running into a military camp where they were temporarily protected. The Somali community helped to rent a helicopter to transfer them back to Juba the next day. Then they were sent to Juba Teaching Hospital for treatment. Dr. Xi and Dr. Yao from the Chinese Medical Team performed Abdullah’s

operation, removing a bullet from his thigh. However, they could do nothing to help Ahmed because of the severity of his injury.

Abdullah and Ahmed were referred to the special wing of Juba Teaching Hospital. But even in this wing, it is difficult for patients to get special care from the nurses and doctors.

Towards the end of 2016, it became clear that the situation in and around Juba was threatening everyone's safety. In November, a group of gunmen rushed into a bar and killed 11 people watching football.

Abraham Taban Eurem, who goes by the name of Moses, is a jobless man in his mid-thirties. He survived an attack on September 12, 2016. He had visited a market in Gora, 25 miles west of Guray, to buy charcoal, and encountered a group of soldiers shooting at people in the market. "I asked [one of the soldiers] whether they were rebels," Moses explains to me.

"There were no rebels. The one who wanted to kill were Dinkas. Nobody answered them. So I think they were not Nuers. The government claimed that the shooters were rebels, but [the shooters] said that they'd found rebels and needed to kill them. There were many soldiers, and even trucks." Three people died in the shooting, and seven were injured. Moses's injuries were the most severe. "Who was responsible for the attack? It was complicated. We didn't know," Moses said.

Moses received two bullets. One was in the upper joint of his leg, breaking the bone. The other one created just a surface wound, leaving the bone intact. His elder brother, Michael Jambo, sent him to Juba Teaching Hospital, but it was a Muslim holiday, and the hospital was closed. So they rushed to the Chinese Friendship Hospital in Tongping. Other injured civilians were referred from Juba Teaching Hospital to other private hospitals in town. Morse's operation was performed two days later, on September 14, by Dr. Bai.

The Chinese Friendship Hospital charged 90,000 SSP for the operation. Jambo called his cousins to ask them to contribute to the cost. Two of them worked for NGOs. They paid 70,000 SSP upon checking in to the hospital. Then they paid the balance of 20,000 SSP.

Moses has two wives. One of them is in Uganda with her two children, because life is difficult in Juba. Moses lives with his sister Nasta and his second wife Alina. Nasta makes a living by selling *esh* (bread). Michael tries to support Moses, but it is difficult. "I make 2,500 SSP. Some people get 3,000. Some 1,500. Some of them 900. How do you make a living? It's impossible. It's a problem. Bought in bulk, milk costs 900 SSP. My income can only keep me and my family alive for one week. People are just pushing. We have only one meal per day. We are pushing to make [our incomes] last until the end of the month." The increased tension in town makes it hard for people to move around and sustain their livelihoods.

After the operation, Moses is put on painkillers. A friend of the family who works in the pharmacy of Juba Teaching Hospital helps him. By the second time I visit Moses and his family, the situation is improving. Policemen patrol at night, but the area looks almost empty. Many families have fled for Uganda, leaving their houses behind. As the cost of living rises, people are taking their children to places in which they can afford to live.

3.5 Difference in Value of Life

Many South Sudanese cannot afford to travel to Juba for treatment. However, during times of crisis, the soldiers of the SPLA are given medical priority. In some cases, the president and high-ranking officials send soldiers to Juba's hospitals for treatment.

On November 26, six soldiers and one civilian were transferred from Bentiu to the Chinese Peace Hospital for treatment. Three were injured in the thigh, one in the abdomen, one in the arm and one in the palm. Bentiu was the capital of Unity state before it was reorganized to give the three new states of Ruweng, Southern Liech and Northern Liech. The latter is Bentiu's current location. During conflict that began in December 2013, the national government lost control of the town to a commander loyal to the then first vice president Riek Machar. Violence in the area continued, and a United Nations official was quoted as saying that the town "simply did not exist anymore," and that it

had been “completely burnt down.”³ In April 2014, hundreds of Bentiu civilians were massacred by the opposition led by Riek Machar.

During and after the civil war in 2016, the town of Leer, close to Bentiu, was a hotspot for conflict, as the government and opposition forces fiercely exchanged fire. Taban Deng, a Nuer appointed as the first vice president, marshaled forces against Riek Machar in Leer.

Ging is a second lieutenant who was shot in the abdomen. As his injury was not related to bone fractures, Dr. Lu took care of him. Ging is a Jikany Nuer from Guit county. He talks about his experience as a soldier, saying that it is difficult to predict whether one will die or not, given the sizeable army presence in the larger Unity state.

Some of them stay alive. Maybe you will be killed, maybe you will live. [The conflict] isn't always big, but they attack from time to time. Maybe 100 will die in one day. It's part of my life. These days, Nuers are fighting against Nuers. We were there for the war. I liked it, because war is good sometimes. Some people didn't like it. But I liked it. If someone kills your brother, you must take revenge.

Ging continues:

“Sometimes you can identify people in the battlefield by their guns and uniforms. We use our own passwords. If we fight, burning the huts, maybe the password *Tao* (“date”) will be used. If you don't return the word *Tao*, you will die. Tomorrow, we will create another one. It changes every time. Of course, we kill our enemies even if we don't like wars. Before 2011, we were fighting our enemies; we were fighting Sudan. After 2013, we

³ Associated Press (January 17, 2014). <https://www.usatoday.com/story/news/world/2014/01/17/south-sudan/4581725/> Accessed Oct. 20, 2018.

killed each other. In 2013, when the war broke out, I burned my bridges. I joined the army. They said you have to join the bush. Fighting is not good. Bullets are everything. Even the water you drink. Even if someone has died in the river, you still drink its water. If you want to swim in the river, you may find a dead body in there. The poison is there. Some people die of poison. It's good when you fight another country. But conflict inside the country is not good.

On the same night, a 16-year-old boy with a gunshot wound to the head checked into the Peace Hospital. He had been returning home when he was shot in the head by two thieves. When I meet him, his sister is standing beside the bed, quietly weeping. Mary, a nurse from Juba Teaching Hospital who has taken the afternoon shift at the Peace Hospital, observes the patient. "He needs a CT scan at least, and an emergency operation. But here I don't think we can do it. We don't have a department of neurology. There is nothing we can do about it. The relatives don't have enough money. We can only maintain his basic health. Even at Juba Teaching Hospital they would be unable to do it."

Mary insists that the boy be kept at the hospital for further observation, and Madam Yu agrees. But money is the problem. Without money, she can't do anything to help him. She wants 1,000 US dollars, or 100,000 SSP.

3.6 "We Don't Want to Be Troublemakers"

At Juba Teaching Hospital, the Chinese surgeons and orthopedist find it difficult to participate in surgeries. "It's hard to tell when they will come, and whether they will

come, so it's better for us to step back and engage only when complicated cases arise," says Dr. Zhai, an orthopedist.

The Chinese orthopedist dislikes treating simple cases, as he believes that it is a waste of his expertise. "I only deal with cases that are challenging and complicated for medical experts like us. I allow my South Sudanese colleagues to handle the simple cases." However, nor is Dr. Zhai responsive to very complicated cases, such as old fractures, because they entail a lot of responsibility.

The Chinese orthopedist and surgeons feel that they are outsiders in their department. They complain that they do not have independent consultation rooms in which to perform their skills because their South Sudanese colleagues are unwilling to give them responsibility for patients, who are the targets of money making in private clinics. "What's the point of interfering in the local doctors' business? It's better to save trouble than seek trouble."

One Chinese surgeon says to me, "It would be much nicer if we had our own space, a specialized department in which we had *shuolesuan* (the power to decide what is what) and could work with other members of our medical team."

So they hold more or less lethargic attitudes towards their work. Before the war broke out in 2016, the orthopedist had performed about 20 surgical operations, but after they resumed their work in October, he and the other two surgeons were reluctant to perform more operations.

3.7 Unfinished Business

Anthropological studies of violence, represented by Scheper-Hughes and Bourgois (2004), Das (2007) and Kleinman (1997), explore the concepts of political violence and social suffering, and the relationship between violence and subjectivity. To examine violence and physical trauma in South Sudan, I draw on Bourgois's concept of a continuum and Scheper-Hughes's idea of everyday violence. In particular, Bourgois offers an analysis of violence that goes beyond everyday expressions to consider broader political and structural processes. He treats violence as a continuum of overlapping forms and forces.

Overlapping temporalities shape the South Sudanese experience of violence. The country's independence was not a turning point in the lived experience of South Sudanese. The increase in gunshot cases is a product of both historical memory and ongoing pressures. South Sudan is a multifaceted space with several layers of temporalities. The two civil wars (1955-1972; 1983-2005) have not yet disappeared from people's social lives. Their memory lingers on, leaving its mark in the form of psychological and physical trauma.

In their analysis of everyday violence, Scheper-Hughes and Bourgois (2004) blur the boundary between war and peace, the visible and the invisible, focusing on that which "can be best described as neither war nor peacetime" (2004: 4). They contend that

aggression is on a continuum that is socially incremental and experienced by perpetrators, collaborators and bystanders as expected, routine, even justified.

Similarly, Debos (2016) describes Chad as hovering between war and peace. People are “under a suspended sentence of death because of the recurrent insecurity” (ibid.: 8), and violence has become routine. Instead of tracing a clear-cut demarcation of war and peace, Debos (2016) uses the term “inter-war” to portray a state in which wars are always emergent. Likewise, Jenkins (1998) shows that terror breaks down any putative distinction between “actual violence and the threat of immanent violence” (ibid.: 124). Building on the concept of “symbolic violence,” Nordstrom and Martin (1992) point to the structural violence hidden beneath societies. “Expanded definitions of violence have been useful in giving a voice to systems of violence no less powerful by virtue of their intangibility. They clearly demonstrate that violence enacted is but a small part of violence lived” (ibid.: 8). As Nordstrom (1998) argues, something “far more complex, multifaceted and enduring than the formal boundaries of war demarcated in military cultures take root in the quotidian life of a country at war.”

Another dimension of temporality is the contingency of risk. In South Sudan today, risk and injury have become interchangeable. Risk, which is increasingly commonplace, results in a growing number of injury cases, which in turn sustain people’s fear of risk. The postwar era does not guarantee a risk-free society; rather, the hidden yet extensive risks arising from tribalism are a leading cause of injury cases.

South Sudanese live with the knowledge that injury may occur at any time, and that the medical expertise required to treat cases of injury is lacking. Violence has a long life in South Sudan. It never entirely disappears from people's lives. As Rylko-Bauner, Whiteford and Farmer (2009) put it, "violence has an aftermath that can extend over years and decades—in the landscape of a war-torn country, in the memories and myths of a people, in the ensuing struggles for resources and power that ignite the next successive conflict, and in the interpersonal relationships of those who live in its shadows" (ibid.: 13). They also note that healthcare provides a "political humanitarian space" in which to combat this violence.

In South Sudan, surgeons and orthopedic doctors in public medical facilities can perform only the most basic operations. Orthopedic surgeries are more often than not characterized by "unfinished business." In this context, injury does not differ much from ordinary illnesses such as malaria. What is counted as "injury" is no longer an acute case occurring over a short span of time; instead, it permeates people's long-term bodily experience like the pain of chronic illness. Gunshot wound injuries are the new normal in South Sudan.

Gun violence in Juba is a form of violence on an ordinary scale. As Das (2007, 7) observes, the afterlife of violence means a transformation of life, "recovered not through some grand gestures in the realm of the transcendent, but through a descent into the ordinary." Gun injuries are seemingly ubiquitous in the lives of South Sudanese people

yet differ from the unspectacular violence of day-to-day life (Scheper-Hughes and Bourgois 2004). Despite their regularity, shootings sometimes still feel sensational.

3.8 Political Economy of Surgery in South Sudan

In terms of life in conflict zones, Agamben's idea of "bare life" captures the right to, or the lack of, life in a state of exclusion (1998). This principle applies to South Sudan. According to Agamben, the exiled criminal is reduced from a politically endowed person who deserves a position within social life to an unprotected person who can be killed without sanction. Agamben recognizes this as a form of *bios*, or bare life, as contrasted with *zoe*, the life of a citizen. In the neoliberal era, refugees, political prisoners and famine victims are excluded from the realm of citizenship due to their lack of political identity or legally recognized status. The mass exodus of South Sudanese to Uganda and Sudan bears testimony to this trenchant concept of bare life.

But the concept of bare life also applies to urban citizens in South Sudan, who are neglected by the welfare system of the state, which is fragmented not only through tribal conflicts involving Dinkas and Nuers, Dinkas and Equatorians, but also through a fragmented medical system increasingly in the hands of NGOs. Many of the South Sudanese I meet in South Sudan aspire to work for these international organizations or join their supply chains. Even doctors who have received orthopedic or surgical training in China end up leaving public hospitals to work for NGOs.

Redfield (2013) identifies the biopolitical agenda of international non-governmental organizations such as Médecins Sans Frontières (MSF). MSF has no intention beyond the “capacity to define exception” in pursuing its goal to “foster life” (p. 21). Redfield argues that “designating MSF’s activity as a minimal biopolitics suggests a simultaneously attenuated and affirmative variation on the theme of Foucault’s biopower” (ibid.: 21). This is a positive biopower, but one that is extremely limited in scope.

A vulnerable and warring state like South Sudan cannot provide its citizens with adequate resources or attention. In the post-war context, who has the right to health and who does not have become immediate concerns. Chinese surgeons in both the public and the private sector work mostly with patients from more or less affluent backgrounds. Jigo works at a foreign embassy as a local staff member, so his medical costs ended up being covered by the embassy and his extended family. Jing, the Nuer soldier, was sent to the Peace Hospital by vice president Taban Deng, who covered his expenses. The Somalian patient had the resources to mobilize treatment costs and stay in the special wing of Juba Teaching Hospital. Moses similarly relied on the contributions of his cousins, who work for NGOs.

Jigo, Jing and Moses are among the few South Sudanese whose resources and networks have enabled them to seek medical treatment at the first possible opportunity.

There are many more who cannot afford to travel to hospitals in big cities to seek treatment immediately, resulting in lifelong disabilities such as osteomyelitis.

South Sudan's private Chinese hospitals are also subject to severe limitations. In Juba's Peace Hospital, Dr. Lu, the Chinese orthopedist, is forbidden from treating fracture cases. The body is broken down into "more valuable" and "less valuable" parts, and Chinese doctors in the public sector are left with the less valuable work, because more valuable parts (such as the arms and legs) gain even more value when South Sudanese doctors refer patients to private clinics for profit-making treatment. In the current political economy of South Sudan, Chinese surgeons are also practicing a limited form of biopolitics.

4. Beneath the Treatable

In summer 2016, a South Sudanese patient who suffered from back pain visited Dr. Zhang, a Chinese acupuncturist at Juba Teaching Hospital. After the treatment, he asked the doctor to give him the medicine in the needle. Dr. Zhang replied that there was no medicine in the needle. The patient did not believe in what he said and insisted on getting the medicine. Dr. Zhang had no way but to break off the needles, when the patient was finally convinced that there was indeed nothing inside the needles.

This medical encounter carries special interest, because it reveals South Sudanese patients' expectations about medicine and treatment from China (*dawa al sin*). Such encounters drove my interest in studying how traditional Chinese medicine (TCM) is perceived and practiced in a post-war African country with many pain cases. I argue that TCM, including acupuncture, gives South Sudanese a sense of hope when many of them are afflicted with pain, but the complexity of pain narratives in South Sudan makes the medical approach based on streamlined TCM a challenging, if not completely impossible, mission. Underneath the treatable symptoms are the untreatable collective psyche. Pain is psychic, social and political as well as somatic. It is an assemblage of the body and the mind, the epistemic and the existential, the speakable and the unspeakable. Pain offers a particularly useful case for examining the nature of medical care offered by China in South Sudan.

Acupuncture and traditional Chinese medicine have long held considerable sway in the Global North, as observed by anthropologists such as Barnes(2005), Zhan (2009) and Anderson(2010) . The locales of their research include Boston, the San Francisco Bay Area, and Ireland. Elisabeth Hsu, a medical anthropologist, claims that, historically, neither acupuncture nor TCM treatment was particularly popular in the Global South, but both are currently showing steady growth in the southern hemisphere.

My research shows that there is a long standing and dynamic relationship between China and Southern (South) Sudan concerning acupuncture and TCM h. Acupuncture in particular has played a key role in helping Chinese doctors construct a medical discourse wherein South Sudanese are projected as recipients of a practically oriented technique. Nonetheless, Chinese medicine and acupuncture are also seen as “miracles” and “miracle cures”, appealing to South Sudanese’ request for fast-track pain relief at a time of turbulence.

To begin with, I will describe the pain narratives of South Sudanese. Then, I will discuss the birth of TCM in contemporary China and its movement to Africa since the 1960s, including South Sudan. In particular, I will highlight cases where acupuncture and TCM are taken on as painkillers or fast-track pain relief. Lastly, I will examine the implications of TCM in Africa now and in the future.

4.1 Experiences of Pain in Post-war South Sudan

Wars and conflicts have inflicted southern Sudan for decades. In 1956, Sudan won independence, but southern states were unsatisfied with their lack of autonomy. Tensions escalated into fighting that lasted until 1972, when the south was allowed for self-governance. In 1983, fighting started again between the Arabs in the north and the Nilotic peoples in the south after the Sudanese government cancelled the autonomy arrangements and imposed Sharia law, or Islamic Law. Roughly two million people died in one of the longest civil wars in Africa, and more than four million were displaced. The independence of South Sudan in 2011 did not bring peace. In 2013, civil war broke out after the president, Salva Kiir, sacked the cabinet and accused Vice-President Riek Machar of planning a failed coup. Over the past five years, over two million people were displaced by the fighting, or fled to neighboring countries.

The varieties of wars and conflict have caused sustained trauma and pain. Pain is extended into clinical and social spaces. Deteriorating living conditions, political instability and ongoing war and conflict all factor into people's experience of pain. Pain can even be traced in people's names. For example, the Dinka name Chol means a replacement child for a brother who has died.

Ana taban – I am tired. I am suffering. It is one of the most frequent expressions one would hear in Juba. Many of my friends said to me, “Africans are traumatized. The whole country is traumatized. We are suffering from pain.” Pain is a ubiquitous entity.

South Sudanese rappers and singers like Silver X and General Paulino even dedicate their music albums to pain. One album was entitled “*wen waja wen*” (Where is your pain?)

In 2016, an artist campaign entitled Ana Taban swept the whole country, inviting ordinary South Sudanese to speak out their pain and suffering. In an interview with Guardian, the artists said, “We are tired of war and all the suffering that comes with it. We are tired of just sitting by and seeing our country burn. We are tired of having a country with vast natural resources and yet a crashing economy. We are tired of the fact that we have a beautiful cultural diversity that is destroyed by tribal animosity. We are tired of having a starving population, yet we have a fertile land. We are tired of being used to kill ourselves for the benefit of a few.”⁴

But it is hard to express pain through words in clinics. South Sudanese patients who are asked to describe their bodily complaints tend to start with a broad expression of pain. Sometimes they can name the exact location of the pain – *waja dahar*, *waja ras*, *waja fi kura*. Sometimes, however, they simply say that they feel general body pain (*waja gisim*, *kulu gisim waja*), or serious pain all over the body (*waja shediid*).

⁴ The Guardian (September 21, 2016). <https://www.theguardian.com/global-development-professionals-network/gallery/2016/sep/21/tired-war-south-sudan-street-artists-calling-peace> Accessed Nov 20, 2018

It is very common for South Sudanese patients to suffer from pain for many years without consulting doctors, to the extent that Chinese doctors are surprised by their levels of pain tolerance. In the meantime, they are confused by the South Sudanese way of expressing pain. “They won’t tell you where the pain is. Instead, they are used to recollecting their medical history that dates back to many years ago. When it comes to pain, they go about in circles, but never hit the nail on the point,” said Dr. Zeng.

“*Fi waja?*” (“Are you in pain?”) Despite their limited command of Juba Arabic, Chinese doctors have mastered this brief phrase when engaging with their South Sudanese patients. Pain is a taken-for-granted thing. Dr. Yao, a physician from the medical team, said that nine out of ten patients coming for consultations would complain of pain, to the extent that it is hard for him to tell whether they are really suffering from pain or not. “From their facial expressions, it seems that they are doing fine, but they said they are inflicted by pain. I cannot get it.”

For many South Sudanese, however, pain reflects a combination of loss and trauma. This was certainly true of a young Dinka man called Thigi, whom I met at Peace Hospital when he brought his aunt for treatment by Dr. Lu. Thigi was also suffering from chronic pain. The 21-year-old Dinka was born in Unity State, which borders Sudan. He lost his father during the Second Sudanese War (1983-2005), but never told anyone about his loss. In a society in which one’s livelihood largely depends on kinship networks, particularly access to a Big Man (*zol kebir*), Thigi was left to his own devices.

In summer 2010, Thigi was riding on a donkey when a “mad man” (*zol mojnunun*) suddenly appeared. The man forced him to dismount from the donkey. The man punched him and ran off. Following the accident, Thigi started coughing. This was in June, at the height of the rainy season. He experienced severe chest pain and shortness of breath that left him unable to sleep until the next morning. He said that sometimes the chest pain was so bad that he could not “feel his inner part.” He prayed to God in the middle of the night. “All who call on God in true faith, earnestly from the heart, will certainly be heard, and will receive what they ask for and desire.”

Thigi’s words exemplify a commonly held view of South Sudanese that their life is ultimately in the hands of God. They are accustomed to accepting life the way it is.

This is well put by Daniel Abot, a bishop of the Episcopal Church of South Sudan & Sudan, when I asked him about South Sudanese’ attitude towards pain. He said, “God has a plan for each and every one. Pain will prepare you to be a better person. It is suffering today but tomorrow it will be a joy.”

When we look at the pain experience of South Sudanese, two contradictory sensibilities emerge. On the one hand, they possess a high threshold for pain. Many years may pass before they finally visit a doctor. On the other hand, when avenues for pain relief are available, they demand the fastest ones.

In Unity State, there are no referral hospitals. The only available medical facilities are primary medical care centers (PMCCs), but they have no qualified staff. The closest

hospital had been in Bentiu, but that city was totally destroyed during the civil war.

Many such professionals either flee the country or seek opportunities with international NGOs. Thigi was taken care of by his uncle. In 2014, his uncle sold a cow, bought Thigi an air ticket, and sent him to Juba for treatment and schooling.

However, life in Juba was a big challenge for Thigi. Without a steady source of support, Thigi “pushed life,” like many South Sudanese say. One day, he called his uncle and said the following.

“Uncle, I know that you have many family responsibilities, but as the son of your brother, I regard you as my father. I wouldn’t recognize my real father. My mother took care of me without question until she became afflicted by TB. I am humbly asking you to support my schooling. I hope that if God permits me to achieve my goals, you will not be sorry.” In tears, Thigi’s uncle replied, “My son, I haven’t forgotten you, but I think you know that my salary is only 4,500 SSP, and it goes straight to my elder son, my wives and your mother.”

Thigi underwent intravenous injections or infusions at various clinics. First, he went to Juba Medical Complex, but there was no result. He did not go to Juba Teaching Hospital, because there was no medicine. “Everything was in the private hospitals. The government has nothing. It just assumes that it is a government hospital without treatment.” His friend also suggested that he visit an American facility affiliated with the Los Angeles, California Hospital in Juba, , but he could not afford the money. Finally,

he went to the Peace Hospital. Injections are prevalent in South Sudan because they are believed to work more quickly than orally administered tablets. Makuach, a medical officer in Gogrial State, told me, “People cannot wait to see the results. They say that when you prescribe injections, you are a good doctor.” However, Thigi’s pain persisted.

After a few attempts at different private hospitals and clinics, Thigi went to see the Chinese medical team at Juba Teaching Hospital, where Dr. Lu performed an ECG. Thigi wanted the doctor to hear more of his story. “When are you going to Beijing? How can I go with you to China? I want to leave South Sudan.” After giving him two packets of cephalothin, Dr. Lu asked him to leave, but Thigi asked Dr. Lu to give him more medicine. He ended up having a gastroscopy. Nothing was found, but he still complained of pain. He said, “If I get medicine, the pain will finish.”

Thigi’s experience reveals the complexity of pain in South Sudan, manifested in bodily, psychic and religious dimensions. An understanding of pain, therefore, should go beyond the lens of the biological and the clinical to incorporate a wider context of experience in the social world. According to Arthur Kleinman, an interpretation of pain must follow the “trajectory of a unique life course through a narrative of suffering” (1997). Like the tip of the iceberg, pain reveals social underpinnings, cultural norms, and historical memories. It goes beyond merely bodily symptoms or linguistic expression. However, pain offers a particularly thorny case for doctors and patients.

For instance, Kaja Finkler (1991) argues that there is tension between the doctors' role as an authority on generalized pain and the patient's role as an owner of his/her own pain. Moreover, there is a distinction between "real" pain and "unreal" pain, as observed by Jackson (2000) in her research at a pain treatment center. In South Sudan, the narratives of pain are multi-layered, posing a challenge to foreign doctors.

However, long-standing wars and conflict have translated into a universal request for pain relief, and people are in a rush to seek fast-track method for coping with pain. In Juba Teaching Hospital, painkillers are among the few types of drug prescribed by doctors. In the pharmacies scattered around the hospital, painkillers sell fast: Diclofenac, Paracetamol, Ibuprofen, Panadol, etc. Most of the time, patients buy painkillers out of their own pockets from private clinics; a lot of the drugs at Juba Teaching Hospital are secretly sold to other clinics. At one of the private clinics, I got some diclofenac tablets allegedly manufactured by Hong Kong Wansheng Health Care Company, but it turned out that this company does not exist in Hong Kong. That means it is counterfeit medicine, but it still has some efficacy for South Sudanese patients.

Since colonial times, foreign (*khawaja*) doctors have been portrayed as possessing magical power in Southern Sudan. In *Kindling the Fire* (Cruickshank 1962), the British military doctor Alexander Cruickshank details his experience as a colonial medical officer based in Southern Sudan, where foreign doctors are held in esteem. South Sudanese patients respond differently to *khawaja* doctors and South Sudanese doctors.

First and foremost, they want to get drugs from foreign doctors. Even when they have been discharged from hospital, they will ask for drugs when they meet foreign doctors at the gate. Patients also seek to build rapport with their doctors to obtain the strongest medicines possible. Furthermore, the ongoing crisis in South Sudan has reconfigured patients' desire, leading them to seek forms of treatment perceived as "rapid," such as Chinese acupuncture and TCM.

4.2 Birth of TCM and its Export to South Sudan

British historian Eric Hobsbawm has argued that many traditions we think of as ancient were in fact invented recently (1983). The term and practice of Traditional Chinese Medicine (TCM) is no exception.

After China was founded in 1949, Chinese medicine underwent many rounds of social engineering. In the 1950s, Chinese medicine was incorporated into Mao's revolutionary plan and the national health system. This initiative went hand in hand with China's period of "socialist transformation", a plan to transform China from an agricultural nation into an industrial one. Guided by this blueprint, Mao was actively involved in developing Chinese medicine to a sufficiently scientific level. The term "Traditional Chinese Medicine" appeared in 1955 to reflect a standardized, government-created and institution-bound medicine (Taylor 2005). Similarly, acupuncture in China

gained a new look. It was reconfigured as “new acupuncture” and given the structure of basic guidelines to facilitate its application across China’s population.

As a result, there was a clear move away from the spiritual aspects of Chinese medicine and a greater focus on the physical body (Hsu 1999). The newly established theory of TCM in the 1970s simplifies the process of the identification of illness and the appropriate dispensation of drugs to a few basic steps, laying the foundation for a ready-to-use TCM designed for institutional consumption (Taylor 2005).

In the meantime, a “barefoot doctors” scheme was introduced to China’s vast countryside regions. The term “barefoot doctor” originated in Shanghai, because farmers in the south often worked barefoot in the paddy fields. The scheme was initiated to transfer medical resources from urban areas to rural areas. Young farmers with reliable political backgrounds were selected for intensive practice-oriented training in TCM and elementary biomedicine, including acupuncture, that lasted for up to eight weeks. These campaigns popularized a simplified form of Chinese medicine, making it accessible to China’s general population before disseminating it to other parts of the world.

In a widely circulated booklet dedicated to barefoot doctors in the countryside (Hebeishengweishengting 1975), the author describes the advantages of acupuncture therapy as “simplicity, economy and availability” and “wide therapeutic applications”.

The only materials required are slim metal needles, alcohol and absorbent cotton. With these you can administer treatment any time and at any place. The equipment is easy to set up and convenient to use, and the need for the

patients to buy medicine is greatly reduced. The materials are inexpensive to manufacture and purchase. Consequently, the cost of treatment is minimal... Acupuncture has been used successfully in diseases of the classic categories of internal medicine, pediatrics, dermatology, obstetrics and gynecology, and in lieu of surgery. (ibid.: 2)

The book lists 49 common illnesses, many of which are pain-related ailments, such as abdominal pain, chest pain and painful menstruation, and suggests ways in which acupuncture can be used to treat them. Mao rushed to convey this “medical success” from China to Africa.

In 1963, China sent its first medical team to Algeria. In 1971, China sent its first medical team to Sudan (including Southern Sudan). Over the last five decades, China has dispatched medical teams to 48 African countries, and every team has been staffed by at least one acupuncturist. Acupuncture has consistently been enlisted as a significant component of Chinese doctors’ medical expertise with African patients. At the peak of this movement, 4 out of 19 Chinese medical staff in Sudan and Southern Sudan were acupuncturists. Two of them were rural and village doctors from Dingbian County Hospital and Beiyuanmen People’s Commune Hospital (Shaanxi Ministry of Health 2019), underlining the thinking that rural doctors can play a vital role in China’s international medical programs.

Historical archives record the healing effect of “Chinese magic needles.” A document from the Shaanxi Provincial Archives shows that in the first half of 1971, over 65,00 Sudanese patients were treated with acupuncture, twice as many as the outpatients

received by the Chinese medical team. In the same year, as many as 18,000 needles of various sizes and 2,000 mugwort sticks were donated to Sudan (including Southern Sudan). Apparently, acupuncture needles were deemed as a significant component of China's medical aid to Sudan and Southern Sudan.

Thanks to the use of acupuncture, there have been a number of “medical successes” :

We have seen many deaf patients, and people suffering from polio. Some patients have given up hopes, and most of have been inflicted by painful suffering. Some of them have visited domestic and foreign experts. They have sought treatment in Egypt, Britain, and France, but to no avail. Our acupuncturists have made full use of our motherland's medicine and applied methods such as controlling acupuncture points. We have successfully treated some patients, or achieved good results, which was welcomed and praised by the Sudanese people....

The Sudan is located in the tropical area, and there are many cases of encephalitis. Some of them become idiots, bringing great suffering to the patients and their families. Having read reports of successful treatment of encephalitis cases through injecting medicine in the dumb acupuncture points, our comrades wanted to apply this method as well. But they did not know the specific way, and it was not clear whether the response to this treatment is dangerous or not. In hopes of alleviating the suffering of the Sudanese people as soon as possible, the comrades in the acupuncture rooms took the risk and experimented such an approach on themselves. They said: ‘We would rather try a thousand needles on our own body than make a single mistake on the Sudanese...’

The daughter of the Sudan Supreme Court is mentally retarded. The six-year-old child has never spoken a single word since she was born. Her father said sadly: ‘The child has never called me dad.’ Our doctor patiently treated the child for more than a year by injections in the dumb acupuncture points and acupuncture treatment. After the treatment, the child can not only speak a lot of words, but also became lively. She can

even continue her studies. In March this year, on hearing that we are leaving for China, her mother grasped the hands of a Chinese female doctor and cried wholeheartedly.

The daughter of the deputy director of the Sudan Military Health Bureau suffered from mild paralysis of the left lower leg because of polio. He was very concerned about his daughter's illness. He had sent her for treatment in several countries, but there was no obvious effect. He came to the Chinese medical team for help. He said sincerely, 'I am now entrusting my daughter to you.' After we treated her for half a year, the girl who had been lame for many years showed a marked improvement. The colonel said, 'You have achieved an impossible task.' He has repeatedly asked us to work in the military hospital. Later, we worked for two afternoons a week in the military hospital...

A major commander married for ten years without a child suffered from impotence. After we treated him for a few months, one day, he happily ran to the hospital and reported good news to the medical team and Sudanese friends: his wife got pregnant. Some Sudanese friends congratulated him. Later, he was transferred to Malakal. As the commander of the military region, he was very friendly to our comrades who worked there...

"An eight-year-old boy suffered from bladder dysfunction due to urinary retention and had no effect after several months of treatment in other hospitals. He had to carry a catheter and a plastic bag, which was very painful. Our acupuncturist put him under treatment. The bladder function was restored in just over ten days, and the external urinary catheter was removed...

Abdullah, who had suffered from pain for 21 years, had been looking for medicine everywhere. When acupuncture started to take effect on him, we were asked to leave the hospital. Abdullah and others went back and forth between the People's Assembly, the Chinese Embassy and the Sudanese Minister of Health. They even wrote a letter requesting that the Chinese doctors not to leave and continue their medical service. The Sudanese people welcome acupuncture treatment, they said in the letter, 'From the medical team here, you can see the world's wonderful doctors, who use modern and traditional medical methods to treat thousands of patients...'

The comrades of the medical team have also been repeatedly invited to visit senior government officials of the Sudanese government. Among them, the Vice-Chairman of the Sudanese Revolutionary Committee, the Deputy Minister of the Ministry of Foreign Affairs, and the Deputy Minister of the Ministry of Foreign Trade have all received the medical teams enthusiastically. The mother of the deputy minister of the Ministry of Foreign Affairs has been paralyzed for more than a decade. She sought treatment in Cairo and London, but her condition was getting worse. After receiving treatment from our acupuncturist, her condition gradually improved. He was very happy, and wherever he went, he would tell his friends that Chinese doctors were ‘miraculous doctors.’ The daughter of the deputy chief of staff of the Sudanese army suffered from deafness and recovered her hearing faculty after receiving acupuncture treatment from the Chinese medical team. He told the medical team: ‘Thanks to your work, I have seen your great achievements and medical development under the leadership of the great leader Chairman Mao...’

The hospital in Omdurman Friendship Hospital had very few patients in the past, and since the arrival of the medical team, it has become quite busy. There are 400 to 500 outpatient visits per day, and acupuncture cases account for as many as 200 patients per day... The patients come from all over Sudan, including Port Sudan, Nyala and other large cities in southern Sudan. In addition, patients from the United Arab Emirates, Libya and other countries took a flight to see the Chinese doctors. People often call or write to the Chinese Embassy in Sudan, hoping to be received by a Chinese doctor. From the morning to the evening, patients were queuing at the office of the hospital, waiting to get a registration card of the Chinese medical team. Due to the increasing number of patients, the hospital has introduced an appointment registration. Outpatients and acupuncture have been reserved from June last year to this year...

A Shaanxi Province gazette also reported an apparently “miraculous treatment” completed by Dr. Li, a rural doctor from Meixian County.

Dr. Li Jinxi used acupuncture therapy at Juba Regional Hospital in South Sudan to treat common diseases in the southern area, such as headache, low back pain, arthritis, rickets, stomach pain, pediatric indigestion, malposition, etc. On a daily basis, he treated about 25 people with a

satisfying effect. The Minister of Education of the Government of Southern Sudan was once suffering from back pain. He had sought a variety of treatments at Juba's regional hospital, but to no effect. Dr. Li carefully selected acupuncture points and inserted the needles. After 20 minutes, the patient could turn over, stand up and walk. Half an hour later, he reported that his symptoms had disappeared altogether, and he had returned to normal. Afterwards, the minister took away four silver needles as a gift.

These accounts and archives have one thing in common: acupuncture is a fast-track approach and its therapeutic effects can be achieved within a very short time.

China's medical assistance to South Sudan was interrupted during the Second Sudanese War, but resumed after South Sudan declared independence in 2011. By that time, Anhui Province had replaced Shaanxi Province as the source of medical aid to South Sudan.

Dr. Ding was the first acupuncturist sent by Anhui to Juba Teaching Hospital after independence in 2011. He obtained a bachelor's degree from Anhui University of Traditional Chinese Medicine and a master's degree from Beijing University of Chinese Medicine. Ding's father had trained as a barefoot doctor in the 1970s. Ding acknowledged his father's technical efficiency and speed as a barefoot doctor, who was removed from his post because of a medical malpractice in the village.

He said, "There are many cases of chronic pain in South Sudan. Acupuncture can offer an efficient method of coping with pain. Other approaches can reduce pain to a certain extent, but they are not as fast as acupuncture." According to Ding, it is difficult

for Chinese medicine to travel abroad, but acupuncture enjoys a technical advantage thanks to its effectiveness in treating acute and chronic ailments.

Dr. Ding wanted a separate consultation room at Juba Teaching Hospital but ended up sharing the physiotherapy department with South Sudanese doctors. The physiotherapy department is divided into three rooms. Like other departments in the hospital, the physiotherapy department is assisted by foreign experts. Francisca, an Italian physiotherapist is supervising four interns. A chart of meridians and points hangs on the wall. On the table stands a figure showing acupuncture points. Dr. Ding visits the physiotherapy department three days a week, and each time, he treats around 30 patients. Every time he goes to the hospital, Ding carries a medicine chest filled with needles and moxibustion materials, just as the barefoot doctors did in the 1960s.

Dr. Ding rushes back and forth, applying needles in places he considers appropriate. Each session lasts for about 10-15 minutes. In some cases, he uses moxibustion to enhance the effect. Moxibustion is the burning of a small amount of mugwort herb on the skin to stimulate an acupuncture point.

Dr. Jimmy Onya, a South Sudanese medical assistant, is following in the footsteps of Dr. Ding. Onya received his medical degree from Uganda in 2000. “Acupuncture” is not a new term for him. As a medical student in Kampala, Onya first encountered the concept of acupuncture through an instructor from Sweden in a class entitled Relaxation Techniques, but the instructor never gave details on how to perform acupuncture. Onya

has no idea why or how acupuncture works, but he is happy to learn some new skills from Dr. Ding.

Juba Teaching Hospital, says Dr. Onya, is a hospital of trauma. There are numerous trauma and pain cases caused by gunshots, motorcycle accidents, or conflict. Those injured in physical fights also end up in the hands of physiotherapists. Many patients also present with lower back pain, partly because South Sudanese like to sleep on beds made from nylon string rather than mattresses. Having lived in Uganda, Onya observes that low back pain is much more common in South Sudan than in Uganda, despite the fact that Ugandans are heavier . One reason, he assumes, is that when South Sudanese make up their beds, they do not use a mattress in the frame; instead, they use nylon strings. The chairs are also made with nylon strings and are not firm. When people sleep in beds or sit in chairs, they sink. However, nylon-made chairs and beds are common in South Sudan, because they are easy to carry when people need to move in turbulent times.

Onya believes that there is a parallel between moxibustion and the heat he needs to treat patients. In addition to working at Juba Teaching Hospital, Onya has a private clinic with four other doctors in Hai Sura. When he visits his patients, he needs a steady flow of heat to work on them. But there is no universal power supply in Juba; many people rely on generators. Sometimes, Onya uses boiling water as a source of heat. Moxibustion offers an alternative means of applying heat. In his words, this represents

“critical thinking” in the face of South Sudan’s scarce resources. Like all governmental organizations and businesses, Juba Teaching Hospital experiences power outages day and night, making it nearly impossible to use electronic physiotherapy equipment like infrared rays. In these cases, moxibustion serves as an alternative source of heat. “I admire it so much.”

Dr. Ding said that 98 percent of the cases in this physiotherapy department are suitable for acupuncture treatment. In the first days after his arrival, he explained acupuncture to the head of the department, the mechanism of acupuncture, the clinical trial range, and precautions for acupuncture. After obtaining the consent of the department head, he received his first patient, who suffered from a sprained waist. His family helped the patient to the physiotherapy department. Because the pain was unbearable, the patient was sweating in the head. He asked the doctor to give him some painkillers.

Dr. Ding told the patient that Chinese acupuncture could help relieve the pain immediately. The patient was suspicious of acupuncture at first, saying “Can acupuncture treat me?” After undergoing acupuncture and cupping treatment, the patient “immediately stood up and the pain disappeared,” according to Ding. The patient said, “Strange! Magic! Unbelievable!” and gave Dr. Ding a thumbs up. With this success, the physiotherapy department began to accept acupuncture. In the next few days, some of the hospital medical staff came to seek acupuncture treatment.

A couple of interns from St. Mary's Medical School also joined in. Under Ding, they studied the basic theory behind acupuncture and moxibustion, such as *jingluo* (channels and collaterals) and *yin yang* (positive energy/negative energy). They also learned how to apply needles to specific sites where *qi* (vital energy) and blood are transported to the body's surface. "It resembles running water. If you stimulate the nerves, *qi* and blood will travel smoothly in the channel systems of the body, reaching a state where yin is balanced and yang is firm, and a coordinated spirit is guaranteed," Ding said. He reduced the acupuncture points to the 30 most commonly used and asked the interns to practice on the figure showing acupuncture points. He told them that "acupuncture can stimulate magic power in the body."

Noel Zino, one of the interns from the training center of Juba Teaching Hospital, felt differently about Ding's method. Zino said it takes time to understand acupuncture, and he would like to know the physiological effect. "Some of the things are complicated. You apply needles on the finger, but how does it affect the eyes? I do not understand. I want to know the science behind. Hormones, nerves, these things we understand. It needs deep explanations: a clear mind, and a scientific mechanism. "

Hemiplegia due to cerebral malaria, including facial paralysis, is commonly reported in the physiotherapy department. A medical student named Justin developed facial paralysis while brushing his teeth. On a Sunday morning in December, a medical student named Justin developed facial paralysis while brushing his teeth. Suddenly, he

had trouble rinsing his mouth with water. Pain shot across the right-hand side of his face, extending to his ear and mouth. His eyes became so swollen that he had trouble closing them, and he found it difficult to eat. Tears ran down his face as he chewed his food. Even the way he talked changed. “The pain lingered. I felt like my face was being burned by fire,” said Justin.

Justin sought conventional physiotherapy at the department. The treatment lasted for four months, but there was no substantial improvement. In April 2016, Justin decided to see Dr. Ding, and started undergoing acupuncture therapy sessions.

Before then, Justin had heard of the word acupuncture, but he had no idea how it worked. To his surprise, the Chinese needles took effect within just a week. The needles were applied to a few major points on his face. He said, “I could feel my blood flow around the parts of my face where the needles entered, as if water were running along the channels”. By the end of the first week, Justin was able to fully close his eyes. This medical case was repeatedly used by Dr. Ding and the Chinese medical team to testify the “miracle of China’s magic needles.”

Another Justin, Justin Lukudu, a 52-year-old agricultural specialist from the Central Equatoria State Ministry of Agriculture, had suffered a stroke in the year before I interviewed him. The stroke had affected the right-hand side of his body. His brother recommended that he see Ding. “I felt that the blood started to flow through my body every time the needles were inserted.” Aside from regular acupuncture and moxibustion,

Ding treated Justin with “fire needles,” or heated needles, to enhance the therapeutic effect. Justin said that it was still difficult for him to raise his right arm as high as he’d have liked, but he was feeling better after a couple of sessions.

Like what the Chinese medical team did in the 1970s, they pay particular attention to high-ranking officials. The Chief of Staff of Joint Monitoring and Evaluation Commission (JMEC) has pain in the right shoulder. He has been treated in many hospitals in Juba, but without obvious effect. Through his Chinese colleagues he hopes to obtain a diagnosis and treatment of the Chinese medical team. Yilientang, one of the Chinese clinics, also invited Chinese acupuncturists to carry out acupuncture treatments for a few officials, including one from the Ministry of Treasury.

Ding notes that physical treatment also involves mental care. Ding says he observes the Hippocratic Oath “to cure sometimes, to treat often and to comfort always” as part of his medical ethics. “South Sudan has been ravaged by civil wars for too long. You need to go beyond diseases and treat the patients with dignity, care and respect. This is an invaluable lesson of traditional Chinese medicine.”

For many patients at Juba Teaching Hospital, however, acupuncture fosters the perception that rapidly working drugs are readily accessible. Hemiplegia patients and their relatives ask the Chinese doctors to give them medicines that will help them move their bodies freely straight away, while ignoring the doctors’ instructions regarding rehabilitation training and self-massage.

Chinese medical teams have also brought several types of TCM to South Sudan, including Shuang Huang Lian oral liquid (a typical Chinese herbal injection widely used to treat acute upper respiratory tract infections), Yunan Bai Yao (a hemostatic powdered medicine famous for stopping bleeding), and Chinese motherwort (granules used to treat menstrual cramps). In the gynecology department, Dr. Zhou distributes Chinese motherwort, Guizhi Fuling capsules (based on cinnamon and poria extract), and Fu Ke Qian Jin Pian (tablets based on extracts of eight herbal plants). He said, “TCM is safer to use compared with biomedicine. What’s more, it’s effective in lessening patients’ pain.”

Dr. Zhou explains that the reason he uses Fu Ke Qian Jin Pian is because of limited conditions in South Sudan. He wanted to explore how Chinese medicine could be used in a clinical setting. He said:

The donated medicine from China, after all, is limited in type and quantity. Then, we will see if there are some diseases that can be treated by Fu Ke Qian Jin Pian. In this way our Chinese medicine can play a role in the hospital. With its limited side effects, Chinese medicine is safe, so we dare to make such an attempt. The nurses and doctors in the gynecology department asked us to give them some medicines. As long as these donated medicines can be used on patients, it’s good. Chinese medicine has its benefits because it’s based on plant extracts. Moreover, it represents China's 5,000 years of culture. You cannot equate Chinese medicine with acupuncture. You have to talk about the story of China.

They have also brought Liu Wei Di Huang Wan (“Six Flavor Tea Pills”), one of the most widely used Chinese herbal formulas. Based on yin-yang theory, or a balance between the positive and negative power of the universe, it is used to nourish yin, or

negative and inward energy of the universe. A Chinese medical team visiting Wau Teaching Hospital and Gogrial State Hospital brought eight boxes of medicine for distribution, including Liu Wei Di Huang Wan. However, a nurse named Santino Deng put Liu Wei Di Huang Wan and Ibuprofen together. Using a ball-point pen, he wrote “antipain” on the medicine bags, and handed a package of Liu Wei Di Huang Wan and Ibuprofen to every patient who completed an acupuncture session.

Deng said, “The doctor said it is a traditional Chinese medicine, with no side effects. I don’t know how it works, but I hear that Chinese medicine is quite effective in easing pain.”

4.3 TCM in Post-war South Sudan and Beyond

Pain emerges not only from physiological processes, but also through negotiation with social worlds. In South Sudan, pain is an assemblage of experiences shaped by wars, conflicts and above all, an unsettling political situation. Ordinary South Sudanese have no way but to “push life.” Pain, as observed by Elaine Scarry (1985), defies language. There is much lying beneath the speakable symptoms in a clinical setting. In South Sudan, it is hard to discern whether when individuals speak of their pain and suffering, they are referring to something purely physical or to something more psychical and social.

This brings me back to the question of Traditional Chinese Medicine. Medical anthropologists (like Judy Farquhar(1994)) imagine that TCM might provide an

alternative to biomedicine, as it comes from deeply rooted social relations and Chinese philosophy. Likewise, in South Sudan, beliefs in supernatural beings and spirits still play a significant part in people's everyday lives and in their conceptions of illness.

However, Mao's radical transformation of Chinese medicine into a highly standardized and scientized national platform has exerted an influential impact upon the development of Chinese medicine in China and in Africa. After the modification of Chinese medicine, the metaphysical concepts of Qi, Yin and Yang, and the Five Phases became less relevant to understanding and treating illness and medical attention shifted to a focus on the physical, tangible features of the body. In other words, TCM from the 1950s onwards has been purged of many holistic features that would be otherwise useful for medical care in a post-war country like South Sudan. In dealing with pain, there is more work needed beyond a paradigm of the body.

Nonetheless, TCM as a streamlined and easily accessible system of treatment speaks to South Sudanese patients' desire for a fast-track method to deal with pain. With the barriers of translation, neither South Sudanese patients nor South Sudanese doctors understand the inner architecture of TCM and acupuncture, and often treat them as just another painkiller. China's position as an economic powerhouse plays here as well, for it has constructed an image of medical miracles in the minds of South Sudanese patients. Its expansive cooperation programs with African countries, including South Sudan, over the last decade have contributed to this positive image of medicine from China.

In her analysis of Chinese medicine in Tanzania (2002), Hsu analyzes Tanzanians' perceptions of *dawa ya Kichina* (Chinese medicine), which is often considered an effective and fast-acting "advanced" medicine, because its ready-made formulas make it look "scientific" and "modern." Such medicine is easy to consume, and its entrepreneurial set-up has several advantages over the bureaucratic structures of "hospital medicine." As Hsu observes, medicine from China, appeals to African patients, thanks to a combination of factors, such as the socialist transcontinental linkage of the 1960s and '70s.

Biomedicine functions as a dominant system, compared to other systems which try to legitimize or differentiate themselves. For example, other traditions may try to appear more "scientific," as in the version of TCM promoted in China and exported to Africa. Acupuncturists cross-trained in biomedicine in China may allude to biomedical disease categories, even as they locate their diagnoses and treatments within Chinese medicine paradigms.

Nonetheless, acupuncture as practiced in South Sudan and the rest of Africa is not a purely scientific enterprise. Different actors are contributing to the otherworldly nature of medicine. Dr. Ding, for example, repeatedly told his interns and patients that "there is magic with the needle." Since the creation of Traditional Chinese Medicine in the 1950s, acupuncture has been consistently employed as a "magic bullet," with the potential to treat a variety of diseases. It is very common to read reports on the dissemination of

zhongguoshenzhen (Chinese magic needles) and *zhongguoshenyi* (Chinese miracle doctors) in Africa.⁵ Some stories about China's acupuncture programs in Africa portray them as almost *baozhibaibing* (a remedy curing all types of diseases), connoting a sense of civil religion that is deeply rooted in China⁶.

In fact, wandering around the streets of Juba, one sees the advertisements posted by "miracle doctors," who claim to have the ability to treat anything, from impotence to resolving family disputes. The practice of Chinese medicine (including acupuncture) is contextualized in a sociocultural setting where healing is strongly based upon religious beliefs. Chinese medicine and acupuncture can hardly distance themselves from such a belief system. Nor can Chinese acupuncturists distance themselves from traditional healers in South Sudan. In the words of Bruno (1993), "we have never been modern."

Many anthropologists have discussed the relationship between religion and medicine. Rivers (1924) points out that despite the progress of medicine and its distance from magic and religion, psychical factors persist. He observes that "Few can now be found who will deny that the success which attended the complex prescriptions, and most

⁵ *People's Daily* (October 30, 2016). <http://world.people.com.cn/GB/14549/4973487.html>
Accessed April. 21, 2019.

⁶ *China Investment* http://www.chinainvestment.com.cn/type_fmgs_post/7025.html Accessed April. 21, 2019.

of the dietetic remedies of the last generation, was due, mainly, if not entirely, to the play of faith and suggestion... Just as there are problems and individuals' cases of disease which need the collaboration of priest and physician, so are these cases in which the physician, the teacher, the moral and social reformer, can help one another far more profoundly and successfully than they have done in the past." (ibid.: 106).

Rivers makes a distinction between magic and religion: magic refers to "a group of processes in which man uses rites which depend for their efficacy on his own power, or on powers believed to be inherent in, or the attributes of, certain objects and processes which are used in these rites. Religion, on the other hand, will comprise a group of processes, the efficacy of which depends on the will of some high power, some power whose intervention is sought by rites of supplication and propitiation. Religion differs from magic in that it involves the belief in some power in the universe greater than that of man himself." (ibid, 4).

Despite its practical and scientific nature in contemporary China, acupuncture is still framed, to a certain extent, as a miracle treatment, revealing the "symbolic reality" inherent in medicine (Kleinman 1973). Kleinman suggests that medicine, from an historical and cross-cultural perspective, is a cultural system in which symbolic meanings take an active part in therapy.

Similarly, Ted Kaptchuk (2002) proposes that complementary therapies partake of efficacious dimensions of ritual healing. Tom Csordas and Elizabeth Lewton (1998)

suggest that “the single most common feature of [ritual] healing forms . . . is that they are in some way religious in nature.” By religion, they mean “any cultural form that highlights the symbolic, sacred, or spiritual element of therapy (1998:436).

Chinese medicine and acupuncture may have nothing to do with “high power”, but they are practiced in a way that suggests the implications of magic and religion. In this way, TCM (including acupuncture) goes beyond its initial design as simplified and accessible medical dexterity for the masses to be practiced with a hint of “miracle cure” in South Sudan, defying the “single story” (Mkhwanazi 2016) discourse about medicine that is used in Africa.

As a result, acupuncture and TCM are conceptualized and practiced mostly as a biomedical intervention but situated in “miraculous treatment”. But “miraculous treatment” can hardly address a South Sudanese’ experience of pain in full. Painkillers or pain management are perhaps effective in the short term, but they do not address the root causes of social pain in South Sudan. In fact, the abuse of painkillers for short-term relief in South Sudan has become a major source of disease, such as gastritis. As South Sudanese nurse Agnes said: “With painkillers, people can live with less pain. But the wound is still there.”

Since Xi Jinping took power in China, TCM has been listed as a key area for development in both China and Africa. Xi has described Chinese medicine as “a gem of ancient Chinese science full of deep philosophical wisdom, representing a thousand years

of the Chinese tradition of keeping healthy. He has also described it as “a key to the treasure house of Chinese civilization.” These words rekindle Mao’s 1955 proclamation that “our motherland’s medicine is a great treasure house.” Under these guidelines, the Chinese government has supported the construction of 10 TCM centers in African countries, and specialized TCM stations have opened in Algeria, Tunisia, Morocco, and Namibia.

In August 2018, the warring parties of South Sudan agreed to sign a new power-sharing agreement, putting an end to the five-year civil war. South Sudanese are celebrating a new beginning of their war-torn country. This year, doctors and nurses from a TCM hospital in Anhui will be dispatched to Juba for one year’s service.

China is asserting itself through TCM in post-war South Sudan, where pain signals the realities of life. The employment of TCM and acupuncture as painkillers or pain relief in South Sudan opens a window into the often uneven -- and sometimes unexpected – globalization of medicine in the contemporary world. A variety of actors participate in the production of desires, values, and symbols related with medicine from China. These values and desires overlap at certain times but there is certainly a mismatch, suggesting the complexity of globalized medicine like TCM.

I situate my work within these contradictions – of a system of TCM that has been purged of the social and cosmological entering a war zone where the social and cosmological are inherent to conceptions of illness; of a people marked by the deep

psychological and political wounds of war who nevertheless seek short-term pain relief – and offer here, by way of conclusion, more a set of questions than answers to these conundrums. What kind of life politics is brought about by Chinese doctors in a post-war country like South Sudan? What insights do these developments offer into the geopolitics of care and the future of China-Africa relations?

When global health initiatives are called upon to put people first (Biehl and Petryna 2013), we need to think more closely about the unexpected transnational connections and different forms of therapy that underwrite how people come into contact with medicine.

5. Reaching out to the Countryside

Medical campaigns are a prominent part of medical service in South Sudan.

Fistula campaigns, cleft lip and palate repair campaigns, and general surgical campaigns are some of the most common campaigns in South Sudan, bringing doctors from outside, including the United States, Cameroon, DR Congo and Egypt, to South Sudan for service over a short period of time. These campaigns normally last for one to two weeks, mostly in big cities such as Juba, Wau and Aweil.

Fistula campaigns receive most attention among the campaigns. In 2006, South Sudan conducted its first fistula campaign, treating 19 patients. The collaborative campaign involving the UNFPA, the Ministry of Health, and a number of NGOs has continued, having treated about 750 patients. Roughly 30-60 female patients receive treatment during the fistula medical campaigns every year. In 2017, the fistula campaign was conducted for two weeks at Juba Teaching Hospital, Wau Teaching Hospital, and Aweil State Hospital, about forty surgeries were performed.

Most campaigns draw upon the medical resources of South Sudan and other countries. In the 2012 fistula campaign, for example, the team was composed of two fistula specialists from Kenya, an anesthetist, a fistula nurse, a theater attendant, and program coordinators. The team also included a psychotherapist to provide psychosocial counselling to patients before and after the surgery. Likewise, the fistula campaign in

2017 was a joint effort of the UNFPA, the Ministry of Health, and Women and Health Alliance International (WAHA).

In a similar fashion, a team of Egyptian specialists in Urology and Ophthalmology visited South Sudan in 2018. They performed cataract surgery at the Buluk Eye Clinic and fistula surgery at the Juba Teaching Hospitals.

Although transient, medical campaigns generate excitement, permeating every corner of the city of Juba when the foreign experts are visiting. Posters featuring smiling girls after a cleft lift operation are posted in the hallways of Juba Teaching Hospital, reminding the patients and passersby of their great success. Social media and newspapers are filled with stories of transformation, turning sick patients into healthy, ones. Social media even invite readers to “come back this evening to see Teng after his successful surgery.”

There are a variety of actors in this form of medical aid, many of whom are African doctors influenced by Christianity. Before the civil war broke out in July 2016, doctors from the Egyptian Orthodox Church had been regular visitors to South Sudan. The church sent a number of medical teams to South Sudan for various surgical campaigns. They were usually at either Juba Teaching Hospital or Wau Teaching Hospital. Their service was interrupted by the war in 2016 and it was not until several months later that they gradually resumed their service. NGOs like Samaritan’s Purse are other major members of this expanding international community.

The United Nations, International Committee of the Red Cross and Médecins Sans Frontières have all organized short-term medical missions for preventative or vaccination campaigns throughout South Sudan. In September 2017, for example, WHO's emergency medical mobile teams reached out to famine-affected areas of South Sudan to facilitate vaccination and cholera treatment in mobile clinics. Infectious disease control was among the priorities of these campaigns. At the weekly UNOCHA health cluster meetings, NGOs meet to report on their latest emergency health intervention and nutrition programs.

Mobile teams ranging from a few individuals to a dozen members are the norm for task forces. *Mobile theaters* and *mobile clinics* are key words in the UNOCHA Humanitarian Response Plan. There are a number of factors affecting humanitarian relief efforts. Logistically, roads are very difficult for travel, because of potential ambushes. Chartering flights is also very expensive. "If you send five people to a place, you may spend up to 30,000 US dollars, which actually reduced the funding for humanitarian aid," said an officer at UNOCHA. Right now, UNOCHA is focused on life-saving activities and disease outbreak, such as malaria.

In rare cases, campaigns could last for a longer period of time. In February 2017, Morocco, in an unprecedented fashion, sent a twenty-member medical team for service at a tent clinic adjacent to John Garang Square in central Juba. They stayed in Juba for more

than three months, reportedly treating 50,000 cases and making it one of the longest medical campaigns in South Sudan.

Doctors from the West also contribute to this medical service. In the spring of 2017, Samaritan's Purse commissioned a specialist from Canada to coordinate the cleft lip and palate surgery campaigns. In the same vein at that time, Melissa Barney, an American surgeon from Oregon, was flown into Juba for a one-week surgical campaign at Juba Teaching Hospital, working with other surgeons, like Dr. Charles Linderman and Dr. Chan Deng. This campaign was a joint effort of Juba Teaching Hospital and Medical Response for the Diplomatic Corps (MRDC), a non-governmental organization providing medical/surgical care for the diplomatic and NGO communities in South Sudan. Like other medical campaigns, MRDC is informed by Christianity. Before going to Juba, Dr. Linderman served in Albania for a number of years, as a missionary of the Orthodox Christian Mission Center.

When it comes to medical campaigns, there is one thing that makes South Sudan distinct from other African countries: a lack of "international clinical volunteerism" (Sullivan 2018) that draws heavily upon medical students from the developed world. This is perhaps not surprising, given the volatile security situation. For example, after the war broke out in 2016, South Sudan consistently has been listed as a Level 4 country by the US Department of State, which advised its citizens against travelling to the country.

International medical students are not as motivated to volunteer in South Sudan as they are in Tanzania, Kenya and Malawi (Wendland 2012).

5.1 Rise of Short-term Medical Missions

In Africa, short-term medical missions historically went hand in hand with missionary work and colonization efforts. Missionaries were tasked not only with treating the patients' bodies but also winning their hearts. One of the forerunners was David Livingstone, known for both his medical expertise as well as his missionary work. Black bodies were treated as targets for medical interventions, moral redemption, and social reform (Vaughan 1994). Vaughan also observes the blurred boundary between colonial medicine and missionary medicine, as they both emphasized the social implications of illnesses.

According to a London Missionary Society booklet published in 1819: "There are moral as well as medical means of preserving health: and the former are hardly less important than the latter...especially in climates which render the duration of health even more dependent on habits and associations, than it is in colder countries (cited in Hardiman 2006: 12).

Medical campaigns gained prominence in the late 1970s and 1980s, thanks to air travel and a growing awareness of health challenges in low- and middle-income countries. By the late 1990s, the advent of the Internet facilitated the growth and visibility of

numerous community groups and nonprofit organizations offering short-term medical missions, leading to discussions of their educational and ethical considerations. Modern-day medical missions can be either faith-based or secular in nature.

By the end of 19th century, there was an apparent shift towards professionalization, pushing aside the role of religion in global humanitarianism, including short-term medical missions. This trend gave rise to the emergence of large numbers of medical doctors working in the developing world (Lasker 2016). It is estimated that as many as 200,000 Americans annually join global health programs, at an annual cost of 750,000,000 USD (ibid).

Previously, the prevention and control of communicable diseases were the focus of global health development programs; however, within the last few years, global surgery has become a priority of global health programs. Once a neglected component of global health, global surgery has quickly proliferated. In 2005, the World Health Organization launched the Global Initiative for Emergency and Essential Care, to promote the importance of surgical care in trauma and emergency situations. For the first time, surgery was included as part of a new comprehensive primary healthcare plan for a major global public health initiative. In 2008, Farmer and Kim of Partners in Health published a paper where surgery was referred to as “the neglected stepchild of global health” (Farmer and Kim 2008) Global surgery was born to advance the notion that surgical care is a fundamental component of global health .

In the meantime, there has been a resurgence of religion in international humanitarian organizations, reshaping the orientation of medical missions. This development is also evident in South Sudan. Daniel Deng Abot, Bishop of Duk Dioceses of the Episcopal Church of South Sudan and Sudan, explained that, from the 1990s onwards, there was a huge increase in the number of South Sudanese followers of Christianity. The Episcopal Church came to southern Sudan in 1905 but grew very slowly. The turning point came in 1991, when the signing of the Nasir Declaration by Riek Machar, Lam Alkol and Gordon Kong resulted in the splitting of SPLM and factional fighting between the Nuer and the Dinka. Large-scale killings propelled people to seek Christianity for spiritual protection. A similar pattern emerged after the two civil wars in 2013 and 2016, with more people turning to religion for protection. By 2015, there were 53 Episcopal dioceses.

Despite the differences in their points of departure, most of the medical campaigns in South Sudan are a response to humanitarian crises (Berry 2014), largely bearing the imprint of religious organizations. The campaigns like to draw upon discourses like “transforming people’s lives” or “marvels of healing” (Hardiman 2006), revealing the teachings of Jesus Christ. Samaritan’s Purse summarizes its mission in Juba as : “After sharing the story of the Good Samaritan, Jesus said ‘Go and do likewise.’ That is the mission of Samaritan’s Purse—to follow the example of Christ by helping those in need and proclaiming the hope of the Gospel.”

In his detailed account of the biblical roots of short-term medical missions, Grundmann (2014) emphasizes the power of “restoration” in healing. He states that healing has been present in Christianity from its earliest times, and healing is characteristic of God’s reign. “The good news of the Gospel is that their original integrity is restored to humans by the reconciliation brought about in Jesus Christ (Ro. 6:1-11; Heb.7:27). This *restitutio ad integritatem* (restitution to original integrity) is commonly termed ‘salvation’, but it has also occasionally been described as a ‘healing’. Christians called to proclaim this restoration to original integrity cannot do so without reference to the passion, crucifixion, and resurrection of Jesus Christ.” (ibid.:12).

5.2 Medical Campaigns in China and Beyond

The world’s first missionary medical mission started in the 1830’s in Canton in southern China under the supervision of Peter Parker, a missionary of the American Board of Commissioners for Foreign Missions. After the People’s Republic of China was founded in 1949, it became increasingly difficult for missionary doctors to stay and practice medicine in and almost all of them had left China by 1952 .

After Mao took power, his political fervor turned to a focus on the public health sector. From the 1950s onwards, China announced a “barefoot doctors” program serving the needs of people in the countryside. It also introduced a rotation system wherein doctors from the city took a few weeks or one year and served as experts in the country or

township hospitals. There was a disparity in the standard of medical expertise in urban and rural areas. The countryside was seen as an immediate target for development of medical expertise, an arrangement that has remained to this day. Under the current system, doctors from major hospitals in the city have a responsibility to support lower-level hospitals in rural areas. This is partially realized through “voluntary consultations” (*yizhen*), medical training, and surgical demonstrations.

Yizhen plays a key role in China’s medical assistance programs. Doctors in city hospitals enter into a partner assistance program with low-ranking hospitals. Mobile medical teams serve as an external support force, promoting the consolidation and development of cooperative medicine in the countryside. After the People’s Republic of China was founded in 1949, teams were established to serve rural areas and ethnic minority groups. In January 1965, Mao issued instructions to organize high-level medical personnel in the cities to train doctors in rural areas. The Ministry of Health immediately implemented the instructions. The core component was to organize advanced medical personnel to carry out medical treatment in the rural areas and to train grassroots health workers. This method of practice was soon listed as a national policy (Xia 2003).

Beijing and other large and medium-sized cities throughout the country implemented Mao’s instructions and quickly organized medical teams to be sent to the rural areas, mountainous regions, pastoral areas, and forested areas for medical treatment (*ibid*). By mid-April 1965, a total of 1,521 medical teams had been organized nationwide,

and 18,697 medical personnel were involved in the service. In the first half of 1965, more than 28,000 people participated in the service. Most medical teams in the provinces and regions had first-rate experts, professors and celebrated practitioners of Chinese medicine. In the 1960s and 1970s, the Beijing medical teams visited underdeveloped provinces, e.g., Gansu, Shaanxi, Yunnan, Jiangxi and Tibet, to prevent and treat diseases. Shanghai, Liaoning, Jiangsu, Shandong, Henan, Hunan, Hubei, Sichuan and other provinces and cities also sent medical teams to Tibet.

In the context of China, medical campaigns are aimed at technical development. The moral redemption and religious brotherhood that are reflected in Christian organizations do not exist in China's medical campaigns. Short-term medical campaigns are an integral part of Chinese medical teams. All the Chinese medical teams working in Africa have conducted short-term medical campaigns in remote areas of the countries they serve. Before the medical teams depart for South Sudan, they are all required to carry out *yizhen* in underdeveloped counties in Anhui Province. In April 2019, the seventh group of medical teams spent two days at a village in Jinzhai County, known as "the cradle of generals." During the campaign, 200 villagers consulted with medical teams.

Surgical campaigns are not a crucial component of the outreach service of Chinese medical teams, but they are starting to play a role in these campaigns. In 2010, Hainan Airlines began to sponsor Tongren Hospital, a Chinese hospital specializing in

ophthalmology and otolaryngology, to conduct eye surgery free of charge in Zimbabwe and Malawi, in the “Brightness Action Campaign.” About 20 ophthalmologists were brought to the two countries for a one-week campaign. This model was later extended to other hospitals and Chinese medical teams. In 2016, five countries, including Sudan, Cameroon, DR Congo, Benin, Togo and Comoros, were selected as beneficiaries of the China-Africa Bright Action Campaign, and about 3,500 cataract patients were treated. In addition, a 12-member team was sent to Sudan for a campaign that lasted for 3 months, treating about 1,000 Sudanese patients.

Before their campaigns in Zimbabwe and Malawi, the “Brightness Action Campaign” had traveled to remote areas of China, e.g., Gansu, Inner Mongolia, Tibet, Hainan, Qinghai and Sichuan, for similar services. These areas, populated mostly by ethnic minorities, are regarded as underdeveloped regions and have been targeted for economic development and poverty reduction. To a certain degree, sub-Saharan Africa is comparable to the frontiers of China.

So far, the medical teams in South Sudan have not focused on surgical campaigns. They rely on conventional approaches, providing basic medical services to needy people in the countryside for a couple of days.

The medical campaigns are usually conducted toward the end of a one-year mission in South Sudan, amid the height of the dry season. The rainy season that lasts from May to November is not conducive to campaigns. The yearlong service culminates

in a rite of passage, as the peak of their service in Juba and as a prelude to the medical team that is to succeed them. For these reasons, *yizhen* has a special significance for Chinese medical teams. Many doctors are excited about the opportunity to travel to other places outside of Juba.

A gynecologist said: “Before I came to Juba, I had known that the most challenging part of our one-year’ service would be *yizhen*. But this is an indispensable part of our mission, and I’ve been looking forward to it for a long time. I want to go to the primitive part of Africa and look at how the people in the most impoverished part of the world is living their life.”

Since the Chinese medical teams began their service in 2013, they have carried out medical campaigns two or three times per year. The first medical campaign was conducted in September 2013 and featured a two-day visit to the Paloich Friendship Hospital in Upper Nile State, located in northern South Sudan. The Paloich Friendship Hospital was built in 2006 with support from the China National Petroleum Corporation (CNPC). Paloich is home to the oil blocks 3 & 7, a key area for oil production for the CNPC.

The total proven reserves of the Paloich oil field are approximately 2.9 billion barrels, and production averages 22,000 barrels per day. During the wars in 2013 and 2016, the oil installations at Paloich were under government control but repeatedly under attack from SPLM-IO rebels loyal to Riek Machar. The CNPC is the biggest shareholder

of the Paloich oil fields, holding 40 percent of the total shares. The Paloich Friendship Hospital has become the first destination of Chinese medical teams in their outreach service.

In September 2013, the first Chinese medical team carried out a two-day *Yizhen* to Yei Civic Hospital. In November of that year, they followed with a two-day medical campaign to Yapa Boma, Lobonok County, in central Equatoria.

In November 2014, the second group of Chinese medical teams conducted a three-day medical campaign in Torit, Eastern Equatoria's capital. In January 2015, they followed with a five-day visit to Rumbek, Lake State. Rumbek was chosen as the capital by the Sudan People's Liberation Movement, regarded as an important position in South Sudan. In 2013, China started to build an advanced hospital in Rumbek. The hospital was named Salva Kiir Mayardit Women's Hospital, specialized in gynecology and offered medical consultations to 1,600 people, including 9 surgeries.

In February 2016, the third Chinese medical team conducted a five-day medical campaign in Yirol, Eastern Lakes State; 3,000 patients were seen, and 8 surgeries performed.

In 2017, the fourth Chinese medical team set a record by conducting a twelve-day medical campaign in Wau, the capital of Wau State and Kuajok in the erstwhile Warrap State. Kuajok is the birthplace of South Sudan president Kiir and home to a number of non-governmental organizations.

At that time, road ambushes were rampant, making it impossible to go by land. A common practice for international NGOs was to rent a United Nations Humanitarian Air Service (UNHAS) chartered plane to fly them to remote areas for humanitarian service. Transportation expenses are a large part of the costs for medical campaigns.

In a similar fashion, a Chinese medical team flew to Wau on March 13, by boarding the local airlines Southern Supreme and returning to Juba on March 24, a chartered plane of UNHAS .

5.3 “You are on God’s Behalf”

As in the past, the medical campaign was headed by the Economic and Commercial Counsellor’s Office of China. The office commissioned an employee of Huawei, a telecommunications company from China, to help with logistics. After a bumpy flight on board an old-fashioned Russian plane, the 14-member medical team arrived in Wau. Several Land Cruisers were waiting at the airport to pick us up and head for Kuajok, about 50 miles north of Wau. The government of Gogrial State dispatched a convoy to guarantee safety along the journey.

I was packed into a Land Cruiser with the translator, the acupuncturist, the pediatrician, the nurse, and one of the surgeons. It was an eye-opening experience for many doctors. Tuku villages and barren land amazed them, and they covered their faces

with masks to keep off dust. “I wish to come back to South Sudan in twenty years when it is developed,” said the pediatrician.

Before they carried out the medical campaigns, Dr. Yao, the translator Han, and a gynecologist, Dr. Xue, had made an assessment trip to Wau and Kuajok. The focus of their trip was on evaluating the living conditions for doctors, rather than assessing the medical conditions of the hospitals where they were about to serve. They had decided to stay at Ebony or Naivasha, two of the best hotels in Kuajok. But when the team arrived in town, the hotels were booked up. The medical team ended up staying at Kuajok City Hotel, composed of a number of bungalow rooms on the outskirts of the city. The hotel owner said, “China is the second world. The Chinese like practical jobs.”

The team members joked that they were *yikusitian*, that is, recalling one’s sufferings in the old society and contrasting them with the happiness in the new society. Some doctors said it was like *zhiqingxiang* – a campaign in the 1960s and 1970s that sent educated youth to the countryside.

The next morning, the medical team started their day with an official visit to the state government. At the welcoming ceremony, Zhang Yi, the economic counsellor said:

In the past, we have brought China medical teams to other places in South Sudan. It’s the first time that they are here. It’s the first time but for sure it will not be the last time. This young nation faces a lot of challenges, but health is among the many priorities. South Sudan is in a shortage of medical services and medical supplies. We brought the Chinese medical to improve the medical service of South Sudan. We are also in the process of modernizing Juba Teaching Hospital. As the security situation improves,

there will be more done to improve the medical facilities. We are confident they will extend the hospitality to the people and make the service a smooth one.

The state governor, Gregory Deng Kuac, who is the brother-in-law of President Kiir, replied:

We are very happy to receive you. We have many sick people, but they cannot afford to go to China. It's a good opportunity for the Kuajok people to receive service from China. We will cooperate with you fully. Here, there is no medicine. There is only one hospital. When you come here, doctors are secondary to God. Doctors are here on God's behalf. We would expect that you will bring more service here.

5.4 “Care for Health, Promote Friendship”

Located in Kuajok, the Gogrial State Hospital is the largest hospital in the former Warrap State, which was divided into Tonj, Gogrial and Twic States. A presidential decree in 2015 divided the original 10 states into 28 states.

The lack of public health professionals is obvious. A report by the State Ministry of Gogrial shows that only 75 percent of the State's medical personnel are working at the 107 health facilities . There are 5 hospitals, 28 PHCCs and 74 PHCUs for a population of nearly one million (Gogrial State 2017).

“You can travel a day without seeing a hospital. Many doctors have left the country. In Twic state, there is only one doctor,” said Dr. Machom, an official from the National Ministry of Health, who was accompanying the Chinese medical team.

There are 81 medical professionals at the Gogrial State Hospital, including eight medical officers, two pediatricians, one plastic surgeon, one dentist, three surgeons, one physician, and one obstetrician-gynecologist. In addition, there were three medical officers and one clinical officer supported by World Vision, an Evangelical Christian humanitarian organization. I ran into Billy, a Ugandan lab technician who had worked at one of the Chinese hospitals in Juba. He was now on a contract with Health Pool Fund, a joint program by the Ministry of Health, UK Aid, Sweden, and US AID.

In 2003, the first operating theater was set up in the hospital, but there were no surgeons. In 2016, the surgical ward started to function, thanks to a technical assistance program under the Intergovernmental Authority on Development (IGAD). The IGAD initiative started in 2011, with experts from neighboring countries taking roles in administration and technical guidance. Through bilateral agreements, Ethiopia, Kenya, and Uganda send civil service support officers to South Sudan for two years. The experts are paired with their counterparts across a range of ministries and sectors, to coach and mentor, enhancing government capacity at the national and subnational levels.

In 2015, Gogrial State Hospital started to receive professional help, under the IGAD initiative, from a surgeon, a gynecologist, two anesthetists, a midwife, and a nurse. But the IGAD team was not stable. By the time we arrived, two members had resigned, including the gynecologist.

The medical team was supposed to arrive on Friday; however, due to flight cancellations, they arrived in Kuajok the following Monday. By the time the Chinese medical campaign got going on Tuesday, Kuajok Radio had broadcast the news for a couple of days. Hundreds of patients were waiting at the entrance to the hospital.

When the Chinese doctors arrived, the news had circulated in town. People came up to greet the Chinese doctors in the market. John, the driver, said to us, “People are saying the medicine from China is good. The Chinese medicine is the original. The Chinese doctors are good.”

In the hospital, the medical team was busy posting banners, one atop the medical department, the other at the entrance to the gynecology department, as these two departments would attract the largest number of visitors. The Chinese medical team in South Sudan had always used a slogan *guan'aijiankang, chuanbo youyi* —“care for health, promote friendship”. This time, the head of the medical team asked the translator to think of a new phrase. Finally, he came up with “Chinese Heart, Boundless love.”

5.5 Business of Drug Distribution

Numerous works have examined the limitations of short-term medical campaigns (Landa 2007, Citrin 2010, Montgomery 2007, 1993). Many medical missions end up distributing drugs, as Landa summarizes in his roundup of short-term medical missions in Latin America and other places. The short stay in a designated place and limited

exposure to the culture make it difficult for medical teams to deliver effective service in the communities they serve.

The Chinese medical team brought eight cardboard boxes of drugs. At the pre-departure briefing, Dr. Yao, the team leader, said they should follow the principle of *qian jin hou song*, which means to control the amount of drugs distributed to the patients at the initial stage, so that there are enough drugs left at the later stage of the campaign. “We should increase our efficiency of working with the patients. Our target is to make everyone get some drugs, instead of leaving them empty handed when the campaign is over,” he said. Regarding surgical operations, he said it depends. “It depends on the actual conditions in the field. If we are confident that we can do the operations, we will do it. Otherwise we will not do the operations. Alternatively, we will advise the patients to go to the big hospitals such as Juba Teaching Hospital.”

The team brought about 300 different drugs, most of which are commonly used, e.g., such as antibiotics, vitamins, metronidazole, norfloxacin, amoxicillin, and levofloxacin. The Chinese Ministry of Health has a drug catalogue, specifying the drugs to be used for medical teams, but the doctors complained that the catalogue is outdated. “We can only order drugs from an outdated catalogue. This is terrible!”

Distributing drugs was a focus of the medical campaign. “If we are not distributing drugs to the patients, we basically cannot do anything during the campaigns because we are constrained by a shortage of medical supplies,” said a physician.

It is obvious that drugs from China had a very positive image. People queued up outside the consultation rooms to get them. Assuming that I was part of the medical team, an immunization officer asked me to help him jump the line. He wanted to see the doctors, but people waiting outside the room wouldn't let him in. However, translators still managed to get their relatives and friends into the clinics.

A dozen bottles of drugs were spread on the table in the physicians' consultation rooms, including compound aminopyrine phenacetin tablets, ibuprofen and sodium bicarbonate (baking soda). Dr. Yao and the gastroenterologist, Dr. Liu, shared one room, helped by two medical assistants who were assigned as translators. Due to the large volume of patients, they spent on average five minutes with each patient. Dr. Yao would check patients' blood pressure or use a portable blood glucose meter to determine their blood glucose.

A middle-aged man, who identified himself as Malong, walked in and sat down, claiming he had pains in his shoulder, limb and stomach.

“How long?” Dr. Yao asked.

“Very long, ” said the medical assistant.

Dr. Yao examined the patients' joints in the lower limb and said. “You don't have very serious pains. It's not a big deal.” Then he turned to the Chinese translator, “The South Sudanese have a common complaint of pains. Nine out of ten report pains. Let's give him some painkillers.” Dr. Yao pulled a dozen painkillers out of the bottle, put them

into a small medicine bag provided by People's Hospital, one of the private hospitals in Juba, and gave it to Malong.

Then Malong told the doctor about other medical issues. In 2013, after he was wounded by a bullet in his back, he was unable to have a satisfactory sexual life with his wife. When he performs sex, he is "paralyzed". After hearing his complaint, Dr. Yao gave him a few pills of Liu Wei Di Huang Wan, a type of Traditional Chinese Medicine used to *bu qi*, or nourish one's vitality.

During the medical campaigns, the obstetrics and gynecology department was among the busiest in the hospital. Women flocked in for consultations regarding reproductive issues. The Chinese gynecologists observed that people in Kuajok want to have more babies than people in Juba.

I met Martin at the gate of Kuajok City Hotel where we were staying. Martin was a secondary school teacher. He had heard about the mission of the Chinese medical team. Martin was from Twic West County. His wife gave birth to three sons, the younger boys being twins, but he wanted to have more children. Martin explained: "Here we need to have more children because during the war time, many lives were lost. That's why we want to compensate for more children. If the wife has only two children, that is not enough. We pay a lot of cows, if the woman only produces two children that is not enough. They should have at least five. People like to have at least three children."

He has been to Wau with his wife to treat infertility. He said his wife's menstruation has been irregular. He has visited some clinics, but it is costly. He sold a cow, then he went for medical treatment.

A South Sudanese woman Fatma walked into the clinic. Her husband has three wives. The other two wives have babies. But she never delivered babies after 2014, which has made her very concerned. She brought her medical report to Dr. Luo.

"She needs to do SSG, you can ask her to do the test in Wau. Maybe Johnson knows. Quality is poor, but it's okay. This is the medicine for her. 2 times 2, 2 times 3," Luo said.

"She did the test before, at home," said Dominique, the assistant.

"SSG Okay? Then ask her to take the medicine first. After that, she can try pregnant (sic)."

"She asked whether she is going to have the baby or is she going to lose it?"

"It's possible. At this moment, she should be relaxed, take the medicine and see whether she will be pregnant. You should take X-ray of SSG. Maybe SSG is opened, but not quickly."

Fatma was from Malakal in Upper Nile. In 2001, she married someone in Wau. She has given birth to four children, but all of them died. The first one passed away because of malnutrition. So did the triplets she gave birth to after a second pregnancy. She did the hormone test, but everything was okay. In Malakal, her hometown, she tried a

traditional mixture of sesame and onion, but it did not work. Her husband also did a fertility test, and everything was fine. She heard on the radio that the Chinese medical team was coming, so she came.

She went to a medical facility of Comboni House, to no avail. She also went to several doctors in Wau but failed. “From My God, God gives the babies, so I don’t care how many I can produce,” she murmured.

Jiang and Luo, the gynecologists, said that these complicated cases need a lot of time, far beyond what they can do in a short-term campaign. What they offered for most patients were vitamins, MNZ, or Noroxin.

5.6 “A Spectacular Operation”

During the campaign in Kuajok, the hospital registered more than 500 patients with medical conditions, 166 cases requiring surgery, more than 700 pediatric cases, 500 cases in gynecology, and 400 cases in dermatology. However, only two operations were performed, one hernia and one gunshot wound. The orthopedist and surgeons attribute it to the lack of an adequate facility and equipment at the hospital, leaving them with no option. The Chinese surgeons were also reluctant to handle the most common cases; they believed these routine cases should not be the responsibilities of experts. “These cases should be assigned to junior doctors or interns”, they said.

What interests them would be a “spectacular” operation, in which they could demonstrate their expertise to their South Sudanese colleagues, but the limited conditions and facilities made it barely possible.

During the campaign in Kuojok, the hospital received an emergency case involving a patient from East Gogrial state. Gem, a 24-year-old Dinka, was shot in his legs when he was attacked by a gang of criminals with guns. People claimed that the gangsters were from the neighboring Nuer community. Gem was sleeping outside with his cows, when someone got in and started to shoot him. “There was shooting now and then, but there was a peace agreement, so there was no more fighting. But there is again conflict now,” said the nurse Akek. He was sent to the state hospital for help.

Dr. Zhai, the orthopedist, said he was limited by the lack of tourniquets and X-ray, and a full-fledged operation was not possible under those the conditions. He was left to do debridement with Dr. Bor, who was the director general of the hospital. Later, he prescribed some ibuprofen and calcium to the patient.

After the team moved to Wau Teaching Hospital, the two surgeons and orthopedists did not perform any operations in the theater. Instead, their service was restricted to the consultation rooms. Hundreds of patients were waiting outside the consultation room, and the three doctors took turns examining the patients.

Many patients were suffering from chronic pains. The most common complaints in the surgical department involved appendixes, hernias, urinary systems, orchitis,

hydrocele, and thyroid cancer. But the Chinese doctors said they can do nothing, because there was a lack of equipment. They prescribed painkillers in most cases. “It is a practical solution,” said one surgeon.

However, the medical campaign offered a good opportunity for the doctors to accumulate medical cases they do not see in Juba Teaching Hospital or back in China. Dr. Zhai made records and took photos of many old fracture cases. “They will be excellent teaching materials for my class,” Zhai said. He is a professor at Wan’nan Medical College in Anhui Province.

Their practice invited inquiries from the patients. Elisio Dou was a policeman before the war broke out in 2015. After he heard on Bakhita Radio that the Chinese team was coming, he took a boda-boda cargo bike and travelled to Wau Teaching Hospital. During the civil war in 2016, Dou, an ethnic Luo, was shot three times, in his legs and abdomen. Even though Dou he worked as a civil servant, the government did not provide any support. Thanks to contributions from his family, he was transferred to Juba for an operation at the Military Hospital; his leg was amputated. Five of his colleagues were also sent to Juba Teaching Hospital at that time. Rich families would send their relatives to Egypt or Khartoum, but he could not afford it.

“If you are disabled, you are disabled. You just stay like that. They will not pay you pensions.” He wanted to travel to Juba for a second operation, but he cannot afford the flight, which easily costs \$100 for a one-way journey. Travel by land was impossible,

due to the ongoing fighting and frequent ambushes, leaving very few choices for people like him.

Dou came to visit the Chinese medical team to see if the doctor can put in another bone so he can walk again. Looking at the X-ray film, Dr. Zhai said, “This kind of operation will take a lot of time. It’s difficult for us to make an operation here. You have too many bone defects. We need assistance of a plastic surgeon.”

Disappointed, Dou left the hospital. “You are just seeing the patients without operations?”

5.7 “Talking is not Enough”

On their last day in Wau, the medical team had planned to perform a half-day’s service at Wau Teaching Hospital. But that morning, gunshots were heard coming from Rose Hotel, where they stayed during the campaign.

It was a turbulent week. On Monday, the Governor of Wau State, Andrea Mayar Acho, issued a series of decrees removing and appointing new officials in his cabinet. On Friday, at least 12 people were killed and seven others injured after opposition forces launched an attack on the Natabu area in the western part of Wau town.

Dr. Yao decided to cancel the last half-day’s service for safety considerations, but I had an appointment with the director of the hospital, Dr. Alex Bakiet. I took a motor taxi and headed for the hospital. Dr. Bakiet studied in China from 1974-1989, where he

received his doctoral degree in medicine from Shanghai Medical University. Dr. Bakiet complained:

Friendship doesn't mean that you should not do the work. Yes, you come to show yourself and understand what our problems are, then help us from the things which we need. They came to do the assessment, but nothing was done. I don't count it. They came empty handed. They didn't bring the tools. Especially orthopedics. The patients are here since last June. They came to assess the patients and they went. You come with the tools. They were just talking as they used to talk. Talking is not enough. They didn't bring the tools and things to do the job. We can do the things if the tools are there. We don't have the tools for skin graft. They saw the patients and did the assessment. The patients have had wound for months, we can do the things if the tools are there. Some of them are happy with the drug distribution, but they are not happy with no operations. Time is too short. Two weeks would be better.

He then compared the Chinese medical team with the Egyptian medical team, which visited Wau for a campaign in 2015. They first came to assess the situation. When they came back, they came with a full plane. Even the dentist came with facilities that can perform dental tumors. 350 major operations. 1000 cataract operations were performed.

Dr. Bor, the director of Gogrial State Hospital, shared the same level of dissatisfaction:

Regarding the surgical department, we expected a larger number of cases. Two cases were performed. One is a gunshot, the other is a hernia. It is not satisfactory. We had booked for one hundred. Most of them are hernia patients. Next time, China should send an expert surgeon. The senior doctor is better. He is an expert, also he treats patients with orthopedics, but due to lack of materials, he couldn't do much work. Orthopedist depends on the materials, X-ray, without them you cannot diagnose.

Even some of the Chinese doctors felt that the campaigns were a waste of resources. “We are putting more focus on the form rather than the content.”

5.8 Two Scenarios of Medical Campaigns

Short-term medical campaigns are an inherent part of humanitarian action in the contemporary world. Drawing on an ethos of compassionate care (Hardiman 2006), contemporary humanitarian action sets out with an agenda of emergency relief in war-torn areas, or places hit by disasters. Bearing in mind “humanitarian reason” (Fassin 2012), the outsiders’ actions “expose new vulnerabilities, mark new terrains and gain control over new bodies” (Beshar and Stellmach 2017). Short-term medical campaigns have established a set of targets and rules of their own. They are initiated as moral responses to human suffering, which is distinctive of Christianity. Medical campaigns in Africa are essentially set out as projects featuring the moral obligations of Western countries to the continent immersed in suffering.

The “emergency imaginary” (Calhoun 2004) is a powerful mechanism giving play to people’s desire to help others. As an integral part of “global health machinery” (Gaines 2011), short-term medical campaigns are grappling with “tensions, opportunities and limits” (Redfield 2012). Thanks to roots in Christianity, short-term medical campaigns are tasked with suffering and oriented towards the elimination of suffering. “Suffering subjects” and “minimal biopolitics” are conferred by the rubric of

humanitarianism. The dominant biopolitical ethics assumes that crises produce suffering subjects waiting to be saved. The soteriological theology (Nguyen 2016)) of Christian missionary medical efforts remains a powerful driver of biomedical and global health programs.

As a significant part of global health, short-term medical campaigns have also become “a standalone industry,” (Abramowitz and Panter-Brick 2015) building on a liberal ethic of “giving back” and “doing good”, or in the words of Teju Cole, “white savior industrial complex” (2012). The fistula campaign in Juba, for instance, has drawn on the concerted efforts of WAHA and UNFPA, with UNFPA providing the surgical kits, including emergency reproductive health kits.

The Chinese medical team’s *Yizhen* does not set out with a discourse of the savior for the suffering. They are informed by a developmental discourse, where the countryside is targeted for future-oriented development. Since its founding, the Chinese government has seen the remote areas as the frontiers for development. In the 1950s, the Chinese government adopted a policy of *songyixiaxiang*, or delivering medicine to the countryside. “The countryside” refers not only to the rural areas as opposed to the city, but also the remote areas or *bianjiang*, such as Gansu, Inner Mongolia, Xijiang and Tibet.

Thanks to Mao’s thought on the Third World, this revolutionary thought was also transferred to African countries, epitomized by a policy of decentralization initiated in China. The remote areas, such as Kuajok, Paloich and Torit, are all imagined as part of

the countryside. It is different from the model of emergency relief where international organizations and foreign expats rush to people in precarious situations. The alleviation of poverty and economic/social development are the two dimensions of the campaigns of Chinese medical teams. Humanitarian reason has not been enlisted as a powerful discourse in China's medical campaigns in South Sudan and Africa at large. Moreover, the Chinese medical team's campaigns have so far not followed the discourse of global surgery, or a "surgical epidemiology" (Thind et al. 2012).

Nonetheless, *Yizhen*, which focuses mostly on the assessment of general health conditions, reflects a continuation of China's medical discourse. It shows China's construction of the countryside, and the type of medical service it was once committed to in Mao's time, both in and out of China. But when humanitarianism, human rights and emergency imagining are defining the contemporary global health order, China's approach to medical campaigns is falling out of fashion. Even Chinese medical teams are reconsidering their way of engaging *Yizhen*, such as syndicated medical campaigns.

6. “They Come as God’s Doctors”

In 2015, a Chinese anesthetist who was working at Juba Teaching Hospital asked a colleague, Dr. Felix, to give him a Bible to read. Until then, he had never been exposed to Jesus Christ or Christianity. After witnessing Dr. Felix and other South Sudanese colleagues praying for patients before surgery, he became interested in religion. He ended up visiting the church of Dr. Felix, who was also a pastor. But he never told Chinese colleagues about this visit, as the Chinese medical team forbids its members to visit religious institutions.

On another occasion, a Chinese pediatrician who went to a Sunday service at St. Joseph’s Church with her colleagues was given a warning, because the team was not allowed to visit local churches without the approval of their supervisors at the Embassy. Nonetheless, despite their scientific approach to medical care, Chinese doctors are closely tied to the world of religion in South Sudan.

The debate between magic, science and religion has been a recurring one among anthropologists. Bronislaw Malinowski, for example, documented that, for Trobriand Islanders, invoking spiritual assistance was a typical means of managing uncertain outcomes (Malinowski 1932). Similarly, E. E. Evans-Pritchard examined related questions of causality and attribution for misfortune among the Azande. He demonstrated that “Why now?” and “Why me?” were questions that could be answered satisfactorily through witchcraft (Evans-Pritchard 1963). Both discussions promoted anthropological

debates along these lines (Lienhardt 1961). The debates suggested that it is not only Trobriand Islanders or the Azande who seek assistance and explanation from deities and spirits, but modern peoples as well.

The entangled relationship between science and religion is particularly evident through the body, medicine and care that get extended into the social world. In 1973, Marcel Mauss produced one of the earliest anthropological accounts of the body and noted that every aspect of bodily movement—from breathing to marching to swimming—was specific to a society. Building on Mauss’ work, Mary Douglas argued that:

...the social body constrains the way the physical body is perceived. The physical experience of the body, always modified by the social categories through which it is known, sustains a particular view of society. There is a continual interchange between the two kinds of bodily experience so that each reinforces the categories of the other. ... Douglas argued that “the care that is given to [the body], in grooming, feeding and therapy, the theories about what it needs in terms of sleep and exercise, about the stages it should go through, the pains it can stand, its span of life, must correlate with categories in which society is seen in so far as these draw upon the same culturally processed idea of the body” (Douglas 1973).

The social implications of the body are evident not only in the cosmogony and practice of traditional medicine but also in biomedicine. As Ludwik Fleck stated in *Genesis and Development of a Scientific Fact* (1979), biomedicine is the product of the social, political and cultural values which support it, and which in turn it supports.

Anthropologists and historians have also debated the religious meaning of social suffering and its connection with morality and humanity. In their analysis of social suffering (2016), Wikinson and Kleinman contend that the “social” was recognized as infused with moral meaning; it was taken as issuing a call for urgent action to combat human suffering and caring for humanity, which can be attributed to the teachings of Christianity.

In his account of the social history of ancient medicine, Ferngren (2009) discusses the importance of suffering in daily medical care in Christianity:

Christian understanding of suffering as salutary, moreover, not only deprived the sick person of stigmatization but gave him or her a purpose with which to endure suffering. The Christian life constituted a fellowship of suffering that united Christians with their Lord and with other believers. The purpose of suffering in the Christian life was to edify and to prepare one for eternal glory in heaven. The value of suffering for the Christian is a theme that is found in the fathers, mixed with an element of popular Stoicism that sometimes seems to glorify suffering but in fact attempts to persuade Christians who wish to avoid suffering that they should accept it for their soul's good.

According to Ferngren, Christianity was characterized by a strong emphasis on philanthropy that urged both individual and corporate care of those in need. Unlike the classical world, Christianity rooted its attitude to philanthropy in theology. The impulse behind Christian philanthropy was encouraging a self-giving love of one's fellow human beings that reflected the love of God in the Incarnation of Christ and his death for the redemption of the world. The suffering that Christians experienced under persecution

prepared them to engage in a program of comfort, consolation, and encouragement, first to fellow Christians and then to others outside their community of faith.

The US Conference of Catholic Bishops summarizes the similar care rendered by Catholics:

The mystery of Christ casts light on every facet of Catholic health care: to see Christian love as the animating principle of health care; to see healing and compassion as a continuation of Christ's mission; to see suffering as a participation in the redemptive power of Christ's passion, death, and resurrection; and to see death, transformed by the resurrection, as an opportunity for a final act of communion with Christ. (2012)

In this chapter, I will highlight the technical feature of the practice of Chinese medical professionalism South Sudan, in contrast with the soteriological theology of Christian missionary medical endeavors. In the theology of salvation the discourse of suffering still defines the human condition (Good 1994).

In a post-war country like South Sudan, technical solutions are not necessarily generated by a moral imperative informed by Christianity and therefore form an ethics of their own. I regard "being technical" the possibility of being modern and progressive and suggesting a future. In accessing medical techniques and medical professionals from China, the South Sudanese associate themselves with a different philosophy of care, moving away from the label of "suffering bodies" conferred by the rubric of humanitarianism. Medical techniques produce the ambient conditions of everyday life – for individuals and society, for the body and the spirit.

6.1 “*God is Great*”

Faith-based healing and care is entrenched in Africa. Good health is usually understood in terms of the relationship with one’s ancestors. Health among Africans is not based merely on how it affects the living, because it is of paramount importance that the ancestors stay healthy so that they can protect the living (Iroegbu 2005). In this understanding, good health is also believed to be the result of appropriate behavior; that is, living in accordance with the traditional values and norms of society (ibid.: 82). Traditional medicine has at its center a belief in the interaction between the spiritual and physical well-being of people (Setswe 1999). Good health also includes viewing an individual as a member of the community; therefore, good health also includes good relations with ancestors and the community.

In *Man Cures, God Heals* (1981), Appiah-Kubi analyzes the dilemma confronting the Akans, The emphasis of both priest-healers and faith-healers on communal care for the sick and the less fortunate and total belief in God as the only real source of healing, is a challenge to the missionary-founded churches, whose healing activities are concentrated in the hands of the doctor and vested mainly in hospital-based services.

For centuries, Christianity has had a close relationship with science, which shapes the way people view health and therapies. The authority of science and the appeal of science-based technologies altered the way many Christians thought about healing. Medicine had long served as a metaphor for the antidote for the sickness of sin, and

Christians had often used medicine as part of their outreach to the sick. However, with the development of science-based medicine, Christianity's dominant status and close relationship to medicine were more difficult to maintain (Porterfield 2005). Competition between Christianity and medicine had existed for centuries, and many theologians found it necessary to remind people to rely more on Christ than on ordinary medicine. In modern times, faith healers argued along much the same lines, but their case was more difficult to make, given the new prestige, authority, and efficacy that scientific medicine enjoyed. Modern believers wanted Christianity to be invested with the same kind of validity people attribute to science.

This is true of South Sudan. Daniel Deng, Bishop of Dioceses of Duk, the Episcopal Church of South Sudan & Sudan, told me that doctors in South Sudan get their knowledge from God, so they use their knowledge to help patients.

The doctors from Japan and China are also human beings created in the image of God. The God doesn't differentiate people from them. It brings us together. A Japanese doctor, or a Chinese doctor, God is using him to help the people, no matter he believes in God or not. Who is less to God? Doctors are here on God's behalf. Sanitation is an important message.

When the Chinese doctors visited Gogrial State for medical campaigns, the governor Gregory Deng Kuac also said at the welcoming ceremony, "When you come here, doctors are secondary to God. "

South Sudanese patients believe God decides where they should go and what they should do. In Wau, I met Peter Lau, who brought his wife to visit Chinese gynecologists

at Wau State Hospital. His wife has not given birth for more than two years, and he expects more children. He said: “God is great. He creates us. Our life will also be put in God. When you are praying God, God will help you what you need. If God says stop, I will stop. More boys or girls, it’s the same. Just God will be doing it. We put our hope in God. When God does his work, says the war be finished, it will be finished. God is great. ”

Catholicism and its medical service have a longstanding presence in South Sudan. Since their first travel to southern Sudan in 1857, medical doctors and hospitals have been an integral part of the Comboni Missionaries of the Heart of Jesus. It operated a PHCC in Malakal. In 2014, the hospital was looted. The Comboni House also operated two hospitals in Lake State and Wau.

Nonetheless, Catholic missionaries still maintain a strong presence in South Sudan. In 2016, a Slovakian missionary sister who ran a hospital in South Sudan was ambushed and shot while driving in the town of Yei . Sister Racková, a member of the Holy Spirit Missionary Sisters, was head of St. Bakhita’s Medical Centre in Yei, had served in Italy, Germany, Austria, Ireland, UK, Indonesia, and Ghana. On the night of May 15, while driving an ambulance from a medical center where she had been delivering a baby, Racková was shot. Five days later, she died in hospital in neighboring Kenya.

Missionary medicine's integration of science and faith can be traced to the founding principles of Catholic Medical Missionaries. In *Mission for Samaritans* (1945), Anna Dengel, founder of the Society of Catholic Medical Missionaries, also known as the Medical Mission Sisters (MMS), defined a framework for mission work that combined religious commitment and medical science. She saw it as a "branch of missionary work through which skilled medical care is given to the sick and poor of mission countries, as a means of relieving their physical suffering and bringing to them a knowledge and appreciation of our Faith" (Wall 2015).

Founded in 1925, the MMS was the first group of its kind in the medical field to be both professional and religious. To Mother Anna, the MMS would be "good Samaritans" who would minister to the sick and to those who fell victim to superstition; most important, science and expert knowledge were essential. She also laid the groundwork for social justice, when she wrote "It is the tremendous debt which we, the white race, owe to the peoples subjected and exploited by our forefathers."

6.2 Newly Gained Respect

Chinese doctors and nurses are exposed to religion in and out of the hospitals and clinics. Posters featuring the Virgin Mary and Baby Jesus are hung all over the departments of Juba Teaching Hospital. The Peace Hospital is located next to the Mosque in downtown Juba. Madam Yu, owner of the hospital, complained that when

loudspeakers are broadcasting prayers on the minaret, the noise from the mosque will have a negative impact upon the business of Peace Hospital. She even wanted to talk to the mosque and shut down the loudspeakers. Likewise, the first time I met Mr. Zhong at the Friendship Hospital, he said religion is not a major influence when it comes to the hospital's daily operations.

There is a chaplain at Juba Teaching Hospital, but most patients have no idea where he is. However, prayers are often heard in the wards. Medhat, an Egyptian IT teacher and a Christian, visits Juba Teaching Hospital every Sunday afternoon and gives all the patients in Wards 2, 4, and 5 a soap and ten South Sudanese Pounds. To many patients, he is an acting chaplain in the hospital.

When many of the doctors and nurses are running their private services outside the public hospital, Felix and a few others are guided by the principles of faith and committed to the service.

Dr. Felix, director of the Department of Anesthesia, said his work is for God. Working in the hospital, therefore, is not just a professional job but also an ethical calling. Every morning, he arrives at the hospital on time, although many of his colleagues will not come to the hospital until 10 or 11 am.

He says: "Here, there are many who share the same thoughts. Most of us are church workers. Some are medical assistants, some are pastors. Some of them are true believers of the church. Sometimes patients believe that this medicine will be good

because this medicine comes from the God. This is my commitment to patients, universal humanity and my own welfare.”

Chinese doctors are often astonished by the attitude expressed by South Sudanese patients concerning life and death. For many of the Chinese personnel, working in South Sudan is so much different than in China, as they are almost never confronted by medical complaints and troubles that are all too common in hospitals and clinics in China.

“Doctors are not respected in China, while in South Sudan you win the patients’ respect,” they said.

The new medical conditions make the Chinese doctors and nurses feel as though they have a newly-gained authority and even freedom, which they hardly ever have in China. All the Chinese doctors working in South Sudan feel that they have far more respect in South Sudan.

Dr. Zheng, a physician at the Friendship Hospital, said he would never expect his children to work as doctors, because doctors in China have neither a decent income nor a respected social status. But work in Africa takes on a new meaning for Chinese doctors, as they feel that they have more say over patients’ lives. They feel that the patients show respect for their work, without making complaints or troubles. He says: “We are faced with patient-doctor disputes every day. If you don’t practice well, your practitioner certificate risks being revoked. You are always worried about the risks and

responsibilities if you are a doctor in China. But here in South Sudan, things are different. ”

Chinese doctors are surprised by the obedient attitude of the South Sudanese. South Sudanese patients do what the doctors tell them to do and almost never complain . Dr. Jiang, an anesthetist, observes the different mentality between Chinese and South Sudanese patients, especially the level of patience displayed in the clinic. No one is noisy in South Sudan, whereas in China, as soon as one person has finished consulting the doctor, another person goes straight to the head of the line.

Dr. Zheng told the stories of Mabu and Gugui, two six-year olds. As early as six months old, Mabu started vomiting. The first time his father brought him to the Chinese hospital, they had to sell two cows to cover the medical expenses. Mabu’s family trusted Dr. Zheng. They said if he can cure their son , it shows God’s grace. If there is no way to save his life, that means his life would be taken away by God.

“I will do my best to treat your child,” Dr. Zheng told them. The treatment succeeded, and by the end of two weeks, the boy could drink a half bowl of milk. Gugui, the second boy, was diagnosed with anemia. However, his uncle told Dr. Zheng that, six months after Gugui was released and returned home, he drowned in the river. Zheng said, “They recounted his death in such a way as if he were taken away by God.”

A 45-year-old South Sudanese female patient who was two-months’ pregnant died in the ward. By the time Dr. Zheng went to check on her, she had passed away. Her

husband was choked up in tears, and her mother wept uncontrollably, amidst the crying of her brothers and sisters. The ambulance took the woman away, leaving Dr. Zheng in astonishment. If it happened in China, Dr. Zheng said he would be questioned by the relatives of the deceased. He felt lucky that it happened in South Sudan, and the relatives left in peace without questioning him or even inquiring about the cause of death.

Waiting is a constant thing. Many patients at Juba Teaching Hospital wait patiently at the entrances of doctors' consultation rooms. If there is no electricity, the doctors will not show up, but the patients just stay there waiting. If they cannot get to see the doctors, they come back the next day.

Dr. Xi, a surgeon, observes the stark differences between China and South Sudan, when it comes to informed consent forms, which he attributes to religion. He showed me a consent form at Juba Teaching Hospital, which said:

[Patient's name] do hereby consent for [name] operation or as may be found necessary by the surgeon after having been fully explained to about the outcome of the operations. I further consent for any type of anesthesia to be used during this operation after also having been explained to about the effects and side effects of these drugs.

Whereas in China, consent forms will list all the possible implications during the operations, because verbal expressions do not carry the same legal effect. "I don't know, but I assume that God is their protector and witness. The form was so simple in content – isn't it a form of God or religion?"

Dr. Hu, a pediatrician working in the neonatal department, sees many more deaths than in China. One day, Dr. Hu led her medical team colleagues on a visit to the neonatal ward. The nurse on duty greeted them, “Good morning”. As usual, there was no electricity. They changed their shoes and went into the room to check on the babies. Two baby girls were lying on the two beds. One of them was born last night, while the other had been treated for five days before dying. She had a shriveled skin, a skeletal body, a bulging and swollen belly. She was not breathing. The combination of dehydration, infection, and suffocation took her life. Her mother cried on the sidelines of the ward. The nurse on duty walked in and said calmly: “Two babies died.” Dr. Hu was silent for a moment and then repeated: “I’m sorry, I’m sorry to hear this. I’m sorry to hear this.”

“I’ve been accustomed to death for so many years in clinical settings but seeing such a dehydrated and skinny child in such a dark and secluded room, it was still a bit challenging.” Dr. Hu’s eyes were wet, and she was sorry that the first time her colleagues at the medical team came to visit the neonatal ward, they were exposed to such a heartbreaking scene.

The rain stopped, and the director of the newborn ward arrived. The nurses informed the director about what had happened. He and the crying mother chatted a while and told Dr. Hu that this was the mother’s ninth child. She was suffering from malnutrition, without breast milk or money to buy milk and drugs. She blamed herself for the sufferings of her child. Then the director comforted her that the baby is already in

peace, where there will be no trouble or pain. He took out fifty South Sudanese Pounds from his pocket and asked the mother to bury her dead child.

The Chinese doctors said that, compared with Chinese patients, South Sudanese patients tend to trust doctors and nurses.

When I met Asia, a Moro woman, she was undergoing treatment at Juba Teaching Hospital . She was from West Equatoria, but fled the Zandeland in 2016, after the war broke out . Ten years ago, her husband went to Khartoum and never returned to South Sudan. She was living with her three children in Maridi. In 2000, Asia developed a huge parotid tumor. She can feel the burning inside and outside her cheeks, and it does not feel right. It has been growing. She had consulted different doctors and treatments to no avail. The doctors had given her amoxicillin, but it had no effect. Through her friend, Julie, who was working in the Department of Anesthesia, she sought help from the Chinese doctors.

Asia, her sister, Mary, and brother-in-law, Musa sit on the ground in front of the theater and talk about the availability of Chinese doctors. Unlike South Sudanese doctors, the Chinese doctors are around, they said. Mary said, “God will be with her. God will be there to help her.”

Dr. Xi said that in China, such a large tumor is inoperable, but Asia put her trust in the Chinese doctors. “I’m not fearing. I want to do it. Because I want to do it, nothing will happen.”

The South Sudanese perceptions on life and death make the Chinese doctors contemplate morality. Dr. Xi said, “A country without faith is morally weak. From life to death, from being sick to dying, South Sudanese patients accept them as part of God’s creation and can accept life as it is.”

He talked with Asia and told her that, if the tumor was not benign, further treatment would be required. Asia did not display any fear or distrust. According to Dr. Xi: “If this is in China, I simply can’t do it. In China, we talk a lot with the patients, and we can’t guarantee that the five facial nerves are pulled out. The tumor is very large, and we don’t know whether it is benign or malignant. The department of stomatology can’t guarantee that a surgery like this will succeed, not to mention us.”

6.3 Good Heart, Care and Commitment

When it comes to medical care in South Sudan, commitment is a key word. Sister Elena Balatti, a Comboni missionary, talked to me about the importance of commitment in health care: “When you have a healthy facility run by the Catholic church, the leadership of that facility is selected among the people who are really committed, because there are many parts of gospels that inspire people’s service in this aspect. Any sickness is brought to Jesus, and he looks after them. God wants people to be well. That’s the message. God creates people not to be sick but to be well.

She went on to say, “Commitment is to look at another person as a human being. Sometimes the doctors and nurses work like machines. To be committed is not to see another person as work to do, not as an object. It’s not a duty. It comes from a person’s good heart.”

Healing, in the Catholic sense, involves the whole person. As Sulmasy put it:

To heal is to restore the state of right relations in a whole person. A healer whose own relations are set right is naturally in a better position to heal. One starts with one’s own spirituality, one’s own relationship with the transcendent, one’s own experience of the Numinous One. To be an effective healer requires the true self-knowledge that comes only from a spiritual source. ‘What a person is before God, that he is, and no more,’ say the Admonitions of St. Francis...Once one knows who one is in relationship to God, all other relationships fall more easily into place, including one’s relationship with patients (2006)

For Dr. Xi, however, what matters is not whether or not God exists: “If their belief contributes to a better person, that’s a good thing. But it does not necessarily mean that we as medical professionals have to believe in it. With the progress of science and technology, we may determine if God exists or not. But given the current circumstances of South Sudan, if God helps them accept life the way it is, religion is a good thing, with the potential of *zhengnengliang* (bringing positive energy).”

South Sudanese have also observed the lack of care on the part of Chinese doctors. James, a Ugandan lab technician at one of the Chinese hospitals said that he doesn’t see the care and commitment of Chinese doctors to their patients. Working with the Chinese

and with Marie Stopes International, he feels that it is a little different working with the Chinese:

They don't feel the patient. They don't try to give that focus and that care. According to our medical ethics, a patient coming to the hospital is your first priority focus. Whatever a patient is lame or poor, when he comes to the hospital, he needs your attention and care. It is really not what most Chinese hospitals are focused on here in Juba. They are focused on get me what you want, I give my services. What I mean by what I want, is show me, give me the receipt card you paid, I give my services, still I won't give my services all. Maybe they know the medical ethics, but they don't apply it. They are not following the ethics. All Africans know the ethics. It is a rule governing your medical profession, no matter what level you are.

James continued:

Medical for me, is like a call. In this way, for you to become a chief Buddhist, a priest, you wake up one day. During the process, you did it very well, but you don't have that hot. So you focus on one job because you don't want to be flawed. I knew it. I told myself one day I want to become a doctor. You work for it. I have seen my colleagues who try to become doctors because they don't have the passion. A patient should be the first priority for the doctor.

But even among South Sudanese, there are different understandings of the commitment of Chinese doctors. Malith, a young man drinking tea outside of Peace Hospital, said:

Your difference with other white doctors is you have a lot of commitment. Secondly, your things are cheaper to be accessible. But for other whites, attitude is not good. You are a bit more related with human beings. You have humanity. You are grounded. The whites think they are supreme people. That's what we call inferior complex. That's what they expose to us. That they are higher than other human beings, which is not the case with medical care. You need to deal with people at their own level. But the whites come and say, the South Sudanese are more stupid, they are poor.

The Chinese doctors feel that they do not need to express verbally their concern to the patients all the time. As long as they do what they should do, that is already a form of care. Dr. Xi said:

You don't need to express 'care' in the operation theater. As doctors, we are doing the same thing and committed to our work. We are doing the same things, which are not different in nature. Regardless of the institution and ideologies we represent, we are fulfilling the responsibility of doctors. Juba Teaching Hospital should not be a place for political factions. A hospital is a place that needs to be coordinated. Doctors should not be get involved in politics. As long as the patients get injured, they should get treatment. Nazi doctors should also treat Jews, and medicine is pure natural science. We are just doctors, using our expertise to help local people. Whether it is a national medical team or *Doctors Without Borders*, this is what a doctor should do. We just use our expertise and technique to treat patients.

For the Chinese doctors, expertise and professionalism are the keys to care. Dr. Jiang, the anesthetist, was trying to apply anesthesia in the department. She found that her South Sudanese colleagues finish a session in a short period of time. They don't care what state the patient is in. The first time she worked in the theater, she was surprised to find the patient, a woman in her 30's, tied down on the theater bed. The woman's eyes were kept open during the entire e process. "This posture would make the patient feel very tired and she can hardly fall sleep. They are even talkative and active throughout the whole process."

When Jiang first arrived at Juba Teaching Hospital, there was a patient whom she wanted to sedate. Her South Sudanese colleagues did not give her permission. The

Chinese medical team donated a lot of Midazolam, but her colleagues did not like it.

When she wants to give a patient 2 mg of Midazolam, she can only administer it secretly, and the patient falls asleep. In contrast, South Sudanese doctors hope that the patient will be lying down all the time, with eyes wide open. From head to toe, patients are tied down on the theater bed, like Jesus on the Cross. As long as the patients are not in pain, her colleagues basically do not talk to them.

Dr. Jiang uses her approach to comfort South Sudanese patients. When they enter the operating room, she will hold their hands. “Don’t be nervous, I will make you feel comfortable.” The 2mg of Midazolam will make the patients feel much more comfortable, Jiang said.

The Chinese doctors’ emphasis on professional work has been observed for some time. Reec, a banker, recalled his encounter with the Chinese doctors. In 1974, he took his uncle, who had a hernia, to a Chinese doctor at Juba Regional Hospital. “The British, the Americans, they were loitering around, but the Chinese did a nice job.” Reec’s uncle had an operation for appendicitis. “They represented China in a very good way. They were just concentrated on the good work. It was just purely professionalism. They followed their profession.”

For about a year, from September 1974, to October 1975, Dr. Bullen, a medical assistant in the eye department, was assigned to work with Dora, a Chinese eye surgeon at Juba Regional Hospital. He said that it was a good time with her. “By God’s chance, I

met her.” The work she did was very good and appreciated. She was the one of the surgeons, taking charge of the ward. Bullen recalled, “The Chinese worked for 16 hours. We worked for 8 hours. There was no comparison to the Chinese’ work. They are ones cooking for themselves. They are the ones attending to OPD. They are the ones working in the raining days. They are appreciated. They work all the time.”

With the advent of commercialized service in Chinese private hospitals, the South Sudanese are experiencing less care. The Peace Hospital rented premises from the Catholic Archdiocese of Juba, but, from time to time, there are conflicts between the hospital and the church.

Samuel Abe Joseph, Administrator for Church Assets, complained of the negligence of the Peace Hospital when treating patients. He said the Chinese medical business is geared towards business, and they don’t put emphasis on care. “Sometimes after the patient dies, or after a major operation, no nurse is assigned to observe the patient for at least 24 hours. The patient is just left like that.”

One of Joseph’s nephews was having hip replacement surgery in January 2016. Joseph went to see him in the evening after surgery. He died in the morning. Joseph was angry that no nurse was assigned to take care of his nephew, and that only his relatives were caring for him. After 4 hours, the patient should be given food and water, but the soup he ate was given by family members. Joseph said, “The care was insufficient. If

the hospital is only concerned of making money instead of caring for the patients, it is not good. They don't care whether you are dying or not.”

Care is insufficient, even in public medical facilities. either. As Sabina, a nurse at Juba Teaching Hospital, put it: “This is a zero-level care. Negative five in terms of care. For us, we live inhuman conditions. How do I care for the patients when you don't have the facility? I am even not interested. When you stay in one place and nothing changes, you become pessimistic. China's existence at least makes things better.”

6.4 Alternatives to Religion-informed Care

In South Sudan, I was repeatedly reminded of Hebrews 12:4-13, *God Disciplines His Children*, which reads:

4 In your struggle against sin, you have not yet resisted to the point of shedding your blood.

5 And have you completely forgotten this word of encouragement that addresses you as a father addresses his son? It says, “My son, do not make light of the Lord's discipline, and do not lose heart when He rebukes you,

6 because the Lord disciplines the one He loves, and He chastens everyone. He accepts as His son.”

7 Endure hardship as discipline; God is treating you as His children. For what children are not disciplined by their father?

8 If you are not disciplined—and everyone undergoes discipline —

then you are not legitimate, not true sons and daughters at all.

9 Moreover, we have all had human fathers who disciplined us and we respected them for it. How much more should we submit to the Father of spirits and live!

10 They disciplined us for a little while as they thought best; but God disciplines us for our good, in order that we may share in His holiness.

11 No discipline seems pleasant at the time, but painful. Later on, however, it produces a harvest of righteousness and peace for those who have been trained by it.

12 Therefore, strengthen your feeble arms and weak knees.

13 “Make level paths for your feet,” so that the lame may not be disabled, but rather healed.

As a pastor said to me, “It is suffering today but a joy tomorrow.” Religion shapes the ways in which South Sudanese perceive their life. Because of the impact of long-lasting civil wars, life is constantly changing, challenging, and unpredictable. Following the revival of Christianity in the 1990s, there has been yet another revival of religion after the two recent civil wars and an increase in the number of preachers in Juba.

Wilkinson and Kleinman (2016) critique the tendency to brush aside considerations of the social worlds of patients in favor of technological advances. In their view, a thorough understanding and appreciation of the cultural milieus of the people – their concepts of health and disease, religion and life as a whole – if of cardinal importance. They take note of notice a significant shift in human suffering, which is no

longer being addressed as a problem for religious instruction or spiritual healing but is being described as a moral outrage, inspiring a demand for investigation and concerted efforts at social reform.

Suffering remains an influential religious and ethical category in South Sudan. An understanding of the human body and health care in South Sudan is expected to start from an insight into suffering and suffering bodies. The Chinese doctors are more focused on “good work” in a professional sense than “care” in a religious sense. In doing so, they are charting a new “regime of living” (Collier and Lakoff 2005).

7. Conclusion

South Sudan is described as a horrible, neglected place needing medical humanitarianism; China's long-standing medical programs in the country complicate this donor-recipient narrative. Humanitarianism in this context is different from Fassin's definition. The Chinese approach to medicine in South Sudan moves away from the emergency-run aid characterizing the international community's medical service in this country.

China's medical teams sent to southern Sudan (1971-1985), the resumption of this mode of medical aid after South Sudan gained independence, and the burgeoning hospitals run by the Chinese are all testimonials to South Sudan's central place in transcontinental interactions, characterized by East-South collaboration and global capitalism behind the medical expertise.

This trend towards globalization distances itself from the global liberal order because of a continuation of "Third World" cooperation arising in the African Independence Movement in the mid-20th century. Highly specialized medical teams from China's Anhui Province and contemporary "barefoot doctors" from Henan and other provinces in China have joined the mobility movement. "The global" in this case is a composite of different temporal and spatial dimensions. Going beyond a place associated with wars and ethnic killings, South Sudan is a hotspot for "revolutionary" thought and market opportunities in the sphere of medical mobility.

The business model and aid model are interrelated, with both retaining the Maoist ideology of the 1960s, which is based on the assumption that medicine can travel to the frontier (*bianjiang*). In other words, South Sudan translates as “the countryside” for purposes of technological development. Although they work in different socio-medical spaces, both “barefoot doctors” and medical teams are regarded by South Sudanese as signifiers of new knowledge and expertise. Revolution shaped China’s medical programs in Africa, but different than France, the Chinese version revolution was not informed by the Enlightenment. Compassion politics is not a core component of China’s international programs. A radical approach to medicine has shaped the geographical landscape of China’s medical transnationalism, embodied by the spaces and human resources. However, the post-Maoist period does not necessarily mean the demise of such a powerful thought in modern times.

Bibliography

- Abramowitz, Sharon Alane, and Catherine Panter-Brick, eds. 2015. *Medical humanitarianism : ethnographies of practice*. Philadelphia: University of Pennsylvania Press.
- Agamben, Giorgio. 1998. *Homo sacer : sovereign power and bare life*. Stanford: Stanford University Press.
- Alden, Chris. 2007. *China in Africa*. London ; New York; Cape Town, South Africa: Zed Books.
- Anderson, Kevin Taylor. 2010. "Holistic medicine not "torture": Performing acupuncture in Galway, Ireland." *Medical anthropology* 29 (3):253-277.
- Antze, Paul, and Michael Lambek, eds. 1996. *Tense past: Cultural essays in trauma and memory*. New York, London: Routledge.
- Appiah-Kubi, Kofi. 1981. *Man cures, God heals : religion and medical practice among the Akans of Ghana*. . New York: Friendship Press.
- Arnold, David, ed. 1988. *Imperial medicine and indigenous societies*. Manchester: Manchester University Press.
- Barnes, Linda L. 2005. "American acupuncture and efficacy: meanings and their points of insertion." *Medical Anthropology Quarterly* 19 (3):239-266.
- Barnett, Michael N. 2011. *Empire of humanity: a history of humanitarianism*. Ithaca: Cornell University Press.

- Barnett, Michael N., and Janice Gross Stein, eds. 2012. *Sacred aid: faith and humanitarianism*. New York ; Oxford: Oxford University Press.
- Barrett, Robert J., and Janis D. Jenkins, eds. 2004. *Schizophrenia, culture, and subjectivity: the edge of experience*. New York: Cambridge University Press.
- Bass, Gary Jonathan. 2008. *Freedom's battle: the origins of humanitarian intervention*. New York: Knopf.
- Beinart, William, Karen Brown, and Daniel Gilfoyle. 2009. "Experts and expertise in colonial Africa reconsidered: science and the interpenetration of knowledge." *African Affairs* 108 (432):413-433.
- Bell, Heather. 1999. *Frontiers of medicine in the Anglo-Egyptian Sudan, 1899-1940*. Oxford: Clarendon.
- Berry, Nicole S. 2014. "Did we do good? NGOs, conflicts of interest and the evaluation of short-term medical missions in Sololá, Guatemala." *Social Science & Medicine* 120:344-351.
- Beshar, Isabel, and Darryl Stellmach. 2017. "Anthropological approaches to medical humanitarianism." *Medical Anthropology Theory*.
- Biehl, João, and Adriana Petryna, eds. 2013. *When people come first: critical studies in global health*. Princeton, New Jersey: Princeton University Press.
- Bodomo, Adams. 2012. *Africans in China: a sociocultural study and its implications on Africa-China relations*. Amherst, NY: Cambria Press.
- Bornstein, Erica, and Peter Redfield, eds. 2011. *Forces of compassion : humanitarianism between ethics and politics*. Santa Fe: School for Advanced Research Press.

- Brautigam, Deborah. 2009. *The dragon's gift : the real story of China in Africa*. Oxford; New York: Oxford University Press.
- Brotherton, Sean P. 2013. "Fueling la Revolución: Itinerant physicians, transactional humanitarianism, and shifting moral economies in post-Soviet Cuba." In *Health travels: Cuban health (care) on and off the island*, edited by Nancy J. Burke, 129-53. Berkeley: California University Press.
- Bruno, Latour. 1993. *We have never been modern*. Cambridge: Harvard University Press.
- Calhoun, Craig. 2004. "A world of emergencies: Fear, intervention, and the limits of cosmopolitan order." *Canadian Review of Sociology* 41 (4):373-395.
- Chan, Stephen, ed. 2013. *The morality of China in Africa : the Middle Kingdom and the Dark Continent*. London: Zed Books.
- Chappatte, André. 2014. "Chinese Products, Social Mobility and Material Modernity in Bougouni, a Small but Fast-Growing Administrative Town of Southwest Mali." *African Studies* 73 (1):22-40.
- Cheng, Yinghong. 2009. *Creating the "new man" : from Enlightenment ideals to socialist realities*. Honolulu: University of Hawai'i Press.
- Citrin, David. 2010. "The anatomy of ephemeral healthcare: "health camps" and short-term medical Voluntourism in remote Nepal." *Studies in Nepali History and Society* 15 (1):27-72.
- Cole, Teju. 2012. "The White-Savior Industrial Complex." *The Atlantic*.
- Collier, Stephen J., and Andrew Lakoff. 2005. "On Regimes of Living." In *Global assemblages : technology, politics, and ethics as anthropological problems*, edited by Aihwa Ong and Stephen J. Collier. Malden, MA: Blackwell Publishing.

- Collier, Stephen J., and Aihwa Ong, eds. 2005. *Global assemblages : technology, politics, and ethics as anthropological problems*. Malden, MA: Blackwell Publishing.
- Collins, Peter, and Anselma Gallinat. 2013. *The ethnographic self as resource: Writing memory and experience into ethnography*. New York: Berghahn Books.
- Comaroff, Jean. 1993. "The diseased heart of Africa." In *Knowledge, power and practice: The anthropology of medicine and everyday life*, edited by Shirley Lindenbaum and Margaret Lock. Berkeley: University of California Press.
- Comaroff, John L., and Jean Comaroff. 1992. *Ethnography and the historical imagination*. Boulder: Westview Press.
- Crozier, Anna. 2007. *Practising colonial medicine : the Colonial Medical Service in British East Africa*. London ; New York: I. B. Tauris.
- Cruikshank, Alexander. 1962. *The kindling fire: medical adventures in the southern Sudan*. London: Heinemann.
- Csordas, Michael J, and Elizabeth Lewton. 1998. "Practice, performance, and experience in ritual healing." *Transcultural Psychiatry* 35 (4):435-512.
- Das, Veena. 2007. *Life and words : violence and the descent into the ordinary*. Berkeley: University of California Press.
- Davey, Eleanor. 2015. *Idealism beyond borders : the French revolutionary Left and the rise of humanitarianism 1954-1988*. Cambridge: Cambridge University Press.
- De Waal, Alex. 1998. *Famine crimes: politics & the disaster relief industry in Africa*. Bloomington: Indiana University Press.

- Debos, Marielle. 2016. *Living by the gun in Chad : combatants, impunity and state formation*. London: Zed Books.
- Dilger, Hansjörg, Abdoulaye Kane, and Stacey Ann Langwick, eds. 2012. *Medicine, mobility, and power in global Africa : transnational health and healing*. Bloomington: Indiana University Press.
- Evans-Pritchard, E. E. 1963. *Witchcraft, oracles and magic among the Azande*. Oxford: Clarendon Press.
- Falzon, Mark-Anthony, ed. 2009. *Multi-sited ethnography : theory, praxis and locality in contemporary research*. Farnham, England ; Burlington, VT: Ashgate.
- Fang, Xiaoping. 2012. *Barefoot doctors and western medicine in China*. Rochester: University of Rochester Press.
- Farmer, Paul E., and Jim Y. Kim. 2008. "Surgery and Global Health: A View from Beyond the OR." *World Journal of Surgery* 32 (4):533-536.
- Farquhar, Judith. 1994. *Knowing practice: The clinical encounter of Chinese medicine*. Boulder, CO: Westview Press, .
- Fassin, Didier. 2009. "Another Politics of Life is Possible." *Theory, Culture & Society* 26 (5):44-60.
- Fassin, Didier. 2012. *Humanitarian reason : a moral history of the present*. Berkeley: University of California Press.
- Fassin, Didier, and Mariella Pandolfi, eds. 2010. *Contemporary states of emergency : the politics of military and humanitarian interventions*. New York; Cambridge, Mass.: Zone Books.

Ferguson, James. 2006. *Global shadows : Africa in the neoliberal world order*. Durham: Duke University Press.

Ferngren, Gary, B. 2009. *Medicine & health care in early Christianity*. Baltimore: Johns Hopkins University Press.

Finkler, Kaja. 1991. *Physicians at work, patients in pain : biomedical practice and patient response in Mexico*. Boulder: Westview Press.

Fleck, Ludwik. 1979. *Genesis and development of a scientific fact*. Chicago: University of Chicago Press.

Fox, Fiona. 2001. "New humanitarianism: does it provide a moral banner for the 21st century?" *Disasters* 25 (4):275-289.

French, Howard W. . 2014. *China's second continent : how a million migrants are building a new empire in Africa*. New York: Alfred A. Knopf.

Gaines, Atwood D. 2011. "Millennial medical anthropology: from there to here and beyond, or the problem of global health." *Culture, Medicine, and Psychiatry* 35 (1):83-89.

Goldstone, Brian, and Juan Obarrio, eds. 2016. *African futures : essays on crisis, emergence, and possibility*. Chicago ; London: University of Chicago Press.

Good, Byron. 1994. *Medicine, rationality, and experience : an anthropological perspective*. Cambridge ; New York: Cambridge University Press.

Gramizzi, Claudio 2014. Tackling illicit small arms and light weapons and ammunition in the Great Lakes and the Horn of Africa. Saferworld.

- Grundmann, Christoffer H. 2014. "Sent to Heal! About the Biblical Roots, the History, and the Legacy of Medical Missions." *Christian Journal for Global Health* 1 (1):6-15.
- Hardiman, David, ed. 2006. *Healing bodies, saving souls : medical missions in Asia and Africa*. Amsterdam ; New York: Rodopi.
- Harvey, David. 1990. *The condition of postmodernity : an enquiry into the origins of cultural change*. Oxford; New York: Blackwell.
- Haskell, Michael L. 1985. "Capitalism and the origins of the humanitarian sensibility, Part 1." *The American Historical Review* 90 (2):339-361.
- Hebeishengweishengting. 1975. *Acupuncture and moxibustion : a handbook for the barefoot doctors of China*. Translated by I. Lok Chang, Nathaniel Macon and Martin Elliot Silverstein. New York: Schocken Books.
- Hobsbawm, Eric, and Terence Ranger, eds. 1983. *The Invention of tradition*. Cambridge; New York: Cambridge University Press.
- Hsu, Elisabeth. 1999. *The transmission of Chinese medicine*. Cambridge, U.K. ; New York: Cambridge University Press.
- Hsu, Elisabeth. 2002. "'The medicine from China has rapid effects': Chinese medicine patients in Tanzania." *Anthropology & Medicine* 9 (3):291-313.
- Hsu, Elisabeth. 2008. "The history of Chinese medicine in the People's Republic of China and its globalization." *East Asian Science, Technology and Society: An International Journal* 2 (4):465-484.
- Hsu, Elisabeth. 2012. "Mobility and Connectedness: Chinese Medical Doctors in Kenya." In *Medicine, Mobility, and Power in Global Africa: Transnational*

Health and Healing, edited by Hansjörg Dilger, Abdoulaye Kane and Stacey Ann Langwick. Bloomington: Indiana University Press.

Hunt, Nancy Rose. 2016. *A nervous state : violence, remedies, and reverie in colonial Congo*. Durham: Duke University Press.

Hutchison, Alan. 1976. *China's African revolution*. Boulder: Westview Press.

Iiffe, John. 1998. *East African doctors : a history of the modern profession*. Cambridge; New York: Cambridge University Press.

Ingold, Tim. 2013. *Making: anthropology, archaeology, art and architecture*. Milton Park, Abingdon, Oxon: Routledge.

Iroegbu, Patrick E. 2005. "Healing insanity: Skills and expert knowledge of Igbo healers." *Africa Development* 30 (3).

Jackson, Jean E. . 2000. *Camp pain: talking with chronic pain patients*. Philadelphia, PA: University of Pennsylvania Press.

Jenkins, Janis H. 1998. "The medical anthropology of political violence: A cultural and feminist agenda." *Medical Anthropology Quarterly* 12 (1):122-131.

Kaptchuk, Ted J. 2002. "Acupuncture: theory, efficacy, and practice." *Annals of Internal Medicine* 136 (5):374-383.

Keane, Webb. 2016. *Ethical life: its natural and social histories*. Princeton: Princeton University Press.

Kleinman, Arthur. 1997. *Writing at the margin: Discourse between anthropology and medicine*: Univ of California Press.

- Kleinman, Arthur M. 1973. "Medicine's symbolic reality: on a central problem in the philosophy of medicine." *Inquiry* 16 (1-4):206-213.
- Krause, Kristine. 2008. "Transnational therapy networks among Ghanaians in London." *Journal of Ethnic and Migration Studies* 34 (2):235-251.
- Lambek, Michael, ed. 2010. *Ordinary ethics : anthropology, language, and action*. New York: Fordham University Press.
- Landa, Apolos. 2007. "Short-term medical missions: a summary of experiences." *Journal of Latin American Theology* 2 (2):104-18.
- Lasker, Judith N. 2016. *Hoping to help: the promises and pitfalls of global health volunteering*. Ithaca: Cornell University Press.
- Lee, Ching Kwan. 2018. *The specter of global China: Politics, labor, and foreign investment in Africa*. Chicago: University of Chicago Press.
- Lee, Christopher J, ed. 2010. *Making a world after empire: the Bandung moment and its political afterlives*. Athens: Ohio University Press.
- Leonardi, Cherry. 2013. *Dealing with government in South Sudan : histories of chiefship, community and state*. Woodbridge, Suffolk ; Rochester, NY: James Currey.
- Li, Decheng. 2007. "Hezuo yiliao yu chijiaoyisheng yanjiu (1955-1983) [Research on Cooperative Medical System and Barefoot Doctor(1955-1983)]." PhD, Zhejiang University.
- Lienhardt, R. G. 1961. *Divinity and experience : the religion of the Dinka*. Oxford: Clarendon Press.

- Lock, Margaret, and Judith Farquhar, eds. 2007. *Beyond the body proper : reading the anthropology of material life*. Durham, NC: Duke University Press.
- MacLeod, Roy M, and Milton James Lewis, eds. 1988. *Disease, medicine, and empire: Perspectives on Western medicine and the experience of European expansion*. London: Routledge.
- Malinowski, Bronislaw. 1932. *Argonauts of the western Pacific; an account of native enterprise and adventure in the archipelagoes of Melanesian New Guinea*. London: G. Routledge & Sons.
- Malkki, Liisa H. 2015. *The need to help: the domestic arts of international humanitarianism*. Durham: Duke University Press.
- Mao, Zedong. 1967. "In Memory of Norman Bethune." *China's Medicine* 87 (5):325-326.
- Mao, Zedong. 1991. *Mao Zedong xuan ji [Selected Works of Mao Zedong]*. Beijing: Ren min chu ban she.
- Marcus, George E. 1995. "Ethnography in/of the world system: The emergence of multi-sited ethnography." *Annual Review of Anthropology* 24 (1):95-117.
- Martin, JoAnn, and Carolyn Nordstrom, eds. 1992. *The Paths to domination, resistance, and terror*. Berkeley: University of California Press.
- McSorley, Kevin, ed. 2013. *War and the body: militarisation, practice and experience*. London, New York: Routledge.
- Minear, Larry. 1991. *Humanitarianism under siege : a critical review of Operation Lifeline Sudan*. Trenton, NJ: Red Sea Press.

- Ministry of Health. 1964. Weishengbu zhaoji de yuanwai gongzuohuiyi qingkuang huibao [Report on the foreign aid work conference convened by the Ministry of Health].
- Mkhwanazi, Nolwazi. 2016. "Medical Anthropology in Africa: The Trouble with a Single Story." *Medical Anthropology* 35 (2):193-202.
- Monson, Jamie. 2009. *Africa's freedom railway : how a Chinese development project changed lives and livelihoods in Tanzania*. Bloomington: Indiana University Press.
- Montgomery, Laura M. 1993. "Short-term medical missions: enhancing or eroding health?" *Missiology* 21 (3):333-341.
- Montgomery, Laura M. 2007. "Reinventing short-term medical missions to Latin America." *Journal of Latin American Theology* 2 (2):84-103.
- Mrázek, Rudolf. 2002. *Engineers of happy land : technology and nationalism in a colony*. Princeton: Princeton University Press.
- Nguyen, Vinh-Kim. 2016. "Anthropology and global health." In *The Ashgate Research Companion to the Globalization of Health*, edited by Ted Schrecker. Farnham, Surrey ; Burlington, VT: Routledge.
- Nordstrom, Carolyn. 1998. "Terror warfare and the medicine of peace." *Medical Anthropology Quarterly* 12 (1):103-121.
- Nordstrom, Carolyn. 2004. *Shadows of war: Violence, power, and international profiteering in the twenty-first century*. . Berkeley: University of California Press.
- Peacock, James L, and Dorothy C Holland. 1993. "The narrated self: Life stories in process." *Ethos* 21 (4):367-383.

- Porterfield, Amanda. 2005. *Healing in the history of Christianity*. New York: Oxford University Press.
- Redfield, Peter. 2012. "The unbearable lightness of ex-pats: double binds of humanitarian mobility." *Cultural Anthropology* 27 (2):358-382.
- Redfield, Peter. 2013. *Life in crisis: The ethical journey of doctors without borders*. Berkeley: University of California Press.
- Rivers, William H. . 1924. *Medicine, magic, and religion : the Fitz Patrick lectures delivered before the Royal College of Physicians of London in 1915 and 1916*. London; New York: Routledge.
- Robbins, Joel. 2013. "Beyond the suffering subject: Toward an anthropology of the good." *Journal of the Royal Anthropological Institute* 19 (3):447-462.
- Rylko-Bauer, Barbara, Linda M Whiteford, and Paul Farmer, eds. 2009. *Global health in times of violence*. Santa Fe: School for Advanced Research Press.
- Sautman, Barry, and Hairong Yan. 2007. "Friends and interests: China's distinctive links with Africa." *African Studies Review* 50 (3):75-114.
- Scarry, Elaine. 1985. *The body in pain: the making and unmaking of the world*. Oxford: Oxford University Press.
- Scheper-Hughes, Nancy, and Philippe I Bourgois, eds. 2004. *Violence in war and peace*. Malden, MA: Blackwell.
- Setswe, Geoffrey. 1999. "The role of traditional healers and primary health care in South Africa." *Health SA Gesondheid* 4 (2):56-60.

- Shaanxi Provincial Revolutionary Committee. 1972. Shanxisheng yuanwai gongzuo huiyi ziliao [Bulletin on Shaanxi Provincial Foreign Aid Work Conference].
- Shaanxi Provincial Revolutionary Committee. 1975. Guanyu shengweishengju shezhi waishizu de qingshibaogao [Report from the Provincial Health Bureau requesting for setting up a foreign affairs group].
- Small Arms Survey. 2009. Supply and demand: Arms flows and holdings in Sudan.
- Sneath, David, Martin Holbraad, and Morten Axel Pedersen. 2009. "Technologies of the imagination: An introduction." *Ethnos* 74 (1):5-30.
- Sullivan, Noelle. 2018. "International clinical volunteering in Tanzania: A postcolonial analysis of a Global Health business." *Global Public Health* 13 (3):310-324.
- Sulmasy, Daniel, P. 2006. *A balm for Gilead : meditations on spirituality and the healing arts*. Washington: Georgetown University Press.
- Taylor, Kim. 2005. *Chinese medicine in early communist China, 1945-63 : a medicine of revolution*. London ; New York: Routledge.
- Thind, A., C. Mock, R. A. Gosselin, and K. McQueen. 2012. "Surgical epidemiology: a call for action." *Bulletin of the World Health Organization* 90 (3):239-40.
- Throop, C. Jason. 2010. *Suffering and sentiment : exploring the vicissitudes of experience and pain in Yap*. Berkeley: University of California Press.
- Tong, Nyuol Lueth. 2013. "The Bastard." In *There is a country : new fiction from the new nation of South Sudan*, edited by Nyuol Lueth Tong. San Francisco: McSweeney's.
- U.S. Conference of Catholic Bishops. 2012. "General introduction and part one of Ethical and religious directives for Catholic health care services." In *On moral medicine :*

theological perspectives in medical ethics, edited by M. Therese Lysaught, Joseph J. Kotva, Stephen E. Lammers and Allen Verhey. Grand Rapids, Mich.: W.B. Eerdmans.

UN Comtrade. 2007. "United Nations Commodity Statistics Database."

UNOCHA. 2016. South Sudan 2017 Humanitarian Needs Overview.

Vaughan, Megan. 1991. *Curing their ills : colonial power and African illness*. Cambridge: Polity.

Vaughan, Megan. 1994. "Healing and curing: Issues in the social history and anthropology of medicine in Africa." *Social History of Medicine* 7 (2):283-295.

Wall, Barbra Mann. 2015. *Into Africa : a transnational history of Catholic medical missions and social change*. New Brunswick: Rutgers University Press.

Wendland, Claire L. 2012. "Moral maps and medical imaginaries: clinical tourism at Malawi's college of medicine." *American Anthropologist* 114 (1):108-122.

Wilkinson, Iain, and Arthur Kleinman. 2016. *A passion for society : how we think about human suffering*. Oakland, California: University of California Press.

Xia, Xingzhen. 2003. "Nongcun hezuo yiliao zhidu de lishi kaocha [A Historical Investigation of the Rural Cooperative Medical Care System]." *Dangdai Zhongguoshi Yanjiu [Contemporary China History Studies]* 10 (5).

Zhan, Mei. 2009. *Other-worldly: making Chinese medicine through transnational frames*. Durham: Duke University Press.