

Neither “Saviour” nor “Exploiter”:
A Historical Study of China’s Medical Assistance in Post-Colonial Tanzania

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DECLARATION OF AUTHORSHIP

I certify that the dissertation I have submitted in application for the award of a Doctor of Philosophy (PhD) at the University of Basel is my original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award. It may not be reproduced by any means, in full or in part, except for short extracts in fair dealings, for research or private study, critical scholarly review or discourse with an acknowledgement, without prior written consent of the author.

Andrea Azizi Kifyasi

Basel, May 2021

ABSTRACT

China's medical assistance to Africa has attracted relatively little attention from scholars compared to other forms of assistance such as economic and political. "A Historical Study of China's Medical Assistance in Post-Colonial Tanzania" examines the implications of Chinese assistance in the development of Tanzania's health sector under the discourse of South-South cooperation. Through the use of archival and other documentary sources collected in Tanzania, China, and Switzerland, as well as oral histories, this study explores how China's medical assistance reflected the Southern agenda of promoting self-reliance and lessening the dominance of Northern countries in medical aid and knowledge in the South. It illuminates social, economic, and political contexts that gave birth to China's medical assistance in Tanzania. The study shows that, after the Arusha Declaration of 1967, the Tanzanian government adopted Chinese health policies such as free health care, the institutionalisation of traditional medicine, and rural health care. It argues that the adoption of Chinese health policies contested the conceptions of the production and transmission of knowledge from the North "core" to the South "periphery". Consequently, the practices of Chinese health policies in Tanzania signal the realisation of knowledge production and exchange from the periphery to the periphery. Indeed, as the study shows, the independent Tanzanian government aspired to become self-dependent. Such endeavours grew in the mid-1960s, following its diplomatic rifts with traditional donors of the North. Under idealistic motives of Southern solidarity, it perceived Chinese aid as a bridge to self-reliance, and indeed, this was the "vision" of the Chinese government as is evident in its foreign aid principles. In the same vein, the Chinese-funded health projects, such as the medical team program, were expected to build the capacity of Tanzania's health sector through medical knowledge production and exchanges with local medical workers. The Chinese-sponsored pharmaceutical industries were planned to maintain the local production of pharmaceuticals and ensure imports, while traditional Chinese medicine research and treatment projects were expected to boost medical knowledge among local researchers and practitioners. Nevertheless, this study argues that China's medical assistance to post-colonial Tanzania was hampered by several drawbacks, which affected its efficiency and sustainability, hence failed to realise the country's anticipated self-reliance. Contrary to the government's expectations, the assistance created unforeseen dependences on Chinese medical doctors, pharmaceutical raw materials, traditional Chinese medicine, and pharmaceutical

technicians sent from China. Findings of this study show that most of the medical projects declined in the absence of Chinese assistance. Such circumstances warrant the conclusion that despite the merits of China's aid, especially in counteracting the dominance of medical aid and knowledge from the North, its assistance hardly functioned as a sustainable solution to health challenges that faced the Tanzanian government. Admittedly, the medical assistance functioned as a soft way of securing allies during the Cold War era and a vital tool in maintaining China's political and economic interests.

ACRONYMS AND ABBREVIATIONS

AAPSO	Afro-Asian Peoples' Solidarity Organisation
AD	<i>Anno Domini</i>
AIDS	Acquired Immune Deficiency Syndrome
AMO	Assistant Medical Officer
ANC	African National Congress
APIs	Active Pharmaceutical Ingredients
ARV	Antiretroviral
ASF	<i>Agopuntura Senza Frontiere</i>
BC	Before Christ
BCG	Bacillus Calmette-Guérin
BWIs	Bretton Woods Institutions
CACMS	China Academy of Chinese Medical Sciences
CCM	<i>Chama Cha Mapinduzi</i>
CCP	Chinese Communist Party
CHF	Community Health Fund
CMTs	Chinese medical teams
DMO	District Medical Officer
DRC	Democratic Republic of Congo
DTAM	Department of Traditional and Alternative Medicine
EAF	East Africana
ECNU	East China Normal University
ENT	Eye, Ear, Nose and Throat
EPI	Extended Program of Immunisation
EU	European Union
FOCAC	Forum on China-Africa Cooperation
FRG	Federal Republic of Germany
FYDP	First Five-Year Development Plan

GDP	Gross Domestic Product
GDR	German Democratic Republic
GHSi	Global Health Strategies initiatives
GPA	Global Programme on AIDS
HIV	Human Immune Virus
ICS	Institute of China Studies
ICT	Information Communication Technology
IDA	International Development Association
IMF	International Monetary Fund
ITM	Institute of Traditional Medicine
JMT	<i>Jamhuri ya Muungano wa Tanzania</i>
KPI	Keko Pharmaceutical Industries
MAT	Medical Association of Tanzania
MCT	Medical Council of Tanganyika
MD	Medical Doctor
MNH	Muhimbili National Hospital
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTC	Medical Training Centre
MTP	Medium-Term Plan
MUHAS	Muhimbili University of Health and Allied Sciences
MVI	Mabibo Vaccine Institute
MRC	Mbeya Records Centre
MwRC	Mwanza Records Centre
NACP	National AIDS Control Program
NAM	Non-Aligned Movement
NATF	National AIDS Task Force
NCI	National Chemical Industries
NDC	National Development Cooperation

NEC	National Executive Council
NGO	Non-Governmental Organisation
NHIF	National Health Insurance Fund
NIMR	National Institute for Medical Research
NMCP	National Malaria Control Program
NRC	National Records Centre
OAU	Organisation of African Union
PHC	Primary Health Care
PRC	People's Republic of China
RAC	Rural Aid Centre
RC	Regional Commissioner
ROC	Republic of China
SAPs	Structural Adjustment Programmes
SEP	Smallpox Eradication Programme
SFYDP	Second Five Year Development Plan
SP	Sulphadoxine-Pyrimethamine
SPA	Shandong Provincial Archives
SSC	South-South Cooperation
STD	Sexually Transmitted Disease
TAC	Technical Advisory Committee
TANU	Tanganyika African National Union
TAWG	Tanga AIDS Working Group
TAZARA	Tanzania-Zambia Railway
TB	Tuberculosis
TCM	Traditional Chinese Medicine
TNA	Tanzania National Archives
TPI	Tanzania Pharmaceutical Industries
TRMU	Traditional Medicine Research Unit
TShs	Tanzanian Shillings

TYDP	Three-Year Development Plan
UDI	Unilateral Declaration of Independence
UN	United Nations
UNDP	United Nations Development Programme
UNGA	United Nations General Assembly
UNICEF	United Nations International Children's Emergency Fund
UNCTAD	United Nations Conference on Trade and Development
UNIDO	United Nations Industrial Development Organisation
URT	United Republic of Tanzania
US	United States
USD	United States Dollar
USSR	Union of Soviet Socialist Republics
UWATA	National Union of Traditional Healers
VMH	Village Medical Helper
WHA	World Health Assembly
WHO	World Health Organization
WHOA	World Health Organization Archives
WTO	World Trade Organization
WW I	First World War
WW II	Second World War
ZJU	Zhejiang University
ZNA	Zanzibar National Archives

DEDICATION

This dissertation is dedicated to my lovely wife Salima, and my children, Paschal, Anthony, and Alica.

INTRODUCTION:

CHINA'S ASSISTANCE TO AFRICAN COUNTRIES

The Chinese people are our true brothers. When we are in difficulties, China is always the first to stand up and offer help. Salim Kijuu, Regional Commissioner, Kagera.¹

The Regional Commissioner of Kagera made the above statement immediately after receiving Chinese medical doctors in his region. The doctors were part of the Chinese medical team working in different regions of the country. They were sent to Kagera to attend to victims of the earthquake that occurred on September 10, 2016. The assertion that the “Chinese” had been “always the first” to support the Tanzanian government did not only raise my curiosity to study the history of China’s medical assistance to Tanzania but also reflected the practice of the South-South cooperation (SSC).² Indeed, the contentions imply that assistance has not only flowed from the North – or “core” – to the South, the so-called periphery, but also from the South to the South.³ Indeed, historically, the Chinese government began to offer assistance to the nations of the Global South soon after its successful 1949 revolution. It mostly directed its aid toward socialist countries. For example, in 1950, it deployed economic and social assistance to Vietnam and North Korea. It further assisted other countries of the South, including Egypt, Morocco, Sudan, and Guinea after the Bandung Conference of 1955.⁴ During the 1950s, China

¹ Quoted in a Speech by H. E. Wang Ke, Ambassador of China to Tanzania, at the farewell reception for the 24th China Medical Team in Tanzania held in Dar es Salaam on November 3, 2017.

² South-South cooperation refers to collaborations that involved exchanges of resources, technology, experience, and knowledge among Global South countries. Such exchanges are executed at bilateral, multilateral, regional, or interregional levels, as well as organised and coordinated by Southern countries. SSC was founded following the 1955 Bandung Conference and grew through coalitions among Southern countries influenced by Asian-African conferences and organisations such as the Afro-Asian Peoples’ Organisation (AAPSO) 1957, the Non-Aligned Movement (NAM) 1961, and the Group of 77 (G-77) 1964. Through SSC, countries of the Global South worked together to find solutions to common development challenges. It became possible for country members to work together since they had supposed shared history and challenges. Against this backdrop, at the Bandung Conference, delegates of Asian and African countries promoted economic, political, social, and technological cooperation among themselves (discussed at length in Chapter 1). See Isaline Bergamaschi and Arlene B. Tickner, “Introduction: South-South Cooperation Beyond the Myths—A Critical Analysis,” in *South-South Cooperation Beyond Myths: Rising Donors, New Aid Practices?* ed. Isaline Bergamaschi, Phoebe Moore and Arlene B. Tickner (London: Palgrave Macmillan, 2017, 1-2; Meibo Huang, “Introduction: South-South Cooperation and Chinese Foreign Aid,” in *South-South Cooperation and Chinese Foreign Aid*, ed. Meibo Huang, Xiuli Xu and Xiaojing Mao (Singapore: Palgrave Macmillan, 2019), 1.

³ The terms “Global South” and the “Global North” are alternatives to “Third World/Developing Countries” and “Developed Countries.” Fuller explanation is offered in the conceptual framework section of this chapter.

⁴ Mohon Shajalal, *et al.*, “China’s Engagement with Development Assistance for Health in Africa,” *Global Health Research and Policy* 2, no. 24 (2017): 2, <https://doi.org/10.1186/s41256-017-0045-8>; Ai Ping, “From Proletarian Internationalism to Mutual Development: China’s Cooperation with Tanzania, 1965-95,” in *Agencies in Foreign*

and the Soviet Union offered moral and material support to African countries fighting against imperialism, colonialism, and neo-colonialism. However, throughout the 1950s, medical assistance was not part of China's aid to the South.⁵

From the outset, the Chinese government executed its aid through cash, materials, project building, and technical cooperation. In 1964, Chinese Premier, Zhou Enlai, explained that the Chinese government's assistance aimed at strengthening the socialist camp, promoting the struggle for political independence and supporting the attainment of self-reliance endeavours in newly independent African countries.⁶ However, Zhou did not mention political and economic benefits that the Chinese government aimed to accrue under the umbrella of "foreign aid". The Sino-Soviet disputes, which heightened in the 1960s, led to the withdrawal of the Chinese government from the Union. Under such circumstances, the Chinese government became both anti-Soviet and anti-American. In contrast, it bolstered relationships with African countries through different kinds of assistance to win their support.⁷ Underscoring the role of Chinese aid to winning over imperialist(s) (USA) and revisionist(s) (Russia), Zhou contended: "Our assistance to Asian and African countries is keenly important for our competition with the imperialists and revisionists for the middle strip. This is a critical link. It is the material assistance. It will not work without material."⁸ Aid, therefore, became a useful tool in China's competition with the United States and the Soviet Union for political and economic influence over African countries. Through different forms of assistance, the Chinese government craved to be considered as a better ally of African countries than the US and the Soviet Union.

Yet, the government of China supplied loans and grants only to countries which forged diplomatic relationships with Beijing. The visit of Premier Zhou to Africa from December

Aid: Comparing China, Sweden and the United States in Tanzania, ed. Goran Hyden and Rwekaza Mukandala (New York: St. Martin's Press, 1999), 165-166.

⁵ Li Anshan, "China's New Policy toward Africa," in *China into Africa, Trade, Aid, and Influence*, ed. Robert I. Rotberg (Washington, D. C: Brookings Institution Press, 2008), 2.

⁶ Menghua Zeng, "An Interactive Perspective of Chinese Aid Policy: A Case Study of Chinese Aid to Tanzania," (PhD diss., University of Florida, 1999), 93-94; Ai, "From Proletarian Internationalism," 170.

⁷ Tianbiao Zhu, "Nationalism and Chinese Foreign Policy," *China Review* 1, no. 1 (Fall 2001): 10.

⁸ Chinese assistance to Africa came when a few countries attained their political independence, and they faced several economic and social challenges. It was easy for the Chinese government to forge diplomatic relations with independent countries through aid. Likewise, several African countries were fighting for political independence, and freedom fighters needed material and moral support, which the Chinese government promised to offer. Thus, China's material support helped it win Africa's support against Soviet revisionism and US imperialism. For the quote, see Olivia J. Killeen, *et al.*, "Chinese Global Health Diplomacy in Africa: Opportunities and Challenges," *Global Health Governance* 12, no. 2 (Fall 2018): 6.

1963 to January 1964 constituted a landmark for his country's engagements with the continent. Zhou put forward "Eight Principles for Economic Aid and Technological Assistance to Overseas Countries" which showed the visions of China's foreign aid and the direction that the Sino-African cooperation was supposed to take.⁹ During this period, medical assistance was provided for the first time, when in 1963, the Chinese government sent its medical team to Algeria to address health challenges and build the capacity of Algeria's health sector.¹⁰ The government further supported different development projects for newly independent African states. For instance, in 1964, it provided a loan amounting to USD 156.40 million to six African states: The Central African Republic (USD 4 million), Congo Brazzaville (USD 25 million), Ghana (USD 20.4 million), Kenya (USD 15 million), Tanzania (USD 42 million), and United Arab Republic (now Egypt) (USD 50 million).¹¹ This assistance played a vital role in boosting Sino-African cooperation.

The period from 1966 to 1977 witnessed a further increase in Chinese assistance to Africa. Medical assistance was extended to several African countries (Chapter 3).¹² Furthermore, the Chinese government heavily deployed loans and grants to Africa, and it financed massive projects such as the Tanzania-Zambia Railway (TAZARA). Between 1970 and 1977, the total aid sent to African states amounted to USD 1.9 billion.¹³ Indeed, China's assistance to Africa throughout the 1960s to 1977 laid a solid foundation for Sino-African relations which, in turn, meant that the Chinese government won recognition in the United Nations General Assembly (UNGA). In the 26th UNGA of October 1971, UN member countries endorsed the proposal of restoring China's legitimate seat in the UNGA, with 26 African countries voting in favour of recognising the legal status of the Chinese government.¹⁴

⁹ The principles, among others, underscored China's commitment to promoting self-reliance to aid recipient countries. See Eight Principles for Economic and Technical Aid Contended by Premier Zhou Enlai when Answering Questions from Reporters of the Ghana News Agency on January 15, 1964 in Ghana, Available in *Afro-Asian Solidarity against Imperialism: A Collection of Documents, Speeches and Press Interviews from the Visits of Chinese Leaders to Thirteen African and Asian Countries*, (Peking: Foreign Languages Press, 1964), 149.

¹⁰ Li Anshan, *Chinese Medical Cooperation in Africa: With Special Emphasis on the Medical Teams and Anti-Malaria Campaign*, (Uppsala: Nordiska Afrikainstitutet, 2011), 9.

¹¹ George T. Yu, "Sino-Africa Relations: A Survey," *Asian Survey* 5, no. 7 (Jul. 1965): 327.

¹² Li, *Chinese Medical Cooperation in Africa*, 9.

¹³ George T. Yu, "Africa in Chinese Foreign Policy," *Asian Survey* 28, no. 8 (Aug. 1988): 855.

¹⁴ David H. Shinn, "China-Africa Ties in Historical Context," in *China-Africa and an Economic Transformation*, ed. Arkebe Oqubay and Justin Yifu Lin (London: Oxford University Press, 2019), 66; Timothy S. Rich and Sterling Recker, "Understanding Sino-African Relations: Neocolonialism or a New Era?" *Journal of International and Area Studies* 20, no. 1 (2013): 63.

However, from 1978 to 1995, the Chinese government reduced its assistance to African countries. This reduction was consistent with China's reform and opening-up policy, as its foreign assistance became more pragmatic than ideological. After the reform, the government of China used foreign aid programmes to attain economic development. Above all, it reconciled with the US and enlarged its opposition to the Soviet Union. Surely, China's increased diplomatic proximity with the US and other countries of the North aimed to attract foreign investment and win advanced technology from them.¹⁵ Yet, the adopted policy had negative impacts on Sino-African cooperation because it resulted in a significant decline of foreign aid to African countries. For example, China's aid to Africa dropped from USD 100.9 million in 1976 to USD 13.8 million in 1982.¹⁶ Likewise, medical assistance to the continent declined tremendously. Li Anshan notes that from 1979 to 1980, there were no Chinese medical teams sent to Africa. Although the program resumed in 1981, there was no increase in the number of the teams from 1988 to 1995.¹⁷

China's thirst for Africa's natural resources prompted the resumption of its assistance to the continent from 1995 to the present.¹⁸ The Forum on China-Africa Cooperation (FOCAC), inaugurated at Beijing in October 2000, deepened its roots in Africa. FOCAC conferences were scheduled every three years. Through FOCAC, China enhanced its influence in the continent by meeting heads of African states or their representatives where several economic, political, social, and technological agreements would be signed. Moreover, the Chinese government used the FOCAC forum to pump different kinds of assistance into several African countries.¹⁹ The forum promoted bilateral ties and cooperation between China and Africa through dialogue.

The preceding expositions show that China's assistance to countries of the Global South, particularly in Africa, has a long and varied history with its economic, technological, and political assistance running parallel to the provision of medical aid. Indeed, its assistance

¹⁵ Peter J. Buckley, Jeremy Clegg and Hi Tan, "Knowledge Transfer to China: Policy Lessons from Foreign Affiliates," *Transnational Corporations* 13, no. 1 (April 2004): 31; Yanzhong Huang, "Pursuing Health as Foreign Policy: The Case of China," *Indiana Journal of Global Legal Studies* 17, no. 1 (Winter 2010): 111; Li, "China's New Policy toward Africa," 7.

¹⁶ Giles Mohan and Marcus Power, "New African Choices? The Politics of Chinese Engagement," *Review of African Political Economy* 115, no. 23-42 (2008): 29, <https://dx.doi.org/10.1080/03056240802011394>.

¹⁷ Li, *Chinese Medical Cooperation in Africa*, 11.

¹⁸ Huang, "Pursuing Health as Foreign Policy," 128.

¹⁹ Li Anshan, *et al.*, *FOCAC Twelve Years Later: Achievements, Challenges and the Way Forward* (Uppsala: Nordiska Afrikainstitutet 2012), 20.

was in line with SSC agenda, which, among other things, aimed to promote self-reliance and sustainability in the health sector of Southern countries as a means of getting rid of dependencies on countries in the Global North.²⁰ Through SSC, Southern countries anticipated neutralising Northern technological and scientific influence by exchanging resources, technology, and knowledge.²¹ Their attempts challenged the existing knowledge from the Global North and proved Global South countries' ability to produce and communicate produced knowledge amongst themselves. Southern countries with relatively strong medical institutions, such as China and Cuba, were the first to provide medical aid to other Southern countries, through which medical knowledge and experiences from donor and recipient countries were exchanged.²²

Not only was there a strong historical relationship between China and Tanzania, but the Tanzanian political elites were also chief allies of SSC. Julius K. Nyerere, then President of Tanzania and Chairman of the South Commission, supported the South-South knowledge production and exchange agenda vigorously, believing that it was crucial for sustainable development.²³ Nyerere's commitment to SSC expanded the country's relationships with economically powerful Southern countries such as China, Cuba, and India, and in exchange, Tanzania received several kinds of assistance from these countries. For instance, from the mid-1960s to the 70s, Tanzania became China's largest aid recipient in Africa.²⁴

1. The Argument

This study examines the significance of China's medical assistance for the development of the health sector of Tanzania within the framework of South-South

²⁰ Margaret Blunden, "South-South Cooperation: Cuba's Health Programmes in Africa," *International Journal of Cuban Studies* 1, no. 1 (June, 2008): 33; Li Anshan, "From 'How Could' to 'How Should': The Possibility of a Pilot U.S.-China Project in Africa," in *China's Emerging Global Health and Foreign Aid Engagement in Africa*, ed. Xiaoqing Lu Boyton (Washington: Center for Strategic and International Studies, CSIS, 2011), 43.

²¹ Meibo, "Introduction: South-South Cooperation and Chinese Foreign Aid," 1; Paschal B. Mihyo, "Practical Problems in the South-South Development Cooperation: Some Experiences Involving Tanzania," *Law and Politics in Africa, Asia and Latin America*, 25, no. 2 (2. Quarterly, 1992); 225.

²² See, for instance, Robert Huish and John M. Kirk, "Cuban Medical Internationalism and the Development of the Latin American School of Medicine," *Latin American Perspectives* 34, no. 6 (Nov., 2007): 77-92, <https://doi.org/10.1177/0094582x07308119>; Li, "From 'How Could' to 'How Should'".

²³ Julius K. Nyerere, "Third World Unity," in *Freedom, Non-Alignment and South-South Cooperation, A Selection from Speeches, 1974-1999*, ed. The Mwalimu Nyerere Foundation (Dar es Salaam: Oxford University Press (T), 2011), 25.

²⁴ Menghua Zeng, "An Interactive Perspective of Chinese Aid Policy: A Case Study of Chinese Aid to Tanzania" (PhD diss., University of Florida, 1999), 177.

cooperation, using post-colonial Tanzania as its focal point. It specifically investigates the social, economic, and political contexts that gave birth to China's medical assistance in Africa. By critically discussing a range of major Chinese-funded health projects since Tanzania's independence in 1961, it analyses the ways in which Chinese medical assistance contributed to nation-building agendas in Tanzania as well as in promoting South-South medical knowledge production, exchanges, and self-sufficiency within Tanzania's health sector.

This work contributes to research on SSC, particularly by examining economic, political, and knowledge entanglements that emerged from bilateral relationships among Southern countries. The study also provides insights into the post-colonial diplomatic history of Sino-African relations, especially in the field of medical diplomacy. While increasing numbers of scholars have studied Chinese economic and political assistance to African countries in the post-colonial period, China's engagement in Africa's health sector remains neglected (see below). The study further adds insights into ongoing debates on "Theory from the South", which underscores the roles that Southern countries have played in scientific developments and challenges the supposed monopoly of the Global North on science and innovation (see below). The thesis examines the ways in which medical assistance provided by some economically powerful countries in the South promoted innovation in medical knowledge and challenged the hegemony of medical knowledge from the Global North. The emergence of donor countries from the South network has not been adequately studied as a shift away from the dominance of Northern and formerly colonising countries.

The main argument of this study is that China's medical assistance, despite some positive effects, did not reliably promote the development of Tanzania's health sector. The assistance provided was executed under idealistic motives of Southern solidarity, which promised to promote self-dependence on the part of the newly independent nations. Yet, its execution was hampered by several drawbacks, which affected its efficiency and sustainability. China's medical aid, which political elites in Tanzania generally perceived as "unconditional" and "emancipatory", created unforeseen dependencies, which, in turn, led to the collapse of most projects funded by the Chinese government. For instance, the two pharmaceutical industries funded by the Chinese government in 1968 were handed over to the Tanzanian government, which had neither enough skilled pharmaceutical personnel nor effective management capacity to run them. Moreover, there was no reliable source of pharmaceutical raw materials (Chapter 5). Similarly, as will be shown in Chapter 3, the Chinese medical team program, which commenced in 1968, prioritised clinical care rather than fostering medical

knowledge exchanges with local medical personnel. Research and treatment programs in the field of traditional Chinese medicines further prompted the spread and practice of Chinese medicine instead of imparting medical knowledge to traditional Tanzanian medicine practitioners and researchers (Chapter 4). Therefore, throughout this study, it will be seen that despite the merits of China's aid, especially in counteracting the dominance of medical aid and knowledge from the North, there was a significant gap between "promise" and "practice". Rather than creating a basis of skills, infrastructures, and materials on which it could have functioned more autonomously and sustainably, Chinese assistance worked as a short-term relief to long-term deficiencies within Tanzania's health sector.

2. Situating the Study: Literature Review

The existing research literature shows that training local medical workers was not a priority of the colonial governments. However, the increasing health challenges, the limited number of medical workers in the colonies, and the colonial ambitions to popularise western biomedicine prompted colonial administrations to launch medical training for at least a few Africans from 1900 onwards. David F. Clyde, Randall M. Packard, John Iliffe, Hellen Tilley and Stacey A. Langwick provide insights into the ways in which colonial authorities introduced and popularised biomedicine in Africa while undermining the survival of the existing indigenous medical practices and approaches.²⁵ Clyde and Iliffe discuss how colonial experts imparted Western medical knowledge to a few Africans who worked as medical assistants, sanitary inspectors, dispensers, and tribal dressers.²⁶ A study by Iliffe and Langwick went further by examining how medical training progressed in post-colonial East Africa, showing the ways in which the new governments invested in training medical personnel.²⁷ Thus, the advent of Chinese medical training on the continent collided with existing medical knowledge systems shaped by the former colonial power, but existing scholarship has not yet shed light on how Chinese medical knowledge challenged the prevailing system and hegemony of

²⁵ David F. Clyde, *History of the Medical Services of Tanganyika* (Dar es Salaam: Government Press, 1962); Randall M. Packard, *A History of Global Health: Interventions into the Lives of other Peoples* (Baltimore, MD: Johns Hopkins University Press, 2016); John Iliffe, *East African Doctors: A History of the Modern Profession* (Cambridge: Cambridge University Press, 1998); read the Introductory Chapter in Helen Tilley, *Africa as a Living Laboratory, Empire, Development and the Problem of Scientific Knowledge 1870-1950*, (United States of America: University of Chicago Press, 2011); Stacey A. Langwick, *Bodies, Politics, and African Healing: The Matter of Maladies in Tanzania* (USA: Indiana University Press, 2011).

²⁶ See, for instance, Clyde, *History of the Medical Services of Tanganyika*, 117; Iliffe, *East African Doctors*, 40.

²⁷ Iliffe, *East African Doctors*; Langwick, *Bodies, Politics, and African Healing*.

biomedicine. The ways and the extent to which Chinese medical knowledge was imparted to the local medical workers requires further investigation to identify its broader implications for post-colonial Tanzania's health sector.

This study also contributes to studies on Tanzanian socialism in the postcolonial period. Scholars have examined, for instance, implications of the policies for economic activities such as agriculture, industry, and commerce – reporting nuanced observations.²⁸ Other studies examined the impact of the policies in light of the environmental harm that was done through such projects. They show that socialist policies went hand in hand with the villagization scheme, which interfered with existing land-use patterns and disrupted ecological relationships between people and their natural environment. This, in turn, led to environmental degradation.²⁹ Generally, the available research literature criticises socialist policies in Tanzania – especially on how the government implemented the policies – underscoring that they made little or no significant contribution to its self-reliance endeavours. Research has paid little attention to health as a major field of African socialism and self-sufficiency. This study covers this gap by examining the implications of socialist policies on health care. By examining the Tanzanian government's attempts to establish a socialist health care system, the study sheds light on the extent to which the policies adopted were, in one way or another, linked to Chinese interventions.

²⁸ Several scholars studied implications of Ujamaa policies in the development of agriculture, industries, commerce and rural transformation. For instance, Idrian Resnick maintains that under the Ujamaa policies, the government perceived industrialisation as key economic takeoff and it invested much on it while fewer efforts were made to produce and improve skilled manpower to run the established industries; as a result, many industries collapsed. Read, Idrian N. Resnick, *The Long Transition: Building Socialism in Tanzania* (London: Monthly Review Press, 1981). Yet, several scholars maintain that under Ujamaa policies, the rural transformation was arduous since the vision of the policies was not clearly interpreted and adopted by officials and peasants; thus, the policies ended in futility. Read, for instance, Priyal Lal, *African Socialism in Postcolonial Tanzania: Between the Village and the World* (New York: Cambridge University Press, 2015); Jannik Boesen, Birgit Storgard Madsen and Tony Moody, *Ujamaa–Socialism from Above* (Uppsala: Scandinavian Institute of African Studies, 1977). Further studies maintain that villagization policies implemented by the government under Ujamaa policies were a mess to rural communities' livelihoods since they led to the decline of farming activities. Read for instance, Maxmillian J. Chuhila, "Agrarian Change and Rural Transformation in Tanzania: Ismani, Circa 1940-2010," *UTAFITI* 14, no. 1 (2019): 1-23; Michaela von Freyhold, *Ujamaa Villages in Tanzania: Analysis of a Social Experiment* (London: Heinemann Educational Books, 1979); Andrew Coulson, *Tanzania a Political Economy* (New York: Oxford University Press, 1982); James C. Scott, *Seeing Like a State*, (London: Yale University Press, 1998); and Louis Putterman, "Tanzania Rural Socialism and Statism Revisited: What Light from the Chinese Experience?" in *Re-Thinking the Arusha Declaration* ed. Jeannette Hartmann (Copenhagen: Axel Nielsen and Son A/S, 1991).

²⁹ Idriss S. Kikula, *Policy Implications on Environment: The Case of Villagization in Tanzania* (Dar es Salaam: Dar es Salaam University Press, 1997); Yusufu Q. Lawi, "Tanzania's Operation Vijiji and Local Ecological Consciousness: The Case of Eastern Iraqwland, 1974-1976," *The Journal of African History* 48, no. 1 (2007): 69-93.

Several scholars have documented the history of biomedical doctors in East Africa and provided some insights into socialist health policies in post-colonial Tanzania, including rural health care.³⁰ Others have studied the general practice of Tanzanian traditional medicine and the implications of the changing government policies for its development.³¹ While these and other studies offer significant contributions in understanding the colonial and post-colonial health systems in Tanzania, they are both broad and general in their approaches. They have not examined the implications of the socialist policies that the country adopted in 1967 to develop the health care system in any systematic manner. In addition, given their theoretical and methodological frameworks, existing studies have overlooked the extent to which SSC influenced the production and circulation of medical knowledge. This study investigates the ways in which the young, low-income nation of Tanzania drew on Chinese aid and knowledge in its government endeavours to offer free health care, institutionalise traditional medicine, provide rural health care, and ban private health practices.

This study also draws from several studies on Cuban medical internationalism, showing that Cuban medical assistance operated under specific criteria. For instance, some recipient countries exchanged Cuban medical aid with resources or trade agreements. Yet, under the banner of “humanitarianism”, the Cuban government provided free medical assistance to low-income countries and states affected by disasters such as floods and earthquakes.³² Thus, the Cuban government reaped concrete benefits from its medical missions. The available literature on Chinese assistance to newly independent African nations does not adequately discuss the (desired) benefits that China might have gained from its long-

³⁰ Iliffe, *East African Doctors*; Amon J. Nsekela and Aloysius M. Nhonoli, *The Development of Health Services and Society in Mainland Tanzania: A Historical Overview-Tumetoka Mbali* (Dar es Salaam: East African Literature Bureau, 1976).

³¹ Langwick, *Bodies, Politics, and African Healing*; Margunn M. Bech, *et al.*, “Changing Policies and Their Influence on Government Health Workers in Tanzania, 1967-2009: Perspectives From Rural Mbulu District,” *The International Journal of African Historical Studies* 46, no. 1 (2013): 61-103; Dalmas A. R. Dominicus and Takashi Akamatsu, “Health Policy and Implementation in Tanzania,” *Keio J. Med.* 38, no. 2 (1989): 192-200; Gideon Kwesigabo, *et al.*, “Tanzania’s Health System and Workforce Crisis,” *Journal of Public Health Policy* 33, no. 1 (2012): S35-S44.

³² See, for instance, Daniel Hammett, “Cuban Intervention in South African Health Care Service Provision,” *Journal of Southern African Studies* 33, no. 1 (Mar., 2007): 63-81, <https://doi.org/10.1080/03057070601136574>; John M. Kirk, Cuban Medical Cooperation within ALBA: The Case of Venezuela,” *International Journal of Cuban Studies* 3, no. 2/3 (Summer/Autumn, 2011): 221-234; Jason K. Brandt, “Effects of Humanitarian Aid: A Cuban Case Study,” (Master’s thesis., Naval Postgraduate School, Monterey California, September 2002); Julie M. Feinsilver, “Cuba’s Medical Diplomacy,” in *A Changing Cuba in a Changing World*, ed. Mauricio A. Font (New York: City University of New York, 2009); Julie M. Feinsilver, “Fifty Years of Cuba’s Medical Diplomacy: From Idealism to Pragmatism,” *Cuban Studies* 41 (2010): 85-104.

term medical missions in the Global South.³³ This study provides a nuanced assessment of China's medical aid to Africa, seeking its motivations beyond a dichotomy of imperialist agendas versus more idealistic motives of Southern solidarity.

Several economic projects funded by the Chinese government in Africa in the 1960s and 70s have been of interest to scholars. The Tanzania-Zambia Railway (TAZARA), for instance, which was among the most significant projects funded by the Chinese government in Southern countries, has been investigated by George Yu and Jamie Monson.³⁴ Among others, Monson shows the ways in which socialist and capitalist visions of development competed in this period of the Cold War, as the TAZARA project coincided with the construction of the highway from Dar es Salaam to Zambia funded by the US government. In the Chinese socialist vision, the railway project sought to alleviate Zambia's dependency on "capitalist" Rhodesian, Angolan, and South African rails and ports by promoting African nations' self-reliance.³⁵ This study examines the manifestation of similar ideological clashes in health projects funded by the Chinese government and traditional donors from the North in Tanzania, as well as the motivations behind Chinese medical aid, which the existing scholarship has neglected.

There is some research on the Chinese medical teams (CMTs), pharmaceutical industries built by the Chinese, and much less on traditional Chinese medicines (TCMs) in Africa. Such works, however, are both broad and general in their approaches and do not show subtle changes in the funded projects over time. Furthermore, they do not uncover the implications of Chinese medical aid in promoting self-reliance and South-South medical knowledge exchange. For instance, some existing literature has examined the activities of Chinese medical doctors in Africa without establishing the systematic history and contexts that gave birth to their interventions.³⁶ Yet, some medical aid projects funded by the Chinese

³³ Read, for instance, Shuang Lin, *et al.*, "China's Health Assistance to Africa: Opportunism or Altruism?" *Globalization and Health*, (2016): 1-5, <https://doi.org/10.1186/s12992-016-0217-1>; Li, *Chinese Medical Cooperation in Africa*; Peilong Liu, *et al.*, "China's Distinctive Engagement in Global Health," *Lancet* 384 (Aug., 2014): 793-804; Liu Jian, "A Healthy Relationship: China-Africa Medical Cooperation Still Going Strong After 50 Years," (August, 2013).

³⁴ George T. Yu, "The Tanzania-Zambia Railway: A Case Study in Chinese Economic Aid to Africa," in *Soviet and Chinese Aid to African Nations*, ed. Warren Weinstein and Thomas H. Henriksen (New York: Praeger Publishers, 1980); Jamie Monson, *Africa's Freedom Railway, how a Chinese Development Project Changed Lives and Livelihoods in Tanzania* (Indiana: University Press, 2010).

³⁵ Monson, *Africa's Freedom Railway*, 2.

³⁶ A general understanding of activities of the CMTs in Africa was studied by Li Anshan, "Chinese Medical Team Abroad for Assistance: History, Achievement and Impact," in *Future in Retrospect: China's Diplomatic History Revisited*, ed. Qin Yaqing and Chen Zhirui (Hackensack: World Century Publishing Corporation, 2016); Li, *Chinese Medical Cooperation in Africa*; Shu Chen, *et al.*, "Chinese Medical Teams in Africa: A Flagship Program Facing Formidable Challenges," *Journal of Global Health* 9, no. 1 (June 2019): 1-6

government in Africa, such as the pharmaceutical industries, received little or even no scholarly attention.³⁷ The majority of publications about Chinese medical assistance to the continent are not historical studies but rather come from the fields of political science and anthropology, which have examined China's recent medical diplomacy, the practice of traditional Chinese medicine in private clinics and other political and anthropological issues.³⁸ This study provides a more differentiated assessment by investigating different forms of medical aid in depth and zooming in on specific case studies. I examine aspects that other studies have omitted, focusing on how these programmes played out on the ground. I investigate the schemes closely in their

<https://doi.org/10.7189/jogh.09.010311>; Liu, "A Healthy Relationship". Yanzhong Huang investigated the general implications of China's reform and opening-up policy of 1978 to the CMT program. Yanzhong Huang, "Domestic Factors and China's Health Aid Programs in Africa," in *China's Emerging Global Health and Foreign Aid Engagement in Africa*, ed. Xiaoqing Lu Boyton (Washington: Center for Strategic and International Studies, CSIS, 2011); Huang, "Pursuing Health as Foreign Policy." Alicia Altorfer-Ong, examined briefly the activities of CMTs in Zanzibar and mainland Tanzania from 1964 to 1970, two years after the inception of CMTs in mainland Tanzania. Read Chapter 5 in Alicia N. Altorfer-Ong, "Old Comrades and New Brothers: A Historical Re-Examination of the Sino-Zanzibari and Sino-Tanzanian Bilateral Relationships in the 1960s," (PhD thes., Department of International History, London School of Economics and Political Science, 2014), 230-273; Paul Kadetz and Johanna Hood, examined the role of the CMT program in fostering self-sufficiency in Madagascar's health sector. Paul Kadetz and Johanna Hood, "Outsourcing China's Welfare: Unpacking the Outcomes of Sustainable Self-Development in Sino-African Health Diplomacy," in *Handbook of Welfare in China* (Handbooks of Research on Contemporary China Series, ed. Beatriz Carrillo, Johanna Hood and Paul Kadetz (Cheltenham: Edward Elgar Publishers, 2017).

³⁷ A study by Geoffrey Banda, Samuel Wangwe and Maureen Mackintosh provides a brief overview of the historical development of pharmaceutical industries in Africa, Tanzania in particular. See, Geoffrey Banda, Samuel Wangwe and Maureen Mackintosh, "Making Medicines: An Historical Political Economy Overview," in *Making Medicines in Africa: The Political Economy of Industrializing Local Health*, ed. Maureen Mackintosh, Geoffrey Banda, Paula Tibandebage and Watu Wamae (England: Palgrave Macmillan, 2016). Brief information about Chinese-funded pharmaceutical industries can also be found in Gail A. Eadie and Denise M. Grizzell, "China's Foreign Aid, 1975-78," *The China Quarterly*, no. 77 (Mar. 1979): 217-234; Maulid Madeni, "The Effects of Privatisation on Performance of the Privatised Enterprises in Tanzania: Case Studies of Aluminium Africa (ALAF), Keko Pharmaceuticals Industries Limited (KPI), and Tanzania-China Friendship Textile Company (TZ-CHINA)," (Masters diss., University of Dar es Salaam, 2002); and Sophia Josephat Mwilongo, "Challenges Perceived by Local Pharmaceutical Manufacturers that Hinder Adequate Production of Essential Medicines in Tanzania," (Masters thes., Muhimbili University of Health and Allied Sciences, 2011).

³⁸ Scholars from political science, international relations and anthropology who studied China's medical assistance includes, Gordon C. Shen and Victoria Y. Fan, "China's Provincial Diplomacy to Africa: Applications to Health Cooperation," *Contemporary Politics* 20, no. 2 (2014): 182-208, <https://dx.doi.org/10.1080/13569775.2014.907993>; Paul Kadetz, "Unpacking Sino-African Health Diplomacy: Problematizing a Hegemonic Construction," *St. Antony's International Review*, 8, no. 2 (2013): 149-172; Jeremy Youde, "China's Diplomacy in Africa," *China an International Journal* (March 2010): 151-163; Drew Thompson, "China's Soft Power in Africa: From the 'Beijing Consensus' to Health Diplomacy," *China Brief* 5, no. 21 (October 13, 2005): 1-5. Research on the practice of traditional Chinese medicine clinics was conducted by Elisabeth Hsu, "Medicine as Business: Chinese Medicine in Tanzania," in *China Returns to Africa: A Rising Power and a Continent Embrace*, ed. Alden C. Large D. and Soares de Oliveira R. (London: Hurst Publishers, 2008); Elisabeth Hsu, "The Medicine from China Has Rapid Effects: Chinese Medicine Patients in Tanzania," *Anthropology and Medicine* 9, no. 3, (2002): 291-314, <https://dx.doi.org/10.1080/13648470216335>; Elisabeth Hsu, "Chinese Medicine in East Africa and its Effectiveness," *IIAS Newsletter*, no. 45 (Autumn 2007): 22; Michael Jennings, "Chinese Medicine and Medical Pluralism in Dar es Salaam: Globalization or Glocalisation?" *International Relations* 19, no. 4 (2005): 457-473, <https://doi.org/10.1177/0047117805058535>; Hilaire De Prince Pokam, "Chinese Medicine in Cameroon," *China Perspectives*, no. 3 (2011): 51-58.

historical contexts and, on this basis, I provide a nuanced evaluation of the South-South knowledge production and its implications for the postcolonial politics of socialism and self-reliance.

Methodologically, available studies on Chinese medical aid have relied on oral testimonies, institutional and government reports, and personal observations as primary sources, neglecting archival sources almost entirely.³⁹ As a result, they have not considered the nuanced history of the emergence, development, and implications of Chinese medical aid to the development of health sectors in recipient countries.

This study pushes further the discussion about the manner in which and the extent to which countries of the South engaged in the fight against pandemics in other Southern countries using the Chinese-funded HIV/AIDS and anti-malaria campaigns in Tanzania as focal points. Up to the present, the contributions of Southern countries in battling pandemics have been of little interest among scholars, creating the impression that countries of the South had nothing or little to offer in response to global health challenges. Studies into the global health campaign by Amy Patterson, Randall Packard, and John Iliffe underscore the roles of traditional global health partners such as the USA, the European Union (EU), the WHO, the World Bank, and the Bill and Melinda Gates Foundation.⁴⁰ Very little is currently known about China's multilateral engagement in global health from the turn of 21st century onwards following its domestic health crisis and economic interests in Africa where medical assistance has become an essential component of China's projection of soft power.⁴¹ Although the available literature

³⁹ See, Shen and Fan, "China's Provincial Diplomacy to Africa"; Kadetz and Hood, "Outsourcing China's Welfare"; and Huang, "Domestic Factors and China's Health Aid Programs in Africa." Very few studies integrated some archival information but with limited oral testimonies from key respondents, see, for instance, Li, *Chinese Medical Cooperation in Africa*; and Altorfer-Ong, "Old Comrades and New Brothers. Lack of relevant sources limited historical understanding of several Chinese medical aid projects in Africa. For instance, Hsu and Jennings maintained that activities of the Chinese doctors working under the TAZARA project influenced the positive reception of TCM clinics in Tanzania, while archival information suggests that activities of Chinese medical doctors and the practice of acupuncture therapy from 1968 onwards gave a chance to the penetration and positive perception of TCM clinics in the 1990s. Read, Hsu, "Chinese Medicine in East Africa," 22; Jennings, "Chinese Medicine and Medical Pluralism," 461.

⁴⁰ Read, for instance, Amy S. Patterson, *Africa and Global Health Governance: Domestic Politics and International Structures* (Baltimore, MD: Johns Hopkins University Press, 2018); Packard, *A History of Global Health*; John Iliffe, *The African AIDS Epidemic: A History* (Athens: Ohio University Press, 2006).

⁴¹ Stephen J. Morrison, "The Prospects for Engaging China with Global Health Issues," in *China's Capacity to Manage Infectious Diseases: Global Implications*, ed. Charles W. Freeman and Xiaoqing Lu (Washington: Centre for Strategic and International Studies, 2009); L. H. Chan, P. K. Lee and G. Chan, "China Engages Global Health Governance: Processes and Dilemmas," *Global Public Health* 4, no. 1 (January 2009): 1-30; <https://dx.doi.org/10.1080/17441690701524471>; Yanzhong Huang, "China's New Health Diplomacy," in *China's Capacity to Manage Infectious Diseases: Global Implications*, ed. Charles W. Freeman and Xiaoqing Lu (Washington: Centre for Strategic and International Studies, 2009); Matthew Brown, Bryan A. Liang, Braden

sheds some light on China's global health multilateralism, research to date has not yet examined China's bilateral entry into global health campaigns. Bilateral medical projects with individual countries in the South that were funded by the Chinese government are essential areas for research attended to in the present study.⁴²

Scholars have debated SSC in rather controversial terms. Some emphasise the fact that China's current engagement was linked to the country's aim to exploit natural resources in low-income countries and that its growing needs for these resources mostly influenced the strong relationship between China and Africa in the 2000s, referring to China's engagement as the "second colonisation of the African continent".⁴³ By contrast, others argue that the increased cooperation between China and African governments has been serving mutual benefits, bolstering their arguments with statistics that reflect the extent to which African countries have benefitted from cooperation with China. Scholarships for African students, medical assistance, infrastructure projects as well as economic investments and trade relationships are mentioned as prime examples of such positive effects.⁴⁴ The debate on China's recent influence in Africa has overlooked the fact that elements of Chinese humanitarianism, respectively imperialist tendencies, have been present in its medical aid to Africa since its commencement.

3. Conceptual and Theoretical Framework

Conceptually, this study contributes to a growing body of literature engaging with "Theory from the South"; that is, initiatives in the Global South promoting knowledge

Hale, and Thomas Novotny, "China's Role in Global Health Diplomacy: Designing Expanded U.S. Partnership for Health System Strengthening in Africa," *Global Health Governance* 6, no. 2 (Summer 2013): 1-18; Xu Jing, Liu Peilong and Guo Yan, "Health Diplomacy in China," *Global Health Governance* 4, no. 2 (Spring 2011): 1-12.

⁴² To date, only brief pieces of information have been published in newspaper articles about Chinese-funded HIV/AIDS research and treatment projects in Southern countries. See, for instance, "Traditional Chinese Medicine has Great Prospects in Dealing with HIV/AIDS," *Xinhua News Agency*, September 25, 2003, "Traditional Chinese Medicine in Tanzania," *Xinhua News Agency*, October 15, 2006, Rodney Thadeus, "China to Help Dar Fight AIDS," *The African*, February 17, 2003, 3.

⁴³ See, for instance, Erica Downs, "The Fact and the Friction of Sino-African Energy Relations," *China Security* 3, no. 3 (2007): 46-48; Erica Downs, "The Chinese Energy Security Debate," *The China Quarterly* 177 (2004): 21-41; also see, Ian Taylor, "China's Oil Diplomacy in Africa," *International Affairs* 82, no. 5 (2006): 937-959; Ian Taylor, "A Challenge to the Global Liberal Order? The Growing Chinese Relationship with Africa," in *Handbook of China's International Relations*, ed. Shaun Breslin (London: Routledge, 2010); Ali Zafar, "The Growing Relationship between China and Sub-Saharan Africa: Macro-Economic, Trade Investment and Aid Links," *The World Bank Research Observer* 22, no. 1 (Spring 2007): 103-130.

⁴⁴ See Li, "China's New Policy toward Africa"; Liu, *et al.*, "China's Distinctive Engagement in Global Health"; Wang Hongyi, "Sino-African Relations Enter a New Stage," *China International Studies* (Fall 2006): 33-48.

generation and scientific innovation. “Theory from the South” can be described as a broad and diverse research agenda affecting different disciplinary fields that subscribes to the common goal of highlighting the contributions that the Global South has made to various fields of science. Thus, it challenges the long-standing sophism that globally relevant knowledge has always emanated from European and North American countries and that Southern regions of the world have been on the receiving end or delivered – at best – raw data incorporated into sophisticated theories by Northern researchers. Indeed, it empowers countries which have been conventionally ill perceived as peripheral, primitive and underdeveloped. Scholars who subscribe to “Southern theory” have emphasised how Southern countries became centres for the production and circulation of knowledge and innovation within the Southern world and beyond Southern borders, showing that southern countries developed genuine and self-conscious modernity as well.⁴⁵ Consequently, Southern countries produced undisputed advancements in science and technology from the ancient to the modern periods. To be sure, the colonization of Southern countries had impeded knowledge production processes. Nevertheless, colonies remained critical sources of knowledge and innovation for the development of modern states of the North.⁴⁶

Indeed, the view that countries of the Global South have been the architects of science, technology and innovation is not new but links up with older Afrocentric scholarship. Among others, Cheikh Anta Diop held the view that Africans were genuine architects of Ancient Egypt’s civilization, which then spread to the North and South.⁴⁷ Theory from the South develops such thoughts further, building on previous criticism. In the field of medical history, scholars such as Helen Tilley have discussed the ways in which the Global South became a source of “raw data” for the Global North – how treatments were tested and plant knowledge exported to the North. Tilley adds that much of the knowledge colonial authorities gathered from local experts and their experiences in the colonies have been unacknowledged or

⁴⁵ Jean Comaroff and John L. Comaroff, “Theory from the South: or, how Euro-America is Evolving toward Africa,” *Anthropological Forum* 22, no. 2 (July, 2012): 113-131 <http://dx.doi.org/10.1080/00664677.2012.694169>; Jean Comaroff and John L. Comaroff, *Theory from the South: Or, How Euro-America is Evolving Toward Africa*, (London: Paradigm Publishers, 2012); Clapperton Chakanetsa Mavhunga, “Introduction: What Do Science, Technology, and Innovation Mean from Africa?” in *What Do Science, Technology, and Innovation Mean From Africa*, ed. Clapperton Chakanetsa Mavhunga (Cambridge: Massachusetts Institute of Technology (MIT) Press, 2017); Fran Collyer, Raewyn Connell, Joao Maia and Robert Morrell, *Knowledge and Global Power: Making New Sciences in the South* (Clayton: Monash University Publishing, 2019).

⁴⁶ Comaroff, and Comaroff, “Theory from the South,” 116; Mavhunga, “Introduction,” 5.

⁴⁷ Read, for instance, Cheikh Anta Diop, *The African Origin of Civilization: Myth or Reality* (New York: Lawrence Hill and Company, 1974).

silenced.⁴⁸ Scholars under the “Theory from the South” umbrella, by contrast, seek to make visible the knowledge that has come from the South, and by doing that, they prove that the South was also a site of theory building, not just one of collecting raw data, such as botanical specimen.

Admittedly, precisely defining the “Global South” and the “Global North” is difficult. The terms, however, are alternatives to denominations like “Third World/Developing Countries” and “Developed Countries.” The use of these terms signals the downfall of the tripartite/hierarchical division, which dominated the Cold War period.⁴⁹ Julius K. Nyerere, then Chairman of the South Commission, defined Southern countries by referring to their interests, connections, and determinations in relation to the “underdeveloped” and the “highly developed” nations. In this regard, geography, ideology, and economic achievements are not decisive influences for identification since countries such as China, India, Brazil, South Africa and a few others have a per capita income higher than some countries of the North such as Albania, Kosovo and Yugoslavia. Certainly, countries of the South were members of the Group 77 (G-77), or the Non-Aligned Movement (NAM). They share basic characteristics such as being former colonies or protectorates, having a comparatively low GDP, and being excluded from international economic decision-making institutions such as the World Trade Organization (WTO), United Nations Conference on Trade and Development (UNCTAD), World Bank, and International Monetary Fund (IMF). In sum, these are countries that would be associated with the “periphery” and lack of political and economic power from a perspective of World Systems Theory.⁵⁰ With such a view, I trace initiatives made by countries of the South to enable the development of knowledge production following the Bandung Conference in 1955 and the Afro-Asian Peoples’ Solidarity Organisation (AAPSO) instituted in 1957. Thus far, scholars have not linked these organisations with the ongoing “Theory from the South” debate. I examine how these movements, which were formed at the height of the Cold War, conceived and developed the idea of assisting one another in addressing several economic, political, social and technological problems. Consequently, I use China’s medical aid in Tanzania to examine the manifestations of the Southern solidarity agenda, considering the fact

⁴⁸ For detailed information read Helen Tilley, *Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870-1950* (Chicago: University of Chicago Press, 2011).

⁴⁹ Comaroff and Comaroff, “Theory from the South,” 126.

⁵⁰ Julius K. Nyerere, “The Meaning of “Development” and of “The South,”” in *Freedom, Non-Alignment and South-South Cooperation*, ed. The Mwalimu Nyerere Foundation (Dar es Salaam: Oxford University Press (T), 2011), 91-92; Comaroff and Comaroff, “Theory from the South,” 127.

that China was among the leading architects and sponsors of Afro-Asian movements and organisations.

A “Southern” perspective goes beyond a parochial analysis of Marxist and neo-Marxist thinkers who view low-income countries as dependent upon high-income nations for markets, capital equipment, consumption of goods and financing. Against this backdrop they premised that the underdevelopment of the South was caused by such “unbalanced” economic and political relationships with high-income countries of the North. In their view, the only way for Southern countries to disentangle such “exploitative” relationships was through severing their economic and political ties with countries of the North.⁵¹ With respect to “aid”, for instance, the dominant perception has been that the only “donors” were Euro-American countries and multilateral financial institutions like the IMF and the World Bank – despite the strong engagement of several Southern countries such as China, India, and Cuba. Consequently, neo-Marxist theory can be somewhat limiting by overlooking the possibility that some countries in the “periphery” provided aid to “peripheral” and “core” countries. Secondly, it leaves unanswered the question of what happens when a so-called peripheral country provides aid to other peripheral countries and whether this type of aid would also count as an example of exploitation. China’s medical assistance to post-colonial Tanzania was an attempt of the “poor” helping the “poor”; capital and experiences flowed from the South to the South. While this study draws from Southern Theory, in order to overcome shortcomings, it avoids a celebratory account by critically inquiring into the process through which SSC was instituted, the usefulness of the knowledge produced and circulated, and the benefits reaped by which stakeholder.

As this study is concerned with health as a question of state responsibility and intervention, I make use of Foucault’s notion of biopower, which he defined as “the set of mechanisms through which the basic biological features of the human species became the object of a political strategy, of a general strategy of power.”⁵² In this regard, the basic functions

⁵¹ Read, for instance, Carol Lancaster, *Aid to Africa: So Much to Do, So Little Done* (London: University of Chicago Press, 1999); William Easterly, *The Whiteman’s Burden: Why the West’s Efforts to Aid the Rest Have Done So Much Ill and So Little Good* (New York: The Penguin Press, 2006); Dambisa Moyo, *Dead Aid: Why Aid Is not Working and How There Is a Better Way for Africa* (New York, NY: Farrar, Straus and Giroux, 2009); Sebastian Edwards, *Toxic Aid: Economic Collapse and Recovery in Tanzania* (Oxford: Oxford University Press, 2014).

⁵² The term “biopolitics” was firstly coined and used by Swedish scholar Rudolph Kjellen in the 1900s and developed further by the French philosopher and social theorist Michel Foucault. It was developed in a series of Foucault lectures given at the College de France from 1975 to 76; see, Antonio Campillo, “Biopolitics,

of biopower were to improve the life of the population, prolong its duration, improve its chances, avoid or reduce biological accidents, and compensate for failings. These basic functions require that the state hold power over the lives of the population, perceiving the population as both biological and political, thus justifies the reasons for the direct states' interventions on the lives of the population.⁵³

Like other “biopolitical” modern states, the independent Tanzanian government was interested in sustaining a healthy population to supply labour, ensure production, and generate wealth for the nation.⁵⁴ The government of Tanzania perceived diseases and other afflictions as both political and economic burdens. Thus, similar to other nations, Tanzania had a regulatory apparatus that was supposed to promote birth rate, and prevent idleness and vagrancy to ensure that the population works appropriately.⁵⁵ Already the colonial state employed biopolitical approaches to ensure effective production in then Tanganyika. It made several interventions to protect and maintain the physical wellbeing of labourers and settlers and passed several public health laws to update health standards. The goal was for African subjects to respond positively to colonial economic investments since the state hoped healthy labourers would be more productive.⁵⁶

The political system of the post-colonial Tanzanian government was centred upon biopower. Soon after its political independence in 1961, Nyerere named diseases among the “enemies” of development. Others included “poverty” and “ignorance”.⁵⁷ Nyerere’s government, therefore, vowed to fight diseases to improve peoples’ health and bring national development. In 1967, following the launch of the Arusha Declaration, the government adopted a socialist path and subsequently made several attempts to improve the wellbeing of the

Totalitarianism, and Globalization,” in *Agnes Heller and Hannah Arendt: A Dialogue*, ed. Angel Prior and Angel Rivero (Cambridge: Cambridge Scholars Publishing, 2018), 96; Michel Foucault, *Security, Territory, Population: Lectures at the College de France, 1977-78*, trans. Graham Burchell (London: Palgrave Macmillan, 2009), 16.

⁵³ Michel Foucault, “Society Must Be Defended”: *Lectures at the College de France, 1975-76*, trans. David Macey (New York: Picador, 2003), 245 and 254.

⁵⁴ For details on symbiotic relations between a healthy population and a state’s power, see Michel Foucault, *The Birth of Biopolitics: Lectures at the College de France, 1978-79*, trans. Graham Burchell (New York: Palgrave Macmillan, 2008), 230.

⁵⁵ The significance of regulatory apparatuses has been elaborated at length by Michel Foucault, *Power/Knowledge: Selected Interviews and Other Writings, 1972-1977*, trans. Colin Gordon (New York: Pantheon Books, 1980), 169-170; Michel Foucault, *Power (The Essential Works of Foucault, 1954-1984, Vol. 3)*, trans. Robert Hurley (New York: The New Press 1st Edition, 2001), 137.

⁵⁶ It was found in such a background that, from the mercantile to capitalist eras, states provided adequate diets (nutrition) to encounter famine and ensure the functioning of biological machines for industrial capitalism, see Foucault, “Society Must Be Defended,” 257.

⁵⁷ Julius K. Nyerere’s Foreword in David F. Clyde, *History of the Medical Services of Tanganyika* (Dar es Salaam: Government Press, 1962), I.

population. Concurrently, his government categorically stated in the manifesto that “people” were a prerequisite for development. The Declaration stated: “The development of a country is brought about by people, not by money. Money, and the wealth it represents, is the result and not the basis of development. The four prerequisites of development are different; they are (i) People; (ii) Land; (iii) Good Policies; (iv) Good Leadership.”⁵⁸ Therefore, Nyerere, a pro-natalist, perceived a healthy population as a source of wealth and an object of surveillance of the state, and his regime regulated several elements to ensure their good health, longevity and productivity.

I use Foucault’s notion of biopolitics to study several attempts undertaken by the post-colonial Tanzanian government under the Chinese government’s assistance to promote the wellbeing of the population. Schematically, the government established pharmaceutical industries to enhance local production of medicines, extend health services to rural areas where the majority of people dwelled, introduced free health care to ensure that all people got access to health care, boosted medical personnel to enhance the delivery of health services and promoted several preventive health care campaigns to contain the emergence and spread of diseases. The government aimed to improve peoples’ lives, control mortality, boost reproduction, increase life expectancy, and create a healthy labour force capable of engaging effectively in production activities vital for economic development and Tanzania’s “nation-building” agenda.

4. Methodological Opportunities and Challenges

While researching Sino-African relationships, George T. Yu wrote: “[. . .] studying China in Africa is much like pursuing a dragon in the bush. The dragon is imposing but the bush is dense.”⁵⁹ Although Yu came to this conclusion in 1968, it is still relevant today. During my research, I encountered several opportunities but also challenges, not least because China’s aid was executed with a high degree of confidentiality. Identification of and access to both archival and oral historical testimonies required more time and patience than I had initially anticipated (see below). This study is primarily qualitative in nature, drawing from both written and oral sources. Data was gathered during the course of two long research trips conducted in

⁵⁸ Julius K. Nyerere, *Ujamaa: Essays on Socialism* (Dar es Salaam: Oxford University Press, 1968), 28-29.

⁵⁹ George T. Yu, “Dragon in the Bush: Peking’s Presence in Africa,” *Asian Survey* 8, no. 12 (Dec. 1968): 1025-1026.

Tanzania and China from January to July 2018 for the first phase and February to July 2019 for the second phase. I further used oral historical narratives, which I gathered in March 2016 when I first met Chinese medical doctors who worked in Tanzania during the 1990s and 2000s.⁶⁰ Their written and oral historical narratives complement each other to bring a history of China's medical assistance in post-colonial Tanzania.

My interview partners included medical workers, government officials, pharmaceutical technicians, and patients. Such diversity complicated the collection of historical narratives, as I interviewed respondents from different institutions and places. At the same time, it allowed me to meet respondents with different backgrounds and specialities who offered a variety of memories and narratives. Informants were first identified through the heads of departments from different relevant institutions from which China's medical aid was sourced and received. The heads of the departments introduced me to the senior employees who worked in/with the project funded by the Chinese government. I interviewed five groups of respondents. Firstly, former members of Chinese medical teams (CMTs) from Shandong province who worked in Tanzania provided insights into the CMTs' history, the ways in which the teams operated their medical services, and how they introduced and exchanged medical knowledge with local medical workers. I also inquired about challenges and achievements experienced, differences compared with western and Soviet medical workers, responses by Tanzanians, as well as the Chinese medical workers' perceptions of Tanzania's public health system. Initially, I anticipated that it would be difficult locating and talking to Chinese doctors who worked in Tanzania, but the Shandong Province Health Bureau connected me with both retired and on-service medical doctors who worked in Tanzania from the 1970s to 2000s.⁶¹ Given the nature of the study and current critiques regarding China's engagement with African countries, the Chinese medical doctors were hesitant to respond to some sensitive questions inquiring about China's benefits from its medical missions in the continent. The doctors were also not ready to talk about the opportunities and privileges they received from the Tanzanian government. Instead, they were more willing to talk about the challenges they experienced and how they endured compared to other medical doctors from the North who were also working

⁶⁰ I first met the CMTs in Jinan City at the moment when I was pursuing my second master's at Zhejiang University.

⁶¹ With the assistance from the Institute of China Studies (ICS) of Zhejiang University (ZJU) and the Department of History of the East China Normal University (ECNU), I contacted the Health Bureau, which connected me with the doctors, and I interviewed them at Jinan City in March 2016 and May 2019.

in Tanzania. However, interviews with medical doctors and health officials from Tanzania (as well as archival information from Tanzania National Archives and Shandong Provincial Archives) provided answers to some more sensitive questions. While I interviewed Chinese witnesses in English, the Chinese doctors neither spoke English nor Kiswahili fluently, so an interpreter did all the transcriptions of the interviews for me.

Secondly, I interviewed former and current employees in pharmaceutical industries sponsored by the Chinese government. I inquired about how the industries were established, their goals, where employees attained their skills, the types of medical products produced, sources of pharmaceutical raw materials for the industries, and the contribution of the industries to the nation-building agenda of self-sufficiency. Locating and talking to workers within the pharmaceutical industries were challenging since the Mabibo Vaccine Institute collapsed in 1986, and its workers were re-allocated to different departments. Thus, they could not be easily found for interviews. Similarly, the Keko Pharmaceutical Industries were privatised in 1997, when more than 95% of its employees were replaced. Up to the present, only one former employee works at Keko while the rest are new with less knowledge about the history of the company. I managed to interview one other former employee who worked with KPI from 1984 to 1997, as well as the former Minister for Industries, each of whom had useful narratives about the industries. Furthermore, archival information and newspaper articles complemented oral historical narratives.

Thirdly, I collected information from patients who consulted the CMTs and TCM doctors in the Dar es Salaam Region. These people provided information on their perceptions of the new medical knowledge and medical services offered by Chinese doctors. Generally, interviews with patients were the most sensitive aspect of my oral history work. For instance, it was difficult to locate patients treated by the CMTs, especially HIV/AIDS patients, given the prevailing stigma attached to affected persons in the community. Furthermore, many patients who attended the TCM clinic passed away, and the clinic collapsed in 2010. However, a retired local medical officer who worked at the clinic from 1987 to 2010 introduced me to one HIV/AIDS patient who had attended the clinic from 1990 to 2010. This patient was cooperative and responded openly to all of my research questions. Further perceptions regarding the clinical services offered by the CMTs were drawn from newspapers and archives, thus complementing the oral historical narratives.

The fourth group of informants were medical personnel in the hospitals where CMTs worked. I inquired about the practice of South-South knowledge production and circulation, the Chinese doctor-patient relationships, patients' satisfaction with the clinical services by the Chinese doctors, the language proficiency of Chinese medical doctors and their general perceptions of the medical knowledge and ability of Chinese medical doctors. Locating local medical workers who worked with the CMTs from the 1970s to 1990s was challenging.⁶² Thus, I interviewed medical workers who worked with Chinese doctors during the 2000s. Overall, they provided a clear understanding of the activities of Chinese doctors in Tanzania. Another challenge was the readiness of informants to spend a long time in discussions. Medical workers were busy with lots of patients' appointments, and they were not available to be interviewed during their time off since many also worked part-time in nearby private hospitals. Detailed information about the activities of Chinese doctors in Tanzania gathered in archives of Tanzania and China complemented oral testimonies given by local medical workers.

Lastly, I consulted retired and in-service officials from Tanzania's Ministry of Health whom I asked about major health projects through which the Chinese government supported the development of the health sector in the country. These government officials were open to narrating the history of Chinese medical aid in the country. However, they were relatively hesitant to comment on the drawbacks of the funded projects, which resulted in hindering its sustainability. Moreover, some officials were not willing to participate in the interviews and gave no significant reasons.⁶³ Despite the challenges, information about health projects funded by the Chinese government was obtained from archives both in China and Tanzania. At the end of the fieldwork, I had collected a total of 37 interviews, which were held at hospitals, government offices, coffee huts, and in the residences of some respondents.

A major part of my primary sources is written documents, gathered from archives and libraries in Tanzania, Switzerland, and China. In the Tanzania National Archives (TNA), I consulted files containing annual reports from the Ministry of Health (MoH) and reports about the activities of the CMTs in Tanzania. In addition, I accessed letters exchanged between the CMTs and the MoH; as well as between the Chinese government and the MoH covering the period from 1968 to 1977. Similar reports and letters covering the period from the 1980s to

⁶² Many of them have retired, and others were transferred to other hospitals which could not easily be located.

⁶³ In one case, a former Minister for Health gave an excuse five times. A day or a few hours before the meeting, he called back regretting that he would not be available and proposed the other dates, which also he regretted.

1990s could not be found. However, the available information was rich enough to reconstruct the history of the CMTs in Tanzania. It was easy to understand, for instance, places where the CMTs were distributed, challenges they encountered, and the way the MoH responded to the needs of the CMTs, the roles of the CMTs in medical knowledge exchange; and the perceptions of the activities of the CMTs by patients, political elites and medical officers from the MoH.

Furthermore, at the TNA, I accessed files containing essential details about the Chinese-funded pharmaceutical industries in Tanzania. The files contained production reports, demands for pharmaceutical raw materials and letters exchanged between the management of the industries and the Ministries of Health and Industries covering the period from 1968 to 1990.⁶⁴ The available sources helped me understand the kind of sponsorship that the Chinese government provided, the types of medical products produced by the industries, sources of pharmaceutical raw materials; challenges encountered by the industries, forces behind their establishment, the *modus operandi* for the pharmaceutical knowledge production and exchange, and the reasons behind their decline.

In the Dodoma National Records Centre (NRC), I consulted files containing letters exchanged between the MoH and the CMTs, memoranda of understanding and reports for the Chinese-funded HIV/AIDS research, and treatment project covering the period from 2000 to 2010. The information obtained shed light on the ways in which the HIV/AIDS project was conceived and developed, and how it declined. Moreover, I analysed reports on the practice of the socialist health system and other relevant government reports. In the Zanzibar National Archives (ZNA), I read letters exchanged between the CMTs and the MoH, as well as reports about Chinese medical teams in Zanzibar. While in Mbeya Records Centre (MRC), I consulted reports and documents concerning the socialist health system as well as activities of Chinese medical doctors in the Mbeya Region. This information was useful in tracing the emergence, development and practice of the socialist health system which came into existence after the Arusha Declaration of 1967. It was easy to examine how rural health care was executed and how the Chinese government influenced its practice in Tanzania. The reports further provided details about the forces behind the decline of the socialist health system and how cost-sharing in the health sector was conceived.

⁶⁴ Information about the Keko plant was dense while a little was found for Mabibo vaccine.

In Geneva, I consulted health-related files at the WHO Archives (WHOA). I read several resolutions by the World Health Assembly (WHA), reports on activities of the Global Programme on AIDS (GPA), and reports on the WHO's campaign against smallpox and tuberculosis in Tanzania. These reports supplemented oral and archival information collected in China and Tanzania. Likewise, in China, I consulted the Shandong Provincial Archive (SPA) and accessed CMTs' mid-year and annual reports, as well as letters exchanged between the CMTs and the Shandong Health Bureau, and between the Health Bureau and the central government of China. I also read documents by the CMTs narrating their activities in Tanzania. Reports about the activities of the CMTs in Tanzania were dense, and they covered the period from 1968 to 1990. The reports supplemented archival information from the 1980s and 1990s, which could not be found in Tanzania. The reports and letters helped me examine forces behind China's medical assistance to Tanzania, challenges encountered by the CMTs, the way the provincial and central government responded to the demands by the CMTs, roles played by the CMTs in promoting South-South knowledge production, circulation, and exchange, the continuities and change of the program and activities of the CMTs in Tanzania, as well as roles played by TCM experts in introducing and spreading TCM knowledge in post-colonial Tanzania. Most of the reports and letters were handwritten, and all of them were in Chinese. To address the language barrier, I hired two research assistants who were fluent in the English and Chinese languages. The assistants translated the selected reports and letters for me. However, I was denied access to some reports, diaries, and letters that were perceived as confidential by the custodians.⁶⁵ Generally, information gathered at SPA enriched the histories about the CMTs and TCM in Tanzania.

Newspapers, government reports, parliamentary proceedings, and relevant grey literature were gathered at the University of Dar es Salaam Main Library-East Africana (EAF), the Muhimbili University of Health and Allied Sciences Library, Tanganyika Library Services-East Africana (EAF), and libraries of the University of Basel, the Department of History and the Swiss Tropical and Public Health Institute. Newspaper articles, for instance, reported of people's perception of the activities of the CMTs, evaluations of the practice of socialist health system and articles about Tanzania's health situation in different historical periods. Grey

⁶⁵ All ordered files had been carefully screened by custodians before being allowed for perusal. Some pages deemed confidential were pinned to restrict access.

literature and research work produced by postgraduate students at the University of Dar es Salaam and Muhimbili enriched my literature review and argument of the study.

The general challenge of archival materials was the incompleteness of the documents I perused. Some files lacked a sequential link to one another. Such cases were much more common at TNA due to misallocation of the files. Some of the ordered files could not be found. This challenge limited a full follow-up of the activities of the CMTs, research and treatment progress at the HIV/AIDS clinic, as well as the progress of pharmaceutical industries funded by the Chinese government. However, I was able to cover many of these gaps through the use of other sources including oral historical narratives, provincial archives, and public record centres.

5. Structure of the Dissertation

Given the nature of the study, the dissertation proceeds thematically – focusing on specific medical projects – rather than strictly chronologically. Chapter 1 disentangles the social and political contexts that were behind China’s medical assistance to Tanzania from 1961 to 1971. It discusses the reasons why the Tanzanian government forged close relations with socialist countries from the mid-1960s, and why it adopted a socialist health system in 1967. Furthermore, the chapter shows that inadequacies in Tanzania’s health sector necessitated the country’s search for medical assistance. As a member of the Afro-Asian Peoples’ Solidarity Organisation (AAPSO), Tanzania qualified for economic, political, social, and technological assistance from other Southern countries. Also, diplomatic rifts between the Tanzanian government and countries of the North such as Western Germany, Britain, and the USA during the mid-1960s, made the government turn to China and the Soviet Union for economic, political, social and technological assistance. Moreover, the chapter shows that China’s struggle over diplomatic recognition against Taiwan in the UNGA influenced its assistance to the South to win allies.

Chapter 2 discusses the emergence and practices of socialist health policies in Tanzania from 1967 to 1990, showing that the Tanzanian government benefited from Southern solidarity by learning and adopting health policies from other “peripheral” countries. Health policies that were initially practised in China, such as free health care, rural health care, and the institutionalisation of traditional medicine, were similarly implemented by the Tanzanian government soon after the endorsement of the Arusha Declaration in 1967. Nevertheless, this

chapter also shows that the policies adopted from China were affected by several colonial legacies. For instance, the rural health care program benefited from experiences of both the colonial administration and Chinese government. Thus, the post-colonial Tanzanian government manipulated both colonial and Chinese health policies to make them fit into its social, economic, and political contexts. This chapter maintains that the spread and adoption of China's health policies by some Southern countries show that development policy did not only flow from the "core" to the "periphery", but they were also communicated between supposed peripheral nations.

Chapter 3 studies concrete projects funded by the Chinese government in Tanzania. It examines the emergence and development of Chinese medical teams (CMTs) in Tanzania from 1968 to 2010. This chapter shows that Africa was the first frontier for the Chinese government to exercise medical assistance before extending it to other countries of the Global South. It depicts the changes and continuities of China's foreign policy and its implications for the CMT program. Furthermore, the chapter analyses the roles played by the Chinese government in capacity building for Tanzania's health sector through training of local medical workers and attending patients. I argue in this chapter that the CMT program was a humanitarian mission but at the same time driven by political and economic calculations. The program acted as a soft way of securing allies during the Cold War era and a vital tool in maintaining China's political and economic interests in Africa. Additionally, the ways in which the CMT program was executed only marginally promoted sustainability and self-dependency in Tanzania's health sector.

The fourth chapter shows that China's medical assistance to Tanzania promoted the spread of China's traditional medical knowledge. The chapter establishes how traditional Chinese medicine (TCM) was introduced, perceived, practised, and developed in post-colonial Tanzania. While TCM was first introduced to the coast of East Africa by Chinese navigators as early as the 15th century, its development only gained momentum in 1968, when China dispatched its first batch of TCM-trained medical teams to Tanzania. Furthermore, this chapter shows that HIV/AIDS-related TCM research and treatment, as well as China's anti-malaria program further influenced the acceptance and practice of TCM in the country. I argue in this chapter that the practice, spread, and acceptance of TCM knowledge to Tanzania were imperative for the promotion of medical knowledge from the South. The Southern countries perceived "South-South knowledge exchange" as an emancipatory undertaking against the dominance of "Northern" or "Western" biomedicine. Nevertheless, discussions in this chapter

show that the good intentions of South-South knowledge exchange could not successfully replace the dominance of medical knowledge from the North.

Chapter 5 discusses the emergence and development of Chinese-funded pharmaceutical industries in post-colonial Tanzania, and retraces their implications for Tanzania's health sector. In order to discern the extent to which the Chinese-funded pharmaceutical industries distinguished themselves from their predecessors, this chapter also includes a brief examination of colonial pharmaceutical industries in the Tanganyika territory. The chapter further discusses how pharmaceutical knowledge was communicated between Chinese and Tanzanian technicians in the context of South-South knowledge exchange and its implications in the development of pharmaceutical industries in Tanzania. I argue that Chinese-funded pharmaceutical industries were conceived under several constraints that hampered their operation and sustainability. Such circumstances intensified Tanzania's dependence on imported raw materials and foreign technical experts to sustain the factories.

The conclusion assesses the consistency and inconsistency of China's medical assistance to Tanzania's nation-building and self-reliance agendas. The findings of this study show that although the Tanzanian government anticipated that medical aid from China would distinctively promote the country's self-reliance agenda, the ways in which such assistance was provided failed to realise those hopes.

CHAPTER ONE:

DISENTANGLING THE CONTEXTS FOR CHINA'S MEDICAL ASSISTANCE TO TANZANIA, 1961–1971

1.1 Introduction

Several scholars have associated China's assistance to Tanzania and other African countries with Cold War politics. They uphold that the assistance aimed to enhance Sino-Tanzanian diplomatic relationship and turn the country's political elites, a vanguard for China's quest for diplomatic recognition in the UN Assembly.¹ This chapter contributes to the preceding claim and examines other discourses that gave birth to China's assistance to Tanzania. It shows that the crisis of the Tanzanian health sector and the government's commitment to the health of the population were decisive influences on medical assistance. Indeed, at independence, the Tanzanian government lacked sufficient medical personnel, had limited distribution within the healthcare infrastructure, and carried a disease burden too heavy for a young nation. On the other hand, the Chinese government executed its aid under the influence of Southern solidarity agendas set by various Afro-Asian movements. Chinese aid arrived timely as it was provided when the Tanzanian government had quarrelled with traditional donors of the North. As a result, the Northern donors such as West Germany, the United Kingdom, and the US withheld all forms of assistance, including medical aid. This chapter further offers a brief background to Sino-Tanzanian relationships and shows how they influenced China's assistance. I argue that Tanzania's diplomatic, economic, and social predicaments of the mid-1960s were fundamental motivations for its reliance on China's aid. I use this as a backdrop to the emergence of Chinese medical teams and other health-related projects discussed in subsequent chapters.

¹ The Tanzania-Zambia Railway (TAZARA) project manifested China's struggle with the alleged US imperialism and Soviet revisionism in Africa. Indeed, China's commitment to the project won the country sympathy and turned political elites in Tanzania and Zambia vanguard to China's bid for the admission to the UN Assembly. For detailed information, read Jamie Monson, *Africa's Freedom Railway: How a Chinese Development Project Changed Lives and Livelihoods in Tanzania* (Indiana: University Press, 2010); George T. Yu, "The Tanzania-Zambia Railway: A Case Study in Chinese Economic Aid to Africa," in *Soviet and Chinese Aid to African Nations*, eds. Warren Weinstein and Thomas H. Henriksen (New York: Praeger Publishers, 1980); Alicia N. Altorfer-Ong, "Old Comrades and New Brothers: A Historical Re-Examination of the Sino-Zanzibari and Sino-Tanzanian Bilateral Relationships in the 1960s" (PhD thes., London School of Economics and Political Science, 2014).

1.2 Health Services Situation at Independence and the Government's Initiatives

At independence, many African countries lacked efficient health facilities and experienced a dearth of trained medical staff. The number of qualified medical personnel such as doctors, nurses, and midwives did not keep pace with the soaring population and social demands. In 1962, the World Health Organization (WHO) reported that 26 independent African countries had a total of about 4,700 doctors (Africans and non-Africans). With this number, a single doctor would have had to attend approximately 18,000 people. However, by 1965, the continent's growing population complicated further initiatives to address the shortage of trained medical personnel. The doctor-patient ratio rose to one doctor for every 20,500 people. Above all, there were very few African (indigenous) doctors. The WHO report shows that in 1965, 26 independent African countries had approximately 1,700 African doctors. Given such a figure, with the absence of expatriates, the doctor-patient ratio would be one doctor for every 50,000 people. Regrettably, some independent African states had no African doctors at all, and others had the ratio of one African doctor for every million people.² Health challenges in most African countries were thus to be tackled by establishing a ramified system of medical institutions to train medical personnel and combat the emergence and spread of diseases. Thus, the countries needed prompt medical assistance to build up their capacity through training and foreign expatriates to work with the few medical personnel.

The situation was not different in Tanzania since, at independence, the country only had about 549 registered medical doctors, of which 400 were residents, serving 10.4 million population. Many of the registered resident doctors were Indians, while Africans numbered only twelve.³ The workforce deficit in the health sector was also the case for the low level of medical personnel. At independence, the government had about 200 African medical assistants and less than 1,000 low-level health care personnel who were tasked with serving 98 hospitals, 22 rural health centres, and 975 village dispensaries.⁴ With such inadequacies, health care provisions were obviously problematic. As a result, the infant mortality rate was about 200 to

² "Paucity of Doctors and Nurses," *Ghanaian Times*, May 14-20, 1967.

³ Richard M. Titmuss, Brian Abel-Smith, George Macdonald, Arthur W. Williams, and Christopher H. Wood, *The Health Services of Tanganyika: A Report to the Government* (London: Pitman Medical Publishing, 1964), 180.

⁴ Julius K. Nyerere, *Freedom and Development/ Uhuru na Maendeleo: A Selection from Writings and Speeches, 1968-1973* (Dar es Salaam: Oxford University Press, 1973), 293.

250 per thousand.⁵ Indeed, the health sector was in turmoil, needing a quick backing from within and outside the country.

The low number of trained medical personnel in Tanzania can be traced back to the fact that the German and British colonial authorities did not open a medical college in the territory, but only a few medical training centres that trained lower medical cadres. This situation was the outcome of an explicit colonial policy. The Colonial Secretary, Malcolm Macdonald, asserted: “Admission [in Britain] to the unified colonial medical service is necessarily confined, broadly speaking, to persons of British nationality, though a person who is born or who is ordinarily resident in a colony, protectorate, or mandated territory, is not excluded; however, it is the policy to train the local inhabitants for minor posts in the health service.”⁶ Amon Nsekela and Aloysius Nhonoli note that throughout British colonial governance, no Tanganyikan was admitted for a Doctor of Medicine (MD) course in Britain.⁷ Makerere College started in 1922 in the neighbouring colony of Uganda, opened its doors to students from Kenya, Tanganyika, and Zanzibar in the mid-1930s when it became East African College. Nevertheless, its annual intake was limited to nine students, so that competition for admission was fierce. As a result, up to the end of 1952, only ten Tanganyikan doctors graduated from Makerere, and only fourteen were in government service by the end of 1960.⁸

The other cause of shortage in medical personnel of African origin was the colonial education system, which racially discriminated Africans throughout the colonial period. The system was three-tiered, dividing Africans, Asians, and Europeans. Africans dominated enrolment at the primary level, while Asians and Europeans dominated the secondary and college levels. For example, in 1960, half of the budget for the Ministry of Education was spent on European and Asian students who constituted less than 2% of the total population. Only one-quarter of the total population of school-going age were enrolled in primary schools, and

⁵ Nyerere, *Freedom and Development*, 294.

⁶ Quoted in Amon J. Nsekela and Aloysius M. Nhonoli, *The Development of Health Services and Society in Mainland Tanzania: A Historical Overview-Tumetoka Mbali* (Dar es Salaam: East African Literature Bureau, 1976), 36.

⁷ Nsekela and Nhonoli, *The Development of Health Services*, 36.

⁸ Nsekela and Nhonoli, *The Development of Health Services*, 46; Titmuss, Abel-Smith, Macdonald, Williams, and Wood, *The Health Services of Tanganyika*, 12.

the country's adult literacy rate among Africans was about 10%.⁹ This context necessitated that nearly all professionally qualified jobs be taken by Europeans and Asians.

This lack of adequately skilled personnel compelled the post-colonial Tanzanian government to rely on expatriates to carry out skilled professional and managerial jobs. Nevertheless, in its First Five-Year Development Plan (1964–69), the government anticipated having fully qualified Tanzanians filling those posts by 1980.¹⁰ Subsequently, in 1963, the government launched the “Africanisation Scheme” to promote the training of local personnel and replace expatriates with some Africans.¹¹ The government, however, did not abstain from seeking the assistance of medical workers from abroad to build its capacity and facilitate knowledge exchange. In his speech, Nyerere contended that:

It is not being self-reliant to refuse to carry out the directions of a foreign engineer, a foreign doctor, or a foreign manager; it is just being stupid. It is absolutely vital that Tanzanians should determine policy; but if the implementation of a particular policy requires someone with good educational qualifications or long experience, it is not very sensible to allow that policy to fail through pride.¹²

Surely, although Nyerere cherished the policy of self-reliance, he was less sceptical over the use of expatriates. He alleged that foreign experts were vital for knowledge exchange, through which local workers would learn gradually to work independently in their absence. With such an attitude, the Tanzanian government retained foreign medical doctors who worked under the British colonial government to build the capacity of its health sector. However, there were not enough foreign doctors to serve the whole country. Thus, the government recruited more medical doctors from Israel, Russia, Yugoslavia, Canada, USA, Britain, and other places, to name just a few (Table 1).¹³ Indeed, the government perceived hiring expatriates as the only feasible solution to addressing the urgent shortage of medical staff. However, even with its

⁹ Kjell J. Havnevick, *et al.*, *Tanzania: Country Study and Norwegian Aid Review* (Moss: A/S Repro-Trykk, 1988), 15; Idrian N. Resnick, *The Long Transition: Building Socialism in Tanzania* (London: Monthly Review Press, 1981), 42.

¹⁰ URT, *Tanganyika, Five-Year Plan for Economic and Social Development, 1st July, 1964-30th June 1969, Volume I: General Analysis, 1964*, VIII.

¹¹ “Africans are Filling the Top Jobs,” *Sunday News*, June 16, 1963, 5.

¹² Julius K. Nyerere, *President Nyerere Explains the Arusha Declaration: The Purpose is Man* (Dar es Salaam: The Mwalimu Nyerere Foundation, 2018), 13.

¹³ “URT, President’s Address to the National Assembly, Tuesday, June 8, 1965,” TNA. Acc. No. 589, Orodha ya Majalada ya Mtu Binafsi, Bhoke Munanka, File No. BMC. 10/03, Speeches of Ministers and Junior Ministers, 23; URT, *Ministry of Health and Social Welfare, Annual Report of the Health Division, 1967, Volume I, 4*; “Doctors ‘Join Up’ Success in Overseas Recruiting,” *Tanganyika Standard*, July 13, 1962, 3.

growing economy, it could not afford to employ enough expatriates to answer the needs of the entire health sector. That is why it welcomed medical staff from friendly countries.

Table 1: Expatriate staff employed on overseas leave terms in the Health Division on 31.12.1967

Country of Origin/Sponsor	Regular Employment			Volunteers		Total
	Doctors	Nurses	Others	Doctors	Nurses	
Britain	22	9	7	2	3	43
India	23	-	8	-	-	31
American Medical Services Int.	1	-	-	-	-	1
Israel	1	-	-	-	-	1
Bulgaria	4	-	-	-	-	4
United Arab Republic (Egypt)	7	-	-	-	-	7
Poland	3	-	-	-	-	3
Sweden	1	-	-	-	-	1
Netherlands	1	-	-	-	-	1
Canada	-	-	-	-	3	3
West Germany	-	-	-	-	2	2
Denmark	-	-	-	-	3	3
Total	63	9	15	2	11	100

Source: URT, Ministry of Health and Social Welfare, Annual Report of the Health Division, 1967 Volume I, 3.

Owing to the shortage of medical personnel in Tanzania, which could not only be met by expatriates and graduates from abroad, the post-colonial government established medical colleges and universities. With the assistance of the Rockefeller Foundation, Basel Foundation for Aid to Developing Countries, United Nations Development Programme (UNDP) and the WHO, the government started a Medical School (now the Muhimbili University of Health and Allied Sciences) at Muhimbili Hospital in March 1963. The mentioned institutions assisted the school in developing curricula, books, salaries of expatriates, equipment, fellowships, construction of buildings, teaching and training of doctors for health care posts in Tanzania, and trained nationals to assume the teaching posts. The nucleus of the school was the Medical Training Centre (MTC) built in 1958, conjointly with Muhimbili Hospital. The school commenced with an intake of ten students with Ordinary Level certificate. In 1964, it adopted the Makerere curriculum and rose the entry qualifications to an Advanced Level certificate with at least subsidiary passes in physics, chemistry and biology. Up to the 1970s, it was able to admit at least 30 medical students annually, and the Ministry of Health (MoH) directly

employed all graduates.¹⁴ With time, the school played a commendable role in building the capacity of the health sector. Nevertheless, graduates from within and outside the country were not sufficient in number to cater to the demands of the health sector.

Table 2: Tanzania’s health staff situation, 1976–1989

Type of Med.Workers	All Doctors	Nationals	Asst. Med. Officers	Med. Asst.	Rural Medical Assist.
1976	683	356	193	770	1,049
1977	727	400	223	930	1,393
1978	769	442	223	1,100	1,690
1979	830	503	258	1,235	2,100
1980	889	566	258	1,400	2,310
1981	950	599	291	1,589	2,691
1982	1,015	732	391	1,808	3,691
1983	1,065	782	436	2,131	4,191
1984	1,115	820	436	2,383	4,601
1985	1,160	865	517	2,633	9,021
1986	1,000	846	250	2,857	9,391
1987	1053	899	283	3,192	9,780
1988	919	805	-	1,049	1,049
1989	978	864	-	3,836	10,414

Source: JMT, Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. C.S. Kabeho, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1990/91, 45.

For instance, ten years after independence, the government recorded a slight increase of registered African medical doctors from 12 in 1961 to 123 in 1971.¹⁵ Consequently, the demand for medical personnel remained higher due to the increasing population and the disease burden. Under such circumstance, the health sector constantly relied on expatriates, especially

¹⁴ “WHO, Assignment Report: Medical School, Dar es Salaam, September 1970-May 1974”; also see “WHO, Requests for Waiver of Application of Programme Support Costs – Training of Health Personnel – Tanzania, Funds – in – Trust, 5/12/1974,” WHOA, File No. TAN-HMD-001, 1974-1979-HMD 5, Training of Health Personnel; “Tenth Anniversary of Muhimbili Medical Centre,” *Daily News*, August 3, 1987, 5; Charles A. Mkonyi, “Emergence of a University of Health Sciences: Health Professions Education in Tanzania,” *Journal of Public Health Policy* 33, no. 1 (2012): S47; URT, *First Five Year Development Plan, 1964-69, Volume I: General Analysis, 1964*, 71; Nyerere, *Freedom and Development*, 293; “URT, Mpango wa Maendeleo wa Shughuli za Afya na Ustawi wa Jamii kwa Kipindi cha Miaka Mitano Kuanzia Julai 1, 1969 Mpaka Juni 30, 1974,” TNA. Acc. No. 589, Orodha ya Majalada ya Mtu Binafsi, Bhoke Munanka, File No. BMC. 10/03, Speeches of Ministers and Junior Ministers, 18; Lucas Meier, “Striving for Excellence at the Margins: Science, Decolonization, and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa, 1943-2000” (PhD diss., University of Basel, 2012), 130.

¹⁵ “A Report from the Office of Principal Secretary, Ministry of Health, Questionnaire Relating to Health Development, 1961-1971, 9th August 1971,” TNA. Acc. 450, Ministry of Health, File No. HED/50/1, Medical Development Plan, 1964-1969.

for critical health cases. Table 2 summarises the number of medical workers in the country and its dynamics from 1976 to 1989.

1.3 Building a Healthy Population

There is too apart from humanitarian reasons another very good reason for wanting a healthy population. This is because we need every bit of energy we have to put to the task of building the nation. Building a nation is not a job to entrust to chronically sick people.¹⁶ Derek Bryceson, Minister for Health, 1963.

The preceding quotation recapitulates the significance of a healthy population in the post-colonial government's nation building agenda. The government anticipated that a healthy and stable nation would be built if the "war" against what Nyerere referred to as the "three major enemies of development": poverty, ignorance, and disease, were fought successfully.¹⁷ To stress the fight against diseases, in 1966, the Minister for Health, H. Makame, argued to change the order of priorities to disease, ignorance, and poverty. He claimed that "[d]iseased children cannot learn at school in order to get rid of ignorance nor can a diseased population be productive in order to get rid of poverty."¹⁸ Such determination aimed at building efficient "human capital" capable of engaging effectively in production, which was vital for building a powerful nation. Indeed, all strategies and mechanisms undertaken by the political authority to improve the population's wellbeing were timely, necessary and consistent with the notion of biopolitics. In line with what scholarship has observed regarding modern "biopolitical" states, the Tanzanian authorities perceived a "population" whose health was vital for it to become productive and contribute to the nation's wealth and political power. Nevertheless, a successful fight against the mentioned "enemies" required intense commitment, efforts, and funds. Undeniably, the government's ambitions were difficult to achieve for a young and low-income country. Therefore, while embarking on several health-related programmes (discussed below), the government also assigned ambassadors the role of seeking support from overseas countries.

¹⁶ "A Speech by Minister for Health, Honourable D. N. M. Bryceson, 1963," TNA. Acc. No. 450, Ministry of Health, File No. HE. 1172, Medical Development Plan.

¹⁷ "Letter from the Minister for Health, Honourable D. N. Bryceson to all Ministry Employees, May 18, 1964," TNA. Acc. No. 450, Ministry of Health, File No. HE. 1172, Medical Development Plan; Phares G. M. Mujinja and Tausi M. Kida, *Implications of Health Sector Reforms in Tanzania: Policies, Indicators and Accessibility to Health Services* (Dar es Salaam: The Economic and Social Research Foundation (ESRF), 2014), 1.

¹⁸ "Message from the Minister of Health, June 29, 1966," WHOA, File No. TAN-HMD-001, 1962-1968, HMD 1, Medical School, Dar es Salaam.

For instance, the Tanzanian ambassador to the United Kingdom, C. S. K. Tumbo, in his press conference of April 13, 1962, requested the British government: “We have declared war against poverty, ignorance, and disease, and we wish to fight this war in our own style, but [. . .] we are short of instruments, and we look upon Britain, the Commonwealth, and all other friendly countries in the world as allies in our struggle.”¹⁹ Tanzania’s endeavour to provide effective health care to its population received massive support from numerous donors (see below).

Tanzanian authorities did not consider the issue of health in isolation but argued that the “three enemies” were interdependent. For instance, due to “ignorance” of nutrition facts, people contracted nutrient-related diseases such as obesity, cancer, diabetes, hypertension, and cardiovascular diseases. Consequently, nutritional campaigns figured among crucial preventive health approaches adopted by the post-colonial government to challenge the colonial health policies, which stressed curative measures.²⁰ Subsequently, the government raised nutritional educational levels described to the people in several ways. For example, nutritional education became part of the school curriculum in July 1963. Furthermore, the government took several measures to ensure the effective production of food crops and boosted economic wellbeing to relieve “poverty” among its population.²¹ Along this line, it established the Freedom from Hunger National Committee in 1964, which was in charge of the coordination and planning of all aspects of food and nutrition. Additionally, the government established nutritional departments at regional and district levels to evaluate the nutritional state of the population and determine reasons for any existing malnutrition. Nutritional departments were responsible for improving the nutritional status of the population through education and other measures. At district levels, nutritional departments were staffed with one nutritional officer, five nutrition teachers, and five village nutrition assessors.²² The government united the efforts of several ministries to fight nutritional diseases. For instance, the Ministries of Health, Education, Agriculture and Community Development worked together to combat nutrient-related diseases, while the Ministry of Labour ensured adequate

¹⁹ “New High Commissioner Aims to Strengthen Friendship Between Tanganyika and Britain, April 12, 1962,” TNA. Acc. No. 593, Orodha ya Majalada Idara ya Habari, File No. CA/6/1, Tanganyika Foreign Service, 1961-1964.

²⁰ URT, *Tanganyika, Five-Year Plan for Economic and Social Development, 1st July 1964-30th June 1969, Volume II: The Programmes, 1964*, 118.

²¹ “Development Plan, Ministry of Health, Nutrition, July 9, 1963,” TNA. Acc. No. 450, Ministry of Health, File No. HE. 1172, Medical Development Plan.

²² “Development Plan, Ministry of Health, Nutrition 9, July 1963,” TNA. Acc. No. 450, Ministry of Health, File No. HE. 1172, Medical Development Plan.

food to certain workers and their families through nutritional allowances. At the same time, the Ministry of Commerce and Industry processed and imported essential foodstuffs.²³ The government's focus on eradicating malnutrition, which was the most alarming challenge, had the unfortunate consequence of downplaying other nutritional diseases mentioned earlier. Nonetheless nutritional campaigns played a commendable role in spreading nutritional education among the population.²⁴

Nutritional campaigns were backed by the *Chakula Ni Uhai* (Food Is Life) programme of 1975, which attempted to respond to the question of what communities produced and ate. The programme strived to enable people to get essential foodstuff and change eating habits to avoid nutritional diseases. The government encouraged peasants to produce enough of several kinds of food crops to cater to the demands and consumption levels of rural people. Several campaigns launched before the *Chakula Ni Uhai* such as *Siasa Ni Kilimo* (Politics Is Agriculture) or the Iringa Declaration of 1972 and the *Kilimo cha Kufa na Kupona* (Life and Death Farming) of 1974 were the vanguard to realising the nutritional campaign.²⁵ Through these operations, the government attempted to attain self-reliance and adequate food production. However, agricultural activities were stalled by droughts which occurred from 1973 to 74; 1981 to 82; and 1983 to 84, severely limiting the production of both food and cash crops, which forced the government to rely on imported foodstuffs.²⁶

Furthermore, from 1973 to 78, the government launched a five-year preventive health education campaign to fight common diseases. The campaign, which was referred to as *Mtu Ni Afya* (Man Is Health), focused on strategies to maintain a healthy environment and individual hygiene. The campaign was largely sponsored by the Swedish International Development Cooperation Agency (SIDA) and cost more than Tshs. 1,450,000.²⁷ It explicitly aimed to raise

²³ "Development Plan, Ministry of Health, Nutrition 9, July 1963," TNA. Acc. No. 450, Ministry of Health, File No. HE. 1172, Medical Development Plan.

²⁴ Interview by Andrea Kifyasi with Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam. Gallus is a retired Principal Assistant Secretary of the Ministry of Health.

²⁵ C. K. Omari, "Politics and Policies of Food Self-Sufficiency in Tanzania," *Social Science Medicine* 22, no. 7 (1986): 770.

²⁶ T. L. Maliyamkono and M. S. D. Bagachwa, *The Second Economy in Tanzania* (London: James Currey, 1990), 4; Deborah Fahy Bryceson, *Liberalizing Tanzania's Food Trade: Public and Private Faces of Urban Marketing Policy, 1939-1988* (Mkuki na Nyota Publishers, 1993), 8; John Shao, "Politics and the Food Production Crisis in Tanzania," *A Journal of Opinion*, 14 (1985): 11 (10-24); G. C. Kahama, T. L. Maliyamkono and S. Wells, *The Challenge of Tanzania's Economy* (Dar es Salaam: Tanzania Publishing House, 1986), 41.

²⁷ "Letter from the Institute of Adult Education of the University of Dar es Salaam, February 15, 1973, to all Regional Development Directors, Allocation of Funds from SIDA Grant for Training Seminars of Mtu Ni Afya Campaign," MRC. Acc. No. 19, File No. D. O. 1/92, Mtu Ni Afya, 1972-1974; Wilson Kaigarula, "Taking Health Services to the People," *Daily News*, March 6, 1979, 4; Margunn M. Bech, *et al.*, "Changing Policies and Their

awareness about the ways in which people could make their lives healthier, inform them about symptoms and ways to prevent common diseases, and encourage literate people to read preventive health-related materials and share their knowledge with their friends and families.²⁸ The programme was carried out from the view that the most common diseases in Tanzania were preventable. Thus, regardless of their class, people were tasked with the responsibility to contain the emergence and spread of several diseases.

The *Mtu Ni Afya* campaign had much in common with preventive health campaigns carried out in other countries of the Global South such as Cuba and China. In the 1950s, for instance, the Chinese government, through “Mass Line for Health,” attempted to prevent the occurrences and spread of common diseases such as bilharzia, tuberculosis, and venereal diseases. Accordingly, in 1952, it launched the “Patriotic Health Movement” which mobilised the Chinese to eradicate rats, flies, mosquitoes, and other carriers of infectious diseases. They also cleared garbage and litter and improved the disposal and recycling of human excreta, and above all, enhanced the quality of water supply.²⁹ Subsequently, in 1966, the Tanzanian Ministry of Health sent medical delegates to study China’s health system. Upon their return home, they recommended that the government adopt several preventive health measures which they learned in China.³⁰ Indeed, adopting preventive health programmes which were similarly implemented by some Southern countries reflected the country’s commitment to the South-South cooperation and admiration of learning from the South.

Unlike the Chinese government, which used both radio and films to transmit preventive health education, the Tanzanian government mostly used radio programmes. Transmitting knowledge through radio broadcast was initially used successfully in 1969 by the Institute of Adult Education of the University of Dar es Salaam in defining goals of the country’s Second Five Year Plan. Through radio programmes, the government also communicated knowledge on the significance of the general election of 1970. Moreover, in 1971, through the *Wakati wa Furaha* (Time for Rejoicing) programme, the government used

Influence on Government Health Workers in Tanzania, 1967-2009: Perspectives From Rural Mbulu District,” *The International Journal of African Historical Studies* 46, no. 1 (2013): 69.

²⁸ “Letter from the Institute of Adult Education of the University of Dar es Salaam, February 15, 1973, to all Regional Development Directors, Allocation of Funds from SIDA Grant for Training Seminars of Mtu Ni Afya Campaign,” MRC. Acc. No. 19, File No. D. O. 1/92, Mtu Ni Afya, 1972-1974; Resnick, *The Long Transition*, 57; Budd L. Hall, *Mtu Ni Afya (“Man Is Health”): Tanzania’s Health Campaign* (Washington: Clearinghouse on Development Communication, 1978), 24.

²⁹ Hall, *Mtu Ni Afya*, 8.

³⁰ “Mambo yalivyo Uchina,” *Nchi Yetu Tanzania*, Desemba, 1966, 22-23.

radio broadcast to communicate economic, political, and social achievements reached after Ten Years of Independence.³¹ In this regard, radio programmes proved useful in reaching many people at the same time. By 1970, the country's total radio audience was estimated at 8 million out of 13.6 million population.³² Therefore, there were noticeably a good number of audiences who could get trained through radio programmes.

In a compelling and entertaining manner, preventive health education spread to different groups of people through the radio. The MoH produced about 12 half-hour radio programmes which were each broadcasted weekly and repeated twice to enhance their understandability.³³ Before the commencement of the campaign, the MoH held at different levels a whole series of seminars aimed at training 750,000 discussion group leaders who coordinated listening groups in their respective communities and led discussions after each session. Indeed, through radio study groups, health education was easily spread to both literate and illiterate populations. Radio campaigns were a useful means of knowledge circulation since, through 1970, more than 80% of the population were considered illiterate; hence, they could not conceivably attend formal health education training.³⁴ In addition to radio programmes, photographs, books, pamphlets, line drawings, posters, and manuals written in simple Kiswahili texts were produced and distributed widely. The government distributed two specially written textbooks to an estimated two million students and put out radio programmes to coincide with discussion group meetings held between May and August 1973.³⁵ The government expected that, through participation in discussion groups, reading circulated books, and listening to the radio health programs, health education would swiftly spread and people would practice what they learned, have their health improved, and diseases reduced.

The *Mtu Ni Afya* campaign targeted common diseases which would possibly be alleviated through certain basic health activities performed individually or communally. Such activities included but were not limited to: drinking clean and boiled water, covering food, building and using latrines, eating a nutritious diet, destroying mosquito breeding sites and

³¹ Hall, *Mtu Ni Afya*, 17.

³² Budd L. Hall, "Revolution in Rural Education: Health Education in Tanzania," *Community Development Journal* 9, no. 2 (April 1974): 133-134.

³³ Hall, "Revolution in Rural Education," 134.

³⁴ Hall, "Revolution in Rural Education," 134; Susan E. Wilson and E. Jackson Allison Jr., "Training Trainers in Developing Countries: Health Education and Mass Media Aspects of Low Cost Sanitation," *Journal of Environmental Health* 48, no. 6 (May/June 1986): 312.

³⁵ Julius K. Nyerere, *President's Report to the TANU Conference, Sept. 1973*, 17; Resnick, *The Long Transition*, 118; Hall, "Revolution in Rural Education," 134.

using nets, killing snails, digging rubbish pits, vaccinations, enlarging windows to allow more ventilation, making racks or stands to hold eating utensils, digging wells, and avoiding spitting in public areas as well as discouraging group use of drinking containers and cigarettes.³⁶ These and other health activities were expected to contain the spread of several diseases such as hookworm, dysentery, water-borne diseases, malaria, schistosomiasis (bilharzia), and tuberculosis. These diseases were widespread and cost the lives of many Tanzanians. However, prominence was given to malaria, which accounted for 10% of all hospital admissions and 7% of all deaths.³⁷

The government was determined to reach notable achievements through health education campaigns. It, therefore, requested medical doctors from Cuba and China, whose health institutions had long practised preventive health education campaigns to spread health education in the country. In different historical periods, Chinese and Cubans suffered from tuberculosis, bilharzia, and malaria. Through preventive health measures, they were able to reduce the pace of these occurrences and the extent of their spread. Their medical doctors dispatched to Tanzania had, therefore, enough experience and knowledge on preventive health education to share with Tanzanians.³⁸ In this vein, in 1973, the Minister for Health, Ali Mwinyi, prompted Chinese medical doctors to transmit preventive health education throughout the villages and hospitals where they worked, and to share transmission strategies with local medical workers.³⁹ Information from the health department of the Shandong province shows that at different occasions, Chinese medical staff spread preventive health education to several villages (Figure 1).⁴⁰

³⁶ Nyerere, *President's Report to the TANU Conference*, 17; Resnick, *The Long Transition*, 119; Hall, "Revolution in Rural Education," 137.

³⁷ Hall, *Mtu Ni Afya*, 24.

³⁸ See, for instance, Hall, *Mtu Ni Afya*, 8.

³⁹ "Rekodi ya Mkutano Uliofanyika Ofisi ya Waziri (Afya) Baina ya Waziri wa Afya Mh. Ali Mwinyi na Viongozi Wapya wa Timu ya Madaktari wa Kichina, Jumamosi, Tarehe, 9.6.1973, Saa Tatu Asubuhi," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5, Technical Assistance China.

⁴⁰ Health Department of the Shandong Province, *The Chinese Medical-Aid Team in the United Republic of Tanzania, 1968-1998* (Shandong, 1998), 74.

Figure 1: Chinese and local medical workers offering preventive health education to villagers (undated, likely 1970s)



Source: Health Department of the Shandong Province, *The Chinese Medical-Aid Team in the United Republic of Tanzania, 1968–1998*, (Shandong 1998), 74.

The health education campaign, however, was arduous since it faced several challenges including radio broadcast interruptions due to bad weather in some places, and radio networks that were yet to be installed in other places – both limiting peoples’ access to the programmes. Therefore, village facilitators who attended health trainings were crucial in informing people with no access to radio services. Additionally, taboos among some ethnic groups hindered them from adopting certain health practices encouraged during the campaign. For instance, some communities held the view that “the faeces of fathers and children, particularly those of fathers and daughters, are not mixed”.⁴¹ Therefore, for such communities, sharing latrines with the entire family was taboo. These and other challenges, however, did not hinder notable successes of the health campaign. Budd Hall and Idrian Resnick tell that in

⁴¹ Hall, *Mtu Ni Afya*, 60.

Dodoma District latrines were built in every house. In other places such as Iringa Region, they built latrines near their houses and next to major bus stops and market areas.⁴² Undeniably, the campaign played a significant role in containing the emergence and the spread of several diseases. Reports from the MoH shows that it increased the coverage of basic sanitation from 20% in 1973 to 80% in 1978.⁴³

Several preventive health education campaigns adopted by the post-colonial government disengaged the country from the hangover of the colonial health policies, which favoured curative measures.⁴⁴ Preventive and educative approaches empowered people with not only technical health knowledge but also the awareness that they had the power to change their lives and hence avoid overwhelming the few available health care infrastructures and medical personnel. The effective spread of preventive health education meant fewer people would seek curative health services and hence reduce the country's disease burden. Consequently, the people themselves became constant agents of preventive health care. However, despite peoples' efforts to maintain their health, the government intervened further to regulate and implement the order of hygiene. Nevertheless, any triumphant drive to build a nation with a healthy population requires support from countries with experience and a strong economy. That is why Tanzania's government extended requests for medical aid to several donor countries. All forms of assistance, however, were curtailed by Cold War politics, which defined diplomatic relationships between donor and recipient countries. Indeed, donor countries only extended loans and grants to countries with mutual ideological understandings.⁴⁵ As a result, Tanzania's diplomatic fracas with Western bloc nations impacted the provisions of loans and grants negatively. This is the subject of the next section.

1.4 Tanzania's Foreign Policy and Its Crisis, 1961–1967

Tanzania attained its political independence at the height of Cold War politics. Consequently, the new government had to decide whether to subscribe to a capitalist or

⁴² Hall, *Mtu Ni Afya*, 46; Resnick, *The Long Transition*, 119; also see Amour Seleman and Mahandev G. Bhat, "Multi-Criteria Assessment of Sanitation Technologies in Rural Tanzania: Implications for Program Implementation, Health and Socio-Economic Improvements," *Technology in Society* 46 (2016): 70.

⁴³ URT, *Ministry of Health, National Guidelines for Rural Community Led Total Sanitation (RCLTS)*, April 2016, 6-7.

⁴⁴ Read, for instance, "A Speech by Honourable D. N. M. Bryceson, M. P., Minister for Health, 1962," TNA. Acc. No. 450, Ministry of Health, File No. HE. 1172, Medical Development Plan.

⁴⁵ Sebastian Edwards, *Toxic Aid: Economic Collapse and Recovery in Tanzania* (Oxford: Oxford University Press, 2014), 40.

socialist ideology or remain a non-aligned state. The government committed to non-alignment while striving to maintain equality, freedom, justice, and dignity. These aspects were summarised in the government's five foreign-policy guidelines outlined by President Julius K. Nyerere. The guidelines included: protection of the integrity and security of the country, support for African liberation and freedom from racist oppression, support of the United Nations in its search for peace and justice, promotion of African unity, and non-alignment in ideological power struggles.⁴⁶ An official statement from the Ministry of Foreign Affairs stipulated that:

We regard the present situation [the Cold War] where the world is riven into hostile ideological dissensions as being unsatisfactory. But it is not the belief of our people that the present divisions are between the good and the bad. We refuse to subscribe to the hideous proposition that one group of contenders is always wrong or that another group is always right. Our policy is to keep out of these automatic assumptions and all that is implied in them. The corollary in this policy is a feeling of friendliness to all nations in the world.⁴⁷

Indeed, the government was determined to not be dragged into the Cold War nor to be used as a pawn in the conflict. Therefore, it remained neutral, extending friendship to both conflicting parties on the basis of mutual non-interference in internal affairs.⁴⁸ Nevertheless, the practicality of this neutrality policy sparked a crisis in Tanzania's foreign relations during the mid-1960s. The mess grew through the unification of Tanganyika and Zanzibar in 1964, which complicated the country's relationship with the Federal Republic of Germany (FRG). At independence, the government of Zanzibar established diplomatic relations with the German Democratic Republic (GDR), while Tanganyika maintained diplomatic relations with the FRG. According to the terms of the union, foreign affairs were a matter for the government of Tanzania. As a result, all diplomatic representations were to be stationed in Dar es Salaam. This union agreement resulted in an untoward attitude from the FRG, in particular, which demanded sole representation to the exclusion of the GDR.⁴⁹

⁴⁶ Paul Bjerck, *Building a Peaceful Nation: Julius Nyerere and the Establishment of Sovereignty in Tanzania, 1960-1964* (New York: University of Rochester Press, 2015), 184; C. G. Kahama, T. L. Maliyamkono and Stuart Wells, *The Challenge for Tanzania's Economy* (Dar es Salaam: Tanzania Publishing House, 1986), 26.

⁴⁷ "Tanganyika Foreign Policy," TNA. Acc. No. 593, Orodha ya Majalada Idara ya Habari, File No. CA/6/1, Tanganyika Foreign Service, 1961-1964.

⁴⁸ President Julius K. Nyerere's Speech Delivered at the opening of TANU National Conference, October 16, 1967, Published in *The Nationalist*, October 17, 1967, 3-4 & 8.

⁴⁹ The FRG was among the leading donors to the government of Tanganyika. It provided grants amounting to USD 297,090 and USD 2,100,000 in 1962/63 and 1963/64, respectively. Before the Germany Unity (Deutsche

The FRG's discontent further resulted in blackmailing the union government to the effect that non-compliance with their demand would adversely affect relations between the FRG and the Tanzanian government. It threatened to withhold scheduled aid and withdraw already released assistance to the country. Despite all the mentioned intimidations, the government of Tanzania permitted the GDR to establish a Consulate General in Dar es Salaam. Subsequently, the FRG withdrew its military aid starting with taking home its fifty servicemen. Nyerere responded by terminating all aid forthwith from the FRG worth USD 32.5 million, informing the FRG Ambassador, Dr Herbert Schroeder, that on principle, he was not prepared to compromise the conditions under which Tanzania received overseas aid. He further charged that the FRG sought to turn the Tanzanian government into its puppet via aid.⁵⁰ Nyerere's uncompromising stand was hailed by several groups of Tanzanians as well as representatives of liberation movements who assembled in Nairobi for the Organisation of African Unity (OAU) conference. Indeed, the FRG's dictates propelled Tanzania's move to self-reliance campaigns (see below).⁵¹ Under threats from the FRG, Nyerere's regime had to decide whether to maintain its relationship with the FRG and forgo the union government or vice versa. Nyerere's regime chose the union government, which, in turn, put an end to all kinds of assistance from the FRG and its allies. However, although the decision to allow both FRG and

Einheit) of 1990, the FRG distinguished itself as a legitimate government of Germany and any state which recognised GDR was no longer a friend of the Bonn regime. Consequently, it channelled its aid to countries which did not forge diplomatic relationships with the GDR. This posture was consistent with the "Hallstein Doctrine" which overtly threatened to cancel diplomatic relations with countries which would recognise what so-called the Soviet Occupation Zone (Sowjetische Besatzungszone); see, for instance, Guido Magome, "Self-Reliance Makes Stronger and Faster Pace," *Daily News*, February 1, 1978, 5-6; Kapepwa I. Tambila, "Aid from the Recipient's Point of View: The Tanzania Experience," in *Diplomacy and Development: Proceedings of the 10th International Conference of Editors of Diplomatic Documents*, ed. Marc Dierikx (The Hague: Institute of Netherlands History, 2010), 82; Severine M. Rugumamu, *Lethal Aid: The Illusion of Socialism and Self-Reliance in Tanzania* (Trenton, NJ: Africa World Press Inc, 1997), 120; George Roberts, "Politics, Decolonization, and the Cold War in Dar es Salaam c. 1965-72" (PhD thes., University of Warwick, 2016), 87; Bjerk, *Building a Peaceful Nation*, 214; Thomas Burgess, "The Rise and Fall of a Socialist Future: Ambivalent Encounters Between Zanzibar and East Germany in the Cold War," in *Navigating Socialist Encounters: Moorings and (Dis) Entanglements Between Africa and East Germany during the Cold War*, eds. Eric Burton, Anne Dietrich, Immanuel R. Harisch, and Marcia C. Schenck (Berlin: Walter de Gruyter, 2021), 176-177.

⁵⁰ "You Can Take Back All Your Aids; Nyerere Tells Bonn," *The Nationalist*, March 1, 1965, 1; Julius K. Nyerere, *Freedom and Socialism: A Selection from writings and speeches, 1965-67* (Dar es Salaam: Oxford University Press, 1968), 90; Priyal Lal, *African Socialism in Postcolonial Tanzania: Between the Village and the World* (New York: Cambridge University Press, 2015), 56-57; Roberts, "Politics, Decolonization, and the Cold War in Dar es Salaam," 44.

⁵¹ "Nyerere's Stand on Bonn Hailed," *The Nationalist*, March 2, 1965, 3.

GDR to have their representation in the country was compatible with the country's neutrality policy, it regrettably conflicted with the Hallstein Doctrine.⁵²

The decisions by Nyerere's government impacted the endurance of the health sector negatively because the FRG extended part of its aid to health care. For instance, Tanzanians pursuing health-related courses in several medical colleges under Bonn government scholarships had to return home where the government pledged to find alternative colleges and universities to enable them to complete their studies.⁵³ While the Tanzanian government refused to succumb to FRG's dictates, it simultaneously sustained a close relationship with the GDR. As a result, it localised Cold War politics in the country as the two conflicting powers had their homes in Dar es Salaam, each trying to show its supremacy over the other. All these incidents happened in 1964, a few years after Tanzania's political independence. It was a period when the country had neither declared an ideology nor was its economy strong enough to forgo external aid.

Furthermore, in 1965, another capitalist power, Britain, similarly entered diplomatic disputes with the Tanzanian government. The Tanzanian campaign for the decolonisation of the Southern Rhodesia (now Zimbabwe) partly influenced the collapse of their bonds. Under its Unilateral Declaration of Independence (UDI), a minority declared independence in Zimbabwe. This incidence sparked anger in some African countries, including Tanzania, which openly criticised the UDI. This diplomatic rift, however, was somewhat different from the rift between the FRG – which was a bilateral incident involving Bonn and Dar es Salaam. The UDI case was multilateral since the OAU was the vanguard for action. Towards the end of 1965, the OAU wanted the British government to resume constitutional responsibility for Southern Rhodesia and bring down Smith's regime. OAU members threatened to sever their diplomatic relations with Britain if it did not meet their demands.⁵⁴ The voices by these OAU members, however, were not impactful since the British government did not take action against the Smith's regime. In response to the OAU declarations, Tanzania was one of the first nine African countries to sever diplomatic ties with Britain. As a result, all London-aid to the country halted. The health sector was severely hurt by the crisis since all medical workers from

⁵² "Politics, Decolonization, and the Cold War in Dar es Salaam," 44.

⁵³ "Wanafunzi nao Watarudishwa toka Ujerumani," *Ngurumo*, Machi 19, 1965, 1.

⁵⁴ Magome, "Self-Reliance Makes Stronger and Faster Pace," 5-6.

Britain working in the country departed immediately after the dispute.⁵⁵ FRG's and Britain's withholding all assistance to the government of Tanzania affected the country's economic and social sectors. Yet, the government did not yield in to economic and diplomatic pressures from Bonn and London. Instead, it promoted "self-help schemes" and prepared citizens to espouse the policies of socialism and self-reliance officially adopted in 1967. Indeed, these diplomatic rifts did not only prompt the Tanzanian government to turn to Beijing and other socialist countries for economic, social, and technological assistance but they also made it cautious of accepting foreign aid as discussed at length in the next section.

1.5 Self-Reliance Agenda and Tanzania's Perception and Paradox of Foreign Aid

Aid giving has a very long history. However, it became robust in 1947 following the proposal by the US Foreign Minister, George C. Marshall. The main motive of his proposal was to reconstruct the severely wounded economies of the European countries which participated in the Second World War. The Marshall Plan was eventually realised in 1948.⁵⁶ The Plan was followed by the Bretton Woods Institutions (BWIs) which similarly focused on rescuing the economy of European countries after the War. At its preliminary stage, countries of the Global South did not receive any assistance from the BWIs even though they were also affected by the War. However, the Cold War politics that followed informed the lack of aid provisions to the South. Later, loans and aid were not only offered for development projects but also for supporting countries fighting for independence and nation-building. For instance, in the 1950s, the US President, Harry S. Truman, advocated assistance to Southern countries, with a focus on states that were in the anteroom of communism. Thus, South Korea and Taiwan became the earliest countries to benefit from US aid.⁵⁷ Indeed, Cold War politics defined economic, political, social, and technological assistance to the South. While US aid aimed at halting the spread of communism, Soviet assistance focused on subverting the extension of capitalism.

⁵⁵ Resnick, *The Long Transition*, 57; Magome, "Self-Reliance Makes Stronger and Faster Pace," 5-6; John Iliffe, *East African Doctors: A History of the Modern Profession*, (Cambridge: Cambridge University Press, 1998), 200.

⁵⁶ David Sogge, *Give and Take: What's the Matter with Foreign Aid?* (Dhaka: The University Press, 2002), 1; John Degenbol-Martinussen and Poul Engberg-Pedersen, *Understanding International Development Cooperation* (London: Zed Books Limited, 1999), 8.

⁵⁷ Edwards, *Toxic Aid*, 40; Degenbol-Martinussen and Engberg-Pedersen, *Understanding International Development Cooperation*, 8.

It is against such background that in 1967 the Tanzanian government endorsed the Arusha Declaration, which spearheaded socialism and self-reliance policies as a means of getting rid of lingering dependence. The Declaration denounced foreign aid as principal and effective means to realise economic development and nation-building. The government perceived grants as a driving force to dependence. Under the Declaration, the government was determined to shift the nation from aid-dependency to self-dependency. Underscoring this Nyerere contended:

[. . .] it is even more stupid, for us to imagine that we shall rid ourselves of our poverty through foreign financial assistance rather than our own financial resources [. . .] there is no country in the world which is prepared to give us gifts or loans, or establish industries, to the extent that we would be able to achieve all our development targets [. . .] even if it were possible [. . .] is this what we really want? Independence means self-reliance. Independence cannot be real if a nation depends upon gifts and loans from another for its development. Even if there was a nation, or nations, prepared to give us all the money we need for our development, it would be improper for us to accept such assistance without asking ourselves how this would affect our independence and our very survival as a nation.⁵⁸

Nyerere realised the duality inherent to potential prospects and dangers from loans and grants: the former being essential for the country's development, and the latter being a danger to that nation's sovereignty because he who pays the piper calls the tune. In this vein, the Declaration did not denounce aid and loans altogether. Instead, the government vowed to receive foreign assistance which promised to help the country move through a transition towards self-reliance.⁵⁹ In abstract, Nyerere's regime was not ready to relinquish its sovereignty to the donors by accepting grants. Nevertheless, his government was less sceptical over foreign loans. The Declaration avowed that:

It is true that loans are better than "free" gifts. A loan is intended to increase our efforts or make those [efforts more] fruitful. But even loans have their limitations. You have to give consideration to the ability to repay. To burden the people with big loans, the repayment of which will be beyond their means, is not to help them but to make them suffer. It is even worse when the loans they are asked to repay have not benefited the majority of the people but have only benefited a small minority.⁶⁰

⁵⁸ Julius K. Nyerere, *The Arusha Declaration and TANU's Policy on Socialism and Self-Reliance*, February 5, 1967, 6-7.

⁵⁹ Nyerere, *The Arusha Declaration and TANU's Policy on Socialism and Self-Reliance*, 7.

⁶⁰ Nyerere, *The Arusha Declaration and TANU's Policy on Socialism and Self-Reliance*, 7.

Despite the commitments, Nyerere's self-reliance ambitions were paradoxical and utopian. The country's dependence upon foreign aid and loans was not meaningfully reduced after the Arusha Declaration due to hurdles it encountered restructuring the economy. As a result, from the mid-1960s through the 1970s, foreign assistance became the lifeline of Nyerere's government, and the country was the world's leading recipient of loans and grants. Rwekaza Mukandala writes that under this self-reliance paradigm, the government became "more like a shameless beggar."⁶¹ Nevertheless, most of its loans and aid were sourced from China and Nordic countries which Nyerere perceived as "comrade in arms". Nyerere supposed that, unlike the US and other imperialist donors, assistance from China and Nordic countries was consistent with the country's self-reliance agenda and would not meddle in internal affairs.⁶² Nevertheless, the manner in which Nordic and Chinese assistance was executed surely did not help the country become self-reliant.⁶³

China and the Nordic countries provided loans and grants to Nyerere's government despite critiques from the US and other traditional donors of the North. Instead, they were inspired by Nyerere's development endeavour, especially the self-reliance agenda, which paralleled their foreign aid policies. Sweden and China, for instance, shared socialist ideology with Nyerere's government. Thus, they had high confidence in Tanzania's authority. Such trust influenced them to assist the country while honouring Nyerere's priorities, the act which Ole Elgstrom calls "aid on recipient's terms".⁶⁴ Foreign aid and loans from China and Nordic countries from the mid-1960s to 80s contributed to several economic and social projects such as roads, rails, agriculture, water and electricity production and supply, as well as health infrastructures. One such memorable project financed by the Chinese government was the construction of the Tanzania-Zambia Railway (TAZARA), a project which had been dismissed by funders from the North.⁶⁵ The Chinese government's commitments to the railway and other

⁶¹ Rwekaza Mukandala, "From Proud Defiance to Beggary: A Recipient's Tale," in *Agencies in Foreign Aid: Comparing China, Sweden and the United States in Tanzania*, eds. Goran Hyden and Rwekaza Mukandala (New York: St. Martin's Press, 1999), 31.

⁶² Resnick, *The Long Transition*, 131; Mukandala, "From Proud Defiance to Beggary," 38; Paul Tiyambe Zeleza, "Dancing with Dragon: Africa's Courtship with China," *The Global South* 2, no. 2 (Fall 2008): 174.

⁶³ This work contributes to a study by Sebastian Edwards which generally examines the roles of foreign aid to Tanzania. See Edwards, *Toxic Aid*.

⁶⁴ Ole Elgstrom, "Giving Aid on the Recipient's Terms: The Swedish Experience in Tanzania," in *Agencies in Foreign Aid: Comparing China, Sweden and the United States in Tanzania*, eds. Goran Hyden and Rwekaza Mukandala (New York: St. Martin's Press, 1999) 116; for Chinese side see Ai Ping, "From Proletarian Internationalism to Mutual Development: China's Cooperation with Tanzania, 1965-95," in *Agencies in Foreign Aid: Comparing China, Sweden and the United States in Tanzania*, eds. Goran Hyden and Rwekaza Mukandala (New York: St. Martin's Press, 1999), 170.

⁶⁵ Monson, *Africa's Freedom Railway*, 3.

projects won it the trust of the Tanzanian authorities, and Nyerere's regime became less hesitant to accept Chinese loans and grants.⁶⁶ Nyerere commended the Chinese government boldly, claiming that its assistance to Southern countries had no elements of imperialism. In a speech delivered to the handing over of the TAZARA he contended:

I used to be endlessly pestered with unsolicited warnings and advice about the dangers of accepting Chinese cooperation. When it became abundantly clear even to the worst detractors of China and the greatest enemies of African freedom and development that China had no imperialist ambitions in Africa, another question was raised. And the question was: "Why is China, a Third World country, being so correct and so generous in dealing with the poor?" My answer to this rephrased suspicion of China is "Ask the leaders of the super-rich countries why they are often so arrogant and so mean in their dealing with the nations of the Third World?"⁶⁷

Nyerere perceived loans and aid from Northern donors as imperialistic in nature and less promising to turn recipient countries self-reliant. In contrast, he perceived China's assistance as worthy and friendly to development.⁶⁸ His perceptions represented the aspirations of many African political elites who resented the economic and political strings attached to foreign loans and aid, aiming for maximum assistance and minimum interference. The Chinese government realised the wishes of African leaders and won the trust of their governments by relaxing conditions attached to loans and grants deployed to the continent. Indeed, the perception of African leaders over loans and grants was that, unlike traditional donors of the North, the Nordic countries, China, and other donors of the South aided Southern countries altruistically. Such perceptions, however, were uncertain.

However, assistance and general trust of Western governments in Nyerere waned in the late 1970s. In 1978, the Chinese government underwent reform and opening-up policy limiting their assistance for foreign internal economic prosperity.⁶⁹ Similarly, Sweden and the Netherlands reduced their support in 1981; while Norway and Finland withheld their assistance

⁶⁶ Interview by Andrea Kifyasi with Joseph W. Butiku, 9th July 2018, Posta-Dar es Salaam. Mzee Butiku is an Executive Director of The Mwalimu Nyerere Foundation. He worked at the statehouse as personal research Assistant of Mwalimu Nyerere from 1965.

⁶⁷ Julius K. Nyerere, 'TAZARA – from a Caricature of a "Chinese" Railway to "Our" Railway,' A Speech at the Handing-over of the Tanzania-Zambia Railway (TAZARA) to Tanzania and Zambia Kapiri Mposhi, Zambia: July 14, 1976, in *Freedom and Liberation: A Selection from Speeches 1974-1999*, ed. The Mwalimu Nyerere Foundation (Dar es Salaam: Oxford University Press (T)., 2011), 95.

⁶⁸ Julius K. Nyerere, 'TAZARA – from a Caricature of a "Chinese" Railway to "Our" Railway,' 97.

⁶⁹ Giles Mohan and Marcus Power, "New African Choices? The Politics of Chinese Engagement," *Review of African Political Economy* 115, no. 23-42 (2008): 29.

in 1984. Political changes and concerns of taxpayers over efficiencies of foreign aid prompted their decisions.⁷⁰ In light of such changes, by the mid-1980s, Nordic countries joined other traditional donors of the North to push Nyerere's government to accept Structural Adjustment Programmes (SAPs) terms and conditions. Nyerere was not ready to endorse them. Instead, he stepped out from power to give a chance to a new regime which accepted the conditions wholeheartedly.⁷¹ Discussions in the next section show that Nyerere's trust of the Chinese and other donors of the South was further influenced by the Southern solidarity propelled by various Afro-Asian movements.

1.6 Afro-Asian Movements and the Southern Solidarity Agenda, 1955–1967

The Cold War politics gave birth to numerous Afro-Asian movements that founded the South-South cooperation (SSC), which propelled the exchange of resources, technology, experience, and knowledge bilaterally, multilaterally, regionally, and at interregional levels among Southern countries.⁷² The politics of the Cold War divided the world into two power blocs, hence prompting the Bandung Conference held in Indonesia on April 18 to 24, 1955, which pioneered establishing the Non-Aligned Movement (NAM) in 1961 Belgrade, Yugoslavia. The Bandung Conference was convened under the commitments of five Prime Ministers of Myanmar, Sri Lanka, India, Indonesia, and Pakistan. Under meetings held from April 28 to May 2, 1954, in Sri Lanka and from December 28 to 29 in Indonesia, they agreed to ally with African and Asian countries to promote economic and cultural cooperation and oppose imperialism, colonialism, and neo-colonialism. The First Asian-African Conference in Bandung was attended by delegates from 29 African and Asian states, through which six were African, and marked the beginning of China's activities in Africa.⁷³ Through the conference,

⁷⁰ For instance, the newly elected regime in Sweden did not cherish socialist ideology prioritised by the former regime, which was compatible with Nyerere's ideology. Edwards, *Toxic Aid*, 114; Elgstrom, "Giving Aid on the Recipient's Terms," 116.

⁷¹ Goran Hyden and Rwekaza Mukandala, "Studying Foreign Aid Organizations: Theory and Concepts," in *Agencies in Foreign Aid: Comparing China, Sweden and the United States in Tanzania*, eds. Goran Hyden and Rwekaza Mukandala (New York: St. Martin's Press, 1999), 21; Edwards, *Toxic Aid*, 54.

⁷² See Isaline Bergamaschi and Arlene B. Tickner, "Introduction: South-South Cooperation Beyond the Myths – A Critical Analysis," in *South-South Cooperation Beyond Myths: Rising Donors, New Aid Practices?* ed. Isaline Bergamaschi, Phoebe Moore and Arlene B. Tickner (London: Palgrave Macmillan, 2017), 1-2; Meibo Huang, "Introduction: South-South Cooperation and Chinese Foreign Aid," in *South-South Cooperation and Chinese Foreign Aid*, ed. Meibo Huang, Xiuli Xu and Xiaojing Mao (Singapore: Palgrave Macmillan, 2019), 1.

⁷³ Six African states which its delegates attended the conference were; Egypt, Ethiopia, Ghana, Liberia, Libya and Sudan, The Ministry of Foreign Affairs, Republic of Indonesia, *Final Communique of the Asian-African Conference of Bandung, 24th April 1955*, 2.

Premier Zhou Enlai of China met delegates from six African countries and established diplomatic relations.⁷⁴ Among others, the conference anticipated decreasing dependence on aid from countries of the North, creating a shift in the international balance of power, neutralising the influence of the North to the South; as well as strengthening and improving their economic ties through the exchange of resources, technology and knowledge.⁷⁵

The Bandung Conference did not set up a continuing secretariat, but it tentatively proposed to hold an Asian-African Conference in Egypt. The First Asian Conference held in New Delhi in December 1956 intensified plans for the Cairo conference. The Delhi Conference formed a preparatory commission that organised the first Afro-Asian Conference from December 26, 1957, to January 1, 1958, in which they invited about 53 African and Asian countries and territories.⁷⁶ The Cairo Conference conceived the name “Afro-Asian Peoples’ Solidarity Movement”, later changed to Afro-Asian Peoples’ Solidarity Organisation (AAPSO) in 1960.⁷⁷ About 507 participants representing 44 African and Asian countries attended the Cairo Conference. Unlike the Bandung Conference, which was attended by six countries from Africa, 127 delegates from 19 African countries and territories attended the Cairo Conference.⁷⁸ The organisation allowed delegates from Asia and Africa to discuss and find solutions to several economic, political, social, and technological problems. The Cairo Conference issued the “Cairo Declaration” which condemned Western imperialism, colonialism, and neo-colonialism, and made Cairo the headquarters of the organisation.⁷⁹

Chinese delegates used the Southern solidarity movement to win political recognition over Taiwan. This was because, from its inception in 1945, the UN recognised Taiwan as the legitimate representative of mainland and island China.⁸⁰ Although mainland China had, since 1949, been under Communist China, the Taipei regime continued to exercise its sovereign

⁷⁴ Bruce D. Larkin, *China and Africa, 1949-1970* (Berkeley, CA: University of California Press, 1973), 16.

⁷⁵ Paschal B. Miho, “Practical Problems in the South-South Development Cooperation: Some Experiences Involving Tanzania,” *Law and Politics in Africa, Asia and Latin America* 25, no. 2 (Quarterly 1992): 225; “From Bandung to Algiers,” *Peking Review* 8, no. 25, June 18, 1965, 16.

⁷⁶ Home A. Jack, “The Cairo Conference,” *Africa Today* 5, no. 2 (Mar. – Apr. 1958): 6. The author of this article attended the conference in Cairo and promptly published an article summarizing events and discussions existed at the conference using official documents he collected.

⁷⁷ Permanent Secretariat of the Afro-Asian Peoples’ Solidarity Organisations, *Afro-Asian Peoples’ Solidarity Movement* (Cairo), 78.

⁷⁸ Jack, “The Cairo Conference,” 5.

⁷⁹ Permanent Secretariat of the Afro-Asian Peoples’ Solidarity Organisations, *Afro-Asian Peoples’ Solidarity Movement*, 6.

⁸⁰ “A Victory for World’s People, Crushing Defeat for U.S. Imperialism,” *Peking Review* 14, no. 44, October 29, 1971, 6.

rights on Chinese soil. Such circumstances caused the fight for diplomatic recognition to escalate between the Beijing and Taipei regimes.

The Chinese government asserted its admission to the UN agenda in numerous AAPSO conferences to gain support from countries of Asia and Africa.⁸¹ Indeed, the organisation had a promising future for China's struggle for political recognition since, by 1960, the AAPSO had about sixty member countries, many of which were UN members.⁸² Unlike any other, the mainland Chinese government became defacto the predominant member of the AAPSO. It had representatives in every committee of the organisation. For instance, it had a representative for the Council, Solidarity Fund Committee, Executive Committee, and a Permanent Secretariat.⁸³ China's representatives thus played a pivotal role in safeguarding the interests of the Chinese government in the organisation. They even upheld the banner criticising the UN, claiming that it was an instrument of neo-colonialism, promoting the AAPSO to demand China's admission to the UN.⁸⁴ For instance, the Executive Committee meeting held in Beirut from 9 to 13 November 1960, accused the UN of denying the admittance of mainland China to its assembly.⁸⁵ Since Taiwan was denied its subscription to AAPSO, Beijing used such a loophole to maintain its political influence over Taipei. Votes for the admittance of the Beijing government in the UN General Assembly (UNGA) rose from two in 1959 to seventeen in 1962.⁸⁶ Surely, the votes additional resulted from the increasing influence of the Chinese government in African and Asian countries.

The AAPSO accrued funds from different groups of people and institutions which supported its objectives. Since only a few countries in Africa and Asia could become sponsors, China and the USSR, throughout the 1960s, were the leading donors to the Afro-Asian Solidarity Fund. They provided funds to run the organisation, scholarships for African and Asian students, medical care, foodstuffs, and clothes to freedom fighters, which in turn meant

⁸¹ Read, for instance, Permanent Secretariat of the Afro-Asian Peoples' Solidarity Organisations, *Afro-Asian Peoples' Solidarity Movement*, 35.

⁸² Permanent Secretariat of the Afro-Asian Peoples' Solidarity Organisations, *Afro-Asian Peoples' Solidarity Movement*, 93.

⁸³ Permanent Secretariat of the Afro-Asian Peoples' Solidarity Organisations, *Afro-Asian Peoples' Solidarity Movement*, 97-113.

⁸⁴ Read, for instance, a Speech by Liu Ning-I, Head of the Chinese Delegation and Vice-Chairman of the Chinese Committee for Afro-Asian Solidarity at the 4th Session of the Afro-Asian People's Solidarity Council held in Bandung on April 10, 1961, in *The Chinese People Resolutely Support the Just Struggle of the African People, Compiled by The Chinese-African People's Friendship Association* (Peking: Foreign Languages Press, 1961), 50.

⁸⁵ Permanent Secretariat of the Afro-Asian Peoples' Solidarity Organisations, *Afro-Asian Peoples' Solidarity Movement*, 35.

⁸⁶ Leon M. S. Slawecki, "The Two China's in Africa," *Foreign Affairs* 41, no. 2 (Jan. 1963): 400.

that both nations dominated and influenced AAPSO's decisions.⁸⁷ This fact explains the instability of the organisation in the 1960s following the Sino-Soviet conflict. The Chinese government charged that Russia's revisionist policies were similar to those of imperialists and hence were unwanted in Asian-African conferences and Afro-Asian movements in general. The Chinese claims divided country members into three groups as some supported the claim while others opposed, and a few remained neutral.⁸⁸ Generally, the authorities of China and USSR wrecked the organisation in the attempt to bring it under their respective directions. Such circumstances, however, also bolstered the provisions of loans and grants to African and Asian countries by the Chinese and USSR governments for the sake of seeking African and Asian support.

Despite its fragmentation in the mid-1960s, the AAPSO established South-South economic, political, social, and technological assistance.⁸⁹ The AAPSO conference convened in Conakry in April 1960 decried the hegemonism of donors to recipient countries. The conference contended: "We declare that foreign capital is not a master but only a guest in our countries. And we will not offend our guest, provided he agrees to behave decently and make no attempt to usurp."⁹⁰ Accordingly, participants of the AAPSO Council meeting of April 1961 compiled a list of so-called agents of neo-colonialism, including traditional donors whose practice of conditional loan-provision they denounced.⁹¹ Parallel to AAPSO's assistance endeavour, Premier Zhou Enlai, in his speech to Ghanaians in January 1964, put forward eight aid principles pledging to respect recipient countries' sovereignty, promote self-sufficiency, and offer assistance with no strings.⁹² These principles were designed to win allies from African and Asian countries, gain their trust, and distinguish Chinese aid from that of the North.

⁸⁷ Permanent Secretariat of the Afro-Asian Peoples' Solidarity Organisations, *Afro-Asian Peoples' Solidarity Movement*, 70-71; CIA Report, *The Afro-Asian Peoples' Solidarity Organization from April 1960-April 1961, June 15th, 1961*, 20; Omar Ali Amer, "China and the Afro-Asian Peoples' Solidarity Organization, 1958-1967" (PhD diss., Geneva University, 1972), 99.

⁸⁸ "Chinese Delegates Attacks Russia at AAPSO Meeting," *Patriot Newspaper*, February 26-March 4, 1967.

⁸⁹ Permanent Secretariat of the Afro-Asian Peoples' Solidarity Organisations, *Afro-Asian Peoples' Solidarity Movement*, 8.

⁹⁰ Permanent Secretariat of the Afro-Asian Peoples' Solidarity Organisations, *Afro-Asian Peoples' Solidarity Movement*, 41-42.

⁹¹ Permanent Secretariat of the Afro-Asian Peoples' Solidarity Organisations, *Afro-Asian Peoples' Solidarity Movement*, 28.

⁹² Eight Principles for Economic and Technical Aid Contended by Premier Zhou Enlai when Answering Questions from Reporters of the Ghana News Agency on January 15, 1964 in Ghana, in *Afro-Asian Solidarity Against Imperialism: A Collection of Documents, Speeches and Press Interviews from the Visits of Chinese Leaders to Thirteen African and Asian Countries* (Peking: Foreign Languages Press, 1964), 149.

Furthermore, members of the AAPSO pioneered South-South knowledge production and circulation. The Second AAPSO Conference held at Conakry in April 1960, recommended production and exchanges of technical know-how among African and Asian people. Exchange of experts, teachers, doctors, writers, artists, journalists, workers, students, and other technical experts was encouraged to take place on the broadest possible scale.⁹³

Additionally, AAPSO members stressed assisting one another to improve social and health services. Commitments to helping one another were reached from the view that some independent countries in Africa and Asia were more advanced than others socially, economically, and scientifically.⁹⁴ The April 1960 AAPSO resolution reached in Conakry contended that: “[The] independent Afro-Asian States which have attained economic, social and scientific progress should [. . .] give all possible aid to countries which are still underdeveloped economically, socially and scientifically.”⁹⁵ In this regard, the AAPSO gave rise not only to medical assistance but also economic and political cooperation among member countries. The government of China was among the first countries from the Global South to provide medical aid to Asia, Africa, and Latin America. It provided medical services to the freedom fighters in Algeria, Zimbabwe, and Mozambique. Moreover, it staffed health centres in independent African countries such as Mali, Zanzibar and Tanzania when colonial medical workers had departed after the countries attained political independence (Chapter 3).⁹⁶ Discussions in the next section show that Sino-Tanzanian diplomatic relationship further informed China’s assistance to the country.

1.7 Sino-Tanzanian Relationship, 1961–1971

We wish to be friendly with all, and we will never allow our friends to choose our enemies for us. It is pursuance of this doctrine that Tanzania is so happy in its new friendship with China; and China has extended her own hand to meet ours. We now have a friend, a great

⁹³ Permanent Secretariat of the Afro-Asian Peoples’ Solidarity Organisations, *Afro-Asian Peoples’ Solidarity Movement*, 12.

⁹⁴ Permanent Secretariat of the Afro-Asian Peoples’ Solidarity Organisations, *Afro-Asian Peoples’ Solidarity Movement*, 54.

⁹⁵ Permanent Secretariat of the Afro-Asian Peoples’ Solidarity Organisations, *Afro-Asian Peoples’ Solidarity Movement*, 59.

⁹⁶ See, for instance, Robert Huish and John M. Kirk, “Cuban Medical Internationalism and the Development of the Latin American School of Medicine,” *Latin American Perspectives* 34, no. 6 (Nov., 2007): 77-92; also see Margaret Blunden, “South-South Cooperation: Cuba’s Health Programmes in Africa,” *International Journal of Cuban Studies* 1, no. 1 (June, 2008): 32-41, for Chinese medical assistance see Liu Jian, “A Healthy Relationship: China-Africa Medical Cooperation still going strong after 50 years.”

new friend, and a friend from whom we were barred in the days of colonialism.⁹⁷ Julius K. Nyerere, Beijing, February 1965.

The preceding statement was uttered by Tanzanian President, Julius Nyerere, in his first visit to China in February 1965. The visit came amid the rifts with Western Germany, the United Kingdom, and other countries in Europe. It was the first, long, and significant trip on which he met and held intensive conversations with Chinese President Mao Zedong and Premier Zhou Enlai. Nyerere, whom the Chinese applauded as an outstanding African statesman and a good friend of China, was warmly welcomed with a flood of people waving and lifting placards that reads “Long Live Sino-Tanzanian Friendship”.⁹⁸ Nyerere’s visit boosted the diplomatic relations, which had begun between the two countries in 1961. However, it was the AAPSO that brought together these independent African and Asian countries and popular political movements. Political parties from African and Asian countries such as the African National Congress (ANC) of South Africa, Tanganyika African National Union (TANU) of Tanganyika, and others were AAPSO members. Key freedom fighters from Africa, such as Oscar Kambona of Tanganyika, Kenneth Kaunda of Zambia, and Joshua Nkomo of Zimbabwe were members of the AAPSO Council.⁹⁹ After informal relationships had matured under the umbrella of the AAPSO, the Chinese government established formal diplomatic relations with Tanganyika on the day of independence, December 9, 1961.¹⁰⁰

The Sino-Tanzanian relationship grew from 1961 onwards. The Tanzanian government was among the first ten African countries to recognise the Beijing regime at the end of 1961. The Chinese government opened its embassy in Dar es Salaam, becoming the first Chinese embassy in East Africa immediately after independence. Its first ambassador, He Ying, presented letters of credentials at the government house in April 1962 and pledged to bolster Sino-Tanzanian friendship.¹⁰¹ He postulated: “I am confident that with the establishment of diplomatic relations between China and Tanganyika, the friendship and co-operation between

⁹⁷ “Fast Growing Sino-Tanzanian Friendship: China Hails President Nyerere’s State Visit,” *Peking Review* 8, no. 9, February 26, 1965, 7; Palamagamba Kabudi, “Tanzania-China Relationship Since the Dawn of the Friendship Treaty,” *Daily News*, October 14, 2020.

⁹⁸ “Fast Growing Sino-Tanzanian Friendship: China Hails President Nyerere’s State Visit,” *Peking Review* 8, no. 9, February 26, 1965, 5.

⁹⁹ Permanent Secretariat of the Afro-Asian Peoples’ Solidarity Organisations, *Afro-Asian Peoples’ Solidarity Movement*, 79.

¹⁰⁰ Ping, “From Proletarian Internationalism to Mutual Development,” 172.

¹⁰¹ “Tanganyika Receives China’s Envoy,” *Sunday News*, April 8, 1962, 1.

the two countries will be increasingly strengthened and developed on the basis of Five Principles of Peaceful Co-existence and the spirit of the Bandung Conference.”¹⁰²

Nevertheless, before 1965, the Sino-Tanzanian relationship developed slowly. There were few agreements signed between the two governments. For instance, in December 1962, the Tanzanian government signed a Cultural Agreement with China, which was followed by an official visit of Tanzania’s cultural delegation led by the Minister of National Culture and Youth, Lawi Nangwanda Sijaona, in October 1963.¹⁰³ On June 11, 1964, the Second Vice-President of Tanzania, Rashidi Mfaume Kawawa, visited China and signed an agreement on Economic and Technical Cooperation. Kawawa’s visit prompted the opening of the Tanzanian embassy in Beijing in October 1964. In February 1965, President Nyerere visited China for the first time and signed the “Sino-Tanzanian Treaty of Friendship.”¹⁰⁴ Nyerere’s visit boosted Sino-Tanzanian friendship as on June 4, 1965, Premier Zhou visited the country and pledged to back Tanzania’s nation-building agenda.¹⁰⁵ Subsequently, on November 22, 1965, the Second Vice-President of Tanzania paid another visit to China regarding negotiations about China’s assistance and other diplomatic resolutions.¹⁰⁶ The growing Sino-Tanzanian relations led to the opening-up of the Chinese Economic and Commercial Mission in Dar es Salaam in 1966. These series of events manifested the mounting development of political and economic ties between the two countries.

The Chinese authorities also gained Tanzanian leaders’ trust because they had supported the liberation struggles in various African countries. While the government of Tanzania strongly supported liberation movements in the Southern African countries, the

¹⁰² The Five Principles of Peaceful Co-existence referred by He included mutual respect for sovereignty and territorial integrity; mutual non-aggression; non-interference in each other’s internal affairs; equality and mutual benefit; and peaceful coexistence. The Principles were adopted from the AAPSO’s Cairo Declaration of 1957 and were officiated in the Sino-Tanzanian Treaty of Friendship signed in 1965. Read, for instance, article II of the “Sino-Tanzanian Treaty of Friendship,” *Peking Review* 8, no. 9, February 26, 1965, 9; for the AAPSO refer to Cairo Declaration which among other things declared Ten Principles which were the basis of the Afro-Asian movement in the Permanent Secretariat of the Afro-Asian Peoples’ Solidarity Organisations, *Afro-Asian Peoples’ Solidarity Movement*, 6-7; “Tanganyika Receives China’s Envoy,” *Sunday News*, April 8, 1962, 1.

¹⁰³ “Record of Conversation from Premier Zhou’s Reception of the Tanganyikan Cultural Delegation,” October 16, 1963, History and Public Policy Program Digital Archive, PRC FMA 108-00032-01, Translated by David Cowig.

¹⁰⁴ “Vice-President Kawawa in China,” *Peking Review*, 25, June 19, 1964, 5; Martin Bailey, “Tanzania and China,” *African Affairs*, 74, no. 294 (Jan. 1975): 39; “Sino-Tanzanian Treaty of Friendship,” *Peking Review* 8, no. 9, February 26, 1965, 9.

¹⁰⁵ Read, for instance, “China-Tanzania Joint Communique,” *Peking Review*, no. 24, June 11, 1965, 7-8; Stephen Mganga, “Tanzania, China Zetimiza Miaka 20 ya Urafiki,” *Uhuru*, Februari 18, 1985, 4.

¹⁰⁶ “Sino-Tanzanian Friendship: Welcome to Vice-President Kawawa,” *Peking Review*, no. 48, November 26, 1965, 13.

Chinese government gave moral and material support to frontline states.¹⁰⁷ China's interventions in liberation movements were viewed as a positive gesture evincing a reliable comrade-in-arms to the people of Tanzania and Africa in general. Several Chinese officials who visited Tanzania repeatedly underscored that both countries were victims of colonialism, and that they had a shared vision of fighting imperialism.¹⁰⁸ Nevertheless, I maintain that China's intimacy with countries of the South was profoundly associated with its struggle for admission to the UNGA. The votes from independent countries of the South were vital for China's admission to the UN Assembly. Subsequently, from the mid-1960s, following the growing Sino-Tanzanian ties, the Tanzanian government actively supported China's admittance to the UN. Its permanent seat established, China's then representative to the UN, danced in the Assembly the day China was officially admitted expressing his happiness.¹⁰⁹

Adopting socialist policies in 1967 further strengthened the Sino-Tanzanian relationship and set the stage for the Tanzanian government to receive large sums of development aid from China. Indeed, reliance on China signalled the country's shift from depending on traditional donors of the North. At independence, Britain had provided more than 90% of development aid to Tanzania. However, from the mid-1960s, the country depended more on aid and loans from the World Bank's subsidiary IDA (International Development Association), whose assistance amounted to 37%; the United States (21%); Sweden (13%); China (12%); while the United Kingdom only provided 04%.¹¹⁰ When West Germany and the British governments severed their development aid to Tanzania, as a result of diplomatic strife, Beijing authorities accommodated Tanzania's need by offering more grants and loans. For example, in September 1965, the Britain government severed a loan of Tshs. 150 million; but in June 1966, China stepped in and provided a loan of Tshs. 40 million and Tshs. 20 million as a grant.¹¹¹ Although the Chinese loans and grants did not cover the gap, it provided a source of relief to the Tanzanian government and won itself the trust as a responsible and reliable ally. Up until December 31, 1967, the Chinese government extended a total of USD 40 million to

¹⁰⁷ Lal, *African Socialism in Postcolonial Tanzania*, 52; Bjerk, *Building a Peaceful Nation*, 183;

¹⁰⁸ "China Tanzania in Frontline of War Against Imperialism," *The Nationalist*, January 3, 1972, 12.

¹⁰⁹ Bailey, "Tanzania and China," 48.

¹¹⁰ Resnick, *The long Transition*: 54; also see Jeannette Hartmann, "The Search for Autonomy and Independence: Foreign Policy and the Arusha Declaration," in *Re-thinking the Arusha Declaration*, ed. Jeannette Hartmann (Copenhagen: Axel Nielsen and Son, 1991) 155.

¹¹¹ Bailey, "Tanzania and China," 43.

the Tanzanian government. In the 1968 financial report, China ranked second among donor countries to Tanzania.¹¹²

China's assistance to Tanzania became even more robust during the 1970s. Government reports show that in 1971, China was the leading donor to the country. Its development aid covered about 56%, followed by the World Bank with 15%, Sweden 10%, and the USA 8%, to mention just a few.¹¹³ Surely, throughout the 1970s, Tanzania depended heavily on China and Sweden to fund its development projects. As a result, relationships between the two countries prospered, and, in particular, Chinese influences in the country thrived. The blossoming Sino-Tanzanian ties drove economic relations between the two countries. In 1971, for instance, China was the primary source of imports to Tanzania, the position which had been previously occupied by the British government since independence. Sales statistics show that imports from China rose from Tshs. 3.1 million in 1967 to about Tshs. 601 million in 1971.¹¹⁴ Likewise, Tanzanian goods exported to China rose from Tshs. 2.8 million in 1967 to Tshs. 84.1 million in 1971.¹¹⁵

Undoubtedly, political elites in Tanzania passionately endorsed the Sino-Tanzanian relationship. While filled with the spirit of Southern solidarity, President Nyerere denounced claims that the Chinese would dominate his country, underscoring that "China is a friend in need."¹¹⁶ His subordinates, too, supported the stand on Sino-Tanzanian relations. The Second Vice President of Tanzania, Rashidi Kawawa, even reaffirmed that China's assistance to the country was without strings attached.¹¹⁷ The preceding contentions warrant the belief that, unlike countries of the North, China was perceived to be a distinctive friend, brother, and an ally of Tanzania and Southern countries in general.

¹¹² Emmanuel Tayari, "A "Renewal" of China-Tanzania Treaty of Friendship (1965), April 28, 2013", accessed November 30, 2018, <http://thecontinentobserver.com/politics/04/28/a-renewal-of-the-china-tanzania-treaty-of-friendship-1965/>

¹¹³ Hartmann, "The Search for Autonomy and Independence," 155.

¹¹⁴ Undoubtedly, the blossoming Sino-Tanzanian relations boosted Sino-Tanzanian trade bonds. However, following the Tanzania-Zambia Railway (TAZARA) commodity loan agreement, the governments of Tanzania and Zambia had to import much of Chinese goods. The two countries required to purchase USD 120.3 million in Chinese goods. Each state needed to import USD 24.06 million in Chinese goods annually for at least five years to meet the target. See, George T. Yu, "Working on the Railroad: China and the Tanzania-Zambia Railway," *Asian Survey* 11, no. 11 (Nov. 1971): 1110-1111.

¹¹⁵ "Tanzania Iliagiza Bidhaa za Sh. Millioni 601 toka China," *Uhuru*, Novemba 29, 1972, 5; Bailey, "Tanzania and China," 49.

¹¹⁶ "China, a Friend in Need-Nyerere," *The Nationalist*, May 7, 1969, 1.

¹¹⁷ "Misaada ya China Haina Mirija," *Ngurumo*, Februari 12, 1968, 1.

Thriving Sino-Tanzanian ties encouraged the adoption of Chinese-related policies by the Tanzanian government. From the mid-1960s, the government tasked its delegates in China to learn numerous Chinese development policies as a crucial means of obliterating the hangover of the inherited colonial modernity.¹¹⁸ Subsequently, some political, economic, and social policies such as the single-party system, self-reliance, rural development, free health care, and the like were adopted by the Tanzanian government (Chapter 2). Nyerere's admiration for Chinese policies was overtly revealed after his first visit to China in February 1965. Upon his return, he addressed the parliament praising the Chinese development policies, which was moulded on a model of self-reliance, a hardworking spirit, and frugality. Nyerere encouraged his officials and citizens in general to follow suit.¹¹⁹

Indeed, Nyerere was so impressed by the Chinese social, economic, and political system that he implemented some learned knowledge and experiences in the 1967 launch of the Arusha Declaration. Generally, from the mid-1960s to the 1980s, the two countries signed several bilateral agreements cooperating in the fields of politics, economy, military, culture, and health. Through 1987, the government of China had financed more than 53 projects in Tanzania, making the country China's leading aid recipient in the South.¹²⁰ Nevertheless, the Sino-Tanzanian relationship was principally one-sided, with the Chinese exporting more of their ideas, capital, goods, and technical personnel, while Tanzanians being typically recipients. Yet, unlike other African countries, the Tanzanian government is reputed to have developed a close friendship relation with China from the Mao Zedong era to the present.¹²¹

1.8 Conclusion

This chapter has examined the contexts which gave rise to China's medical assistance in post-colonial Tanzania. It has shown that political as well as social predicaments which confronted the Tanzanian government from the mid-1960s, made China's medical assistance a necessity. The "war" against diseases needed adequate financial and human resources, which Tanzania's government lacked – especially after it squabbled with traditional donors of the North. Such social and political discourses made China's medical assistance appear necessary

¹¹⁸ Bailey, "Tanzania and China," 41.

¹¹⁹ "Unity Being Cemented, Says Mwalimu: Union Making Great Progress," *The Nationalist*, April 27, 1965, 2.

¹²⁰ Menghua Zeng, "An Interactive Perspective of Chinese Aid Policy: A Case Study of Chinese Aid to Tanzania" (PhD diss., University of Florida, 1999), 177.

¹²¹ Xi Jinping, *The Governance of China* (Beijing-China: Foreign Language Press, 2014), 333.

and emancipatory. Nevertheless, the discussion has shown that China's medical assistance was strategically used as a means to gain allies from independent African countries. In Tanzania, medical assistance strengthened diplomatic relations with the Beijing regime and made the Tanzanian government a vanguard of the battle for China's admission to the UNGA. Against the foregrounding done in this chapter, subsequent chapters discuss several Chinese-funded health projects in different parts of Tanzania from 1968 to the 1980s.

CHAPTER TWO:

GOING EAST? A SOCIALIST HEALTH SYSTEM AND ITS PRACTICE IN TANZANIA, 1967–1995

2.1 Introduction

Unlike the previous chapter, which examined forces behind China’s medical assistance, this chapter adds knowledge to studies on Tanzanian socialism. Several studies have examined the implications of socialist policies on economic activities¹ and environments,² drawing strong critics underscoring that the policies impeded the economic and social development of the country, however leaving out other key concerns, including social infrastructures such as health, water, and schools. Other scholars studied the development of the health sector in Tanzania and the practice of socialist-related health services.³ While these and other studies have contributed significantly to understanding Tanzanian socialism and the health system, they are both broad and general in their approach. As a result, they rarely discussed the ways and the extent to which the South-South cooperation (SSC) promoted the production and circulation of medical knowledge and experiences within the Southern world. This chapter, therefore, examines the influence of the Southern solidarity agenda into the diffusion of Chinese-related health policies in Tanzania. It identifies health policies which the government learnt from China and assess its practicality to a young and low-income country.

¹ Maxmillian J. Chuhila, “Agrarian Change and Rural Transformation in Tanzania: Ismani, Circa 1940-2010,” *UTAFITI* 14, no. 1 (2019): 1-23; Priyal Lal, *African Socialism in Postcolonial Tanzania: Between the Village and the World* (New York: Cambridge University Press, 2015); Jannik Boesen, Birgit Storgard Madsen and Tony Moody, *Ujamaa – Socialism from Above* (Uppsala: Scandinavian Institute of African Studies, 1977); Idrian N. Resnick, *The Long Transition: Building Socialism in Tanzania* (London: Monthly Review Press, 1981); James C. Scott, *Seeing Like a State* (London: Yale University Press, 1998).

² Idris S. Kikula, *Policy Implications on Environment: The Case of Villagization in Tanzania* (Dar es Salaam: Dar es Salaam University Press, 1997); Yusufu Q. Lawi, “Tanzania’s Operation Vijiji and Local Ecological Consciousness: The Case of Eastern Iraqwland, 1974-1976,” *The Journal of African History* 48, no. 1 (2007): 69-93.

³ John Iliffe, *East African Doctors: A History of the Modern Profession* (Cambridge: Cambridge University Press, 1998); Amon J. Nsekela and Aloysius M. Nhonoli, *The Development of Health Services and Society in Mainland Tanzania: A Historical Overview-Tumetoka Mbali* (Dar es Salaam: East African Literature Bureau, 1976); Stacey A. Langwick, *Bodies, Politics, and African Healing: The Matter of Maladies in Tanzania* (USA: Indiana University Press, 2011); Margunn M. Bech, et al., “Changing Policies and Their Influence on Government Health Workers in Tanzania, 1967-2009: Perspectives From Rural Mbulu District,” *The International Journal of African Historical Studies* 46, no. 1 (2013): 61-103; Dalmas A. R. Dominicus and Takashi Akamatsu, “Health Policy and Implementation in Tanzania,” *Keio J. Med.* 38, no. 2 (1989): 192-200.

The chapter discloses that from 1966 to 77, the Tanzanian Ministry of Health (MoH) sent medical delegates to study China's health system. It further argues that the practice of free health care, the institutionalisation of traditional medicine, rural health care and the banning of private health services were informed by knowledge that the delegates learnt from China. Nevertheless, the chapter shows that some policies adopted were marked by colonial continuities. The government manipulated both colonial and Chinese health policies to make them fit into its social, economic and political plans. However, the economic crisis of the 1980s, which coincided with liberalisation policies, affected these health policies. The chapter builds upon the argument that the adoption of Chinese health policies did not only signal that Tanzania was evolving toward the east but also manifested the resolve of Southern countries to encounter their social challenges through sharing knowledge and experiences among themselves.

2.2 Tanzanian Socialism: Learning from China?

Prior to 1967, the Tanzanian government had no clear ideology, but rather positioned itself as a non-aligned country with neither capitalist nor socialist commitments. However, from the mid-1960s, the government adopted several policies connected to socialism. It introduced the Arusha Declaration in January 1967, which was endorsed by the National Executive Council (NEC) of Tanganyika National Union (TANU), the ruling party, in February 1967.⁴ To implement socialist policies, TANU laid down the principles of socialism in its constitution. It denounced class differentiation and postulated that all human beings were equal and had rights to dignity and respect. Endeavouring to ensure economic justice, TANU welcomed the government's effective control over the major means of production.⁵ Definitely, the policies of TANU and the Arusha Declaration defined the social, economic and political path of the government, which spearheaded two main principles, "socialism" and "self-reliance". Under socialism, the Declaration ought to eliminate the exploitation of "man by man" and consolidate the government's control of major means of production such as land, forests, minerals, water, oil, electricity, banks, and industries. According to the principle of self-reliance, the government was diffident to foreign grants, loans, private investments, and

⁴ C. G. Kahama, T. L. Maliyamkono and Stuart Wells, *The Challenge for Tanzania's Economy* (Dar es Salaam: Tanzania Publishing House, 1986), 31.

⁵ URT, *The Arusha Declaration and TANU's Policy on Socialism and Self-Reliance* (Dar es Salaam: Publicity Section 1967), 1.

other forms of assistance, driving it into a dependent state. At the same time, it encouraged self-help schemes and local resources as primary agents of development.⁶

Socialism, loudly pronounced after the Arusha Declaration, draws its background from TANU's pamphlet drafted by President Julius Nyerere in 1962. Nyerere endeavoured to make socialism TANU's ideology and socio-economic policy that would underpin the government's activity.⁷ Indeed, at first, the ideology was all about Nyerere's thoughts, and he wrote almost all the theoretical papers and books. Thus, it took time for officials at different administrative levels, party leaders and citizens to understand and implement the policy accordingly.⁸ Characteristically, socialism, famously known as *Ujamaa* in Tanzania, was meant to be "Tanzanian socialism". The adoption of the Kiswahili word *Ujamaa* deliberately aimed to root its meaning in traditional conception. Nyerere insisted that it used the African word "*Ujamaa*" to emphasise the African-ness of the adopted policy. The literal meaning of *Ujamaa* was "family-hood". According to Nyerere, the term "socialism" meant the art of living and working together for communal benefit.⁹ He added that Tanzanian socialism was based on the pre-colonial past with its unique design. In his words: "We are not importing a foreign ideology into Tanzania and trying to smother our distinct social patterns with it. We have deliberately decided to grow as a society out of our own roots, but in a particular direction and towards a particular kind of objective."¹⁰ From Nyerere's words, Tanzanian socialism was founded from certain characteristics of a traditional social organisation.

Thus, the socialist policy adopted in 1967, extended and modified traditional social relations to meet life challenges in the twentieth-century world. Drawing from traditional patterns of social living, Nyerere aimed to create something unique from the prominent socialist architects.¹¹ Nevertheless, scholars contested Nyerere's claims that *Ujamaa* was

⁶ URT, The Arusha Declaration and TANU's Policy on Socialism and Self-Reliance, 1-4; also see Rune Skarstein and Samuel M. Wangwe, *Industrial Development in Tanzania: Some Critical Issues* (Uppsala: Scandinavian Institute of African Studies, 1986), 6.

⁷ Julius K. Nyerere, *Ujamaa: Essays on Socialism* (Dar es Salaam: Oxford University Press, 1968), 8.

⁸ Maximillian Julius Chuhila, "'To Plan is to Choose': Navigating Julius Nyerere's Economic and Political Thoughts, 1961-1980s," in *From African Peer Review Mechanisms to African Queer Review Mechanisms? Robert Mugabe, Empire and the Decolonisation of African Orifices*, ed. Artwell Nhemachane and Tapiwa V. Warikandwa (Bamenda: Langaa Research and Publishing CIG, 2019), 381; Lal, *African Socialism*, 30; Resnick, *The Long Transition*, 82-87.

⁹ Julius K. Nyerere, *Nyerere on Socialism* (Dar es Salaam: Oxford University Press, 1969), 28; "Mwalimu Defines Socialism," *The Nationalist*, August 28, 1967, 1; Paul Bjerk, *Building a Peaceful Nation: Julius Nyerere and the Establishment of Sovereignty in Tanzania, 1960-1964* (New York: University of Rochester Press, 2015), 98.

¹⁰ Julius K. Nyerere, *Freedom and Unity/Uhuru na Umoja: A Selection from Writings and Speeches 1952-1965* (Dar es Salaam: Oxford University Press, 1966), 28.

¹¹ Nyerere, *Nyerere on Socialism*, 28.

distinct from other forms of socialism practised in Asia and Europe. J. L. Kanywany underscores that nothing was purely African about *Ujamaa*; instead, it was only its linguistic expression. In his view, many of which were stated in the manifesto were taken from Asian and European socialist convenors.¹² I similarly hold that Nyerere adopted several ideas and practices from Maoism (discussed below).

Tanzanian socialism was arguably founded on the view that capitalism was undesirable for the economic, social and political development of Tanzania and Africa, as, for instance, seen in the fact that there were few indigenous capitalists in independent African countries to conceive and maintain a capitalist economy. Nyerere strictly opposed reliance on foreign capitalists to develop a capitalist economy in Tanzania, arguing that they would threaten African countries' sovereignty through their unbearable conditions.¹³ Unfortunately, a full-brown socialist state was also unattainable to low-income African countries. However, Nyerere was intrigued by Maoism, which, unlike Marxism-Leninism, maintained that the peasantry possessed socialist consciousness, so were the revolutionary vanguard in pre-industrial nations than proletariats.¹⁴ Furthermore, Nyerere argued that socialism – unlike capitalism – had roots in traditional African social organisation. Nyerere envisioned that African countries would maintain self-reliance and develop human equality and dignity for all people through socialism.¹⁵

At the same time, the Tanzanian socialist ideology adopted many of its ideas from China. In his first visit to China in 1965, Nyerere was impressed by several observations, including the commune system, self-reliance, and frugality of the Chinese people.¹⁶ Nyerere visited China for the second time in 1968 and postulated that he had “[...] come to China to learn [...] The last three days have confirmed my conviction that we have a lot to learn from

¹² J. L. Kanywany, “Theoretical Problems of Ujamaa,” in *Re-Thinking the Arusha Declaration* ed. Jeannette Hartmann (Copenhagen: Axel Nielsen and Son A/S, 1991), 45.

¹³ Severine M. Rugumamu, *Lethal Aid: The Illusion of Socialism and Self-Reliance in Tanzania* (Trenton, NJ: Africa World Press, 1997), 122-123.

¹⁴ Maurice Meisner, “Leninism and Maoism: Some Populist Perspectives on Marxism-Leninism in China,” *The China Quarterly*, no. 45 (Jan.-Mar. 1971): 18.

¹⁵ Julius K. Nyerere, *The Rational Choice, a Speech Delivered on his behalf by the First Vice President Aboud Jumbe in Khartoum in the 1970s*, 3.

¹⁶ “Fast Growing Sino-Tanzanian Friendship: China Hails President Nyerere’s State Visit,” *Peking Review* 8, no. 9, February 26, 1965, 7; Sebastian Edwards, *Toxic Aid: Economic Collapse and Recovery in Tanzania* (Oxford: Oxford University Press, 2014), 75; Martin Bailey, “Tanzania and China,” *African Affairs* 74, no. 294 (Jan. 1975): 41.

China.”¹⁷ Moreover, Nyerere perceived China’s social, economic, and political policies as a perfect path to sustainable development, arguing other Southern countries to learn from China.¹⁸

Notwithstanding its immature economy, the Chinese government adopted a socialist policy soon after the 1949 Revolution. Contrary to the view that a full-blown socialist nation could not exist in low-income countries, the practice of the policy in China showed promising results and gave courage to other countries to follow suit. In his third trip to China in April 1974, Nyerere reaffirmed how the practice of socialism in China inspired his regime. He argued:

Two things convince me that socialism can be built in Africa and that it is not a Utopian vision. For capitalism is ultimately incompatible with the real independence of African states. The second thing which encourages me is China. It is because it appears to me that, among the millions of unique individuals in this society, there has been created a spirit of working together for the good of the community and the country. China is providing an encouragement and an inspiration for younger and smaller nations which seek to build socialist societies.¹⁹

The preceding expositions testify to the fact that Tanzanian socialism learned enough from China. Nevertheless, Nyerere denied such allegations, underscoring that the policy was based on the needs of the people and not on Chinese philosophy.²⁰ He added that claims of copying the policies from Moscow and Beijing subscribe to the view that Africa, and in this particular case, Tanzania, had nothing to contribute to the world and that all good things came from elsewhere. However, Nyerere admitted that adopting some ideas from any other place was not a sin provided that the government learned and proceeded to think and not to copy.²¹ When Nyerere visited China in 1974, he underscored that learning from China did not mean he would implement the policy uncritically. He told Mao Zedong that: “We shall not flatter you by trying to make an exact copy of what we see. But I hope we shall be good pupils who learn and then apply their lessons to their own situation.”²² In this regard, Nyerere did not limit

¹⁷ “President Nyerere’s Speech at the Farewell Banquet he Gave in Peking on June 21,” *Peking Review*, no. 26, June 28, 1968, 8.

¹⁸ “President Nyerere’s Speech at the Farewell Banquet he Gave in Peking on June 21,” *Peking Review*, no. 26, June 28, 1968, 8.

¹⁹ “President Nyerere Ends Visit to China,” *Peking Review* 17, no. 14, April 5, 1974, 7.

²⁰ “Nyerere’s Stress on Self-reliance,” *The Nationalist*, April 9-15, 1967.

²¹ Nyerere, *Freedom and Unity/Uhuru na Umoja*, 47-48.

²² “Chairman Mao Meets Nyerere,” *Peking Review* 17, no. 13, March 29, 1974, 9.

himself to the Chinese. Instead, he learned policies from China and other socialist and non-socialist countries and moulded them to fashion “socialism with Tanzanian characteristics”.

Discussions in the subsequent sections show that at independence, Tanzania and China faced similar health challenges. They both encountered medical dependencies, unequal provision of health services between the haves and the have-nots, rural and urban areas and other social disparities. Such commonalities gave room for the exchanges of knowledge and experiences.

2.3 Free Health Care, 1967–1988

Under German and British colonial governments in Tanganyika, health services to the indigenous population had not been provided free of cost, as patients in all hospital grades paid for the service. In some incidences, the colonial governments provided free health care to deprived communities. In most cases, colonial health care was extended to only a few areas, preferentially in the production zones, settlers’ habitations and a few business towns and cities. Worse still, the services were racially segregated, Europeans enjoying the first-class healthcare, Indians, Arabs and coloured the second, and Africans the third.²³ The colonial government prioritised the wellbeing of labourers, settlers, soldiers, businesspersons and administrative personnel who directly contributed to colonial economic production. The neglect of Africans’ access to colonial health care led them to rely on local healing systems. Indeed, throughout colonial periods, social and economic status was the determining factor in the provision of health services. Thus, the post-colonial Tanzanian government inherited a capitalist-oriented health care system characterised by an unequal distribution and provision of health care services. Nevertheless, the post-colonial government did not promptly undo colonial health policies. Instead, it made some adjustments to accommodate patients with low income. For example, in 1962, the government issued hospital fees for patients attending government hospitals. The fees varied depending on the grades of hospitals. Grade I, outpatients were charged Tshs. 20 per day while grade III outpatients paid Tshs. 2. The government offered free health services to outpatients admitted to Grade IV hospitals.²⁴

²³ Kjell J. Havnevik, *et al.*, *Tanzania: Country Study and Norwegian Aid Review* (Moss: A/S Repro-Trykk, 1988), 15.

²⁴ Grade II hospital were not included in the schedule as they were discontinued. More information is available in, “Government Hospital Fees, a General Notice, July 1, 1962,” TNA. Acc. No. 450, Ministry of Health, File No. HEM/20/14, Private Practice Policy.

Costs for inpatient services varied depending on the status of the hospital and grade. For instance, grade I inpatients admitted to Princess Margaret (now Muhimbili), Mount Meru (Arusha), and Tanga hospitals were charged Tshs. 60 per day, while grade I inpatients admitted to all other hospitals paid Tshs. 50 per day. Similarly, grade II inpatients admitted to the same hospitals mentioned above paid Tshs. 35 per day while grade II inpatients admitted to all other hospitals paid Tshs. 30 per day. Such variances were not noticed to grade III inpatients since they all paid Tshs. 6 per three days in all hospitals. As it was to outpatients, grade IV inpatients received free health care in all hospitals.²⁵ Additionally, half of the standard fee was charged for children under the apparent age of 14. When the child was an infant so young that was considered desirable on medical grounds to admit the mother also, a single fee at adult rates was charged. The antenatal registration fee for attendance at grade I outpatient sessions was charged Tshs. 60. The mentioned fee covered all of outpatient examinations and investigations.²⁶ Generally, the 1962 health policy brought slight changes to the delivery of health services in Tanzania. It gave a chance for grade IV, both inpatients and outpatients to get free health services in public hospitals and sections. However, the policy retained health service grades and fees as introduced by the colonialists. Offering health services in grades maintained social inequalities between the haves and the have-nots. Such differentiations were inconsistent with the socialist policies which the government adopted in 1967.

While on his first visit to China in February 1965, President Nyerere admired China's health care policies and subsequently devised a socialist approach to healthcare. After Nyerere's visit, the MoH set plans for learning about China's health system, sending a delegation of medical doctors to China for a study tour in 1966. Several aspects of the Chinese health policy, including free health care, enthused the delegates. The MoH considered free health care as important and consistent with the government's socialist policies.²⁷ Subsequently, after the Arusha Declaration, the country's national health policies emphasised the need to provide equitable and sufficient health services to all citizens. The socialist government perceived hospital fees illegitimate since they consolidated social disparities and

²⁵ "Government Hospital Fees, a General Notice, July 1, 1962," TNA. Acc. No. 450, Ministry of Health, File No. HEM/20/14, Private Practice Policy.

²⁶ "Government Hospital Fees, a General Notice, July 1, 1962," TNA. Acc. No. 450, Ministry of Health, File No. HEM/20/14, Private Practice Policy.

²⁷ "Mambo yalivyo Uchina," *Nchi Yetu Tanzania*, Desemba, 1966, 22-23; URT, *The Arusha Declaration and TANU's Policy on Socialism and Self-Reliance*, 1; Interview by Andrea Kifyasi with Joseph W. Butiku, 9th July 2018, Posta-Dar es Salaam. Mzee Butiku worked at the statehouse as a personal research assistant of Mwalimu Nyerere from 1965.

restrained access to health care to low-income communities. Therefore, under Tanzania's socialist health system, the government provided free health services in both inpatient and outpatient clinical services through a network of established government dispensaries, health centres, and hospitals.²⁸ Extending free health care – maintained access to essential health services to all, which, in turn, enabled the country to have a healthy community and serviceable labour force needed for national development. Concurrently, the free health care went synchronously with free education from primary to university levels and hence rekindled the fight against “enemies” of development, ignorance, poverty, and disease, declared by Nyerere.

Undeniably, free health care was burdensome to the Tanzanian government, which had to allocate sufficient funds to purchase and distribute medicines and medical equipment. From 1970 to 74, the health sector's share in the total government expenditure ranged from 6 to 6.9%. At its beginning, the government could afford the costs because the population was relatively small, not more than 13 million people. The increase in population went parallel with the increase in costs for the free health care. For instance, spending for the health sector rose to more than 7% of the total government expenditure from 1975 to 77, following the increase in population from 13.171 million in 1970 to 16.498 million in 1977 (Table 3). The annual increase in population raised government expenditure in the health sector, which, in turn, threatened the supply of free health care to a low-income country.

The delivery of free health services declined officially in 1988. During this period, the government could no longer afford financing health services due to economic challenges caused by the high debts, droughts, decreased donor funding, diseases, oil crisis and devaluations.²⁹ From 1978 to 1989, the government budget records show that the soaring population from 15.976 million in 1975 to 22.611 million in 1987 overwhelmed the government's ability to afford free health care. Its spending on the health sector fell from 7.1% in 1975/76 to 4.0% in 1987/88 (Table 3).

²⁸ Havnevick, *et al.*, *Tanzania: Country Study*, 168.

²⁹ See, for instance, T. L. Maliyamkono and M. S. D. Bagachwa, *The Second Economy in Tanzania* (London: James Currey, 1990), 4; Deborah Fahy Bryceson, *Liberalizing Tanzania's Food Trade: Public and Private Faces of Urban Marketing Policy, 1939-1988* (Mkuki na Nyota Publishers, 1993), 8; Benno. J. Ndulu and Charles K. Mutalemwa, *Tanzania at the Turn of the Century: Background Papers and Statistics* (Washington DC: The World Bank, 2002), 12; Rwekaza Mkandala, “From Proud Defiance to Beggary: A Recipient's Tale,” in *Agencies in Foreign Aid: Comparing China, Sweden and the United States in Tanzania*, ed. Goran Hyden & Rwekaza Mkandara (London: MacMillan, 1999), 5.

Table 3: Government health expenditure, 1970/71 to 1989/90

Year	Health Expenditure Tshs. (Mill.)	Health Expenditure as % of Total Expenditure	Population (Mill.)
1970/71	152	6.2	13.171
1971/72	159	6.2	13.602
1972/73	207	6.5	14.047
1973/74	294	6.5	14.506
1974/75	426	6.9	14.980
1975/76	425	7.1	15.976
1976/77	561	7.1	15.976
1977/78	646	7.3	16.498
1978/79	688	5.3	17.036
1979/80	721	5.0	17.507
1980/81	815	5.5	18.080
1981/82	992	5.4	18.658
1982/83	983	5.1	19.255
1983/84	1171	5.4	19.871
1984/85	1329	4.8	20.506
1985/86	2446	6.2	21.162
1986/87	2213	4.2	21.874
1987/88	3074	4.0	22.611
1988/89	5509	5.0	23.1
1989/90	6532	4.6	272.2

Source: Modified from Lucian A. Msambichaka, *et al.*, *Economic Adjustment Policies and Health Care in Tanzania* (Dar es Salaam: Dar es Salaam University Press, 1994), 95.

Such decline exacerbated maternal mortality rates and diminished the availability of drugs and medical equipment in the government-owned hospitals.³⁰ The government's failure pulled the country towards major lending institutions such as the World Bank and International Monetary Fund (IMF), which, among other conditions, required the government to reduce spending in the social sector, including health. For instance, in 1987, the World Bank advocated greater reliance on user charges, insurance mechanisms, the private sector and administrative decentralisation policies to overcome the crisis.³¹

³⁰ Angwara D. Kiwara, "Health and Health Care in a Structurally Adjusting Tanzania," in *Development Challenges and Strategies for Tanzania: An Agenda for the 21st Century*, ed. Lucian A. Msambichaka, Humphrey P. B. Moshi and Fidelis P. Mtatikolo (Dar es Salaam: Dar es Salaam University Press, 1994), 281-282.

³¹ "Dr Y. Hemed, Source of Health Revenue from People who are Willing to Pay," MRC. Acc. No. 30, File No. M.10/5, Ulipiaji matibabu General, 1996-2006; Issa G. Shivji, "Liberalisation and the Crisis of Ideological

The increasing pressure from donor countries, the World Bank and IMF prompted Tanzania to launch the cost-sharing policy. While the pressure from these multilateral lenders and other traditional development partners were behind the country's move to the cost-sharing policy, the government did not openly admit it. Instead, it defended the decisions arguing that the policy aimed at generating additional revenue for health facility operations, increasing the quality of health services in government facilities, strengthening the referral system and rationalising the utilisation of health services, as well as improving equality and access to health services.³² Admittedly, pressure from outside and within forced the Tanzanian socialist regime to turn to capitalist policies, which it had been criticising since 1967. I hold that the commencement of cost-sharing policy was among means the government adopted to win back the sympathy of traditional donors of the North after they had withheld their assistance to the country throughout the 1980s.

The cost-sharing trial started in 1988 with every outpatient paying Tshs. 20 in a single attendance at any public health centre. However, its implementation brought several challenges, such as the mishandling of the collected dues in the hospitals since medical workers lacked practical knowledge of financial management. Furthermore, low-income communities complained that they could not afford the proposed fees. These and many other reasons prompted the government to drop the fee shortly afterwards, stating that it needed further research and analysis to implement the policy effectively.³³ However, the 1990 joint research by Tanzanian medical experts and Britain Development Agency affirmed that Tanzanians were ready for a cost-sharing program. The readiness of the people was rooted in their determination to see improvement in the provision of health care services. From the mid-1980s, economic shortfall led to inadequate provisions of health care services in Tanzania. As a result, many public health centres lacked essential medicines and medical equipment. The crisis further led to the overall deterioration of physical health infrastructures such as electricity and water supply. It also impelled poor management, low wages and other incentives for health care

Hegemony," in *Re-Thinking the Arusha Declaration*, ed. Jeannette Hartmann (Copenhagen: Axel Nielsen and Son A/S, 1991), 135.

³² T. L. Maliyamkono and H. Mason, *The Promise* (Dar es Salaam: TEMA Publishers, 2006), 454.

³³ JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. Amrani H. Mayagila, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1993/94*, 53.

workers, which, in turn, lowered their morale.³⁴ These circumstances drove both internal and external demands for the Tanzanian government to introduce several forms of cost-sharing.

Implementation of the cost-sharing policy resumed in 1993 when the government reintroduced health service grades (I, II, III, IV) which redefined the quality of the services, costs, and kinds of prospective patients. Undoubtedly, the grades sustained the colonial and pre-socialist social disparities whereby patients with high, middle, and low incomes received health services with varying qualities. High-income patients afforded costs charged at grade I and II, which were relatively higher for more sophisticated health services. For instance, upon its commencement, patients attending grade I and II paid a consultation fee of Tshs. 500 at referral, 300 for regional and 150 for district hospitals. Furthermore, grade I patients paid hospitalisation fee of Tshs. 2,000 at referral, 1,500 at regional and 1,000 for district hospitals per patient per day. While grade II patients paid Tshs. 1,000 for the referral, 750 for regional and 500 for district hospitals. The government anticipated that patients who demanded grade I and II services would eagerly accept the cost-sharing policy; as a result, they were the first to be touched by the policy on July 1, 1993.³⁵

In contrast, middle-income patients attended mostly to grade III health services where the quality of the services was moderate consistent with their costs. Patients of this category paid consultation fees of Tshs. 300 for referral, 200 for regional and 100 for district hospitals. Unlike grades, I and II, grade III patients paid once for the hospitalisation irrespective to hospitalisation period. For instance, they paid Tshs. 500 in referral, 300 for regional and 150 for district hospitals. The cost-sharing for this category was effective in the second phase commencing on January 1, 1994. Admittedly, grades, I, II and III, accommodated fewer Tanzanians, mostly being businessmen, political elites and a few groups of formal and informal employees. The majority of Tanzanians with low-incomes attended grade IV health services, which offered cheap but poor services. The services for this category were mostly executed through health centres and dispensaries. Unlike grades, I, II and II, the government gave time for grade IV beneficiaries and service providers to get prepared for the cost-sharing scheme,

³⁴ JMT, Wizara ya Afya, *Hotuba ya Waziri wa Afya Mhe. Amrani H. Mayagila, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1993/94*, 53; Phares G. M. Mujinja and Tausi M. Kida, *Implications of Health Sector Reforms in Tanzania: Policies, Indicators and Accessibility to Health Services* (Dar es Salaam: The Economic and Social Research Foundation (ESRF), 2014), 1.

³⁵ JMT, Wizara ya Afya, *Hotuba ya Waziri wa Afya Mhe. Amrani H. Mayagila, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1993/94*, 54-55.

and the charges commenced in 1996 (see below).³⁶ The government used two-thirds of revenues collected to purchase medicines and medical equipment, and the remainder was spent on other health-related expenditures.³⁷ On the one hand, revenues collected through cost-sharing were an essential resource for the improvement of the quality of health care services. On the other hand, community financing transferred the responsibility of the socialist government to a third party.

As hinted above, the cost-sharing program began late for rural dispensaries (grade IV) to give time for the government to persuade villagers to accept the policy and train service providers in proper ways of collecting and handling funds. The government noted that the effective execution of the policy demanded more preparation, including training in financial management, printing of receipts books, and training medical workers.³⁸ It took until 1996 for the government to establish the Community Health Fund (CHF), through which villagers and other non-civil servants voluntarily joined the prepayment scheme. The scheme aimed to reach about 85% of the population living in rural areas and others outside the formal employment sector. Under CHF, household members paid a fixed annual fee to get access at the primary level of health facilities.³⁹ Moreover, in 1999, the Tanzanian government introduced the National Health Insurance Fund (NHIF), aiming at providing quality health care to its recipients. The early beneficiaries of the scheme were civil servants and their dependants, but it has become recently open to private membership. Under NHIF, employees in the public formal sector contributed 3% of their monthly salary, and their employers matched the same. NHIF covered health costs for the principal member, spouse and up to four below eighteen years legal dependants. The actual execution of the Insurance was realised in 2001. The MoH assured NHIF members of getting sustainable health care in all public hospitals and some privately run hospitals.⁴⁰ However, the membership turnout has been less promising. Up to

³⁶ JMT, Wizara ya Afya, *Hotuba ya Waziri wa Afya Mhe. Amrani H. Mayagila, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1993/94*, 54-55.

³⁷ “Principal Secretary, Ministry of Health, Wananchi Kuchangia Huduma za Jamii, Afya, Muhtsari wa Mapendekezo ya Viwango na Maeneo ya Kuchangia, July 1, 1993,” MRC. Acc. No. 30, File No. M.10/1/3, Medical Policy and Instructions General, 1990-2004.

³⁸ JMT, Wizara ya Afya, *Hotuba ya Waziri wa Afya Mhe. Amrani H. Mayagila, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1993/94*, 54-55.

³⁹ Peter Kamuzora and Lucy Gilson, “Factors Influencing Implementation of the Community Health Fund in Tanzania,” *Health Policy and Planning* 22 (2007): 95; Gemini Mtei and Jo-Ann Mulligan, “Community Health Funds in Tanzania: A Literature Review,” *Consortium for Research on Equitable Health Systems* (January 2007): 1.

⁴⁰ JMT, Wizara ya Afya, *Hotuba ya Waziri wa Afya Mhe. Dk. Aaron D. Chiduo, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 2000/2001*, 7.

September 2018, the NHIF registered about 7% while CHF covered about 25% of the Tanzanian population, making a total of 32% for both NHIF and CHF.⁴¹ Additionally, the funds collected through cost-sharing could not cover the Ministry's health budget.⁴² This challenge forced the government to keep financing the health sector from its internal and external sources.

Nevertheless, from the 1990s to the present, the government offered free health services to four groups of patients. These included: children of 0–5 years, pregnant women (clinic and delivery), elders of 60 years and above, and patients with contagious diseases such as HIV/AIDS, cancer, TB, leprosy and sickle-cell anemia, regardless of their ability to pay.⁴³ Notwithstanding a few categories of people, for whom the government waived their hospital fees, the introduction of cost-sharing buried equality in the delivery of health services since people with low income were unable to afford the prescribed costs, and many turned to traditional medicine and church hospitals which charged lower fees.⁴⁴ Consequently, cost-sharing contributed significantly to dismantling the socialist health system, which lasted for more than two decades in Tanzania.

2.4 Institutionalisation of Traditional Tanzanian Medicine, 1968–1990

Before the coming of Europeans to Africa and Tanzania in particular, Africans depended entirely on local methods of diagnosis and treatment of diseases. Even after European missionaries and colonial governments came to the continent, the majority of Africans continued to rely on traditional medicine not only because modern curative facilities were not adequate but also the traditional methods of therapy were considered more effective by many Africans.⁴⁵ Certainly, biomedical practices did not fully dismantle traditional healing systems⁴⁶

⁴¹ URT, *National Health Insurance Fund (NHIF), First Quarter Fact Sheet, September 2018*, 3-4.

⁴² Selemani Mbuyita and Ahmed Makemba, "Equity in Health in Tanzania: Translating National Goals to District Realities," *EQUINET Discussion Paper*, no. 54 (Dec. 2007): 6.

⁴³ JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. Dk. Aaron D. Chiduo, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1999/2000*, 19.

⁴⁴ Maliyamkono and Mason, *The Promise*, 456.

⁴⁵ "Letter from Chief Medical Officer, February 12, 1969 to all Regional Medical Officers, Research in Indigenous Systems of Therapeutic and Traditional Medicine," MRC. Acc. No. 13, File No. HE.11/86, Private Medical and Dental Practitioners, 1954-1972.

⁴⁶ The WHO defines traditional medicine as the sum total of the knowledge, skill and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness. It uses mainly medicinal plants, mineral substances, and animal parts, and relies exclusively on traditional healers to provide health care. While herbalism is the most common practice, it also relies on divination and spiritualism. See, WHO, *WHO Global Report on Traditional and Complementary Medicine*, 2019, 8; M. Fawzi

in Tanzania, and Africa at large. Instead, local healers integrated several elements of biomedical practices such as injections, which seemed useful in curing ailments.⁴⁷ The practice of traditional healing systems in Tanzania was, however, strongly criticised by missionaries who perceived it as “heathen”. Missionaries attempted to defeat local healing systems by spreading biomedical health care in several parts of the country. They devalued local medicine by linking it to superstition while promoting biomedicine as an alternative. Therefore, throughout colonial periods, missionaries attached religious activities to health services, underscoring the rhetoric of saving the “body” and “soul” to win converts.⁴⁸

In contrast, both German and British colonialists recognised traditional health practitioners as health service providers. However, their services were strictly controlled and sometimes restricted over witchcraft accusations.⁴⁹ During the German colonial era, the practice of traditional medicine was open to practitioners with certificates indicating their locations of practice and illnesses they treated. Through the British Medical Practitioners and Dentists Ordinance of 1929, the British colonial government allowed traditional health practitioners to practice in their communities under permission from respective traditional authorities.⁵⁰ However, the government prohibited healing systems which involved the so-called witchcraft practices such as divination. The Witchcraft Ordinance of 1928 viewed the possession of charms, occult powers, organisation of ordeal or any other “witchcraft” practices as a crime liable to imprisonment of not exceeding seven years or fine amounting to Shs. 4,000.⁵¹ The British colonial government banned witchcraft-related practices following the lesson learnt during the Maji Maji war of 1905 to 07, where witchdoctors greatly influenced warriors to fight the German colonial rule fearlessly. Although Africans were greatly defeated, the colonial government worried about their persuasive power and considered them a threat to

Mohomoodally, “Traditional Medicine in Africa: An Appraisal of Ten Potent African Medicinal Plants,” *Evidence-Based Complementary and Alternative Medicine*, (December 2013): 1-3.

⁴⁷ Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Cambridge: Polity Press, 1991), 24.

⁴⁸ Terence O. Ranger, “Godly Medicine: The Ambiguities of Medical Mission in Southeast Tanzania, 1900-1945,” *Social Science Medicine* 15B (1981): 262; Vaughan, *Curing their Ills*, 56-66.

⁴⁹ Z. H. Mbwambo, R. L. A. Mahunnah and E. J. Kayombo, “Traditional Health Practitioner and the scientist: Bridging the Gap in Contemporary Health Research in Tanzania,” *Tanzania Health Research Bulletin* 9, no. 2 (May 2007): 117.

⁵⁰ Torunn Stangeland, Shivcharn S. Dhillion and Haavard Reksten, “Recognition and Development of Traditional Medicine in Tanzania,” *Journal of Ethnopharmacology* 117 (2008): 294 (290-299); Rogasian L. A. Mahunnah, Febronia C. Uiso and Edmund J. Kayombo, *Documentary of Traditional Medicine in Tanzania: A Traditional Medicine Resource Book* (Dar es Salaam: Dar es Salaam University Press, 2012), 45.

⁵¹ Simeon Mesaki, “Witchcraft and the Law in Tanzania,” *International Journal of Sociology and Anthropology* 1, no. 8 (December 2009): 134.

colonial administration.⁵² Nevertheless, they allowed the practices of healing systems that mostly utilised medicinal herbs⁵³ through which they created favourable strategies to benefit from it. For instance, in 1928, through its research station at Amani-Tanga, the colonial government assigned a botanist to examine efficacies of herbal medicine used by local practitioners. Subsequently, in the 1934/35 annual report, the colonial botanist reported that some medicinal plants used by local herbalists might be useful in European pharmacology.⁵⁴ On the one hand, this implies that the colonial government controlled the practices of local healing systems for their ends, but on the other, the permission granted to local herbalists played a role in developing traditional medical knowledge during colonisation, thus laying the ground for its flourishing during the post-colonial period.

Notwithstanding the practicality and acceptability of traditional medicine in the pre-colonial and during the colonial period, the independent Tanzanian government did not promptly promote the practice of traditional medicine. It neither coordinated nor linked activities of traditional health practitioners with the organised health services.⁵⁵ However, after the Arusha Declaration of 1967, the government began to promote the use of traditional medicine to maintain its endurance amid the spread of biomedicine. The government encouraged local healing practices to rescue a health sector nearly overwhelmed by the country's soaring population and disease burden amid the government's drive to extend health care to all. Moreover, under the self-reliance policy, the government anticipated promoting the practice of traditional medicine to avoid dependence on biomedicine. During this period, the government perceived traditional medicine as a valuable resource for the actual development of health care. The promotion of traditional medicine further aimed to enable Tanzanians to address health challenges using their local medical knowledge. Severe reliance on imported biomedicine seemed to bolster the wealth to the Global North. Thus, given the country's weak economy, biomedicines were too expensive to import.⁵⁶

⁵² Langwick, *Bodies, Politics, and African Healing*, 45-46.

⁵³ According to WHO, herbal medicines include herbs, herbal materials, herbal preparations and finished herbal products that contain, as active ingredients, parts of plants, other plant materials or combinations thereof. In some countries, herbal medicines may contain, by tradition, natural organic or inorganic active ingredients that are not of plant origin such as animal and mineral materials. See, WHO, *WHO Global Report on Traditional and Complementary Medicine*, 2019, 8.

⁵⁴ Langwick, *Bodies, Politics, and African Healing*, 53.

⁵⁵ Titmuss, Abel-Smith, Macdonald, Williams, and Wood, *The Health Services of Tanganyika*, 72.

⁵⁶ Mahunnah, Uiso and Kayombo, *Documentary of Traditional Medicine in Tanzania*, 18; Langwick, *Bodies, Politics, and African Healing*, 9-10.

The 1968 symposium on African Medicinal Plants held in Senegal, which Tanzanian officials attended, further exemplified the need to promote the use of traditional African medicine. The attempts, however, were inspired by the Chinese health system, which prioritised the use of traditional medicine. After the Chinese Communist Revolution of 1949, Mao Zedong directed practitioners of traditional medicine and western-trained medical doctors to work together. The Chinese government encouraged traditional health practitioners to contribute their medical knowledge for the development of health care.⁵⁷ Therefore, traditional health practitioners and western-trained doctors worked together, and they were all paid by the government. The Chinese government went further by establishing schools and colleges which offered teachings and training to traditional medicine students. In 1955, it institutionalised traditional medicine and established the Academy of Traditional Chinese Medicine, currently called China Academy of Chinese Medical Sciences (CACMS), which played a vital role in adding scientific value to traditional Chinese medicine through medical research and training. Up to 1964, there were about 20 medical colleges and schools, training doctors in traditional Chinese medicine.⁵⁸ Formally trained traditional health practitioners covered the gap of the needed medical personnel, which, in turn, reduced mortality and morbidity rates from 250 at the Revolution-era to 10 per 1000 in the 1970s. Furthermore, life expectancy rose from 30 at liberation period to 70 in the 1970s. Through the use of both traditional and biomedicine, the government eradicated most troubling diseases such as schistosomiasis, polio, measles, whooping cough, malaria, trachoma, typhoid fever, bilharzia, and smallpox.⁵⁹

The Tanzanian government admired the achievements that China attained over a short period and took several initiatives to learn from them. The 1966 delegation of the MoH recommended, among others, the institutionalisation and use of traditional medicine in hospitals parallel to western biomedicine. Lucy Lameck, who was also a delegate, was impressed with the use of traditional Chinese medicine together with biomedicine. She said: “I visited one hospital and saw many boxes full of medicinal herbs. I was further surprised to see

⁵⁷ For further details, read Chapter 3 in Kim Taylor, *Chinese Medicine in Early Communist China, 1945-63: A Medicine of Revolution* (New York: RoutledgeCurzon, 2005) 30-62; Chien Hsin-chung, “Chinese Medicine: Progress and Achievements,” *Peking Review*, no. 9, February 28, 1964, 18.

⁵⁸ “Taarifa Fupi ya Safari ya Jamhuri ya Watu wa China, 16-23 Julai 2006,” NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 7; Ling Yang, “Training Medical Workers,” *Peking Review*, no. 46, November 13, 1964, 23.

⁵⁹ “Report on Visit of Ministry of Health Delegation to the People’s Republic of China, September 1977,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

patients prescribed to take traditional medicine in government dispensaries and hospitals.”⁶⁰ The Chinese government pledged to boost traditional medicine knowledge to practitioners and researchers in Tanzania to ease its integration with biomedicine.⁶¹

The Chinese model prompted Tanzania’s MoH to institutionalise and integrate traditional medicine with biomedicine. In 1968, the government legally recognised and began to move towards the integration of traditional and biomedicine. The Medical Practitioners and Dentist Ordinance of 1968 recognised the existence of traditional health practitioners⁶² and their right to practice traditional medicine.⁶³ Yet, not all kinds of healers were legally allowed to practice their services. Instead, the government adopted the 1928 Witchcraft Ordinance and hence prohibited healers whose medical practices invoked supernatural powers. Under such contexts, the government’s legal system did not accept divinations, and it perceived them as chaotic and a threat to the nation’s peace and security as well as development. Thus, herbalists were more encouraged than specialists in spirit possession or sorcerers.⁶⁴ These attempts imply that the post-colonial government endeavoured to differentiate “witchcraft” practices from healing and magic as it had been the case during the British colonial period.

The legal recognition of the local health system eased the establishment of the first National Union of Traditional Healers (UWATA) in 1971. The Union was a useful forum for medical knowledge exchanges and cooperation among practitioners. Furthermore, through UWATA, the government monitored the activities of traditional health practitioners to enhance their effectiveness.⁶⁵ The government allowed practices of local healing systems prone to registering with the MoH at their respective district offices. Through their registration form, healers recorded places they intended to work, kinds of diseases they cured and the

⁶⁰ My translation from Kiswahili in “Mambo yalivyo Uchina,” *Nchi Yetu Tanzania*, Desemba, 1966, 22-23.

⁶¹ “Mambo yalivyo Uchina,” *Nchi Yetu Tanzania*, Desemba, 1966, 22-23; also see China’s commitment in “China’s Obligation to Small Nations,” *The Nationalist*, June 30, 1967, 8.

⁶² It should be recalled that traditional medicine practitioners in Tanzania comprised of herbalists, ritualists or spiritualists and midwives (Chapter 4). Read, for instance, Harald Kristian Heggenhougen, “Health Services: Official and Unofficial,” in *Tanzania Crisis and Struggle for Survival*, ed. Jannik Boesen, Kjell J. Havnevik, Juhani Koponen, and Rie Odgaard (Uppsala: Scandinavian Institute of African Studies, 1986), 312; Vaughan, *Curing their Ills*, 60.

⁶³ URT, *Medical Practitioners and Dentists Ordinance (Amendment) Act, May 1968*.

⁶⁴ Mesaki, “Witchcraft and the Law in Tanzania,” 132.

⁶⁵ Mahunnah, Uiso and Kayombo, *Documentary of Traditional Medicine in Tanzania*, 7; Ann Beck, “The Traditional Healer in Tanzania,” *A Journal of Opinion* 9, no. 3 (Autumn 1979): 4.

commitment that their therapies did not involve the so-called witchcraft.⁶⁶ The registration did not only help the government to control their services but also have their statistics.

Nevertheless, the recognition was negatively perceived by conventional doctors who mistrusted the ability and effectiveness of traditional health practitioners. Conventional doctors opposed the ministry's call for cooperation between traditional and conventional health practitioners.⁶⁷ The increasing mistrust between the two groups of health service providers was not only a challenge but also an opportunity for the scientific development of traditional medicine. The ministry made several attempts to "modernise" activities of traditional health practitioners through scientific research. In 1969, it launched research on traditional medicine that involved contacting famous local traditional African doctors and recording their methods of practice in accurate detail. The government research team also carried out chemical analysis of herbs used in treatment by traditional health practitioners and made clinical trials for selected methods of treatment.⁶⁸ The institutionalisation of traditional medicine was an emancipatory approach giving freedom to traditional health practitioners who had been offering their services in the dark corners due to intimidation by religious leaders and government authorities.⁶⁹

Initiatives to scientific research, institutionalisation, and integration of traditional medicine with biomedicine made a breakthrough in 1974. During this period the government launched a research unit for traditional medicine at the University of Dar es Salaam's Faculty of Medicine of Muhimbili Medical College. The Traditional Medicine Research Unit (TMRU), which became an Institute of Traditional Medicine (ITM) in 1991, strived to put biomedically efficacious herbal medicine for use by conventional and traditional health practitioners.⁷⁰ It played a role in identifying useful health practices that could be adopted, and *materia medica*, which could be modernised and developed into drugs for use by humans. Furthermore, the institute was determined to disentangle pre-colonial and colonial ways of communicating traditional medicinal knowledge, which mainly relied on informal training and inheritance by establishing formal training for practitioners of traditional medicine. Subsequently, it offered

⁶⁶ Langwick, *Bodies, Politics, and African Healing*, 39.

⁶⁷ Mbwambo, Mahunnah and Kayombo, "Traditional Health Practitioner and the scientist," 117; Elizabeth Karlin Feerman, "Alternative Medical Services in Rural Tanzania: A Physician's View," *Social Science Medicine* 15B (1981): 400.

⁶⁸ "Letter from Chief Medical Officer, February 12, 1969 to all Regional Medical Officers, Research in Indigenous Systems of Therapeutic and Traditional Medicine," MRC. Acc. No. 13, File No. HE.11/86, Private Medical and Dental Practitioners, 1954-1972.

⁶⁹ "Traditional Medicine: Will the Medicine man Regain his Lost Honour?" *The Nationalist*, June 30, 1971, 4.

⁷⁰ Langwick, *Bodies, Politics, and African Healing*, 18.

short and long training courses on the development of traditional medicines to facilitate the improvement of knowledge, skills and practice of various stakeholders in traditional medicine development and drug discovery.⁷¹ These roles show that the institute internalised elements of biomedicine within its training, research and general practice consistent to its endeavour of turning traditional medicine more scientific (Figure 2). Activities of the ITM and the whole institutionalisation process leaned on herbal medicines compatible with scientific methods compared to other local healing systems which invoked supernatural powers.

Figure 2: The phytopharmacological screening of different herbs at TMRU, 1985



Source: “Herbs Enter Conventional Medicine,” *Sunday News*, July 28, 1985, 5.

From its inception, the institute conducted systematic studies and research of the plants suitable for making drugs for human use. It further embarked on the development of gardens for medicinal and aromatic plants. The MoH anticipated that the research carried out by the institute would promote the development and use of traditional medicine and substitute imported drugs.⁷² Besides medical research, the institute held scientific proof of medicines produced by traditional health practitioners to ensure their safety for human consumption, and above all, improve their practices, turning it into a credible scientific cure. The institute

⁷¹ From 2009 to the present, ITM offers short courses training Level I and II as well as a master and PhD degrees in Traditional Medicines and Development. Interview by Andrea Kifyasi with Rogasian L. A. Mahunnah, 21 July 2018, Tabata Kisiwani, Dar es Salaam. Professor Mahunnah was the former Director of the Institute of Traditional Medicine (1994), First President of Traditional Medicine in Tanzania and the former Chairperson of the Traditional and Alternative Health Practice Council of Tanzania.

⁷² “Tenth Anniversary of Muhimbili Medical Centre,” *Daily News*, August 3, 1987, 5; Interview by Andrea Kifyasi with Professor Rogasian L. A. Mahunnah, July 21, 2018, Tabata Kisiwani, Dar es Salaam; Modest C. Kapingu, June 8, 2018, Institute of Traditional Medicine (ITM), Muhimbili University of Health and Allied Sciences (MUHAS), Dar es Salaam. Dr Kapingu is a senior research at the ITM

regularised activities of the practitioners without depriving them of their medical knowledge and social functions.⁷³

The establishment of the TMRU eased the flow of traditional medical knowledge between the practitioners of China and Tanzania. On December 13, 1962, the two countries signed the Cultural Agreement in which, among other things, they agreed to exchange experiences in the fields of modern and traditional medicine.⁷⁴ The agreement was reached while the Tanzanian government had yet to recognise and institutionalise traditional medicine legally. Thus, throughout the 1960s, traditional medical knowledge exchanges practically did not exist between the two countries. Instead, the medical knowledge exchanges realised in the 1970s after the launch of the Sino-Tanzanian Joint Project on Traditional Medicine. The research project yielded promising results and added value to the development of traditional medicine. Between 1974 and 1975, the joint research team collected samples of over 1,000 herbs used by traditional healers in Tanzania (Figure 3).⁷⁵ In 1977, traditional medicine researchers from ITM took over the research project and collected about 2,500 specimens of medicinal plants. Some specimens tested in the laboratory were efficacious, and researchers endorsed them for clinical trials.⁷⁶

In the 1980s, initiatives in favour of using traditional medicine parallel to western biomedicine showed promising results. During this period, the ITM endorsed efficacious medicines for use in hospitals alongside modern medicine. The Minister for Health spoke to the National Assembly that about seven types of herbal drugs researched by the institute would be ready for use in hospitals by 1985. The Faculty of Medicine at the Muhimbili Medical College proved that the medicines presented were able to cure some diseases.⁷⁷ Moreover, in 1990, the institute conducted research on traditional medicine capable of treating diabetes,

⁷³ Morice Maunya, "Traditional Healers now in Mainstream Health Services," *Daily News*, February 28, 1991, 5; Beck, "The Traditional Healer in Tanzania," 4.

⁷⁴ Read, for instance, Article 6 in URT, *Cultural Agreement Between the Government of the United Republic of Tanzania and the Government of the People's Republic of China, 1962*, 3.

⁷⁵ Economic Commission for Africa, *Chemical Industry Development Programme: Report of the First ECA/UNIDO Chemical Industry Development Programme Mission, May-October 1978*, 113; Langwick, *Bodies, Politics, and African Healing*, 62.

⁷⁶ "Amend your Laws on Medicine, Africa Told," *Daily News*, September 30, 1977, 3; also see "Tenth Anniversary of Muhimbili Medical Centre," *Daily News*, August 3, 1987, 5.

⁷⁷ The seven herbal drugs included *azadirachta indica* – a popular herb locally known as *Mwarobaini* – used for treating malaria and fever, *calendula officinalis* with a potential for treating stomach pains, *cinchona succirubra* used for the preparation of quinine and chloroquine drugs for malaria cases, *cynara scolymas* for containing blood vein problems, *digitalis lanata* for heart ailments, *saponaria officinalis* and *tagetes patula* for treating blindness, see "Herbs Enter Conventional Medicine," *Sunday News*, July 28, 1985, 5; "Local Herbs Usable in Hospitals," *Daily News*, March 21, 1987, 3. Langwick, *Bodies, Politics, and African Healing*, 62.

malaria, asthma, ulcers, and HIV/AIDS. Among the eight kinds of traditional medicines observed, one was effective in controlling diabetes and others were capable of curing chronic malaria and ulcers.⁷⁸ Surely, achievements reached by the ITM brought hope and relief as the availability of more local medicine would ease the burden on the government, which spent a considerable amount of foreign currency to import drugs. Above all, the discovered local medicines were particularly meaningful in curbing the dominance of biomedicine in health care and therefore a promising step toward self-reliance.

Figure 3: A Tanzanian traditional healer, Ibrahim Mapembe (first left), explaining to Chinese doctors how he treats patients and the herbs he uses for treatment, 1975



Source: “Traditional Healers and ‘Health for All’”, *Sunday News*, February 19, 1984, 8.

From 1974 to 90, the MoH vigorously coordinated and gave prominence to the activities and services of the ITM over the services of traditional health practitioners. Such context created an impression that the government abandoned the practitioners and devalued their services. It further created endless complaints from traditional health practitioners

⁷⁸ JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. Prof. Phillemon M. Sarungi, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1992/93*, 40; Interview by Andrea Kifyasi with Febronia C. Uiso and Edmund J. Kayombo, June 8, 2018, Institute of Traditional Medicine (ITM). Uiso and Kayombo are senior researchers at the Institute.

demanding more support and considerations from the MoH.⁷⁹ Fortunately, in February 1991, the MoH considered their demands and took several initiatives to coordinate their activities. Among other things, it formally included traditional healers in its mainstream health service. The Minister for Health, Professor Philemon Sarungi, said: “I am here to announce to you [traditional medicine practitioners] that you are now a fully recognised sector and my Ministry is now working to chart out guidelines and policies under which your activities would be coordinated nation-wide.”⁸⁰ Before the official recognition, traditional practitioners worked on an individual basis, and the MoH did not effectively coordinate the services offered with the rigor needed in the exercise of preventing and healing diseases. From the 1990s, more tangible attempts were taken by the government to promote the use of traditional medicine parallel to biomedicine. The ITM owed to the support it received from the Chinese government. In 1991, the Minister for Health acknowledged the support and affirmed that Tanzania was making headway on her research in traditional medicine because of the assistance it received from the Chinese government.⁸¹

The institutionalisation of traditional medicine pleased many Tanzanians who trusted traditional medicine more than biomedicine. The available research illuminates that many patients went to hospitals or clinics as a last resort, after traditional medicine had failed. Additionally, about 60% of the urban population and over 80% of the rural population in Tanzania relied on traditional medicine. Moreover, traditional health practitioners in Tanzania enjoyed a much more agreeable ratio of patients they attended to than biomedical doctors. The ratio of traditional health practitioners was 1:500 patients while that of biomedical doctors was 1:25,000 by 2012.⁸² These glimpses imply that traditional medicine contributed significantly to the development of primary health care in Tanzania. They further show that sufficient use of traditional medicine was vital for the development of local medical knowledge, a key to the attainment of medical self-sufficiency.

⁷⁹ Interview by Andrea Kifyasi with Edmund J. Kayombo, June 8, 2018, Institute of Traditional Medicine (ITM).

⁸⁰ Maunya, “Traditional Healers now in Mainstream Health Services,” 5.

⁸¹ “Sarungi Praises Chinese,” *Daily News*, September 7, 1991, 3.

⁸² Mahunnah, Uiso and Kayombo, *Documentary of Traditional Medicine in Tanzania*, 8.

2.5 Rural Health Care, 1969–1980

For, while other people can aim at reaching the moon, and while in future we might aim at reaching the moon, our present plans must be directed at reaching the village. Julius K. Nyerere.⁸³

From Nyerere's quote, government priorities varied from one country to another. While rural health care was not a concern to some countries of the North, Nyerere's government made it a priority, mainly after the launch of the Arusha Declaration in 1967, where social infrastructures such as health, schools, and water were entrenched in the concept of "socialism and rural development".⁸⁴ The government recognised that a country's development depended on the welfare of its citizens; that is why it vowed to improve people's health by extending social services to rural areas where the services were mostly lacking. The rural health care program was initially recommended in the Titmuss report of 1964, which showed that there were two to three trained doctors for every 100,000 people in rural areas by 1963. It recommended the post-colonial government to prioritise staffing rural health centres to fight diseases effectively, curb rural-urban migration and hasten agricultural production, which was the backbone of the country's economy.⁸⁵ However, it was since the Arusha Declaration of 1967 that the Tanzanian government took the rural health care agenda seriously.

Tanzania's rural health care policy was comparable to Chinese rural health care schemes. After the Revolution, Chairman Mao set up Four Health Principles, which became the basis for the development of health care. The first principle contended the necessity of medical and health works to serve workers, peasants and soldiers. The second principle stressed preventive health care, while the third accented the unification of doctors of traditional and biomedicines. In the fourth principle, Mao underscored the integration of health work and mass movement.⁸⁶ Rural health care was covered in the first principle, which underscored inclusive health care. Medical works such as prevention of diseases, clinical practices, scientific research and training of personnel had to proceed from serving workers, peasants and soldiers, and not only a particular class of people.

⁸³ Quoted in Nsekela and Nhonoli, *The Development of Health Services and Society in Mainland Tanzania*, 20.

⁸⁴ Resnick, *The Long Transition*, 192.

⁸⁵ See, for instance, Chapter 5 in Richard M. Titmuss, Brian Abel-Smith, George Macdonald, Arthur W. Williams, and Christopher H. Wood, *The Health Services of Tanganyika: A Report to the Government* (London: Pitman Medical Publishing, 1964), 106-107.

⁸⁶ Wu Chieh-ping, "For Workers, Peasants and Soldiers," *Peking Review*, no. 8, February 21, 1975, 9.

Several health campaigns, such as the Patriotic Health Campaign, which stressed preventive health care, were implemented by the government to fight diseases in urban and rural areas. Yet, the government attempts failed to improve rural health care. Up to the 1960s, diseases were rampant and rural communities lacked enough medical personnel, medicines, health centres, and medical equipment.⁸⁷ Such challenges saddened Chairman Mao, who openly criticised the Ministry of Public Health for paying less attention to rural health care. Mao argued:

Tell the Ministry of Public Health that it only works for fifteen per cent of the total population of the country and that this fifteen per cent is mainly composed of gentlemen, while the broad masses of the peasants do not get any medical treatment. First, they don't have any doctors; second, they don't have any medicine. The Ministry of Public Health is not a Ministry of Public Health for the people, so why not change its name to the Ministry of Urban Health, the Ministry of Gentlemen's Health, or even to Ministry of Urban Gentlemen's Health?⁸⁸

By 1965, over 500 million of China's population were peasants. Given the fact that agricultural activities were the backbone of China's economy, the emphasis on rural health care was imperative.⁸⁹ Besides, Mao's rural health care aimed to bridge the gap between urban and rural conditions and make medical health work serve the majority instead of a small percentage of the population. Mao underscored: "We should leave behind in the city a few of the less able doctors who graduated one or two years ago, and the others should all go into the countryside."⁹⁰ To adhere to Mao's better rural health care endeavour, the Ministry of Public Health had to transform the health care system to build a genuinely socialist health service that would contribute to the country's socialist revolution. Subsequently, in 1966, following China's Great Proletarian Cultural Revolution, crowds of urban medical and health workers throughout the country were sent to rural areas to deliver medical care to peasants and workers.⁹¹ Thus, from 1966 onwards, medical graduates were channelled to rural health

⁸⁷ Zhou Xun, *The People's Health: Health Intervention and Delivery in Mao's China, 1949-1983* (Montreal: McGill-Queen's University Press, 2020), 12.

⁸⁸ Mao Tse-tung, "Directive on Public Health, June 26, 1965," in *Selected Works of Mao Tse-tung Volume IX*, (India: Pragathi Book House, 1994), 216.

⁸⁹ Hua Hsin, "Chinese Factory's Long March from Dustpans to Hospital Equipment," *Daily News*, October 19, 1977, 4.

⁹⁰ Mao, "Directive on Public Health, June 26, 1965," 217.

⁹¹ Zhou, *The People's Health*, 192-193.

centres, dispensaries, and hospitals. For instance, by 1973, the Ministry of Public Health reallocated to rural areas more than 100,000 medical workers.⁹²

Similarly, at independence, Tanzania had more than 90% of rural dwellers who depended on their survival from agricultural activities. The government noticed that investing in rural health care was key to bettering life for rural communities and the country at large. Consequently, Tanzania's economic destiny dwelled heavily on peasants who were the primary producers of both food and cash crops. To promote peasants' production, the government, among others, extended health services to their vicinities.⁹³ Rural health services, therefore, constituted a crucial investment consistent with Nyerere's commitment to socialism and rural development, as well as his bio-political endeavour. The state anticipated that people would produce more if they were energetic and healthier.

The Tanzanian government approached the rural health care program through a three-tier structure of personnel and facilities, consisting of village health posts, dispensaries, and health centres. It considered villages as the basic unit of the health care system. Thus, it placed prime importance on village health care. Nevertheless, the delivery of health care in rural areas was challenging. The main hurdles were rooted in the structure of the villages themselves. Rural communities were scattered and the voluntary concentration of the scattered homesteads, administered from 1963 by the Rural Settlement Commission, was not progressing well. Up to 1965, only about 3,400 families resided in the newly established villages.⁹⁴ Despite such noticed failure, the government found it necessary for people to live in organised settlements to facilitate rural development. Nyerere argued: "We shall not be able to use tractors; we shall not be able to build hospitals or have clean drinking water; it will be quite impossible to start small village industries without a rural population living in villages."⁹⁵ Consequently, the government perceived villagization as the only feasible means of reaching economic and social development.

Bringing together previously scattered communities heightened after the Arusha Declaration, where through the Cooperative Societies Act of 1968, the government encouraged the registration of the newly established settlements as *Ujamaa* villages. Such attempt

⁹² Wu, "For Workers, Peasants and Soldiers," 10.

⁹³ Wilson Kaigarula, "Taking Health Services to the People," *Daily News*, March 6, 1979, 4.

⁹⁴ Kikula, *Policy Implications on Environment*, 21.

⁹⁵ Kikula, *Policy Implications on Environment*, 14.

persuaded some communities to reside in the established villages, reaching a total of 300,000 people in about 650 villages by 1969. However, the pace was below the government's expectations. Thus, through the President Circular No. 1 of 1969, and Presidential decree of 1973, resettlement became compulsory, while the government applied both coercive and persuasive means to make sure that all families reside in *Ujamaa* villages by the end of 1976.⁹⁶ Coercive measures led to a violent confrontation between villagers and the campaign teams in several places of the country. Such confrontation prompted numerous critics from scholars, associating villagization campaign with the declining rural economy throughout the 1970s.⁹⁷

Despite the odds, the villagization campaign was an essential means of putting communities together to facilitate the provision of social services. This view implies that the campaign brought both hardships and opportunities to the rural communities. President Nyerere, in his report to the Tanganyika African National Union (TANU) conference of September 1973, made this clear: "It is one thing to leave a tiny, sun-baked, and waterless *shamba* in Dodoma District and move into a new village where water is or soon will be, available and elementary medical and educational facilities are being constructed for the first time."⁹⁸ Nyerere anticipated that rural dwellers would benefit more under the villagization scheme since the government would extend all necessary social services to them. However, the resettlement scheme was not supported by the will of the majority in many parts of the country. Some rural communities perceived the scheme as a form of dislocation and loss since they were forced to move away from their residences in which they had heavily invested for years. Others accepted it wholeheartedly, perceiving the resettlement as an opportunity to get access to social services and a better life as promised by political elites.⁹⁹

Nevertheless, the promised social infrastructures such as schools, roads, and health centres were established by villagers themselves through a "self-help" spirit, with minimal backing from the government. Nyerere put this clear that: "People must be helped to understand that they will get the better services in the *Ujamaa* Villages because they will be able to work together to create them; it must be with this understanding that they join."¹⁰⁰ Up to 1983, about

⁹⁶ Kikula, *Policy Implications on Environment*, 22; URT, *Second Five-Year Plan for Economic and Social Development July 1, 1969-June 30, 1974, Volume I: General Analysis*, 1969.

⁹⁷ Read, for instance, Chuhila, "Agrarian Change and Rural Transformation in Tanzania," 13; Andrew Coulson, *Tanzania a Political Economy* (New York: Oxford University Press, 1982), 168-176; also see Scott, *Seeing Like a State*, 223-261; Lawi, "Tanzania's Operation Vijiji," 73.

⁹⁸ Julius K. Nyerere, *President's Report to the TANU Conference, Sept. 1973*, 6.

⁹⁹ Lal, *African Socialism in Postcolonial Tanzania*, 177.

¹⁰⁰ Nyerere, *President's Report to the TANU Conference*, 10.

35% of the rural population lived in established *Ujamaa* or developed villages where the government extended its health services.¹⁰¹ Through the self-help scheme, village governments mobilised people to establish health posts, village dispensaries, schools and roads, which, in turn, encouraged economic and social development.

The government development plans were structured according to the rural health care program. For example, in the Second Five Year Development Plan, it stressed on the preventive health services through the agency of rural health centres. The government anticipated establishing health centres throughout the country. It aimed to attain the ratio of one health centre to every 50,000 people. With this target, the government needed to establish 240 health centres to meet the demands of the whole country. Besides the supervision of dispensaries in their respective areas, health centres were also responsible for organising preventive campaigns, such as nutrition education, environmental sanitation, maternal and child health services and immunisation.¹⁰² Under the Second Plan, the government further proposed to establish enough rural dispensaries as it endeavoured to reach a ratio of a single dispensary to every 10,000 people. The government achieved its target by increasing development capital in the health sector from 2.2% allocated in the First Five Year Development Plan to 8% in the Second Five Year Development Plan.¹⁰³ The government plans were realistic since the budget for the Ministry of Health increased from Tshs. 8,538,000 in the 1971/72 financial year to Tshs. 14,198,000 in the 1973/74. While in 1971, there were about 87 rural health centres, by the end of 1973, the number of centres increased to 135. Likewise, the number of dispensaries rose from 1,445 in 1971 to 1,594 in 1973.¹⁰⁴

Furthermore, in the 1977/78 financial year, the government allocated Tshs. 15,800,000 for the completion of new rural health centres and dispensaries in different regions of Tanzania. The allocated funds were additional to Tshs. 18,590,000, spent in the 1976/77 financial year for the same purpose. The government's target was to establish at least 10 to 15 rural health centres and 40 to 50 dispensaries per year.¹⁰⁵ The 1970s and 80s were economically challenging periods for the Tanzanian government. It experienced droughts, the oil crisis and

¹⁰¹ "World Drug Market Manual, November 19, 1982," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

¹⁰² URT, *Second Five-Year Plan for Economic and Social Development, July 1, 1969-June 30, 1974, Volume II: The Programmes, 1969*, 101.

¹⁰³ URT, *Second Five-Year Plan for Economic and Social Development, July 1, 1969-June 30, 1974, Volume I: General Analysis, 1969*, 162-164.

¹⁰⁴ Nyerere, *President's Report to the TANU Conference*, 16.

¹⁰⁵ "Big Cash Set Aside for Rural Health," *Daily News*, July 13, 1977, 1.

a war fought with Uganda; thus, it spent much on purchasing imported foodstuff, oil, and weapons. Despite the mentioned challenges, the government was devoted to improving health services, particularly in rural areas. Subsequently, it directed more funds to the rural health care. Table 4 shows that between 1971 to 80, the government's shares in rural health services rose from 20% to 42%. The government's commitment in allocating more funds for rural health care aimed to meet deliberations by its Second Five Year Development Plan where it anticipated to establish about 80 rural health centres in various districts of Tanzania.¹⁰⁶ Despite the evidence that the government allocated considerable funds for rural health care, the actual implementation of the program needed more funds, medicines, medical equipment, and personnel, which were not readily available. Such inadequacies curtailed the sound achievements of the project.

Table 4: Budgetary allocation ration between rural and urban health care

Financial Year	Rural	Urban
1970/71	20%	80%
1974/75	37%	63%
1976/77	41%	59%
1979/80	42%	58%

Source: Created by the author based on data from Dominicus and Akamatsu, "Health Policy and Implementation in Tanzania," 199.

The establishment of the rural health posts and dispensaries went hand in hand with the staffing program. At independence, most rural health posts in Tanzania lacked trained medical personnel. Such a situation too existed in China. At liberation, China had only about 20,000 doctors trained in the western medical schools who mostly worked in urban areas. Its villagers depended mainly on traditional Chinese medicine practitioners.¹⁰⁷ After the Revolution, Chairman Mao established several strategies to create a healthy community, which would engage fully in production and bring a successful socialistic revolution in agriculture, industry, and science. Mao stressed the improvement of health facilities throughout the country while providing priority to rural areas where the majority of people lived. With the engagement

¹⁰⁶ "Letter from the Office of Chief Medical Officer, Ministry of Health and Social Welfare, June 30, 1971 to all Regional Medical Officers, Rural Health Centres 1969/74," TNA. Acc. No. 450, Ministry of Health, File, No. HEH/41/4, Rural Health Centres, Ulanga District; Dominicus and Akamatsu, "Health Policy and Implementation in Tanzania," 199; Gerardus Maria van Etten, *Rural Health Development in Tanzania: A Case-Study of Medical Sociology in a Developing Country* (Assen: Van Gorcum, 1976), 43-44.

¹⁰⁷ Chien, "Chinese Medicine: Progress and Achievements," 18.

of Mao's regime, it took about three years to implement a rural health care policy where staff and facilities in rural areas were improved.¹⁰⁸

While learning from China, the Tanzanian government vowed to staff rural health posts and dispensaries, and it subsequently established the Village Health Care Scheme in 1969. The scheme was famously known as "First Aid-Kit Scheme", and was run by Village Medical Helpers (VMHs). The scheme aimed to provide health care to villages which had not had health centres since the colonial era. Through village health posts, the scheme intended to obviate the need for a journey of more than 20 to 30 miles for the people seeking health services. Moreover, village health posts anticipated reducing considerably the number of outpatients attending for comparatively trivial ailments at regional and district hospitals. It further aimed to get enough health practitioners to address village health challenges. Moreover, the scheme intended to empower and encourage villagers to help themselves in the early stages of addressing health challenges. Through the scheme, the government anticipated that VMHs would address common and non-complicated health challenges. The government aimed to have at least two VMHs (one male and a female) in each village. Local administrations employed VMHs who worked for their respective ethnic groups or belonged to the same ethnic group as that of the area in which they were to be employed. By 1974, the government had trained 2,218 VMHs who were working in the villages throughout the country.¹⁰⁹ Generally, VMHs supplemented long-trained medical staff who were fewer to cater to the needs of the government.

The name "village medical helpers" was analogous with the British colonial "tribal dressers"¹¹⁰ of 1925 and the Chinese "barefoot doctors"¹¹¹ (*chìjiǎo yīshēng*) of 1965 in

¹⁰⁸ "Report on a visit of Ministry of Health delegation to the People's Republic of China, September 1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

¹⁰⁹ "WHO, National Health Planning in Tanzania: Report on a Mission, August 1, 1973-April 28, 1974," WHOA, File No. TAN/SHS/002, 1972-1974-SHS/NHP, National Health Planning, 8; "Letter from the Principal Secretary, Ministry of Health, August 25, 1977 to all District Executive Directors of Tanzania, Mpango wa Huduma za Afya Vijijini," NRC. RAS-DOM 9/5/06, File Ref. No. M. 10/19 Medical Including Health Village Dispensaries, 1965-1982; Christopher Magola, "Accent on Rural Health," *Daily News*, December 4, 1982, 6; also see Kaigarula, "Taking Health Services to the People," 4.

¹¹⁰ The British tribal dressers scheme was initially introduced by the British Director of Medical and Sanitary Services, Dr J. O. Shircore, in 1925. The scheme trained mainly lower medical personnel assigned roles to address common local diseases in their respective villages.

¹¹¹ Before using the term "barefoot doctors", the term "peoples commune" was used which meant a lower cadre of medical personnel working in communes. The term "barefoot doctors" was later given as a certificate to youths providing clinical care to the communes. The name came from Southern farmers who often worked barefoot in the rice paddy fields. The government recruited such lower medical cadre from a group of youths who received minimal training in treating minor illnesses, immunisation, environmental sanitation, and other preventive

structure and practice. Findings from the present study show that the Tanzanian government utilised both experiences it learned from the British and the Chinese. The delegates from MoH sent to China for a study tour learned that the Chinese government strived to improve its health services by providing short training programs to its medical personnel.¹¹² Short training courses enabled the country to have a large number of medical personnel. For instance, up to 1977, it had about 4,000,000 barefoot doctors.¹¹³ Chinese achievements in staffing rural health centres were, therefore, admired and adopted by the Tanzanian government.

The VMHs scheme trained lower medical personnel. The training was elementary and chiefly confined to the treatment of common local diseases. District medical officers (DMOs) were responsible for executing the training program.¹¹⁴ The course lasted a minimum of three months. The training sessions were held in their respective districts and regional hospitals. Training for VMHs included lectures on basic anatomy and general medicine subjects, mother and child welfare, village government's political structure, environmental sanitation, food and nutrition, and knowledge on undesirable customs and beliefs that had a bearing on village health. For example, some communities forbade pregnant women and children from eating some varieties of foodstuffs such as eggs, leading to severe malnourishment for both the mother and child.¹¹⁵ The three-month training also included a management course that aimed to acquaint trainees with managerial skills to control village health posts.¹¹⁶ The government expected that trainees would be in a position to deal effectively with the average assortment of rural sick and that they would do a certain amount of treatment of minor ailments, render first aid, and act as collecting agents for the hospitals (Figure 4).¹¹⁷ Furthermore, VMHs had to provide at least minimal preventive and curative services to the villages without a dispensary or health centre and connect their respective villages to the official chain of referrals if more skilled services other than simple village-based were required. The government smoothed

services. For further details see, Xiaoping Fang, *Barefoot Doctors and Western Medicine in China* (New York: University of Rochester Press, 2012).

¹¹² "Mambo yalivyo Uchina," *Nchi Yetu Tanzania*, Desemba 1966, 22-23.

¹¹³ "Report on a visit of Ministry of Health delegation to the People's Republic of China, September, 1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

¹¹⁴ "Letter from the Principal Secretary, Ministry of Health, August 25, 1977 to all District Executive Directors of Tanzania, Mpango wa Huduma za Afya Vijijini," NRC. RAS-DOM 9/5/06, File Ref. No. M. 10/19 MEDICAL Including Health Village Dispensaries, 1965-1982.

¹¹⁵ "Letter from District Medical Officer of Mbozi District to the Regional Medical Officer, January 2, 1971, Village Helper Course," MRC. Acc. No. 13, File No. HE.11/1, Rural Medical Aids General, 1971-1980; Christopher Magola, "Programme Brings Health Care to Rural Folk's Door," *Daily News*, March 5, 1987, 4.

¹¹⁶ Magola, "Programme Brings Health Care to Rural Folk's Door," 4.

¹¹⁷ Magola, "Programme Brings Health Care to Rural Folk's Door," 4.

effective delivery of health services to the trainees by equipping them with first-aid kits containing drugs for common health cases such as malaria, diarrhoea, and other tropical diseases. It further provided simple medical equipment such as complete delivery kit, a scalpel with a blade, scissors, dressing, forceps, gallipot, and kidney dish to VMHs after completion of their course.¹¹⁸

Figure 4: A village medical helper providing first aid (undated, likely 1970s)



Source: WHO/Didier Henrioud

¹¹⁸ “Letter from the Office of the Principal Secretary, May 19, 1983 to the Programme Officer, UNICEF, First Aid Kits for Village Health Workers,” TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

Like the British tribal dressers and China's barefoot doctors, the selection of the VMHs involved local administration, which was their main employer. However, the post-colonial Tanzanian government improved the selection process by training village leaders regarding rural health care and their roles as employers of the VMHs. The village leaders consulted villagers and recommended four names (two males and two females). Eligible persons were required to be: permanent residents in the village, liked and respected by all, married and/or owned a durable house and farm in the village, married and living together with a spouse, aged between 25 and 45 years, and a diligent member of the Tanganyika African National Union (TANU).¹¹⁹ Additionally, applicants were required to hold a minimum standard of primary education. Primary school graduates with sufficient knowledge and ability to read and write well in Kiswahili, with a working knowledge of English, were considered in priority. To commit VMHs to the service, the government demanded that they fill in agreement forms committing them to serve the village for at least five years after completion of their training.¹²⁰

Most of the criteria used by the post-colonial Tanzanian government to admit eligible candidates for the VMHs program resembled those used by the British colonial government. Similarly, the criteria resembled and differed from those used to select barefoot doctors in China. For instance, the Chinese government considered trainees with secondary school certificates. Such qualification allowed trainees to advance their medical education and get promoted to village medical doctors. In the 1980s, when the barefoot doctors' scheme collapsed, some barefoot doctors went for further training and got employed as village medical doctors.¹²¹ The selection of secondary school graduates would not work both in colonial and post-colonial periods in Tanzania since there were very few secondary school graduates.¹²² As a result, the British recruitment system, which was embraced by the post-colonial Tanzanian

¹¹⁹ "F. D. E. Mtango, Helena Restrepo, K. G. M. M. Alberti, O. Dale Williams, S. Dodu, Tanzanian Integrated Non-Communicable Diseases Prevention and Control Studies, Report of a Review of Activities, Geneva, Switzerland, August 17-19, 1983," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

¹²⁰ Magola, "Programme Brings Health Care to Rural Folk's Door," 4; for the British Tribal Dressers see "Letter by the Director of Medical Services to the Provincial Commissioner of the Southern Highlands Province, Mbeya, January 3, 1937," TNA. Acc. No. 450 Ministry of Health, File No. 209/1, Instructions for Tribal Dressers; "F. D. E. Mtango, Helena Restrepo, K. G. M. M. Alberti, O. Dale Williams, S. Dodu, Tanzanian Integrated Non-Communicable Diseases Prevention and Control Studies, Report of a Review of Activities, Geneva, Switzerland, August 17-19, 1983," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

¹²¹ Daqing Zhang and Paul Unschuld, "China's Barefoot Doctor: Past, Present, and Future," *The Lancet* 372, (November 29, 2008): 1866.

¹²² More details about Tanzania's education situation read Kahama, Maliyamkono and Wells, *The Challenge for Tanzania's Economy*, 23.

government, limited further training to VMHs and left them jobless after the decline of the program.

Like the British tribal dressers, the VMHs scheme acquainted trainees with notions of biomedicine. Such a training system contrasted with that in which the Chinese prepared trainees in both biomedicine and traditional Chinese medicine. The Chinese training system was in line with the Maoist policies, which stressed integrating biomedicine and traditional medicine in health care.¹²³ Archival records show that before the opening up of dressing stations in colonial Tanganyika, biomedicine was prevalent in only a few towns.¹²⁴ Therefore, dressing stations played a vital role in popularising biomedicine to the interior of Tanganyika. Similarly, the negligence in training VMHs in traditional Tanzanian medicine played a role in popularising biomedicine in rural areas.

The post-colonial Tanzanian government was dedicated to promoting preventive health care. Under its First Five Year Development Plan of 1964–69, the government prioritised both preventive and curative measures. It realised that many health challenges such as bilharzia, diarrhoea, malaria, hookworm, malnutrition, enteric infection and the like were preventable. Thus, it stressed vaccination and health education. The government premised that preventive knowledge would spread to people through health education. Accordingly, the MoH circulated knowledge on the significance of wearing shoes, digging and using latrines, proper attention to nutrition, and cleanliness (Chapters 1 and 5).¹²⁵ The government perceived VMHs as an effective means of transmitting preventive knowledge to villagers. Lessons related to health education, essential immunisations, clean and adequate water, environmental sanitation, standard housing, adequate and balanced diet, control of major endemic diseases, mother and child services, family planning, and secondary prevention of diseases and injuries were imparted to the trainees to meet the government's ambitions. The stress on preventive education was consistent with the barefoot doctors' scheme, which also extended preventive medical knowledge to trainees for the same purpose.¹²⁶

¹²³ Xiaoping Fang, "Changing Narratives and Persisting Tensions: Conflicts Between Chinese and Western Medicine and Professional Profiles in Chinese Films and Literature, 1949-2009," *Medical History* 63, no. 4 (2019): 463.

¹²⁴ "Organisation of Rural Medical Work in the Western Province," TNA. Acc. No. 450, Ministry of Health, File No. 209/7, Tribal Dressing Stations and Government Rural Dispensaries-Tabora District.

¹²⁵ "Budget Speech by Minister for Health, June, 1965," TNA. Acc. No. 589, Orodha ya Majalada ya Mtu Binafsi, Bhoke Munanka, File No. BMC. 10/03, Speeches of Ministers and Junior Ministers, 6.

¹²⁶ Zhang and Unschuld, "China's Barefoot Doctor," 1866; "F. D. E. Mtango, Helena Restrepo, K. G. M. M. Alberti, O. Dale Williams, S. Dodu, Tanzanian Integrated Non-Communicable Diseases Prevention and Control

The British tribal dressers had worked in different respective dressing stations erected by villagers themselves with minimal assistance from their government. The status of the stations varied from one province to the next, depending on financial ability.¹²⁷ Similarly, the Chinese barefoot doctors were stationed in simple health units established by villagers and their local governments on a self-help basis.¹²⁸ Likewise, the post-colonial Tanzanian government, through its district and village officers, organised villagers to establish simple buildings and used them as village health posts. Such initiatives were in line with the 1964 Titmuss report, which recommended the government to involve villagers in community development programmes in the spirit of “self-help”, to improve health care services at the grassroots level.¹²⁹

The Titmuss suggestions were backed by the Presidential Circular No. 2 of 1968 which subjected all minor community development projects such as schools, dispensaries, community centres, teacher’s house and the like to a “self-help scheme”.¹³⁰ Such attempts show government initiatives to empower people to use the resources and skills they jointly possessed for their welfare and development. The government supported self-help projects with technical advice, roofing materials, pipes and other capital assistance.¹³¹ At the same time, the village community furnished village health posts with simple facilities such as a table and chairs. Moreover, village governments covered travelling costs for the helpers to enable them to travel to health centres and collect drugs and equipment. Additionally, the village governments exempted the helpers from other village development activities such as road construction, cultivating *Ujamaa* farms and the like, to enable them to deliver medical services effectively.¹³²

VMHs received monthly allowances from their respective village government councils, similar to the British tribal dressers and Chinese barefoot doctors. In China, for

Studies, Report of a Review of Activities, Geneva, Switzerland, 17-19 August 1983,” TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

¹²⁷ “An Inspection Report by Sd. B. A. Coghlan, Medical Officer, Musoma to the Director of Medical Services, of February 21, 1935,” TNA. Acc. No. 450 Ministry of Health, File No. 209/1, Instructions for Tribal Dressers, Revised Edition.

¹²⁸ “Report on a visit of Ministry of Health delegation to the People’s Republic of China, September 1977,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

¹²⁹ Titmuss, Abel-Smith, Macdonald, Williams, and Wood, *The Health Services of Tanganyika*, 100.

¹³⁰ “The State House, Presidential Circular No. 2 of 1968, Self-Help Schemes, August 24, 1968,” TNA. Acc. No. 593, Orodha ya Majalada Idara ya Habari, File No. IS/P/120/59, Distribution of Press Releases, 1963-1970.

¹³¹ “The State House, Presidential Circular No. 2 of 1968, Self-Help Schemes, August 24, 1968,” TNA. Acc. No. 593, Orodha ya Majalada Idara ya Habari, File No. IS/P/120/59, Distribution of Press Releases, 1963-1970.

¹³² “Letter from the Head of the Department, Mvumi Hospital to Village Chairmen and Chair Health Committee, Mpango Kuhusu Wahudumiaji wa Afya Vijijini (Village Medical Helpers),” November 2, 1977,” NRC. RAS-DOM 9/5/06, File Ref. No. M. 10/19 Medical Including Health Village Dispensaries, 1965-1982.

instance, barefoot doctors were paid by the people whom they served. In some places, barefoot doctors received peasant's share, just like other peasants working on farms while in other provinces the resident of each commune paid one to two yuan per year as allowance for the doctors. Thus, patients received clinical care free of charge. Under this system, China had two groups of medical workers: the ones who were paid by the government and those who were paid by communes. Such dual practice reduced the central government's expenditure and enhanced people's access to health care.¹³³ Though details showing the amounts of monthly allowances received by VMHs are missing, village governments were obligated to enforce fee collection and surely saw to it.¹³⁴

Investments in rural health care required both political will and financial ability. Political elites in Tanzania were determined to seeing rural health care scheme become a success. However, the country's ill economic situation was the main hindrance. To address the financial deficit, the Tanzanian government requested and received support from different donors. Although the Chinese government influenced the government to establish a village health care scheme, funding for the scheme did not flow much from China. Instead, the scheme was backed by the Basel Foundation for Aid to Developing Countries and other traditional donors of the North. The Basel Foundation provided 1,000,000 Swiss francs for buildings and the equipment of the Rural Aid Centre (RAC) at Ifakara in 1961. It also donated 200,000 francs annually to run the course and to develop and maintain the centre.¹³⁵ The RAC trained low medical cadres, such as rural medical aids and assistant medical officers. However, following the government needs of VMHs, it adjusted its training to meet the demand.¹³⁶ The United Nations International Children's Emergency Fund (UNICEF) and the Swedish International Development Cooperation Agency (SIDA) also sponsored the programme. The Swedish government, for instance, signed an agreement in May 1973 whereby it committed to donating 35 million Swedish kronor to Tanzania's disposal to support the development of rural health services during the fiscal years 1972/73 to 1976/77.¹³⁷ Furthermore, village medical helpers

¹³³ "Report on a visit of Ministry of Health delegation to the People's Republic of China, September 1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

¹³⁴ Magola, "Programme Brings Health Care to Rural Folk's Door," 4.

¹³⁵ Rudolf Geigy, "Rural Medical Training at Ifakara: Swiss Help to Tanzania," *The Lancet* 285, Issue, 7400 (June 26, 1965): 1385-1386.

¹³⁶ Lucas Meier, "Striving for Excellence at the Margins: Science, Decolonization, and the History of the Swiss Tropical and Public Health Institute (Swiss TPH) in (Post-) Colonial Africa, 1943-2000" (PhD diss., University of Basel, 2012), 171.

¹³⁷ "Rural Health Programme, Terms of Reference for Review, 1976-77," NRC. RAS-DOM 9/5/06, File Ref. No. M. 10/19 Medical Including Health Village Dispensaries, 1965-1982.

received bicycles, medicines and medical equipment from the central government, but provided by UNICEF as grants. In 1976, for instance, about 56 bicycles were distributed to the helpers working in Dodoma, Lindi, Mbeya, and Mtwara. The VMHs who served scattered *Ujamaa* villages were the first to receive bicycles.¹³⁸ Bicycles helped them to reach many rural patients on time.

Despite the order from the Minister Ally Hassan Mwinyi in 1972, directing medical graduates to work in rural dispensaries, unfavourable living and working conditions dissuaded many candidates.¹³⁹ Therefore, up to 1977, VMHs dominated health care delivery in rural health posts, while most of the medical graduates worked in towns and cities. This context created the impression that medical staffs with short training were destined for rural areas, while qualified medical doctors were for towns and cities.¹⁴⁰ In September 1977, the Minister for Health, Leader Stirling, issued another order to force medical graduates to work in rural areas for some years before they apply for allocation to towns and cities.¹⁴¹ Subsequently, many doctors were relocated to rural areas following the Ministry's order (Table 5). The Ministry's decisions were consistent with the recommendations made by delegates of the MoH who went to China for a study tour. The delegates realised that by 1965, the Chinese government mobilised thousands of Chinese doctors from towns and cities and re-allocated them in rural areas to prevent diseases, treat people, and transmit preventive health education to rural communities. These delegates recommended that the government should improve the living and working environments to convince medical graduates to work in rural health centres.¹⁴²

¹³⁸ "UNICEF, Plan of Operations for Development of Public Health Services (DPHS) in the United Republic of Tanzania, Interim Addendum for Development of Basic Health Services, July, 1991," WHOA, File No. TANZANIA/UNICEF-5, 1968-1972-SHS, Development of Public Health Services; "Letter from the Principal Secretary, Ministry of Health, August 26, 1976 to Development Directors, Mtwanyo wa Kwanza kwa Wahudumiaji wa Afya Vijijini," NRC. RAS-DOM 9/5/06, File Ref. No. M. 10/19 Medical Including Health Village Dispensaries, 1965-1982.

¹³⁹ "Madaktari wafike pia Vijijini," *Uhuru*, July 15, 1972, 1; Heggenhougen, "Health Services: Official and Unofficial," 310.

¹⁴⁰ Interview by Andrea Kifyasi with Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam. Mzee Gallus is a retired Principal Assistant Secretary, Ministry of Health.

¹⁴¹ "Doctors to Work in Rural Areas," *Daily News*, September 30, 1977, 5; also see Kaigarula, "Taking Health Services to the People," 4.

¹⁴² "Report on a visit of Ministry of Health delegation to the People's Republic of China, September 1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

Table 5: Urban-rural distribution of medical workers

Year	1972	1976	1978	1980
Doctors				
Urban	418	487	513	598
Rural	216	399	479	547
Nurses				
Urban	2606	2760	2868	3570
Rural	1653	2060	3322	4705
Medical Auxiliaries (MAs* & RMAs*)				
Urban	208	456	624	910
Rural	605	1363	2166	2800

Source: Modified from Heggenhougen, “Health Services: Official and Unofficial,” 310.

Government’s decisions to force medical graduates to work in rural areas intended to level the unequal distribution of medical workers in rural and urban areas as shown in Table 5. From colonial to post-colonial periods, urban dwellers who constituted less than 10% of the total population enjoyed a more sophisticated type of health service. At the same time, the remaining majority endured inadequate health service with short-time trained medical personnel.¹⁴³ Before government efforts to prioritise rural health care, the national health system was structured like a pyramid, whereby well-equipped hospitals, research centres, specialist doctors, and auxiliary medical facilities were situated in big cities. At the bottom, however, there were several districts, each with district hospitals and health centres, lacking basic facilities. Consequently, achieving equitable health care required the MoH’s commitment to reconsidering how its limited resources could better serve rural areas.

Despite the merits, the VMH scheme faced several problems, such as the inadequate funding by the local authorities (employers), which threatened its very survival. Some village governments did not provide monthly allowances and other incentives to VMHs.¹⁴⁴ The lack of allowances and incentives influenced some VMHs to look for potential jobs in towns. The

** MAs stands for Medical Assistants, and RMAs for Rural Medical Aids.

¹⁴³ Kaigarula, “Taking Health Services to the People,” 4.

¹⁴⁴ “PHC Coordinating Section, Ministry of Health, A Briefing on PHC Programme for the Italian Delegation Visiting Tanzania, October 15, 1983,” TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

1988 MoH evaluation report shows that about 12% of VMHs left their jobs.¹⁴⁵ Moreover, village health posts lacked an adequate supply of medicines and medical equipment, especially from the end of the 1970s and 1980s when the economic crisis severely hit the Tanzanian government. Following the crisis, the government lacked enough foreign currency to purchase medicines and medical equipment. Such context hindered health care delivery by the VMHs.¹⁴⁶

Additionally, some rural communities mistrusted health services offered by VMHs. Gallus Namangaya Abedi asserts that some villagers worried when they were approached by a helper dressed in trousers and a shirt, rather than the crisp white coats worn by doctors (Figure 4). Similarly, they were shunned by and isolated from the learned medical staffs who perceived them as incompetent cadres.¹⁴⁷ Such challenges discouraged VMHs engagement in the delivery of health care in rural communities. Consequently, from the 1980s and 90s, the VMHs scheme lost its relevance since it lacked effective management and community support. Like for China's barefoot doctors, the cost-sharing policy, which emerged in the 1990s, buried VMHs scheme in Tanzania. The free health care services provided by VMHs declined. Thus, a few remaining VMHs turned to other professions.¹⁴⁸

The rural health care scheme implemented by the Tanzanian government became the cornerstone of the international conference on primary health care (PHC) held at Alma-Ata (Almaty), Kazakhstan, in September 1978. The conference made a declaration to meet the health needs of people throughout the world. The declaration identified VMHs as one of the foundational cornerstones of having a comprehensive PHC, a programme that would be a global strategy for achieving "Health For All" by 2000.¹⁴⁹ Tanzania was in an advantageous position since, even before the Alma-Ata conference, it had already in place a well-structured health care system from the grassroots level for more than a decade. With such initiatives, the

¹⁴⁵ JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. Prof. Phillemon M. Sarungi, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1991/92*, 17.

¹⁴⁶ Michele Barry and Frank Bia, "Socialist Health Care in Tanzania: A View from Kilimanjaro Christian Medical Centre," *Annals of International Medicine* 104, no. 3 (1986): 438; Heggenhougen, "Health Services: Official and Unofficial," 311.

¹⁴⁷ Interview by Andrea Kifyasi with Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam; "E. J. I. Kato, Assessment of Village Health Workers' Diagnostic and Treatment Capabilities in Selected Villages in Maswa District, Tanzania, Faculty of Medicine, University of Dar es Salaam, February 28, 1983," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care, 3.

¹⁴⁸ For barefoot doctors read Zhang and Unschuld, "China's Barefoot Doctor," 1866, and for cost sharing policy in Tanzania read JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. Amrani H. Mayagila, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1993/94*, 54-55.

¹⁴⁹ WHO, *Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, September 6-12, 1978*, 61-62.

WHO commended the country for having one of the most thoughtfully designed health systems based on human equality and the foundations of justice.¹⁵⁰ The “Health For All” agenda was in line with Tanzania’s socialist policies adopted during the Arusha Declaration of 1967 and the ruling party’s ideology of 1971. Socialist principles spearheaded the equality of man, preservation of life and health, which were also included in the Alma-Ata declaration. The PHC program, which the MoH implemented after the Alma-Ata conference, incorporated more than 2000 VMHs who were working throughout the country.¹⁵¹ The preceding assertions imply that the Tanzanian government practised the “Health For All” agenda before the 1978 conference. Nevertheless, after the Alma-Ata conference, it reviewed and updated its health care delivery system to conform with the PHC.

2.6 Banning Private Health Services Practice, 1977–1992

Although the Tanzanian government vowed to maintain equality among its citizens to conform to socialist ideology, it retained the 1958’s private practice policy endorsed by the colonial government. The policy left a room for the operation of the private domiciliary practice, consulting practice and special procedures.¹⁵² Under private domiciliary practices, a patient had the choice of attending either government-owned health centres or private ones. The policy allowed people and organisations to own and practice private hospitals. There were a few private health service centres during the British colonial period, but their number would explode after independence. For instance, by 1973, there were about 32 private health centres in Dar es Salaam alone, many owned by Tanzanians, Indians and the British. Private institutions were also established up-country and were mostly owned by Indians, Tanzanians, Italians, British, Kenyans, Australians, Pakistanis, and Swiss.¹⁵³ Thus, private health services functioned parallel to government-owned hospitals. Above all, while the number of health facilities under private practitioners was lower than the number of institutions provided by the government (Table 4), their doctors were almost half of the total number of doctors in the

¹⁵⁰ Rose Kalemera, “Well Done Tanzania, Says WHO Chief,” *Daily News*, July 27, 1987, 1.

¹⁵¹ “J. A. S. Mahalu, Primary Health Implementation in Tanzania,” TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care: International Conference on Primary Health Care, Declaration of Alma-Ata, Alma-Ata, USSR, 6-12 September 1978; “Applied Village Health Worker Research and Evaluation Project in Tanzania, September 1983,” TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

¹⁵² “Medical Department, Private Practice secular of 1958,” TNA. Acc. No. 450, Ministry of Health, File No. HEM/20/14, Private Practice Policy.

¹⁵³ “List of Private Practitioners in Tanzania-Mainland,” TNA. Acc. No. 450, Ministry of Health, File No. HEM/20/14, Private Practice Policy.

country. For instance, in 1961, there were 419 registered doctors in the country, of whom about 239 were in government service, while 180 were in private practices.¹⁵⁴ This context seems to indicate that patients attending private health services were likely to get more effective health care compared to those who attended the government service.

Private practitioners spread mostly in town and cities, hence, widening the medical services gap between urban and rural dwellers. People in urban areas enjoyed efficient health services from both the government and private practitioners. Since profit maximisation was the determining factor in establishing private practices, towns and cities were preferred over rural areas. As private practices paid high wages to their medical workers, they likewise attracted more medical graduates. Amon Nsekela and Aloysius Nhonoli write that out of 30 dentists only ten worked in government or volunteer agencies.¹⁵⁵

The survival of private practitioners under the socialist regime was uncertain. In the 1970s, the Tanzanian government realised that private practitioners were inconsistent with its socialist ideology. Therefore, in 1977 the parliamentary procedures of banning the practice of private health services were tabled. Recommendations made by delegates of medical workers who went to China for a study tour backed the banning agenda. The delegates learned that under socialist policies, the Chinese government had prohibited private practitioners.¹⁵⁶ The recommendations were an eye-opener to political elites as they realised that ten years after Tanzania had opted for socialism, one professional field was yet to be effectively touched by the country's socialist endeavours to eradicate exploitation in its many and varied ramifications. Before the ban, private medical practitioners in Tanzania enjoyed, so to speak, the heaven of their own, notwithstanding complaints that they highly exploited low-income patients.¹⁵⁷

Both politicians and ordinary citizens demanded the outlawing of private health services in Tanzania. Socialist allies wanted private health institutions to be closed to allow the government to practice fully socialist policies.¹⁵⁸ While supporters of socialism demanded the closure of the private health practitioners, other citizens argued against it, maintaining that

¹⁵⁴ Nsekela and Nhonoli, *The Development of Health Services and Society in Mainland Tanzania*, 79.

¹⁵⁵ Nsekela and Nhonoli, *The Development of Health Services and Society in Mainland Tanzania*, 80.

¹⁵⁶ "Report on a visit of Ministry of Health delegation to the People's Republic of China, September 1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

¹⁵⁷ R. Mwinyimbegu, "Private Hospitals Must Go Now," *Daily News*, January 19, 1977, 6.

¹⁵⁸ Mwinyimbegu, "Private Hospitals Must Go Now," 6.

private health services were important since they gave patients the freedom to choose where to get adequate health services. They further backed the fact that the services offered by private health practitioners were effective and quick compared to public health services. The other point opposing the ban was that the government had inadequate health service centres; thus, banning private services would complicate health care delivery. In this view, the government needed to promote the establishment of more private health services by local and foreign investors instead of banning them.¹⁵⁹ Surely, the government health centres were overcrowded and provided inadequate services due to an acute shortage of medical personnel and limited resources. Yet, conflicting views from pro-socialism and anti-socialism groups were inevitable, given the fact that the ban came at the height of Cold War politics.

Notwithstanding the contribution of private health services and the peoples' divergent opinions over their presence, the government regarded it as necessary to ban their practices to attain equality in service delivery and fulfil the "Health For All" agenda. Theoretically, the idea was revolutionary in the sense that it premised to provide free medical services to all Tanzanians. Allies of socialism accused private hospitals of delivering health services to a particular class of people who afforded the expenses. They further alleged owners of private hospitals of persuading well-trained doctors working in public hospitals to retire prematurely and join their hospitals with the promise of higher salaries.¹⁶⁰ Furthermore, the government claimed that private medical practitioners were more concerned with making money than providing services to patients. The Minister for Health cautioned: "It is not good that anybody should make [a] private profit out of human suffering."¹⁶¹ The government suspected public medical staff members of stealing medicines and selling them to private hospitals and apothecaries.¹⁶² The government anticipated that outlawing private hospitals would eventually address the outlined shortcomings.

Prohibiting the practice of private health practices had all the blessings of President Nyerere, who regularly maintained that health was not an appropriate sector for profit-making and private hospitals were inconsistent with the socialist policies cherished by his regime.¹⁶³

¹⁵⁹ K. K. Asher, "Unnecessary Hardship," *Daily News*, January 13, 1977, 7; also see Jeremiah Mwakasonda, "Are all Private Doctors Qualified?" *Daily News*, January 13, 1977, 7.

¹⁶⁰ Johnhanes Ndossi, "Jumping Over a Stick, Landing on a Snake!" *Daily News*, January 13, 1977, 7.

¹⁶¹ Quoted in Iliffe, *East African Doctors*, 209.

¹⁶² Jeremiah Mwakasonda, "Are all Private Doctors Qualified?" *Daily News*, January 13, 1977, 7.

¹⁶³ URT, *The Address Given to the National Conference of Chama cha Mapinduzi by the Chairman, Ndugu Julius K. Nyerere, on 20th October, 1982 at Diamond Jubilee Hall, Dar es Salaam*, 27.

Thus, influences from the Chinese government as well as pressure from political elites and ordinary citizens were behind the ban on the practice of private health services.

The long-time outcry to end the practice of private health services ended up in 1977 after the government had signed the Private Hospital (Regulation) Act. Under the Act, the Tanzanian government made it illegal for any individual or organisation to manage or cause to be managed any private hospital except on behalf of an approved organisation.¹⁶⁴ Up to 1977, more than 20% of doctors were working in private health sectors. Thus, restricting the operation of private health services was, from one perspective, the government's initiative to bring more doctors to the public health sector. After the closure of private health centres, the government convinced medical workers from private sectors to join the national health service and pledged to buy all medical equipment and related facilities used by the expelled hospitals.¹⁶⁵

Nevertheless, the ban did not touch some private health centres owned by non-profit Non-Governmental Organisations (NGOs), mostly under religious institutions. Retaining them was not only the concern of political elites but also of the ordinary citizens. The government maintained non-profit health practitioners since they charged relatively low fees and sometimes, they offered free health care to low-income families. Non-profit health practitioners charged low fees since they received most of their medicines and medical equipment in the form of aid.¹⁶⁶ Yet, not all private practitioners under NGOs got approval certificates to operate. Under the 1977 Act, the MoH stipulated criteria for the approval of organisations to run private health services. According to the Act, religious and non-religious organisations were eligible for approval if: they had as objects the advancement of religion, or, they were established for the promotion of the welfare of workers and peasants, or they were engaged in the advancement of any other public purpose.¹⁶⁷

The Minister for Health had a mandate to disapprove or cancel approval certificates of any organisation which engaged or intended to engage in the management of private health services to make profit or promote the economic interests of the members of the

¹⁶⁴ "URT, The Private Hospitals (Regulation) Act of 1977," MwRC, File No. M.10/1, Medical and Health, Medical Policy and Instructions, 1.

¹⁶⁵ "World Drug Market Manual, November 19, 1982," TNA. Acc. No. 450, Ministry of Health, File No. HE/H/30/7A, Primary Health Care.

¹⁶⁶ Mwinyimbegu, "Private Hospitals Must Go Now," 6.

¹⁶⁷ "URT, The Private Hospitals (Regulation) Act of 1977," MwRC, File No. M.10/1, Medical and Health, Medical Policy and Instructions, 1.

organisation.¹⁶⁸ Generally, from 1977, the government strictly prohibited to manage private health centres without special approval certificate from the MoH. Any person who managed unregistered private health services was guilty of an offence and was liable on conviction to a fine not exceeding Tshs. 50,000 or to imprisonment for a term not exceeding three years, or to both fine and imprisonment.¹⁶⁹

Despite the ban, there remained a considerable number of private health institutions which supplemented government health services. The 1992 World Bank statistics show that by 1988, NGOs owned about 96 hospitals while government hospitals amounted to 74. However, the government outnumbered NGOs in health centres and dispensaries. Statistics show that it had 266 health centres and 2205 dispensaries by 1988 while NGOs owned 11 health centres and about 730 dispensaries in the same period (Table 6).¹⁷⁰

However, the ban on the practice of private health services did not survive liberalisation. The 1986 structural adjustment programmes (SAPs), which the Tanzanian government signed with the IMF, forced the government to allow private investment in economic and social sectors. From 1986 on, several internal and external campaigns demanded the resumption of the operation of private health services in Tanzania. For example, the Medical Association of Tanzania (MAT), tirelessly lobbied the government to allow the operation of private health practitioners.¹⁷¹ Eventually, in 1991, the government resumed the operation of private health services following the passing of the Private Hospitals (Regulation) (Amendment) Act. Under this Act, the government allowed qualified medical practitioners and dentists to manage private health facilities with the approval of the MoH.¹⁷² The lift of the embargo led to a boom in private health services in Tanzania. For example, up to 1995, there were more than 300 private clinics and hospitals in Dar es Salaam. Above all, many private apothecaries extended to different parts of the country.¹⁷³

¹⁶⁸ “URT, The Private Hospitals (Regulation) Act of 1977,” MwRC, File No. M.10/1, Medical and Health, Medical Policy and Instructions, 2.

¹⁶⁹ “URT, The Private Hospitals (Regulation) Act of 1977,” MwRC, File No. M.10/1, Medical and Health, Medical Policy and Instructions, 3.

¹⁷⁰ World Bank Report, *Tanzania AIDS Assessment and Planning Study*, June 1992, 7.

¹⁷¹ Interview by Andrea Kifyasi with Joseph W. Butiku, July 9, 2018, Posta-Dar es Salaam.

¹⁷² URT, *The Private Hospitals (Regulations) (Amendments) Act, 1991*, 1.

¹⁷³ Iliffe, *East African Doctors*, 218.

Table 6: Total health facilities by region and management, Mainland Tanzania, 1988

SN.	Region	Hospitals		Health Centres		Dispensaries	
		Govt	NGOs	Govt	NGOs	Govt	NGOs
1	Tanga	5	7	15	---	136	67
2	Coast	4	2	11	---	90	44
3	Morogoro	4	7	15	1	131	52
4	Lindi	4	3	12	---	88	12
5	Iringa	5	8	16	---	91	50
6	Ruvuma	2	5	13	---	93	36
7	Kilimanjaro	5	8	13	4	93	42
8	Arusha	6	6	11	---	115	65
9	Dodoma	5	1	16	1	148	24
10	Mara	3	4	11	---	92	31
11	Rukwa	2	1	11	1	73	15
12	Singida	2	4	12	---	75	46
13	Tabora	4	3	10	1	84	22
14	Kigoma	3	2	10	---	94	26
15	Mbeya	4	6	17	---	149	37
16	Mtwara	3	2	13	---	99	9
17	Mwanza	4	7	26	---	204	34
18	Kagera	1	10	12	---	132	15
19	Shinyanga	4	2	19	---	137	30
20	Dar es Salaam	4	8	3	3	81	73
Totals		74	96	266	11	2205	730

Source: World Bank Report, *Tanzania AIDS Assessment*, 1992, 7.

2.7 Conclusion

This chapter attempted to draw out some of the ways in which Chinese health policies inspired health policy developments in post-colonial Tanzania. The discussions showed that, between 1966 and 1977, the MoH sent delegations of medical experts to study China's health system. Recommendations made by these envoys reinforced the government's decisions to practice free health care policy, institutionalise traditional medicine, rural health care, and ban private health service practices. The government, however, did not copy the policies uncritically. Instead, these were learnt and applied based on the country's economic and social situation. To some extent, the post-colonial government moulded some colonial health practices to conform to the socialist path. Inspired by China's parallel endeavour to pursue a distinct socialist path, Tanzanian authorities adopted socialist health policies and bolstered their

relationship with China. As the example of health policies shows, China's influence was not limited to direct transfers of resources and knowledge. Rather, the country also served as an inspiration "from the South" in less direct ways. This chapter has foregrounded the understanding of other means of China's medical assistance to Tanzania, which are the subject of the subsequent chapters.

CHAPTER THREE:

ANGELS OF GOD? UNPACKING THE HISTORY AND ROLES OF CHINESE MEDICAL TEAMS IN TANZANIA, 1968–2010

3.1 Introduction

[Chinese medical doctors] made new contributions to the friendship between the two countries, by inheriting and carrying forward the spirit of “being fearless of hardship and dedicated to heal the wounded and rescue the dying with boundless love.” [. . .] [U]pholding the international humanitarian spirit, the Government of China has assigned medical teams to Tanzania for nearly half a century, which has played [a significant] [. . .] role in sharing advanced medical experiences, providing medical equipment and medicine, improving Tanzania’s health care capacity, promoting the development of medical and health undertaking of Tanzania, as well as consolidating friendship between the two countries. The Chinese doctors were honoured by Tanzanian people as “Angel[s] of God” and “Angel[s] in White”, which is a good paraphrase for the long-standing friendship between China and Tanzania.¹ Wang Ke, Ambassador of China to Tanzania, Dar es Salaam, November 3, 2017

The preceding quotation recapitulates the roles and perceptions of Chinese medical teams (CMTs) in Tanzania from the point of view of the Chinese Ambassador. It shows that besides clinical care, the CMTs worked as medical trainers and diplomats. Yet, there is a relatively small body of literature that is concerned with the activities and varying roles of CMTs in Africa. Several scholars studied the activities of the CMTs on the continent in a rather general manner – lacking a country-wise data approach, thus leaving many open and specific questions unattended.² They have generally examined, for instance, the contexts behind the

¹ A speech by H. E. Wang Ke, Ambassador of China to Tanzania, at the Farewell Reception for the 24th Chinese Medical Team in Tanzania, Dar es Salaam, November 3, 2017.

² The CMT program’s history in Africa is even longer than five decades, yet specific and systematic historical studies are missing. A few available research literature include; Li Anshan, “Chinese Medical Team Abroad for Assistance: History, Achievement and Impact,” in *Future in Retrospect: China’s Diplomatic History Revisited*, ed. Qin Yaqing and Chen Zhirui (Hackensack: World Century Publishing Corporation, 2016); Li Anshan, “From “How Could” to “How Should”: The Possibility of a Pilot U.S.-China Project in Africa,” in *China’s Emerging Global Health and Foreign Aid Engagement in Africa*, ed. Xiaoqing Lu Boyton (Washington: Centre for Strategic and International Studies, CSIS, 2011); Li Anshan, *Chinese Medical Cooperation in Africa: With Special Emphasis on the Medical Teams and Anti-Malaria Campaign* (Uppsala: Nordiska Afrikainstitutet, 2011); Shu Chen, *et al.*, “Chinese Medical Teams in Africa: A Flagship Program Facing Formidable Challenges,” *Journal of Global Health* 9, no. 1 (June 2019): 1-6, <https://doi.org/10.7189/jogh.09.010311>; Liu Jian, “A Healthy Relationship: China-Africa Medical Cooperation Still Going Strong After 50 Years,” (August 2013).

CMT program and neglected discussing its roles in South-South medical knowledge production and exchange. While the previous chapter showed indirect ways in which the Chinese government assisted the Tanzanian government through exposure to its health policies, this chapter studies China's direct form of assistance using the CMT program as its focal point. This chapter examines the history of CMTs in Tanzania from 1968 to 2010. It shows that Africa was the first frontier for the Chinese government to exercise medical assistance before its extension to other continents. This chapter depicts the change and continuities of China's foreign policy and its implications for the CMT program. Furthermore, it discusses several means of medical knowledge exchanges and their roles in building the capacity of the health sector in Tanzania. The roles of the CMTs embroiled within the Chinese government's foreign policy, which cast their activities as humanitarian.³ Nevertheless, I argue that the CMT program was a humanitarian mission, but at the same time driven by political and economic calculations. The program functioned as a soft way of securing allies during the Cold War era and a vital tool in maintaining China's political and economic interests in Africa. At the same time, the ways in which the CMT program unfolded in Tanzania, did translate into modest increases in sustainability and self-dependency in its health sector.

3.2 A History of Chinese Medical Teams in Africa

Chinese medical teams in Africa have a long history. To a large degree, this was the first assistance that the Chinese government began to offer to the African continent. CMTs started first in Algeria in 1963 as a result of the Algerian government's requests in 1962 following similar requests to Northern countries and the Red Cross. Algeria's requests came after experiencing rapidly deteriorating health services following the withdrawal of French medical staff soon after the liberation war in 1962. The 1963 dispatch of Chinese doctors to Algeria marked the beginning of the Chinese government's medical assistance to Africa, Latin America, Asia, Oceania and Southern Europe.⁴

³ A Speech by H. E. Wang Ke, Ambassador of China to Tanzania, November 3, 2017.

⁴ The Republic of Malta, a Southern European country, is the only European nation receiving CMTs. Malta, which signed diplomatic relations with China in 1972, has been receiving medical teams from Jiangsu province for more than 25 years to the present. Unlike countries of the South, China's medical aid to Malta is neither relief nor charity since Malta's health system is quite strong. China's medical aid, therefore, aimed at bolstering diplomatic relations between the two countries and mostly boosting the practice of traditional Chinese medicine. By 2014, the Jiangsu province dispatched about 11 batches with a total of 66 medical doctors. See, for instance, Li Bo, *et al.*, "The Development of China's Medical Assistance Based on Jiangsu Province's Medical Aid to Malta and Zanzibar: Review and Suggestions," *Chinese Journal of Disaster Medicine* 6, no. 3 (March 2018): 122;

The CMT program was among several frontiers of China's medical assistance to Africa. Other frontiers that preoccupied medical teams included building hospital infrastructures. This category involved the construction of hospitals, donation of drugs and medical equipment. Further categories included the construction of pharmaceutical factories, training of health personnel and control of malaria. The lack of sufficient medical personnel in many African countries made the CMT category a more interventionist form of medical assistance than the rest. Therefore, the largest share of China's health aid was spent on the CMTs.⁵ The Chinese government recruited medical workers from different provinces, where each province dispatched medical workers to one or more African countries (Table 7). Thus, the local government sent the teams abroad while the central government, through its Ministry of Public Health, administered the program. A single medical team usually comprised members from different medical departments such as physicians, surgeons, gynaecologists, ophthalmologists, acupuncturists, pharmacists, radiologists, laboratory technicians, anaesthesiologists, and nurses. The team also included cooks for Chinese food and language translators. In total, a single team had between 15 and 25 or more people, and each of them worked for two years.⁶ From 1963 to 1978, the Chinese government carried mostly the costs for maintaining medical teams, while recipient countries carried a fraction of it. The Chinese government met costs for language training, food, salaries, medicines, and transport, while recipient countries provided the team with medical facilities, medical instruments, accommodation as well as security.⁷

After the first CMT mission to Algeria, other African countries received CMTs in consecutive years. For instance, up to the end of the 1960s, about seven African countries received CMTs.⁸ There was an increase in the number of CMTs to Africa between 1970 and 1978, whereby about 22 African countries received CMTs (Table 7).⁹ The increase in the number went concurrently with the rise of African countries which signed for diplomatic

"Diplomatic Relations Established Between China and Malta," *Peking Review* 15, no. 9, March 3, 1972, 3; Li, "From 'How Could' to 'How Should,'" 41, also see Shuang Lin, *et. al.*, "China's Health Assistance to Africa: Opportunism or Altruism?" *Globalization and Health*, (2016): 1. <https://doi.org/10.1186/s12992-016-0217-1>.

⁵ Peilong Liu, *et al.*, "China's Distinctive Engagement in Global Health," *Lancet* 308 (August 2014): 795.

⁶ Interview by Andrea Kifyasi with Ge Yonghe, March 1, 2016, Jinan. Ge is a Director of Medical Department, Health and Family Planning Commission of Shandong Province.

⁷ Global Health Strategies initiatives (GHSi), *Shifting Paradigm: How the BRICS are Reshaping Global Health and Development*, (2012), 64; Li, *Chinese Medical Cooperation in Africa*, 7.

⁸ Li, "From 'How Could' to 'How Should,'" 41.

⁹ Gail A. Eadie and Denise M. Grizzell, "China's Foreign Aid, 1975-78," *The China Quarterly*, no 77 (Mar. 1979): 228.

relationships with China. China's medical assistance to African countries further increased in the 1970s following the support African countries provided to China in its admission to the UN Assembly in 1971.¹⁰

However, the dispatch of the CMTs changed drastically in the 1970s following China's reform and opening-up policy. For example, from 1978, China's foreign policy focused more on economic than ideological and political relations, than was the case for the Maoist regime.¹¹ China's assistance to Africa dropped not only in the health sector but also in economic terms. During this period, government intervention focused primarily on internal economic reconstruction rather than expansion abroad, hence affecting former beneficiaries of Chinese assistance.¹² For example, from 1979 to 1980, some former African recipients ceased to receive medical assistance. Also, by 1980, almost 60% of the CMT beneficiary countries were required to share costs to bring and sustain CMTs in their countries. As a result, some beneficiaries failed while others managed to uphold the CMTs for a short time. All this translated into a marked deficit of medical personnel and complicated the delivery of health care in their countries. Worse still, China did not sign new contracts with any African country from 1988 to 1994, which meant it lost interest in extending medical assistance abroad. Lastly, medical teams started to charge fees to patients. The charges implicated that the Chinese government attached economic benefits to the CMT program. Thus, they reflected China's market-oriented economic reforms, as the government transformed the CMT into a profit-making project.¹³

This decline did not stay for long. From 1981 to 1987, the Chinese government sent teams to about ten countries (Table 7). After a freeze of almost six years (1988–1994), medical teams began to flow from 1994, when Namibia, the Comoro Islands, and Lesotho received medical doctors for the first time.¹⁴ The medical teams, however, retreated from countries with political instabilities. For example, in 1991 and 97, the Chinese government withdrew teams

¹⁰ Li, *Chinese Medical Cooperation in Africa*, 9.

¹¹ Yanzhong Huang, "Pursuing Health as Foreign Policy: The Case of China," *Indiana Journal of Global Legal Studies* 17, no. 1 (Winter, 2010): 111; Li Anshan, "China's New Policy toward Africa," in *China into Africa, Trade, Aid, and Influence*, ed. Robert I. Rotberg (Washington, D. C: Brookings Institution Press, 2008), 7.

¹² Giles Mohan and Marcus Power, "New African Choices? The Politics of Chinese Engagement," *Review of African Political Economy* 115, no. 23-42 (2008): 29, <https://dx.doi.org/10.1080/03056240802011394>.

¹³ Yanzhong Huang, "Domestic Factors and China's Health Aid Programs in Africa," in *China's Emerging Global Health and Foreign Aid Engagement in Africa*, ed. Xiaoqing Lu Boyton (Washington: Centre for Strategic and International Studies, CSIS, 2011), 20.

¹⁴ Li, *Chinese Medical Cooperation in Africa*, 12.

from Somalia and Congo Kinshasa. Moreover, as well as from African countries which signed diplomatic relationships with Taiwan. Countries such as Liberia in 1989, Burkina Faso in 1994, and the Gambia in 1995, as well as Sao Tome and Principe in 1997, did not receive CMTs because they recognised Taiwan. The diplomatic rifts between China and Taiwan amplified the withdrawal of the CMTs. The teams to Liberia resumed in 2005 after the country restored diplomatic relations with China. In the years after the 2000s, CMTs increasingly were sent to African countries (Table 7).¹⁵

Generally, from its inception in 1963, the Chinese government sent a large number of CMTs to Africa. By 2009, it dispatched about 21,000 medical workers to 69 countries of the Global South. Among them, about 17,000 medical workers were in 48 African countries.¹⁶ The table below shows the trend of Chinese medical workers in different African countries from 1963 to 2013. After this broad overview of the CMT program in Africa, this chapter moves on to discuss specific case studies.

Table 7: African countries with their respective serving provinces, 1963–2013

Country	Dispatching Province	Year Started	Number CMTs up to 2013	Number of Aided Facilities	Changes
Algeria	Hubei	Apr. 1963	23	0	Withdrew in Feb. 1995 due to war, re-dispatched in 1997
Zanzibar	Jiangsu	Aug. 1964	26	1	
Somalia	Jilin + Shanghai	June 1965	13	2	Withdrew in 1991 due to civil war
Congo Brazzaville	Tianjin	Feb. 1967	22	4	Withdrew in 1997 due to civil war, and returned in Dec. 2000
Mali	Zhejiang	Feb. 1968	23	1	
Tanzania	Shandong	Mar. 1968	22	2	
Mauritania	Heilongjiang	Apr. 1968	30	5	
Guinea	Beijing	June 1968	23	2	
Sudan	Shanxi	Apr. 1971	31	2	
Equatorial Guinea	Guangdong	Oct. 1971	26	1	

¹⁵ Li, *Chinese Medical Cooperation in Africa*, 12.

¹⁶ Xi Jinping, *The Governance of China*, (Beijing: Foreign Language Press, 2014), 334; GHSi, *Shifting Paradigm*, 64; Li, *Chinese Medical Cooperation in Africa*, 42.

Sierra Leone	Hunan	Mar. 1973	16	1	Withdrew in 1993 due to war, re-dispatched in Dec. 2002
Tunisia	Jiangxi	June 1973	20	1	
DR Congo Kinshasa	Hebei	Sept. 1973	15	1	Withdrew in 1997 due to war, and returned in June 2006
Ethiopia	Henan	Nov. 1974	17	1	Interrupted in Sept. 1979, and returned in Dec. 1984
Togo	Shanghai +Shanxi	Nov. 1974	20	2	
Cameroon	Shanghai+Shanxi	June 1975	16	6	Interrupted in Jan. 1979, and dispatched by Shanxi in 1985
Senegal	Fujian	July 1975	15	1	Withdrew in 1996, and re-dispatched in Sept. 2007
Madagascar	Gansu	Aug.1975	19	1	
Morocco	Shanghai + Jianxi	Sept. 1975	-	6	Jiangxi province joined in 2000
Niger	Guangxi	Jan. 1976	17	1	Withdrew in July 1992 and re-dispatched in Dec. 1996
Mozambique	Sichuan	Apr. 1976	19	0	
Sao Tome and Principe	Heilongjiang + Sichuan	June 1976	11	0	Withdrew in 1997 after Sino-STP diplomatic relations ended
Burkina Faso (Upper Volta)	Beijing	June 1976	10	1	Withdrew in 1994 after Sino-BF diplomatic relationship suspended
Guinea-Bissau	Guizhou + Sichuan	July 1976	14	4	Withdrew in 1990 and re-dispatched by Sichuan in 2002
Gabon	Tianjin	May 1977	17	2	
Gambia	Tianjin +Guangdong	May 1977	9	5	Dispatched by Guangdong province instead in 1991, and withdrew in 1995
Benin	Ningxia	Jan. 1978	19	3	
Zambia	Henan	Jan. 1978	16	1	
Central African Republic	Zhejiang	July 1978	15	2	Withdrew in July 1991, re-dispatched in Aug. 1998
Chad	Jiangxi	Dec. 1978	10	1	Withdrew in 1979 and re-dispatched in 1989; withdrew in 1997 and re-dispatched in 2006; withdrew in Feb. 2008

					due to war and re-dispatched in May 2008
Botswana	Fujian	Feb. 1981	13	1	
Djibouti	Shanxi	Feb. 1981	17	2	
Rwanda	Inner Mongolia	June 1982	16	3	
Uganda	Yunnan	Jan. 1983	16	1	
Zimbabwe	Hunan	May 1985	13	3	
Libya	Jiangsu	Dec. 1983	5	0	Contract expired in 1994 and was not renewed
Cape Verde	Heilongjiang +Sichuan +Hunan	July 1984	15	2	Dispatching province changed to Sichuan in Feb. 1998, and late changed to Hunan
Liberia	Heilongjiang	July 1984	7	2	Withdrew in 1989 and returned in 2005
Burundi	Guangxi + Qinghai	Dec. 1986	15	1	The dispatching province was changed to Qinghai
Seychelles	Guangxi	May 1987	14	1	
Comoros	Guangxi	1994	9	1	
Namibia	Zhejiang	Apr. 1996	9	1	
Lesotho	Hubei	June 1997	9	0	
Eritrea	Henan	Sept.1997	8	1	
Angola	Sichuan	2007	3	2	Postponed, since the accommodation was not ready. The first batch finally arrived on 23 June 2009
Malawi	Shaanxi	June 2008	3	0	
Ghana	Guangdong	2008	3	3	The team set off on 29 December 2009
South Sudan	Anhui	2012	1	1	

Source: Modified from Liu, et al., “China’s Distinctive Engagement in Global Health,” 796–797; Li Anshan, Chinese Medical Cooperation in Africa, 10–11.

3.3 Origin, Roles and Distribution of CMTs in Tanzania

The dispatch of medical teams to Tanzania resulted from a severe crisis of the health sector following the withdrawal of medical assistance from West Germany and the United Kingdom due to diplomatic rifts in the mid-1960s (Chapter 1). Following the crisis, Tanzania’s Minister for Economic Affairs and Development Planning, Paul Bomani, made a special request for the CMTs to the Chinese government in 1966. The Chinese Ambassador to

Tanzania, He Ying, backed the request.¹⁷ The official signing of the Memorandum of Understanding (MoU) for the CMT program between the two countries was, however, delayed since the Tanzanian Minister for Health, Derek Bryceson, who was British-born and educated at Cambridge, was extremely sceptical of the quality of Chinese doctors. It was only after Bryceson attended a conference held at the University of Dar es Salaam in 1967, where visiting Chinese Professor Wu Jieping presented the development of medical services in China, that the Minister for Health changed his perception of what Chinese doctors could offer to Tanzania.¹⁸ Due to the Minister's original scepticism, the 1966 request for medical assistance had been drafted and sent to China by the Minister for Economic Affairs and Development Planning rather than the Ministry of Health. The presentation by Wu spread widely and influenced even President Julius Nyerere to hold a private conversation with Consul Zhou Boping about Chinese medical doctors to Tanzania. Nyerere referred to Wu's presentation as an eye-opener about the quality of China's health care system.¹⁹

In 1967, the Ministry of Health (MoH) sent a detailed report about Tanzania's health challenges to Chinese Premier Zhou Enlai. The report informed about the deprived medical and health condition of the country where several diseases such as smallpox, leprosy, tuberculosis, malaria, typhoid, bilharzia, filariasis, and other prevalent high morbidity diseases were rampant. Indeed, medical inadequacies such as lack of medical staff, medicines, and medical equipment disadvantaged the country's dealing with health challenges.²⁰ A tour to China by medical delegates of Tanzania in November 1967, amplified the request for the CMTs. The delegates met Premier Zhou and signed a general agreement on the CMT program, upon which Zhou ordered Shandong province to send medical teams to Tanzania.²¹ On May 6, 1968, the Ministries of Health of the two countries signed a contract for the CMT program (Figure 5).²² The MoU assigned the Shandong province to send CMTs to Tanzania every two years. Consequently, from 1968 to the present, the Shandong province has been sending

¹⁷ "A Special Report, Chinese Medical Assistance to Tanzania, May 12, 1972," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

¹⁸ Alicia N. Altorfer-Ong, "Old Comrades and New Brothers: A Historical Re-Examination of the Sino-Zanzibari and Sino-Tanzanian Bilateral Relationships in the 1960s," (PhD thesis, Department of International History, London School of Economics and Political Science, 2014), 254.

¹⁹ Altorfer-Ong, "Old Comrades and New Brothers," 255.

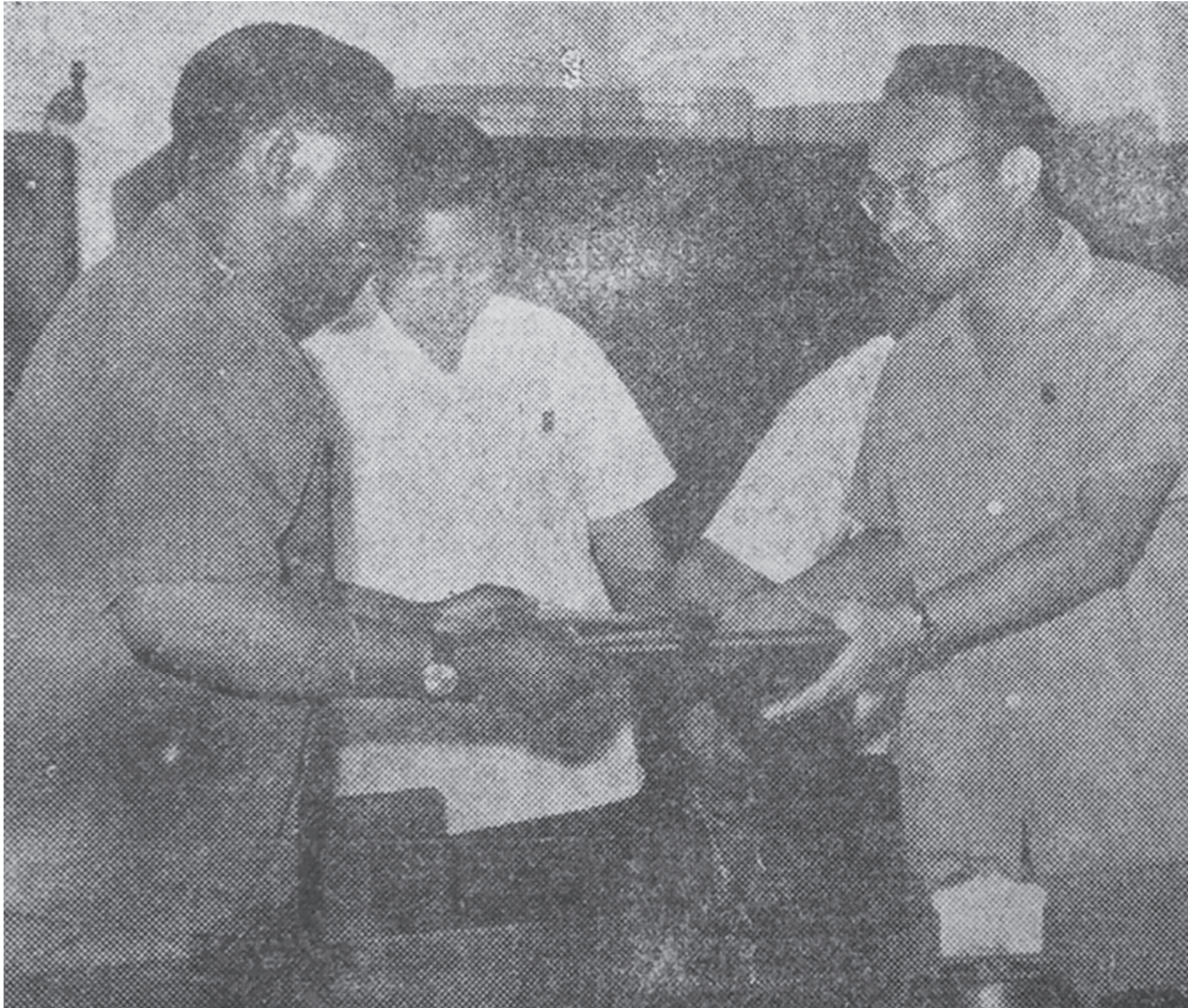
²⁰ "A Special Report, Chinese Medical Assistance to Tanzania, May 12, 1972," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China; also see, Health Department of the Shandong Province, *The Chinese Medical-Aid Team in the United Republic of Tanzania, 1968-1998*, (Shandong, 1998), 11.

²¹ "Medical Aid to Tanzania, 1968," SPA. File No. A034-03-006, Shandong Province Health Bureau.

²² The Chinese ambassador to Tanzania, Chou Po-Ping, signed on behalf of his country, while the Minister for Health, A. K. Shaba signed for the Tanzanian government, see "Madaktari Zaidi toka China Watakuja," *Uhuru*, Mei 7, 1968, 1; "China Yasaidia Tanzania Dawa na Madaktari," *Ngurumo*, May 7, 1968, 1.

medical teams to Tanzania.²³ Tanzania, for its part, stood with China, sustained the One China policy and gave valuable support on China's admission to the UN Assembly (see below).

Figure 5: Minister for Health A. K. Shaba (left) and the Chinese Ambassador to Tanzania Chou Po-Ping (right) exchanging MoUs for the CMT program to Tanzania on May 6, 1968



Source: "Madaktari Zaidi toka China Watakuja," *Uhuru*, Mei 7, 1968, 1.

Deploying medical teams to Tanzania was an essential part of China's foreign medical aid, but also the most prolonged mission in the history of Shandong province.²⁴ The program

²³ "URT, Ministry of Health and Social Welfare, the 40th Anniversary on Chinese Medical Team Workers in Tanzania, 1968-2008," NRC. Ministry of Health and Social Welfare, 14/05/03, File Ref. No. HC. 74/311/02 Chinese Medical Team 2007-2010; Interview by Andrea Kifyasi with Sun Yazhou, March 1, 2016, Jinan. Sun is the Vice Director, Chinese Medical Department, Health and Family Planning Commission of Shandong Province. He worked as a short time (40 days) CMT member in 1991.

²⁴ Interview by Andrea Kifyasi with Che Yansong, March 1, 2016, Jinan. Che is an Assistant Consultant, Division of Medical Service, Technology, Education and International Exchange and Cooperation, Healthy and Family Planning Commission of Shandong Province; Ge Yonghe, March 1, 2016, Jinan.

contributed significantly to the development of bilateral friendly relations between the two countries (see below). While working in Tanzania, CMTs were entitled to the holidays paid for by the Chinese and Tanzanian governments. Chinese doctors were also entitled to a one-month leave after eleven months of service in Tanzania. To avoid any problems in the host country, the CMTs observed laws and orders promulgated by the government. Moreover, according to the signed agreement, the Tanzanian government had the leeway to either shorten or request an extension of the service of any Chinese doctor.²⁵

The Chinese government dispatched the CMTs to Tanzania at the height of Cold War politics when the UN Assembly did not recognise the Chinese government. Instead, the UN recognised the Taiwanese government as representative of the whole of China (Chapter 1). Furthermore, it was the period when China, alienated from the Soviet Union, was fighting against both so-called US “imperialism” and Soviet “revisionism.” Thus, throughout the 1960s and 1970s, the Chinese experts deployed by the government to work overseas spearheaded the fight against “imperialism” and “revisionism” while maintaining their country's influences and interests.²⁶ These contexts informed the recruitment, training, and activities of the CMTs sent to Tanzania. For instance, medical doctors dispatched in the 1960s and 1970s were all faithful members of the Chinese Communist Party (CCP). Party membership was a necessary selection criterion for recruits since their government assigned them a role to spread Maoism, boost Sino-Tanzanian friendship and maintain China’s influence in the region.²⁷ The partisanship criterion continued even after China halted political propaganda following its reform and opening-up policy in 1978. The Chinese government needed diligent medical doctors who were capable of defending China’s political, social, and economic interests overseas.²⁸

The doctors from the Shandong province recruited for service in the CMT possessed specific professional and physical merits such as clinical training with tertiary qualifications, good professional recommendations with at least five to ten years working experience, healthy physique with a maximum age of 55. Under such criteria, most of the doctors sent to Tanzania were older than 30 years of age, and many were married though they were not allowed to travel

²⁵ “Letter from Consulate of the People’s Republic of China in Zanzibar, August 17, 1978 to Honourable E. I. M. Mtei, Minister for Finance and Planning, the Government of the URT,” ZNA. Group Index. DO. Ministry of Trade and Industry, File No. DO5/25, 1976 March to May 1983, Mahusiano na Nchi za Nje-China.

²⁶ Huang, “Pursuing Health as Foreign Policy,” 111.

²⁷ “Medical Aid to Tanzania, 1968,” SPA. File No. A034-03-006, Shandong Province Health Bureau.

²⁸ “Job Description and Work Reports of the Medical Team in Tanzania, 1981,” SPA. File No. A034-06-159, Shandong Province Health Bureau, Foreign Affairs Office.

with their families.²⁹ As shown in Table 8, the number of male doctors surpassed females since the Shandong province had fewer female doctors. Above all, most of the female doctors were unwilling to join the CMT program since they attended more to social responsibilities at home than their male counterparts.³⁰ The province needed to recruit qualified doctors to meet regulations by the Registrar of the Medical Council of Tanganyika (MCT) who verified the merits of their professional qualifications. The council had a mandate of issuing medical doctors with professional working licences or otherwise based on council's promulgated criteria.³¹ In the 1960s and 70s, the Shandong province encountered difficulties in mobilising qualified medical personnel to participate in CMT program, especially in the categories of gynaecology, anaesthesia, surgery and other more skilled personnel since it did not have enough experts in those fields. Unlike the Cuban government, which had an excess of medical personnel from the 1970s,³² many Chinese provinces suffered a shortage of skilled medical personnel due to their growing population and disease burden.³³ For instance, in 1981, a single Chinese doctor attended to 1,730 patients. However, the situation was worse in Africa since, in the same period, a single doctor in Kenya attended to 10,140 patients while in Sudan 9,800 and Ghana 7,200.³⁴ Despite the demands of medical doctors at home, the prevailing Cold War politics made the dispatch of CMTs overseas politically and economically imperative for the Chinese government (Chapter 1).

Chinese doctors deployed to Tanzania were experts with varying specialisations depending on prevailing health challenges and special requests from Tanzania's MoH. Oral anecdotes I collected support the theory that there were negotiations between officials from the MoH and Shandong Health Bureau about the kinds of experts demanded by the Tanzanian

²⁹ "The Dispatch of Medical Aid Team to Tanzania, 1978," SPA. File No. A034-06-0358, Shandong Province Health Bureau; Interview by Andrea Kifyasi with Deng Shucai, May 23, 2019, Jinan. Deng was a member of CMT in Tanzania from 1978 to 1980.

³⁰ Interview by Andrea Kifyasi with Qin Chengwei, July 22, 2018, Posta-Dar es Salaam. Qin is an anaesthesiologist and a Team Leader of the CMTs working in Tanzania.

³¹ "Letter from Registrar, September 5, 2009 to the Principal Secretary MoH, headed, Letter of Authorization," NRC. Ministry of Health and Social Welfare, 14/05/03, File Ref. No. HC. 74/311/02 Chinese Medical Team 2007-2010.

³² Robert Huish and John M. Kirk, "Cuban Medical Internationalism and the Development of the Latin American School of Medicine," *Latin American Perspectives* 34, no. 6 (Nov. 2007): 82. <https://doi.org/10.1177/0094582x07308119>.

³³ Interview by Andrea Kifyasi with Ge Yonghe, March 1, 2016, Jinan.

³⁴ Li Chengrui, "Only Socialism Can Develop China," in *China Changes in 40 Years*, ed. Beijing Review (New Star Publishers, 1989), 27.

government.³⁵ Prior to the 1990s, following the country's dearth of all kinds of medical personnel, the MoH requested and received experts of all levels of expertise (specialists and non-specialists). For example, in 1972, it received a team of more than thirty members including five surgeons, six physicians, one anaesthetist, two acupuncturists, seven gynaecologists and obstetricians, seven eye, ear, nose and throat (ENT) doctors, five interpreters, and one matron.³⁶ Similarly, in 1976, it received more than forty members comprising nine surgeons, three physicians, two paediatricians, six gynaecologists, three anaesthetists, six ENT experts, six acupuncture specialists, eight physicians, eight assistant physicians, three radiographers, one driver, and one interpreter.³⁷ However, from the 1990s onwards, the number of local medical personnel increased. Yet, they were mostly physicians who needed further training and mentorship to address pressing health cases. Subsequently, the MoH requested and received specialist doctors to address more critical health cases of ENT, gynaecology, obstetrics, and surgery to easy mentorships and address cases that could not be adequately cared for by local personnel.³⁸

Chinese doctors underwent language training before travelling overseas. This training was of importance because their activities involved interactions with patients and local doctors. While Tanzania's lingua franca is Kiswahili, many Tanzanians speak and understand English with varying levels of fluency. The CMTs dispatched to Tanzania attended six months training in English and Kiswahili in Jinan.³⁹ Under Mao's regime, language training stressed Kiswahili since the doctors spent half of their time in rural areas where the majority of people spoke Kiswahili and local languages. Moreover, under Mao, China anticipated spreading its influence and political propaganda. Thus, the CMTs had to interact effectively with political elites and other influential people, and the interaction was more effective through Kiswahili.⁴⁰ However,

³⁵ Interview by Andrea Kifyasi with Simon Ernest, May 7, 2018, MoH Headquarters, Dar es Salaam. Simon is a Health Service Administrator, Directorate of Curative Services, Ministry of Health, Community Development, Gender, Elderly and Children; Che Yansong, May 23, 2019, Jinan.

³⁶ "List of Names of Doctors of the Chinese Medical Team, July 1, 1972," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5, Technical Assistance China.

³⁷ "Muhtasari wa Mkutano wa Ndugu L. D. Stirling Waziri wa Afya na Madaktari wa Kichina Uliofanyika Tarehe 25 Agosti, 1976 Saa 5:30-6:15 Adhuhuri Katika Ukumbi wa Chumba cha Mkutano Wizara ya Afya, Dar es Salaam, Tarehe September 7, 1976," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5, Technical Assistance China.

³⁸ Interview by Andrea Kifyasi with Simon Ernest, May 7, 2018, MoH Headquarters, Dar es Salaam.

³⁹ Interview by Andrea Kifyasi with Sui Guangxin, March 1, 2016, Jinan. Sui is a Director, Provincial Hospital and was a CMT member from 1995 to 1997; Chen Zhufeng, March 1, 2016, Jinan. Chen is a Director Qianfon Mountain Hospital and was a CMT member from 2003 to 2005 and 2007 to 2013.

⁴⁰ "Medical Aid to Tanzania, 1968," SPA. File No. A034-03-006, Shandong Province Health Bureau.

from the 1980s, following China's reform and opening-up policy, the training stressed the English language since the CMTs had to interact and learn more from foreigners working in Tanzania (see below).⁴¹

As the language barrier persisted nonetheless, each team included of two or more translators. In the 1960s and 1970s, the Chinese government dispatched a large number of doctors to Tanzania who were sited in several regions and districts. Such distributions demanded more translators, at least one in each region. For instance, in 1972, 34 doctors were placed to Tanzania and divided into small teams sent to different district hospitals of Morogoro, Dodoma, Kigoma, Musoma, and Mbeya regions, where each team required its own translator.⁴² The language barrier was still not solved since translators were unfamiliar with some medical terms and they did not always accompany medical doctors in their work sites.⁴³ Song Tao, who worked as an interpreter for more than eight years, admitted that he translated ordinary conversation, especially when the teams met government officers and rarely to patients. However, Song underscored that the language handicap was always critical in the early months, but the teams addressed the challenge gradually as they interacted with patients and local doctors.⁴⁴

The recruitment of translators was consistent with the needs of the Chinese government. As to the CMTs, translators were faithful members of the CCP. Indeed, their functions and competences went far beyond translation. For instance, they worked as drivers of the CMTs and wrote reports and minutes after a meeting with government officials. Translators also taught the English language to the doctors at night and assisted medical workers when needed. More importantly, they interacted with different groups of people and engaged in political discussions to discern people's perceptions of the Chinese presence in Tanzania in comparison to doctors from "imperialist" countries. In the same vein, they read local newspapers and reported to the Chinese government about their discoveries. They compiled and submitted reports detailing political and economic situations of Tanzania as well

⁴¹ "Job Description and Work Reports of the Medical Team in Tanzania, 1981," SPA. File No. A034-06-159, Shandong Province Health Bureau, Foreign Affairs Office.

⁴² "List of Names of Doctors of the Chinese Medical Team, July 1, 1972," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

⁴³ Interview by Andrea Kifyasi with Rajabu Kisonga, April 24, 2018, Dodoma Regional Referral Hospital.

⁴⁴ Interview by Andrea Kifyasi with Song Tao, March, 16 2018, Posta-Dar es Salaam.

as the activities of the CMTs after every six months for a brief mid-year report and annually for the extensive report.⁴⁵

Before the dispatch of the CMTs in Tanzania, the Shandong province sent a team of doctors to study the existing needs in health care, living conditions, work environment, climatic conditions, and political atmosphere in the country. There were two rounds of visits: the first preceding the arrival of the whole team, and the second, as a follow-up, taking place before the teams started working. In January and February 1968, a group of five doctors, one nurse and one interpreter led by Tsao Yuen-Chung carried out a 40-day medical tour in 16 districts and one city of Tanzania. The team went to Mtwara and spent four days studying the kind of medical assistance appropriate for the region and the suitability of the living and working environment. They visited Ligula Hospital, Mtwara dispensary and Rutamba health centre before proceeding to Nachingwea, where they visited the district hospital and dispensaries. The team further went to Dodoma and Singida Regions and visited regional hospitals, clinics and health centres.⁴⁶ After the visits, they documented the existing health challenges such as the lack of medicines and medical equipment, lack of electricity and water supply, and the challenge of transport and communication. The team did not only study Tanzania's health system and the challenges facing the health sector but also performed a diplomatic and political role. For instance, they explored the stability and influence of countries of the North in Tanzania and studied people's perception of China and Mao's philosophy. In their report, they noted that imperialist countries still had a strong influence in Tanzania despite the country's taking the socialist path in 1967. The team provided suggestions for curbing the hardships and improving the living and working conditions to ensure their effective performance and comfortability.⁴⁷ Their reports marked a wakeup call and guided their preparations before travelling to Tanzania. Nevertheless, preliminary tours ended up in the 1980s since activities of the CMTs were limited to four regions (see below) whose living and working conditions were already familiar.⁴⁸

⁴⁵ "Job Description and Work Reports of the Medical Team in Tanzania, 1981," SPA. File No. A034-06-159, Shandong Province Health Bureau, Foreign Affairs Office, also see "Work Report and Letters of the Medical Team in Tanzania, 1983," SPA. File No. A034-06-310, Shandong Province Health Bureau.

⁴⁶ "Medical Aid to Tanzania, 1968," SPA. File No. A034-03-006, Shandong Province Health Bureau, also see "Chinese Medical Team in Mtwara," *The Nationalist*, February 1, 1968, 8; "Madaktari wa Kichina," *Ngurumo*, Februari 12, 1968, 1; "Chinese in Singida," *The Nationalist*, February 1968, 8.

⁴⁷ "Medical Aid to Tanzania, 1968," SPA. File No. A034-03-006, Shandong Province Health Bureau.

⁴⁸ From the 1980s onwards, activities of CMTs were limited to Dodoma, Tabora, Mara and Dar es Salaam regions. Interview by Andrea Kifyasi with Simon Ernest, May 7, 2018, MoH Headquarters, Dar es Salaam.

Figure 6: A villager holding happily Mao's photo (undated, likely 1970s)

Source: Health Department of the Shandong Province, *The Chinese Medical-Aid Team*, 51.



Preliminary preparations were vital for the accomplishment of the CMTs medical and political missions to Tanzania. Archival information supports that activities of the CMTs in the 1960s and 70s also involved political propaganda. For example, the Chinese doctors spread Mao's publications (red books) to political elites, college students, doctors, and patients. They further criticised imperialism and neo-colonialism in their talks to different groups of Tanzanians. They carried and distributed printed photographs of Mao to regional, district, and

village leaders (Figure 6). In Dodoma Region, a Regional Commissioner (RC) received Mao's photo and "kissed" it. While in Butiama-Mara, Nyerere's brother received the photo and hung it on the house's wall. Such deeds enhanced China's influence in the country and boosted Mao's popularity and his anti-imperialistic propaganda. Through activities of the CMTs, many Tanzanians knew Mao. The Director of Muhimbili National Hospital first did not know Mao, but came to know him through books and photos he received from Chinese doctors as gifts.⁴⁹ After the reform and opening-up policy, the CMTs engaged in discouraging the influence of pro-Maoists who were against the reform and opening-up policy. The doctors further commended the merits of the newly adopted policy to Sino-Tanzanian relations. Additionally, they spread Deng Xiaoping's speeches and publications to enhance his influence and strengthen understandings of the reform and opening-up policy in Tanzania.⁵⁰

During the height of Cold War politics, the Chinese government anticipated that capitalist countries would spy the Chinese government through Chinese working overseas. Hence, at its inception, the CMTs working in Tanzania were forbidden from interfering in the internal affairs of the recipient country, talking to journalists, attending entertainment centres, and revealing the secret of the Chinese government to foreigners. Moreover, the government prohibited them from arguing with foreigners, having a private connection with them, including romantic relationships and marriages.⁵¹ Generally, throughout Mao's reign, the CMTs had limited interactions with foreigners in Tanzania. Nevertheless, after Deng Xiaoping's reform and opening-up policy, the CMTs interacted with foreigners strategically. The government enhanced doctors' training in English. Recruitment processes gave preference to doctors who mastered the English language, precisely to facilitate interactions with foreigners, which were deemed imperative in order to boost medical science and technology. The Chinese government, therefore, instructed the CMTs to work closely with foreign doctors, examine their technical expertise and learn from them.⁵²

⁴⁹ "Job Description and Work Reports of the Medical Team in Tanzania, 1981," SPA. File No. A034-06-159, Shandong Province Health Bureau, Foreign Affairs Office.

⁵⁰ "Work Reports of the Medical Aid Team in Tanzania, 1978," SPA. File No. A034-06-035, Shandong Province Health Bureau.

⁵¹ "Medical Aid to Tanzania, 1968," SPA. File No. A034-03-006, Shandong Province Health Bureau.

⁵² "Job Description and Work Reports of the Medical Team in Tanzania, 1981," SPA. File No. A034-06-159, Shandong Province Health Bureau, Foreign Affairs Office.

Figure 7: Map showing places where CMTs worked in Tanzania from 1968 to 2019



Source: Created by the Geographic Information System (GIS), Institute of Resource Assessment (IRA), University of Dar es Salaam, September 2019, based on data from “Work Reports of the Medical Aid Team in Tanzania, 1978,” SPA. File No. A034-06-035, Shandong Province Health Bureau, and “List of Names of Doctors of the Chinese Medical Team, July 1, 1972,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

Table 8: The CMTs dispatched to Tanzania, 1968 to 2011

Year	Team	Batch No.	Month	Male	Female	Total
1968–1970	1	1	May ⁵³	30	13	43
1968–1969	1	2	Aug.	1	-	1
1968–1970	1	2	Aug.	3	-	3
1968–1971	1	2	Aug.	23	5	28
1969–1971	1	2	Jan. & May	8	1	9
1969–1972	1	2	Oct.	1	-	1
1970–1972	1	2	Jan.	1	-	1
1970–1972	2	1	Aug.	36	10	46
1971–1973	2	2	April	29	9	38
1972–1974	3	1	Aug.	39	6	45
1973–1975	3	2	Aug.	27	10	37
1974–1976	4	1	Sept.	38	8	46
1975–1977	4	2	July	30	7	37
1976–1978	5	1	Aug.	37	8	45
1977–1979	5	2	Aug.	34	7	41
1978–1980	6	1	Aug.	31	11	42
1979–1981	6	2	Aug.	14	5	19
1980–1982	7	1	Aug.	28	14	42
1981–1983	7	2	Aug.	13	6	19
1982–1984	8	1	Sept.	15	3	18
1983–1985	8	2	Sept.	13	5	18
1984–1987	9	1	Aug.	12	5	17
1985–1987	9	2	Sept.	16	6	22
1987–1989	10	-	Sept. & Dec.	25	13	38
1989–1991	11	-	Aug., Sept. & Dec.	28	8	36
1991–1993	12	-	Aug.	31	9	40
1993–1995	13	-	Aug.	26	13	39
1995–1997	14	-	Aug.	19	9	28
1997–1999	15	-	Aug.	16	7	23
1999–2001	16	-	Aug.	18	6	24

⁵³ Information from the health department of the Shandong province such as *The Chinese Medical-Aid Team*, 117, shows that the first batch was dispatched to Tanzania in March 1968. In contrast, many sources I consulted mention that the first batch arrived in May 1968. For this research, I use May 1968, the month when the MoU was signed and recorded by many sources. See, for instance, “A Special Report, Chinese Medical Assistance to Tanzania, May 12, 1972,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China; “Madaktari Zaidi toka China Watakuja,” *Uhuru*, Mei 7, 1968, 1; “China Yasaidia Tanzania Dawa na Madaktari,” *Ngurumo*, May 7, 1968, 1.

2001–2003	17	-	Aug.	20	5	25
2003–2005	18	-	Aug.	21	4	25
2005–2007	19	-	Aug.	23	2	25
2007–2009	20	-	Aug.	18	6	24
2009–2011	21	-	Aug.	22	3	25
Total	21			746	224	970

Source: Modified from Health Department of the Shandong Province, The Chinese Medical-Aid Team, 117–126; Health Department of the Shandong Province, Unforgettable Memory: The Chinese Medical Teams in the United Republic of Tanzania and Seychelles, 1968–2008 (Shandong, 2008), 135–145; Health Department of the Shandong Province, Do not Afraid the Hardship, be willing to Contribute, Heal the Wounded and Rescue the Dying, Great Love no Boundaries, 1968–2013 (Shandong, 2013), 118–129.

The MoH distributed the CMTs among different regional and district hospitals. The number of doctors sent to the hospitals varied depending on the demands and health challenges reported by recipient regions. The number of Chinese doctors received per batch further determined its variation.⁵⁴ For example, the first batch had 43 doctors and was divided into eight groups distributed among the districts of Mara, Dodoma, and Mtwara regions.⁵⁵ The second batch had 46 doctors who were divided into 14 teams sent to the districts of Kigoma, Tabora, Shinyanga, Mbeya, and Morogoro regions. The third batch was divided into 11 teams, and they worked in Musoma, Dodoma, Morogoro, Mbeya, Kigoma, Mtwara, Nachingwea, Newala, Kondoa and Singida.⁵⁶ Thus, the CMTs provided medical services to different regions of Tanzania. Up to 2015, they had worked in 13 regions of Tanzania, including Dodoma, Tabora, Mara, Mtwara, Lindi, Kigoma, Shinyanga, Mbeya, Morogoro, Singida, Mwanza, Arusha and Dar es Salaam (Figure 7).⁵⁷ However, from the 1990s onwards, the services by the CMTs concentrated on only four regions of Tanzania, namely Dar es Salaam, Dodoma, Tabora, and Mara.⁵⁸

⁵⁴ “A Memo, 5/6/1973,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

⁵⁵ “China Yasaidia Tanzania Dawa na Madaktari,” *Ngurumo*, May 7, 1968, 1.

⁵⁶ “A Report on Chinese Medical Assistance to Tanzania, May 12, 1972,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

⁵⁷ “Work Reports of the Medical Aid Team in Tanzania, 1978,” SPA. File No. A034-06-035, Shandong Province Health Bureau; “List of Names of Doctors of the Chinese Medical Team, July 1, 1972,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China; also see Johanna Jansson, Christopher Burke and Tracy Hon, *Patterns of Chinese Investment Aid and Trade in Tanzania* (South Africa: Centre for Chinese Studies, University of Stellenbosch, 2009), 2.

⁵⁸ Interview by Andrea Kifyasi with Simon Ernest, May 7, 2018, MoH Headquarters, Dar es Salaam.

In this regard, CMTs did not spread to all regions and districts of Tanzania because of the limited number of doctors. Their services reached regions that reported many health cases. Furthermore, regions and districts where outstanding politicians and leaders had their origins were served in priority. For example, Chinese doctors worked in Mara Region, the home province of President Nyerere. They further worked in Monduli District, the constituency of the Prime Minister, Edward Moringe Sokoine, and to Mtwara the home and constituency of the Minister for Health, Shaba. It is likely that political leaders' influence prompted the distribution process. Furthermore, the Chinese government probably gave priority to such regions to win the hearts and minds of political elites in Tanzania. Historical and prominent regions of Tanzania were also of priority. For instance, teams worked in Dodoma, the national capital and the headquarter of the ruling party, Chama Cha Mapinduzi (CCM), a partner of the Chinese Communist Party (CCP), and, in Dar es Salaam, the economic capital of the country. Medical teams from other countries worked in regions with low political influence such as Tanga and Coast for the case of Cuban doctors, Morogoro for the case of Italian doctors and Mbeya for the case of Soviet doctors.⁵⁹ Indeed, the distribution of the CMTs in Tanzania was done strategically to accomplish China's medical and political missions in the country.

Generally, China's medical assistance to Tanzania has lasted for more than 50 years to the present, and the dispatch of CMTs by the Shandong province has never stopped despite the changes in China's foreign policy (discussed below). This long-term medical assistance gave confidence to the Chinese President, Xi Jinping, to mention in 2013 that China and Tanzania were "all-weather friends".⁶⁰ Available statistics show that up to 2017, Shandong province deployed 24 batches of CMTs with an equivalent total of about 1080 medical workers.⁶¹ The structure and activities of the CMTs in Tanzania changed with time, echoing to the dynamism of China's foreign policy as elaborated at length in the next section.

⁵⁹ For Soviet doctors read "Bomani to Discuss Aid in Moscow," *Sunday News*, November 2, 1967, 1, and for Cuban doctors read "Cuba Sends More Doctors," *Daily News*, September 12, 1977, 3, and "Italian Doctors Arrive," *Daily News*, July 19, 1977, 1, for Italians.

⁶⁰ The statement was made by Chinese president Xi Jinping in his state visit to Tanzania in 2013, read Xi, *The Governance of China*, 333.

⁶¹ A Speech by H. E. Wang Ke, Ambassador of China to Tanzania, November 3, 2017.

3.4 “Neither Permanent Friends nor Enemies”: The Dynamics of China’s Foreign Policy and its Implications to the CMT Program in Tanzania

China’s foreign policy was never static but changed instead, resonating with the political and economic interests of the Chinese government. For example, in the 1960s and early 1970s, the foreign policy targeted at enabling China to win diplomatic recognition over Taiwan and get admitted into the UN General Assembly (UNGA). China vowed to maintain relationships with countries of the South for the sake of their votes to the Assembly. During this era, it extended medical assistance to countries of the South which supported “One China policy”.⁶² Countries that recognised Taiwan as a nation were removed from Beijing’s friends list and disqualified from receiving medical assistance from China.⁶³

In an attempt to forge close relations and win allies, the Chinese government dispatched a large number of doctors to Africa and carried most of the cost burden related to hosting them. For instance, throughout the 1960s and 1970s, Shandong province dispatched medical workers to Tanzania in two batches per single medical team which arrived in the country in the intervals of either months or a year. This tendency enabled the MoH to receive medical doctors from China every year between 1968 to 1985. For instance, the batch of the first team went to Tanzania in May 1968 and was joined by the second batch in August 1968. Other medical workers of the second batch went to Tanzania in January, May, and October 1969, making a total of 86 medical workers of the first medical team to Tanzania (Table 8). Consistently, the first batch of the second medical team arrived in August 1970 and was joined by other members of the second batch in April 1971, making a total of 84 medical workers of the second medical team. Surely, at the beginning of the CMT program, Tanzania received a more significant number of Chinese medical doctors than other African countries, which, in turn, enhanced Sino-Tanzanian relations. On the one hand, the dispatch of Chinese doctors to Tanzania was couched in humanitarian discourse and indeed cost the Chinese government dearly, given the country’s own shortage of trained medical personnel. On the other hand, China’s devotions were driven by political calculations, since Nyerere, and Salim Ahmed

⁶² Huang, “Pursuing Health as Foreign Policy,” 108.

⁶³ See, for instance, Li, *Chinese Medical Cooperation in Africa*, 12.

Salim,⁶⁴ a permanent representative of Tanzania to the UN, had significant influence regarding China's admission in the UNGA campaign.⁶⁵

Before changes in China's foreign policy, the Chinese government mainly carried costs for hosting CMTs in Tanzania. It met charges for domestic salary, international travelling, and language training. Moreover, the government compensated hospitals which members of the CMTs came from during their training at home and service abroad.⁶⁶ The Chinese government also shipped to the port of Dar es Salaam the daily necessities for the CMT, including imported means of transportation, air conditioners, electrical household appliances, and food. The shipments were exempted from tax at the port of Dar es Salaam, and the Tanzanian government assisted in matters such as customs, declaration, clearance, and forwarding to meet all the necessary costs as import duty charges.⁶⁷

Furthermore, throughout Mao's reign, the Chinese government provided grants of medicines and medical equipment to Tanzania to address deficits. Under the signed MoU, the Tanzanian government was to supply the CMTs with medical equipment and drugs for their work.⁶⁸ Nevertheless, many hospitals in post-colonial Tanzania lacked enough medical equipment and medicines supply. The government depended mainly on imported drugs and medical equipment, which were less satisfactory and sometimes delayed in reaching the

⁶⁴ Salim Ahmed Salim was a Tanzanian who served in several international diplomatic positions including Tanzania's Ambassador to the People's Republic of China, 1969-1970, and a Permanent Representative of Tanzania to the United Nations, 1970-1980. His vigorous support to the admission of China in the UNGA labelled him as a pro-China officer, and this punished him when he contested for UN Secretary-General seat in 1981. The US and its allies were not ready to see Salim, a pro-China activist, hold such a prestigious international position. The Chinese government highly respects Salim, and he has been awarded a Friendship Medal, China's highest honour to foreigners recently (2019). Up to the present Salim is the only African to be awarded such medal. Read, for instance, James Kandoya, "China Gives Dr Salim Unique Medal of Friendship for His UN Seat Effort," *The Guardian*, September 21, 2019.

⁶⁵ See, Julius K. Nyerere's Speech at the United Nations General Assembly, in *Nyerere Freedom and Development/ Uhuru na Maendeleo: A Selection from Writings and Speeches, 1968-1973* (Dar es Salaam: Oxford University Press, 1973), 205. Nyerere's speech was a direct campaign for China's admittance in the UNGA.

⁶⁶ "Agreement for China's Medical Assistance by the PRC to Zanzibar, June 15, 1964," ZNA. Group Index. AJ. Medical Department, File No. AJ26/92, 1964 June, Chinese Agreement; also see, "Protocol Between the Government of the United Republic of Tanzania and the Government of the People's Republic of China on Dispatching Medical Team from China to Serve in Tanzania from August 2007 to August 2009," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 3.

⁶⁷ "Agreement for China's Medical Assistance by the PRC to Zanzibar, June 15, 1964," ZNA. Group Index. AJ. Medical Department, File No. AJ26/92, 1964 June, Chinese Agreement; also see, "The Agreement Protocol of 2007-2009," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 3.

⁶⁸ "Letter from Consulate of the People's Republic of China in Zanzibar, August 17, 1978 to Honourable E. I. M. Mtei, Minister for Finance and Planning, the Government of the URT," ZNA. Group Index. DO. Ministry of Trade and Industry, File No. DO5/25, 1976 March to May 1983, Mahusiano na Nchi za Nje-China.

country and hospitals. The Chinese government intervened by offering grants. For instance, the first team of doctors went to Tanzania with a total of 1,000 boxes containing drugs and medical equipment. Consistently, other CMTs carried along with medicines and medical equipment.⁶⁹ Indeed, grants for medicines and medical equipment were imperative not only for the CMTs work but also for the general improvement of health care services in Tanzania. The donated facilities supplemented a few available in hospitals, and hence improved the community's wellbeing.

Throughout the 1960s to 1977, the Tanzanian government carried few costs for hosting the CMTs. The government met costs for the return flights and upcountry trips. While in Tanzania, the teams travelled by train for those allocated to places linked to the railway network, such as Singida, Mbeya, and Dodoma. The ministry sent cars to doctors posted to regions close to Dar es Salaam. Others who worked in remote places such as Mara, Shinyanga, and Kigoma travelled by flight. Moreover, the Tanzanian government provided lodging for the CMTs and covered costs related to house maintenance, water, electricity, and phone bills. Additionally, it provided security guards and cleaners for the residences of the CMTs as well as drivers for each of the Chinese doctor teams and team leaders and met their necessary costs.⁷⁰ These assertions show that compared to costs incurred by the Chinese government, Tanzania paid significantly less for hosting the CMTs in the country, which reflected the importance the Chinese government attributed to its partners in the South.

Yet, China's enthusiasm for hosting CMTs in Tanzania ended in 1978 after the Chinese government opened up its doors to the world. A statement by the State Planning Commission avowed: "We [Chinese] must expand our economic technical and cultural exchange with other countries on the principle of equality, mutual benefit and one supplying what the other needs."⁷¹ The statement added:

⁶⁹ "Madaktari Zaidi toka China Watakuja," *Uhuru*, Mei 7, 1968, 1; Interview by Andrea Kifyasi with Che Yansong, March 1, 2016, Jinan.

⁷⁰ "A Memo, 6/6/1973," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China; "Chinese Medical Delegation Meets Principal Secretary AFYA, September 12, 1972," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China; "Protocol Between the Government of the United Republic of Tanzania and the Government of the People's Republic of China on Dispatching Medical Team from China to Serve in Tanzania from August 2007 to August 2009," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 4-5; also see, "Letter from Consulate of the People's Republic of China in Zanzibar, August 17, 1978 to Honourable E. I. M. Mtei, Minister for Finance and Planning, the Government of the URT," ZNA. Group Index. DO. Ministry of Trade and Industry, File No. DO5/25, 1976 March to May 1983, Mahusiano na Nchi za Nje-China.

⁷¹ "China's Open-Door Policy," *Daily News*, September 13, 1977, 2.

We must learn hard from the good experience of other countries and combine this with our own originality. We learn from other countries and introduce their advanced technology to meet our needs, not to hinder but to promote our own creativeness, not to weaken but to increase our ability to develop our national economy and achieve modernization independently.⁷²

The statement continued: “Only those most decadent and reactionary ruling classes close their doors and reject any good things from other lands.”⁷³ Definitely, China’s open-door policy was inconsistent with Maoist policies which limited interactions with foreign countries, especially from the North.⁷⁴ The government implemented the policy after Chairman Mao and his comrade Premier Zhou passed away. Repercussions of the policy change were especially visible in countries of the Global South. China’s assistance to the South declined as it shifted its interest to countries with advanced technology, mostly from the North. The post-Mao leaders stressed economic gains for the Chinese government over ideological and political interests. Consequently, they discouraged aid with less or no economic interests. In 1982, Hu Yaobang, a Communist Party chairman, emphasised that the “provision of free aid was in the interest of neither side”.⁷⁵

These changes in foreign policy affected the dispatch of medical doctors to Tanzania, as the Chinese government began to send medical doctors in a single batch only every two years. Furthermore, medical workers dispatched to Tanzania dropped from over 40 per batch in the 1960s and early 1970s, to below 20 from 1979 onwards. Even worse, from 1987 to 1993, the Tanzanian government received a team with less than 40 medical workers. The number of medical doctors further declined from 1995 to 2011, when the government received a team with less than 30 medical workers (Table 8). Undeniably, the decrease in the number of medical doctors sent to Tanzania affected the delivery of health care, especially in complex health cases and rural areas where Chinese doctors spent half of their time.⁷⁶

Chinese doctors working in Tanzania supported the newly adopted reform policy. In their annual report of 1978, they advised the government to reduce costs spent on the CMT program by cutting down the number of medical workers sent to Tanzania. A team leader, Yu

⁷² “China’s Open-Door Policy,” *Daily News*, September 13, 1977, 2.

⁷³ “China’s Open-Door Policy,” *Daily News*, September 13, 1977, 2.

⁷⁴ Huang, “Pursuing Health as Foreign Policy,” 111.

⁷⁵ Huang, “Domestic Factors and China’s Health Aid Programs in Africa,” 20.

⁷⁶ Interview by Andrea Kifyasi with Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam. Gallus is a retired Principal Assistant Secretary, Ministry of Health.

Changan, affirmed that the Shandong province lacked enough medical personnel and it faced several health challenges. Thus, it was advantageous for the province to encourage doctors to work at home.⁷⁷ Their advice manifested the fact that the execution of the program did not satisfy some medical workers. In their view, sending medical doctors abroad was worthless and hurt the delivery of health care in their province. The annual report of 1986 further underscored the reform of the CMT program. However, the report went further by discouraging the distributions of the CMTs to several districts of Tanzania. They argued that the distributions increased maintenance costs and hindered effective delivery of health services since some medicines and medical equipment, foodstuffs, cooks, translators, and medical experts had to serve many different locations. In their view, the mentioned facilities would have been satisfactorily used if they had been concentrated into a few hospitals.⁷⁸ As a result, at the end of 1980, the activities of the CMTs were concentrated into four regional referral hospitals, and they did not work in rural dispensaries. Nevertheless, despite the policy change, Shandong province has never stopped dispatching medical workers to Tanzania from its inception to the present. The changes of the foreign policy implicated their number, activities, and costs of hosting them in Tanzania.

The changes in China's foreign policy increased the burden of hosting CMTs to recipient countries. From 1978, the Tanzanian government paid more to bring and host the CMTs. Under the 1978 MoU signed between the two countries, the government had to cover some expenses previously carried by the Chinese government. For instance, it began paying monthly allowances, including board expenses and pocket money for the CMTs amounting to Tshs. 900 per month per head. Under the MoU, the government had to adjust the allowances if the commodity price fluctuation would exceed 10%. As a result, on October 25, 1979, the CMTs demanded the increase of allowances from Tshs. 900 of 1978 to Tshs. 1,400 per head per month due to the soaring inflation. In the 1980s, when Tanzania's economy was in turmoil, its currency lost value. Thus, allowances shot from Tshs. 1400 of 1979 to Tshs. 2,250 per head per month as from October 1, 1981.⁷⁹ Information about the living allowances for the 1990s

⁷⁷ "Work Reports of the Medical Aid Team in Tanzania, 1978," SPA. File No. A034-06-035, Shandong Province Health Bureau.

⁷⁸ "Medical Aid Team in Tanzania, 1986," SPA. File No. A034-06-637, Shandong Province Health Bureau.

⁷⁹ "Letter from Consulate of the People's Republic of China in Zanzibar, August 17, 1978 to Honourable E. I. M. Mtei, Minister for Finance and Planning, the Government of the URT," ZNA. Group Index. DO. Ministry of Trade and Industry, File No. DO5/25, 1976 March to May 1983, Mahusiano na Nchi za Nje-China; "Letter from the Consulate of the People's Republic of China in Zanzibar, October 25, 1979 to the Principal Secretary to the Ministry of Finance and Planning of the United Republic of Tanzania," ZNA. Group Index. DO. Ministry of Trade

could not be found. However, data from the mid- to late-2000's shows that the constant decline of the local currency influenced the execution of payments in the USD. Article VII of the 2007 MoU instructed the Tanzanian government to pay living allowances of about USD 170 equivalent to Tshs. per head per month. Subsequently, in February 2009, the MoH issued Tshs. 16,834,734, three months allowance to 25 Chinese doctors.⁸⁰ The initiation of allowances to the CMTs and its tremendous increase over time added cost burden to Tanzania's economy, while reflecting the priorities of the post-Mao regime, which discouraged free aid to overseas countries.

Furthermore, from the 1980s, the Tanzanian government had to arrange and meet costs for the CMTs' tours of several parts of the country, including the National Parks for the doctors to have a holiday. Thus, before the expiration of the contract, or after CMT had worked in the country for about twelve months, the government set a fifteen-day holiday and seven-day trip to Kilimanjaro, Ngorongoro, and Serengeti or any other places of interest proposed by the CMTs.⁸¹ The cost burden for regional and district governments was considerable. For example, in 1981, Chinese doctors visited Mikumi National Park, Bagamoyo, and Serengeti National Park, where regions/districts hosting them covered all costs related to the tour amounting to Tshs. 144,510 in total.⁸² Costs for the tour rose with time. For example, in 1996, the Dodoma Regional government alone spent Tshs. 2.5 million for the tour by Chinese doctors working at the referral hospital. The regional government complained over the costs arguing that they were higher and a burden to the government given the economic plight of the country.⁸³

and Industry, File No. DO5/25, 1976 March to May 1983, Mahusiano na Nchi za Nje-China; "Letter from the Principal Secretary to the Treasury of the URT, February 25, 1982 to Mr Chung Chien Hua, Economic Representative of the PRC to the URT," ZNA. Group Index. DO. Ministry of Trade and Industry, File No. DO5/25, 1976 March to May 1983, Mahusiano na Nchi za Nje-China.

⁸⁰ "The Agreement Protocol of 2007-2009," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 4-5; "Minute, February 25, 2009," NRC. Ministry of Health and Social Welfare, 14/05/03, File Ref. No. HC. 74/311/02 Chinese Medical Team 2007-2010.

⁸¹ "Protocol Between the Government of the United Republic of Tanzania and the Government of the People's Republic of China on Dispatching Medical Team from China to Serve in Tanzania from August 2007 to August 2009," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 4-5.

⁸² The costs were determined by the number of doctors, the region/district received. For instance, Dar es Salaam paid Tshs. 2,500, Mtwara 5,505, Monduli 15,000, Singida 30,000, Kigoma 21,000, Dodoma 11,000, Tabora 19,000, Shinyanga 20,000 and Musoma 15,000, see "Job Description and Work Reports of the Medical Team in Tanzania, 1981," SPA. File No. A034-06-159, Shandong Province Health Bureau, Foreign Affairs Office.

⁸³ "Letter from Regional Medical Officer, July 26, 1996 to the Minister for Health, Ziara ya Madaktari wa Kichina Mbuga za Wanyama," Dodoma Regional Referral Hospital, File No. PA. 133/250/01 Chinese Medical Team, Health Services, Technical Assistant, 2016.

Furthermore, after the policy change, the Chinese government stopped supplying free medicines and equipment to Tanzania. Instead, it agreed to continue providing grants of medicines and medical equipment while charging fees to patients in which about 70% of the fees collected belonged to the CMTs, and 30% went to respective hospitals. According to the MoU, the charges aimed to maintain the sustainability and effectiveness of the CMT program since the money collected was sent to China's MoH for the purchase of drugs and medical equipment for use by the next batch of the CMTs. Chinese doctors presented to the hospital management the costs and quantity of the donated medicines for further reference.⁸⁴ Thus, there were two pharmacies in the hospitals where the CMTs worked, one for the Chinese-made medicines served by a CMT member and the other for general medicines served by local pharmacists. Oral and archival evidence shows that Chinese-made medicines were sold cheaper than medicines sold at local pharmacies.⁸⁵ This strategy promoted the use, popularity, and market of Chinese-made drugs in Tanzania in line with the priorities formulated by China's senior officer from the MoH: "China's health aid should not only serve China's foreign policy but also act as a broker for economic development in China and recipient countries."⁸⁶ Surely, from 1978, the Chinese government manipulated the CMT program to promote the market for Chinese medicines in Tanzania. These manipulations increased especially in the 1990s, following official approval of Chinese anti-malaria medicine (artemisinin), where the CMTs promoted its efficacy and prescribed the therapy to patients with malaria.⁸⁷

From the mid-1990s, China's interests in Africa resumed, fuelled by the government's thirst for natural resources and political hegemony, as scholars have maintained. Yanzhong Huang states that in the 2000s, China's medical assistance to Africa heightened and bolstered China's friendship with many African states, which, in turn, helped the Chinese government to tap into natural resources, dilute criticism from countries of the North over its violation of

⁸⁴ "The Agreement Protocol of 2007-2009," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 2-3.

⁸⁵ Interview by Andrea Kifyasi with Rajabu Kisonga, April 24, 2018, Dodoma Regional Referral Hospital; "Taratibu za Dawa kwa Wachina," Dodoma Regional Referral Hospital, File No. PA. 133/250/01 Chinese Medical Team, Health Services, Technical Assistant, 2016; "Letter from the CMTs, February 4, 2000 to Regional Medical Officer, Formal Statement about Medical Aid to Regional Medical Officer," Dodoma Regional Referral Hospital, File No. PA. 133/250/01 Chinese Medical Team, Health Services, Technical Assistant, 2016.

⁸⁶ Quoted in Huang, "Domestic Factors and China's Health Aid Programs in Africa," 20.

⁸⁷ Deborah Brautigam, "U.S. and Chinese Efforts in Africa in Global Health and Foreign Aid: Objectives, Impact, and Potential Conflicts of Interest," in *China's Emerging Global Health and Foreign Aid Engagement in Africa*, ed. Xiaoqing Lu Boyton (Washington: Centre for Strategic and International Studies, CSIS, 2011), 4.

human rights at the UN, and win the competition to host the 2008 Olympic games.⁸⁸ From 1995, it bolstered diplomatic ties with African countries through waiving several costs for hosting CMTs endorsed shortly after the policy change. It further re-dispatched a large number of medical doctors to several African countries.⁸⁹ In Tanzania, for instance, from August 2009, the Chinese government covered costs related to monthly allowances and return tickets for the CMTs. The Chinese government also took steps to permanently waive costs related to logging. It has recently built a house in Dar es Salaam to be used by members of the CMT and other technical teams sent to Tanzania. The house was meant to improve the living conditions of the Chinese medical doctors and relinquish costs the Tanzanian government incurs for rent.⁹⁰ These assertions imply that from the mid-1990s, China lessened the cost burden of some African countries while using CMT program to bolster its relationship with African countries and portray itself as a more responsible and reliable partner than traditional donors of the North.

3.5 The CMT Program and the South-South Knowledge Exchange Agenda

China's medical assistance to Tanzania included exchanges of medical knowledge with local medical workers, a role which was initially performed mainly by countries of the North. In the name of Southern solidarity, South-South knowledge production and transmission were cast as a key to self-dependency.⁹¹ Consequently, the Chinese government implemented the Southern agenda by dispatching medical doctors while promising to foster knowledge exchange. In line with Mao's philosophy, the Chinese doctors perceived recipients to have prior knowledge which was worth sharing while working together. Mao underscored to Chinese experts working overseas that:

A country, whether big or small, has its knowledge. All of us should have the habit of being students to learn from our colleagues in every matter, whether language or traditions,

⁸⁸ Huang, "Pursuing Health as Foreign Policy," 128.

⁸⁹ For Chinese government commitment to medical assistance in the 2000s read Part IV of "China's African Policy, January 2006," *Xinhua News Agency*, October 2006, 6-7.

⁹⁰ "Talking Notes for the Permanent Secretary on the Occasion of Farewell and Welcome Ceremony to the Chinese Medical Team in Tanzania, August 14, 2009 at New Holiday Inn," NRC. Ministry of Health and Social Welfare, 14/05/03, File Ref. No. HC. 74/311/02 Chinese Medical Team 2007-2010; Interview by Andrea Kifyasi with Edwin Mng'ong'o, May 7, 2018, MoH Headquarters, Dar es Salaam; Song Tao, May 6, 2018, Posta, Dar es Salaam.

⁹¹ Permanent Secretariat of the Afro-Asian Peoples' Solidarity Organisations, *Afro-Asian Peoples' Solidarity Movement* (Cairo), 12.

whether the knowledge of the disease or the work of artisans, whether work plans or how to do, physicians, specialists even patients all of them are our teachers.⁹²

Chinese doctors dispatched to Tanzania in the 1960s and 1970s received more formal training than many local medical experts but were advised to learn from the local medical workers. Oral testimonies support that despite pitfalls (discussed below) Chinese doctors worked cooperatively with local medical doctors.⁹³

Training local medical workers was among the goals to which the Chinese government pledged itself from the commencement of the CMT program. In 1965, Premier Zhou visited Zanzibar and underscored the role of Chinese doctors in building the capacity of the recipient country's health sector. He said:

Now we have several dozens of CMTs abroad, yet it is not enough. CMTs should not only cure the disease, but help training work. They should bring medicine and facilities, train African doctors, who can be self-reliant and would work even if CMTs went away.... We would provide sincere help to any independent country. Our assistance is to make the country able to stand up. Just like building a bridge, so you can cross the river without a staff. That would be good.⁹⁴

Zhou's commitment was highlighted by Mao when he met Nyerere in 1974. Mao reaffirmed that the role of CMTs in Tanzania would be "teaching" local medical doctors and "clinical care" to patients.⁹⁵

The exchange of medical knowledge was executed through long-term and short-term training in numerous Chinese medical colleges and through the CMT program, where local medical workers learned while working together with Chinese doctors (discussed below). The aforementioned ways of training were comparable to the system applied by the Cuban government, which also trained local medical workers of recipient countries on site while others received government scholarships for further training in Cuban medical schools.⁹⁶ The Chinese government offered several scholarships to Tanzanians to pursue medical education

⁹² "Report of the Chinese medical doctors to the Minister for Health, January 27, 1967," ZNA. Group Index. AJ. Medical Department, File No. AJ29/322, 1964 September to 1966 December, Ripoti ya Madaktari wa Kichina.

⁹³ Interview by Andrea Kifyasi with Gallus Namangaya Abedi in June 6, 2018, Posta-Dar es Salaam; John G. Myonga, April 24, 2018, Dodoma Regional Referral Hospital.

⁹⁴ Quoted in Li Anshan, *China and Africa in the Global Context: Encounter, Policy, Cooperation and Migration*, (Cape Town: Africa Century Editions (ACE) Press, 2020), 293.

⁹⁵ "Medical Aid to Tanzania, Work Reports, Job Descriptions and Distribution Table, 1975," SPA, File No. A034-04-085, Shandong Province Health Bureau, Revolutionary Committee, Policy Office.

⁹⁶ Huish and Kirk, "Cuban Medical Internationalism," 80.

in China, mostly in the 1970s, at the height of the Sino-Tanzanian relationship. Scholarships were for both long-term studies and short-term training courses executed in different Chinese medical colleges. For instance, in November 1973, about five Tanzanians, all females, were sponsored by the Chinese government to pursue a medical education in Chinese universities.⁹⁷ The Chinese government offered more scholarships in 1976, when five local medical workers attended a three-months' training in replantation and acupuncture, and one person went on for a long-time medical education. A few Tanzanians received provincial government scholarships, whereby, in 1984, the surgical department of the Shandong Medical Academy admitted two Tanzanians.⁹⁸

Long- and short-time training exposed Tanzanians to Chinese medical knowledge and health care systems. This exposure served to maintain trust in the effectiveness of Chinese health care, which, in turn, bolstered the country's influence in Tanzania. In 1977, a delegate of medical workers led by the Principal Secretary of the MoH, G. J. Kileo, attended a short-term training in China, upon returning to Tanzania, Kileo wrote an appreciation letter saying:

All of us were very excited to see your Revolution in practice. We were particularly impressed by your health delivery system. I think the World has a great deal to learn from your experience, and in particular from the way you have been able to improve the health of the rural population in a very short time. Your willingness to share this experience with us is praiseworthy, and I would like to assure you that on our part, we shall always appreciate exchanging experiences with you.⁹⁹

From the above quotation, it is apparent that medical training for Tanzanians in China persuaded the adoption of some of the Chinese health policies in the country as I elaborated on at length in Chapter 2. Moreover, the training influenced the shift from medical knowledge dependence upon countries of the North. Training opportunities offered by the Chinese

⁹⁷ Names of Scholarship recipients were, Hawa Kawawa, Naomi Lunogelo, Victoria Dionice, Josephine Ndemaeli, and Sabina Mnaliwa, see "Waenda China," *Uhuru*, Novemba 27, 1973, 5.

⁹⁸ "Letter from the office of the Embassy of the People's Republic of China in the United Republic of Tanzania, March 8, 1977 to the Principal Secretary of the MoH," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China; "Letter from the Ministry of Education to the Principal Secretary Ministry of Health of June 14, 1976, Ndugu Lema Kupewa Scholarship ya China Kusomea Udaktari Huko China 1976/77," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China; "Notifications and Letter for Medical Aid to Tanzania, 1984," SPA, File No. A034-06-363, Shandong Province Health Bureau, Foreign Affairs Office.

⁹⁹ "Letter from the Principal Secretary, Ministry of Health, to the Vice Minister of Public Health, Ministry of Public Health, People's Republic of China, October 13, 1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

government made the MoH realise that China was an adequate place for medical knowledge production and transmission.

Cold War politics hijacked the expediency and sustainability of the Chinese government sponsorships to Tanzania's medical students. In the 1970s and 1980s, medical students who pursued medical studies in socialist countries such as China, Rumania, Russia, and Cuba were highly discriminated against the "Makerere Group", composed of Tanzanians who pursued medical studies at Makerere in Uganda as well as medical schools in Europe and the US. Graduates from socialist countries, especially China, were perceived as less skilful, and the Medical Council of Tanganyika (MCT) did not recognise their certificates.¹⁰⁰ The council regarded MD certificates offered by Chinese medical colleges as advanced diplomas, and it recognised the graduates only as assistant medical officers (AMOs). The issue became serious in the mid-1980s, where the Tanzanian government denied employment to medical graduates from China.¹⁰¹ The Makerere Group queried the relevance of the duration of studies in China, where MD students studied for less than seven years. It should be remembered that following China's attempt to boost the capacity of the health sector, it had reduced the universally accepted training period for the MD program from seven to five years. Moreover, after the Cultural Revolution of 1966 to 76, it further reduced the training period to three years. Such attempts enabled China to have about 2,800,000 qualified but the short-trained doctors, and a comparatively favourable ratio of one doctor per 250 people by 1977.¹⁰²

The duration of between five- and three-year training for the MD program was inconsistent with the globally accepted training system. However, chairman Mao advocated the system politically directing that:

¹⁰⁰ The Medical Council of Tanganyika was established in 1959 to oversee medical and dental practice in Tanzania. The Council is mandated power to register or deregister medical and dental practitioners based on qualifications.

¹⁰¹ Interview by Andrea Kifyasi with Modest C. Kapingu, June 8, 2018, Institute of Traditional Medicine (ITM), Muhimbili University of Health and Allied Sciences (MUHAS), Dar es Salaam. Modest was awarded Chinese government scholarship, and he studied at Nanjing University; He secured employment without any hurdles as he was employed when Cold War politics was coming to an end; Naomi Vuhahula Mpemba, August 1, 2018, Goigi-Mbezi Beach, Dar es Salaam. Naomi pursued her medical education (MD) in China, and she was among graduates who were affected by the challenge of Cold War politics. However, she survived and secured government employment at Mhimbili National Hospital as an Assistant Medical Officer.

¹⁰² "Report on Visit of Ministry of Health Delegation to the People's Republic of China, September 1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

Medical education should be reformed. There's no need to read so many books. How many years did Hua T'o [Hua Tuo]¹⁰³ spend at college? How many years [of] education did Li Shih-chen [Li Shizhen]¹⁰⁴ of the Ming dynasty receive? In medical education there is no need to accept only higher middle school graduates or lower middle school graduates. It will be enough to give three years to graduates from higher primary schools. They would then study and raise their standards mainly through practice. If this kind of doctor is sent down to the countryside, even if they haven't much talent, they would be better than quacks and witchdoctors and the villages would be better able to afford to keep them. The more books one reads the more stupid one gets.¹⁰⁵

Mao himself stressed idealism and the “right” political allegiance – “a red heart” – over academic training. To him, what mattered most was not the number of years trainees accumulate but the passion and eagerness of the trained personnel. This context explains why, after liberation, medical schools in China promoted Maoism and indoctrinated medical trainees with socialist ideology. Besides professional training, medical students attended a socialist political education.¹⁰⁶

The Chinese government established a one-year upgrade course in Chinese medical colleges to enable the recognition of the graduates by the MCT. Accordingly, the MCT recognised medical graduates admitted to the upgrade course. By contrast, the MoH demoted graduates who did not join the upgrade course to the rank of AMOs and others were recategorized to administrative posts.¹⁰⁷ This incident discouraged prospective medical students from accepting Chinese government scholarships since they perceived China as an undesirable place for medical education compared to European and American medical colleges. General statistics of medical doctors from Tanzania who pursued medical courses in China are missing. However, oral accounts show that the number declined over time throughout the Cold War period.¹⁰⁸

¹⁰³ Hua Tuo was a Chinese physician who lived during the late Eastern Han dynasty. He was the first person in China to use anaesthesia during surgery.

¹⁰⁴ Li Shizhen was a Chinese acupuncturist, herbalist, naturalist, pharmacologist, physician and writer of the Ming dynasty. He is considered as the greatest scientific naturalist of China.

¹⁰⁵ Mao Tse-tung, “Directive on Public Health, June 26, 1965,” in *Selected Works of Mao Tse-tung Volume IX*, (India: Pragathi Book House, 1994), 216.

¹⁰⁶ Ling Yang, “Training Medical Workers,” *Peking Review*, no. 46, November 13, 1964, 23.

¹⁰⁷ Interview by Andrea Kifyasi with Naomi Vuhahula Mpemba, August 1, 2018, Goigi-Mbezi Beach, Dar es Salaam, also see Stacey A. Langwick, *Bodies, Politics, and African Healing: The Matter of Maladies in Tanzania*, (Bloomington, IL: Indiana University Press, 2011), 61.

¹⁰⁸ Interview by Andrea Kifyasi with Modest C. Kapingu, June 8, 2018, Institute of Traditional Medicine (ITM), Muhimbili University of Health and Allied Sciences (MUHAS); Naomi Vuhahula Mpemba, August 1, 2018, Goigi-Mbezi Beach, Dar es Salaam.

Moreover, medical knowledge was transferred to local doctors through on-site training. A study by Paul Kadetz and Johanna Hood shows that CMTs working in Madagascar primarily provided clinical care to patients, and they hardly spent time training local medical workers. In this regard, they generally concluded that the CMT program failed to build capacity and improve the local health sector sustainably.¹⁰⁹ Unlike Madagascar's case, findings from Tanzania show that Chinese doctors did share knowledge with local medical workers. However, the role of knowledge sharing and mentorship was less stressed than clinical care. The MoU signed between the two countries put training as optional. For example, Article II of the MoU stated the duties of the CMTs that they had:

[. . .] to assist the Tanzanian side, through close cooperation with the Tanzanian medical personnel, to carry on medical work (exclusive of medical legal cases), and to exchange experience and learn from each other in the course of medical practice. If necessary, the Chinese doctors may, in their respective departments, train the Tanzanian doctors so as to enhance their ability in medical services.¹¹⁰

Assertions from the above quotation imply that local medical workers had to learn from the Chinese doctors in the course of medical practice. The agreement used the term “may” inferring that Chinese doctors were not obligated to train local doctors. Nevertheless, archival evidence collected from Zanzibar shows that the doctors did train local medical workers, allocating at least one hour per week to train them in basic physical diagnosis and practical pharmacology.¹¹¹ In mainland Tanzania, Chinese doctors did not allocate a particular time for formal training but disseminated knowledge in the course of medical practice.¹¹²

From the existing pieces of evidence, it is clear that on-site training did not equip local medical workers with sufficient medical knowledge for them to work independently, especially with regard to complicated health cases. This shortcoming defeated the goal of using the CMT

¹⁰⁹ Paul Kadetz and Johanna Hood, “Outsourcing China’s Welfare: Unpacking the Outcomes of Sustainable Self-Development in Sino-African Health Diplomacy,” in *Handbook of Welfare in China (Handbooks of Research on Contemporary China Series*, ed. Beatriz Carrillo, Johanna Hood and Paul Kadetz, (Cheltenham: Edward Elgar Publishers, 2017), 339.

¹¹⁰ “Protocol Between the Government of the United Republic of Tanzania and the Government of the People’s Republic of China on Dispatching Medical Team from China to Serve in Tanzania from August 2007 to August 2009,” NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008.

¹¹¹ “Report of the Chinese medical doctors to the Minister for Health, January 27, 1967,” ZNA. Group Index. AJ. Medical Department, File No. AJ29/322, 1964 September to 1966 December, Ripoti ya Madaktari wa Kichina.

¹¹² Interview by Andrea Kifyasi with Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam; John G. Myonga, April 24, 2018, Dodoma Regional Referral Hospital.

program as a bridge to self-dependency. Accounts from local medical workers contend that many Chinese doctors could neither speak English nor Kiswahili fluently.¹¹³ Such linguistic handicap limited medical knowledge exchanges and implied that the six months of language training the CMTs received were insufficient. In the 1978 annual report, the CMTs affirmed that the language barrier was the main hindrance to passing medical knowledge on to local medical personnel. However, this study noted that practical medical works such as surgery gave local doctors more opportunities to learn by seeing and practising under the guidance of Chinese doctors (Figure 8).¹¹⁴

Reciprocal learning between Chinese and local medical workers seemed to have been even more problematic. This research has found that in most cases, Chinese experts were disseminating medical knowledge to local personnel. Nevertheless, they somewhat learned medical practices from local experts through interactions and observations in the course of medical practices, hence gained experience in addressing several unaccustomed diseases.¹¹⁵ Moreover, Chinese doctors conducted medical research while working in Tanzania, which further enhanced their expertise. For instance, in 1978, the CMTs working in the Kigoma and Dar es Salaam regions conducted medical research on tropical diseases which were less prevalent in China, and they composed intensive reports about their discoveries.¹¹⁶

A few cases reflect the legacy of Chinese medical doctors in places where they worked. For instance, in Dodoma Regional Referral Hospital, Rajabu Kisonga testifies that he successfully learned from Chinese doctors and managed to take over the eye department after the doctors left. Kisonga, who was a mere physician (not eye specialist), worked closely with Chinese doctors and after two years he could address many eye cases except surgery.¹¹⁷ Other evidence collected from Zanzibar reveals that trainees from the surgical department addressed several surgical cases by themselves after they worked for a year with Chinese doctors. Others from the eye clinic attended eye cases independently after having been trained by Chinese

¹¹³ Interview by Andrea Kifyasi with John G. Myonga, April 24, 2018, Dodoma Regional Referral Hospital, Amunga Meda, July 18, 2018, Mhimbili National Hospital, Dar es Salaam.

¹¹⁴ “Work Reports of the Medical Aid Team in Tanzania, 1978,” SPA. File No. A034-06-035, Shandong Province Health Bureau; Interview by Andrea Kifyasi with Elisiana Danford and Martha Manyirezi, April 24, 2018, Dodoma Regional Referral Hospital; Ding Zhaowei and Jin Xunbo, May 23, 2019, Jinan. Ding and Jin were CMT members in Tanzania from 1990 to 1992 and 1995 to 1997 respectively.

¹¹⁵ Interview by Andrea Kifyasi with Deng Shucai, May 23, 2019, Jinan; Ding Zhaowei and Jin Xunbo, May 23, 2019, Jinan.

¹¹⁶ “Work Reports of the Medical Aid Team in Tanzania, 1978,” SPA. File No. A034-06-035, Shandong Province Health Bureau; Interview by Andrea Kifyasi with Deng Shucai, May 23, 2019, Jinan.

¹¹⁷ Interview by Andrea Kifyasi with Rajabu Kisonga, April 24, 2018, Dodoma Regional Referral Hospital.

doctors.¹¹⁸ These assertions imply that the CMT program would have played a resounding role in boosting medical knowledge if the donor (China) and the recipient (Tanzania) countries had created a conducive environment and effective strategies for the knowledge exchange. However, within the modality of training, the framework of the signed agreements and language barriers were the main hindrance to on-site medical knowledge exchange.

Figure 8: A Tanzanian dentist practising dental surgery under a Chinese doctor (undated, likely 1970s)



Source: Health Department of the Shandong Province, *The Chinese Medical-Aid Team*, 76.

3.6 Challenges Encountered by the CMTs in Tanzania

Before they were sent to Tanzania, the CMTs were prepared in terms of language training, orientations on Tanzania's social and political systems and visits to working stations

¹¹⁸ "Report of the Chinese medical doctors to the Minister for Health, January 27, 1967," ZNA. Group Index. AJ. Medical Department, File No. AJ29/322, 1964 September to 1966 December, Ripoti ya Madaktari wa Kichina.

in the country. However, the CMTs faced numerous challenges related to transport as well as living and working environments, mostly during the 1960s through to the 1980s. In the 1960s, the challenge of transport, especially to the rural areas, was critical. Roads were hardly passable, especially during the rainy season. Public buses were limited to towns and cities, and only a few went to the countryside. Although by the 1960s and 1970s, China's economic and social infrastructures were less advanced, they already had better roads, electricity and water supplies, as well as friendly public transport in many places. Consequently, the overall economic and social situation in Tanzania was somewhat a shock to the CMTs, and they took time to get used to the new lifestyle (see below).¹¹⁹ The MoH gave CMTs vehicles, but they did not supply enough for all, and some were old, which, in turn, led to frequent breakdowns. Ineffective transportation services forced the Chinese doctors to travel on foot through forests and mountains along with portable medical equipment and drugs to reach *Ujamaa* villages.

Chinese doctors did not hire porters to carry medical boxes and other equipment (Figure 9). However, in some places, village leaders recruited youths to escort the doctors and carry their items.¹²⁰ Indeed, their response to the transportation difficulties differed distinctively from colonial transport systems when African porters carried goods and equipment for colonial authorities. Consequently, inconveniences in real transport systems complicated the transportation of food, medicines, and medical equipment that in the end, affected effective clinical care.¹²¹ The health department of the Shandong province recorded other hurdles encountered by the CMTs in rural areas in which the doctors complained saying:

In December of 1971, ENT [Eye, Nose and Throat] physician Lu Xiuying and I went to [. . .] [one of *Ujamaa* village] for the medical tour. [. . .] [the village was] 300 kilometres away from the medical station. We stayed there for three days, attended more than 200 people, did minor surgery for ten times and delivered a child. The operational work is very stressful. What is more, we have to boil water and cook for ourselves. The night is especially tough. Our accommodation is a broken house in church. There is a hole in the roof. At night I can even see the moon and the stars through the hole. The house is very dirty because nobody has lived in it for a long time. After a busy day, we are very tired and want to have a good sleep at night. But the chaos with mice and pigeons and sparrows on the roof prevented us

¹¹⁹ Interview by Andrea Kifyasi with Deng Shucui, May 23, 2019, Jinan; Sui Guangxin, March 1, 2016, Jinan.

¹²⁰ Interview by Andrea Kifyasi with Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam; Deng Shucui, May 23, 2019, Jinan.

¹²¹ "Medical Aid Team in Tanzania, 1986," SPA, File No. A034-06-637, Shandong Province Health Bureau.

from sleeping. In an unfamiliar foreign country, we feel more afraid. What we can only do is to look forward to the coming of the dawn.¹²²

Figure 9: CMT members heading to *Ujamaa* villages in Mtwara Region, 1971



Source: Health Department of the Shandong Province, *Unforgettable Memory*, 25.

As many of my informants emphasised, living and working conditions in rural areas were frustrating. However, archival evidence shows that, in some places, the MoH and village leaders attempted to better accommodate the Chinese doctors. The MoH provided safari beds to doctors working in rural areas. For example, in April 1971, the regional medical officer of Mtwara received four safari beds from the MoH and gave them to Chinese doctors working in several *Ujamaa* villages.¹²³

Inadequate supply of medicines, medical equipment, water, and electricity further hampered the activities of CMTs in Tanzania. The medical supplies that CMTs brought along did not meet the demands. Furthermore, the use of some medical equipment was hampered because of the lack of electricity supply in some hospitals. Besides, many health centres lacked

¹²² Translated from Chinese text by Guo Suhang under my request, in Health Department of the Shandong Province, *The Chinese Medical-Aid Team*, 11.

¹²³ “A Memo, 14/4/1971,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

modern medical equipment.¹²⁴ Lu Jianlin, a Chinese medical team leader, working in Zanzibar, complained: “The most painful thing for us is we know we could save some patients, but because of lack of equipment, we cant.”¹²⁵ The economic crisis which heavily affected the country in the 1980s caused serious cutbacks in government expenditure on health, falling from 7.1% in 1975/76 to 4.0% in 1987/88.¹²⁶ While the Tanzanian government attempted to address the challenges of providing essential medicines, health service, and equipment, its economic muscles to achieve this task remained limited. Thus, it ended up touching a few areas by providing generators and other social amenities like water and improvement of weather roads.¹²⁷

Chinese medical doctors further encountered unaccustomed diseases which challenged their medical expertise. There were diseases which the doctors knew of theoretically but had never confronted throughout their professional life in China. Trachoma was of those largely unknown diseases. Rajabu Kisonga, who also works at eye department in Dodoma, tells that when the first-time patients with trachoma consulted the eye department, Chinese doctors were worried to attend to them before going back to reference books to revise their medical knowledge. Kisonga adds that trachoma was mostly caused by unhygienic conditions triggered by lack of water, absence of latrines, flies, and proximity to cattle, which, according to Chinese doctors, were unknown problems in many parts of China.¹²⁸ Ding Zhaowei and Jin Xunbo contended that unaccustomed diseases were both a challenge and an opportunity for Chinese doctors to apply their medical expertise and gain new experiences.¹²⁹

The hot climatic conditions in some regions where Chinese doctors worked, particularly in Dar es Salaam and Zanzibar, further complicated their working and living environment. A document by the health department of the Shandong province recorded complaints by the doctors:

¹²⁴ “Medical Aid Team in Tanzania, 1981,” SPA. File No. A034-06-157, Shandong Province Health Bureau; Interview by Andrea Kifyasi with Ding Zhaowei and Jin Xunbo, May 23, 2019, Jinan.

¹²⁵ Quoted in Ding Ying, “Chinese Medical Teams Bring Hope to the Sick and Injured in Tanzania,” *China Report* (October 2011): 16.

¹²⁶ Lucian A. Msambichaka, *et al.*, *Economic Adjustment Policies and Health Care in Tanzania* (Dar es Salaam: Economic Research Bureau, University of Dar es Salaam, 1997), 95.

¹²⁷ “Letter from Daktari Mkuu wa Mkoa, Shinyanga, to Katibu wa TANU, Mkoa wa Shinyanga, 15th August, 1974, Madaktari wa Kichina,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

¹²⁸ Interview by Andrea Kifyasi with Rajabu Kisonga, April 24, 2018, Dodoma Regional Referral Hospital.

¹²⁹ Interview by Andrea Kifyasi with Ding Zhaowei and Jin Xunbo, May 23, 2019, Jinan.

When our country is in winter with snow, Tanzania is in the rainy season. After the rain, hot sunlight shines in the jungle, on the fields, steaming, hot and humid. Even at night, the rooms are always up to thirty-three or thirty-four degrees, with the smell of the rainy season. Big mosquitoes bite during the day. At night, more mosquitoes can even paste the bulb.¹³⁰

However, Deng Shucaï and Sui Guangxin, who also worked in Tanzania, tells that the climate was only a challenge in the early days since they got used to it with time.¹³¹

Furthermore, Chinese doctors encountered a threat over dangerous communicable and non-communicable diseases that were not common in China such as malaria, typhoid, cholera, and HIV/AIDS. Doctor Chen, who also worked in Tanzania, said: “When I came to Tanzania for the first time, I was scared of deadly infectious diseases such as malaria, yellow fever and AIDS.”¹³² Archival evidence shows that the Chinese government inoculated the CMTs to enhance their immunity to diseases such as cholera, tuberculosis, and smallpox.¹³³ However, many still contracted diseases. For instance, in 1986, six out of eight Chinese doctors working in Tabora contracted malaria.¹³⁴ The Chinese Embassy in Tanzania repatriated medical workers with complicated health problems. In 1986, a cook, Yu Shanjie and doctor Su Zhongyuan left the country after facing serious health problems. On the one hand, such challenges threatened Chinese doctors but, on the other hand, increased their attention and that of the hosting government.¹³⁵ Still, from the inception of the CMT program to the present, only one Chinese doctor died while working in Tanzania.

¹³⁰ Translated from Chinese text by Guo Suhang under my request in Health Department of the Shandong Province, *The Chinese Medical-Aid Team*, 12.

¹³¹ Interview by Andrea Kifyasi with Deng Shucaï, May 23, 2019, Jinan; Sui Guangxin, March 1, 2016, Jinan.

¹³² Quoted in Ding, “Chinese Medical Teams Bring Hope,” 16.

¹³³ Interview by Andrea Kifyasi with Zhang Jing, April 11, 2016, Hangzhou. Zhang is a Program Officer and French Interpreter at Zhejiang Provincial Centre for Health and Medical Cooperation, a Public Institution Affiliated to Health and Family Planning Commission of Zhejiang Province; “Chinese Medical Delegation Meets Principal Secretary AFYA,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China; Interview by Andrea Kifyasi with Che Yansong, May 23, 2019, Jinan.

¹³⁴ “Medical Aid Team in Tanzania, 1986,” SPA. File No. A034-06-637, Shandong Province Health Bureau.

¹³⁵ “Medical Aid Team in Tanzania, 1986,” SPA. File No. A034-06-637, Shandong Province Health Bureau.

Figure 10: CMT members preparing a vegetable garden (undated, likely 1980s)



Source: Health Department of the Shandong Province, *Unforgettable Memory*, 101.

Additionally, Chinese medical doctors working in Tanzania encountered challenges related to foodstuffs and their preparations, as they were often forced to compromise and make do with the available local foodstuffs to cope with the situation. The Chinese government first attempted to address this hurdle by dispatching a cook with every medical team. However, they did not adequately address the challenge because, in Tanzania, Chinese doctors divided into small groups comprising five to eight doctors or more and worked in different district hospitals. A cook had to accompany a single group. Therefore, other doctors had to cook by themselves, which, in turn, consumed part of their working hours.¹³⁶ Similarly, some food items desired by Chinese were either missing or unavailable in adequate supplies. Historically, Chinese food is based on two components; *fan* which comprised grains and other starches and *cai* which included vegetables and meat. These two divisions made a complete Chinese cuisine. Some essential foodstuffs such as noodles, soybean products, some kinds of vegetables, herbs related

¹³⁶ “Job Description and Work Reports of the Medical Team in Tanzania, 1981,” SPA. File No. A034-06-159, Shandong Province Health Bureau, Foreign Affairs Office; Interview by Andrea Kifyasi with Deng Shucui, May 23, 2019, Jinan.

foods, different kinds of sauces and Asian spices were not plentifully available in Tanzania. To address this, the Chinese government imported some foodstuffs, and the Tanzanian government waived their taxes at the Dar es Salaam port.¹³⁷ In some places of Tanzania, the CMTs planted several kinds of vegetables (Figure 10) and kept chickens and ducks to produce their desired foodstuffs which were either missing or not adequately available in the local market.¹³⁸

3.7 Perceptions of the Medical Services Offered by Chinese Doctors in Tanzania

Prior to 1968, Chinese doctors had neither worked in Tanzania nor had any experience with the country's health challenges. Unlike medical doctors from Britain, the expertise of Chinese doctors was little known by both political elites and Tanzanian community at large. This scenario and the prevailing Cold War politics prompted a negative perception of Chinese doctors.¹³⁹ Chinese doctors themselves realised that patients, medical doctors of the North, and political elites had little faith in their expertise. To win their approval and eliminate doubts, Chinese doctors worked harder and with great enthusiasm. A leader of the first CMT dispatched to Algeria in 1963 told his team members: "Kindness and willingness to help alone cannot establish us here [in Algeria]. We must be useful and offer concrete help as well."¹⁴⁰ However, sources strongly suggest that hard work and competence convinced many Tanzanians that the CMTs were their best option. For instance, in Mbeya region, patients from different nearby districts travelled to Mbeya Regional Hospital to get treatment from CMTs.¹⁴¹ Kadetz and Hood similarly observed that patients in Madagascar travelled more than 45 kilometres to get treated at a hospital with CMTs.¹⁴²

¹³⁷ "Protocol Between the Government of the United Republic of Tanzania and the Government of the People's Republic of China on Dispatching Medical Team from China to Serve in Tanzania from August 2007 to August 2009," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008.

¹³⁸ "Medical Aid to Tanzania, Work Reports, Job Descriptions and Distribution Table, 1975," SPA, File No. A034-04-085, Shandong Province Health Bureau, Revolutionary Committee, Policy Office; Interview by Andrea Kifyasi with Che Yansong, May 23, 2019, Jinan.

¹³⁹ Interview by Andrea Kifyasi with Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam.

¹⁴⁰ Quoted in Zheng Yang, "Doctors Bridging Borders: Chinese Doctors Working in Africa Build Cultural Bridges," *China Academic Journal Publishing House* (August 2013): 50.

¹⁴¹ "Utekelezaji wa DK. 37 NA 38, Dr S. M. Kinunda, 12/9/1974," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

¹⁴² Paul Kadetz and Johanna Hood, "Outsourcing China's Welfare: Unpacking the Outcomes of Sustainable Self-Development in Sino-African Health Diplomacy," 348.

Figure 11: Clinical care to patients in a village by Chinese doctors, 1972



Source: Health Department of the Shandong Province, *The Chinese Medical-Aid Team*, 17.

Throughout the 1960s to 80s, hospitals and places with CMTs thrived (Figure 11), and some patients attempted to bypass the queue in several ways, including writing letters to seek special permits from the MoH. For instance, *Mzee* Mohamedi Swala tried unsuccessfully to get attended by Chinese doctors at Muhimbili Hospital. Fortunately, he got a chance through the letter he had written to the MoH. The Ministry gave him an introductory letter, which helped him get attended swiftly. Part of the introductory letter read: “[. . .] [Mohamed Swala] has been ill with left hemiparesis since 1968. He also gives [a] history of High Blood Pressure. He has been treated by a number of doctors with very little if any improvement. He has heard that Chinese doctors can help him. He has, therefore, asked us for assistance to see Chinese doctors.”¹⁴³ This incident shows how difficult it could be for patients to obtain hospital treatment as well as their tenacity to benefit from the CMTs. A similar situation prevailed in

¹⁴³ “Letter from the Office of the Principal Secretary, Ministry of Health, March 20, 1973, to the Team Leader, Chinese Medical Team, Bwana Mzee Mohamedi Swala,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

Zanzibar, whereby Chinese medical doctors working at Lenin Hospital¹⁴⁴ (now Mnazi Mmoja Hospital) sacrificed their leave to attend patients who flocked to the hospital seeking clinical care.¹⁴⁵

Oral accounts affirm that patients flocked to places where the CMTs worked since they heard the good news about their expertise, provision of free services and they had been suffering from several health cases without effective clinical care for so long.¹⁴⁶ Generally speaking, the CMTs' hardworking spirit and their kindness to patients won them trust. They wrote in their 1975 annual report that some patients thought medicines offered by Chinese doctors were more efficacious than alternatives provided by local and foreign doctors of the North while noting that their therapeutic values were the same.¹⁴⁷ However, from the 1990s onwards, fewer patients arrived at hospitals where CMTs worked, partly because the number of local medical personnel increased, whom many patients preferred over Chinese doctors.¹⁴⁸ Moreover, during this period, the Tanzanian government commenced the cost-sharing policy which made patients pay to get attended by either Chinese doctors or local medical workers. Additionally, Chinese doctors charged fees to patients.¹⁴⁹ Thus, the CMTs attended only patients who afforded hospital fees.

¹⁴⁴ Socialist countries played a significant role in building Zanzibar's health sector's capacity after its successfully Revolution in 1964, after which medical workers, who were mostly Arabs, left the country. Subsequently, numerous changes existed in Zanzibar's health sector. As a result, its main hospital was officially called the "V. I. Lenin Hospital" to appreciate the assistance from the socialist bloc. Nevertheless, in the 1990s, following the collapse of the socialist bloc, capitalist countries argued for changing the hospital's name to qualify for medical assistance. Interview by Andrea Kifyasi with Ramadhan Machano, July 24, 2018, Stone Town, Zanzibar; also see John Iliffe, *East African Doctors: A History of the Modern Profession*, (Cambridge: Cambridge University Press, 1998), 200.

¹⁴⁵ "Letter from Consulate of the People's Republic of China in Zanzibar, November 13, 1965 to the Ministry of Health, Zanzibar, Tanzania," ZNA. Group Index. AH. Treasury and Finance Records, File No. AH72/32, 1964 September to 1971 March, Technical and Economic Cooperation Between the Government of People's Republic of China and the Government of Zanzibar.

¹⁴⁶ Interview by Andrea Kifyasi with Cleopa David Msuya, July 6, 2018, Upanga-Dar es Salaam. Honourable Msuya is a retired Prime Minister of Tanzania (1980-1983 and 1994-1995), former Minister for Finance (1972-1975 and 1983-1990) and Minister for Industries and Commerce (1975-1980 and 1990-1994); Joseph W. Butiku, July 9, 2018, at The Mwalimu Nyerere Foundation Headquarters, Posta-Dar es Salaam. Butiku is an Executive Director, The Mwalimu Nyerere Foundation in Tanzania. He worked at the statehouse as personal research Assistant of Mwalimu Nyerere from 1965, Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam.

¹⁴⁷ "Medical Aid to Tanzania, Work Reports, Job Descriptions and Distribution Table, 1975," SPA, File No. A034-04-085, Shandong Province Health Bureau.

¹⁴⁸ Interview by Andrea Kifyasi with Simon Ernest, May 7, 2018, MoH Headquarters, Dar es Salaam; Rajabu Kisonga, April 24, 2018, Dodoma Regional Referral Hospital.

¹⁴⁹ "The Agreement Protocol of 2007-2009," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 4-5.

Oral testimonies further illustrated the nuanced patients' perceptions of the services offered by the CMTs in some places. The nuances were influenced by communication barriers, which created two groups of patients with a contrasting level of satisfaction over the received clinical services. A group of middle-class patients, who also spoke English, were well informed about the CMTs and were attended by the Chinese doctors whose English was at a good level of proficiency. Many patients from this group were satisfied with the clinical services they received from the doctors. The second group comprised ordinary patients who did not speak English and whose Kiswahili was not fluent but mixed with local dialects. The latter category preferred the services from local doctors who spoke Kiswahili and some local languages with them. They reported less favourably on the services they received except those which involved surgery. Patients belonging to this non-surgical group often consulted local doctors asking them to confirm whether the prescriptions were consistent with their ailment cases.¹⁵⁰ Mistrust arose from the fact that these patients were less confident of their abilities to express themselves before the Chinese doctors and that they could not be sure whether the doctors' prescriptions correlated with their expressed health cases.

Testimonies over the abilities of Chinese doctors in delivering clinical care differed according to the places in which they worked. For instance, in 1968, G. M. Chiliko, a Member of Parliament of Mwibara constituency of Northwestern Tanzania, testified in parliament that Chinese doctors proved themselves efficient and capable. He further stated that their services increased the number of people attending hospitals for health care and decreased public complains in Mwibara constituency.¹⁵¹ Such positive recommendations, especially from political elites, were rather influenced by the general contexts of the health sector in the 1960s and the activities of the CMTs in Ujamaa villages. However, such praises persisted even after the 1960s, especially regarding Chinese doctor's ability to address critical health cases. For instance, at Kitete hospital-Tabora, patients applauded abilities of the CMTs in surgeries of ears, nose, throat, and eyes. In April 1998, Chinese surgeons did about 100 eye surgeries successfully, after which 20 patients were doing fine, while ten regained their sight and 70

¹⁵⁰ The nuanced perceptions between the middle class and ordinary patients were mostly relevant from the 1980s onwards when the language training to the Chinese doctors stressed on the English language than Kiswahili. Dr Kisonga and Dr Myonga contended that many ordinary patients consulted them to verify their prescriptions after meeting Chinese doctors. In contrast, middle-class patients seemed to be satisfied with the services, and they did not ask them for further clarifications. Interview by Andrea Kifyasi with Rajabu Kisonga and John G. Myonga, April 24, 2018 at Dodoma Regional Referral Hospital.

¹⁵¹ "Chinese Doctors Praised by Mara Region MP," NRC. PMO-RALG 8/2/3, File Ref. No. LGRD. N2/21, Tanzania News Bulletin, 1968-68.

were gradually recovering.¹⁵² Such clinical achievements added value and acceptance of the Chinese doctors, and more importantly, justified their presence in Tanzania.

Figure 12: President Nyerere (sixth left) with Chinese doctors in Butiama, 1985



Source: “Matembezi ya Marafiki wa Mwalimu Butiama,” *Uhuru*, Oktoba 31, 1985, 3.

The activities of the Chinese doctors were also commended by officials of Tanzania’s ruling party, Chama Cha Mapinduzi (CCM), which is also a partner of the Chinese Communist Party (CCP). On different occasions, CCM officials met the CMTs and praised their clinical care to patients. Bidding farewell to a CMT and welcoming another team in 1991, the Party Vice-Chairman, Rashidi Kawawa, paid tribute to the CMTs and the Chinese government saying: “Your services are appreciated by Tanzanians because you are kind and caring, things that have moved a lot of people.”¹⁵³ Meetings of CMTs with the ruling party leaders bolstered relationships between CCM and CCP political parties. Findings of this study show that Chinese doctors competed vigorously to meet and attend government and party officials, who were attended by people with higher expertise to earn positive appreciation (Figure 12). For instance, the CMTs working in Mara region took care of Nyerere’s family. In August 1975, they camped

¹⁵² Mujuni Anatory, “China yatoa Misaada kwa Hospitali,” *Heko*, April 25, 1998.

¹⁵³ Mussa Lupatu, “Kawawa Hails Chinese Doctors,” *Daily News*, August 30, 1991, 5.

at Nyerere's residence in Butiama to attend Nyerere's mother, who was sick.¹⁵⁴ Such enthusiasm to provide care to political elites was not limited to Tanzania alone. Mu Tao and Yu Bin show that the CMTs working in Uganda offered special clinical care to President Yoweri K. Museveni and his government officers.¹⁵⁵ Such prioritisations allowed for easier acceptance and earned them the hearts and minds of political elites. Diplomatically, positive annotations from the party and government officials were of importance. Larry Hanauer and Lyle J. Morris maintain that some African political elites praised China's assistance to ensure continued support from the Chinese government.¹⁵⁶

Furthermore, members of parliament (MPs) in Tanzania appreciated activities of Chinese doctors, and some requested the MoH to send them to their respective constituencies. For instance, in the parliamentary session of April 1971, the MP of Tarime, Omolo, requested that the MoH allow CMTs to stay longer at Tarime District Hospital and rural dispensaries. A favourable reputation of the doctors supported this request. In his words: "Health care services offered by our brothers, Chinese doctors who volunteered to help us in hospitals and dispensaries in Mara Region are outstanding. Can the Ministry request them to live and work in villages for two consecutive years instead of just two weeks?"¹⁵⁷ Machunga, the MP of Nanyumbu constituent, also requested the dispatch of the CMTs to Masasi District.¹⁵⁸ However, Chinese doctors dispatched to Tanzania would not fill the demands of the MPs. Generally, the requests did not only require the acceptance of the CMTs services by the MPs but also reflected demands for medical personnel in several constituencies of Tanzania.

Nevertheless, perceptions of CMTs were rather negative among some medical doctors from other countries working in Tanzania. Information from the health department of the Shandong province shows that the CMTs complained about the fierce competition between Chinese doctors and doctors from other countries. Huang Xichang, the leader of the 14th batch of the CMTs to Tanzania, said: "In Tanzania, there are doctors from more than ten countries,

¹⁵⁴ "Medical Aid to Tanzania, Work Reports, Job Descriptions and Distribution Table, 1975," SPA, File No. A034-04-085, Shandong Province Health Bureau.

¹⁵⁵ Mu Tao and Yu Bin, *President Y. K. Museveni and Uganda: The Permanent Snow Mountain on the Equator and the Pearl of Africa, English Edition*, (Shanghai: Shanghai Lexicographic Publishing House, 2016), 266.

¹⁵⁶ Larry Hanauer and Lyle J. Morris, *Chinese Engagement in Africa: Drivers, Reactions and Implications for U.S. Policy*, (Washington DC.: RAND Corporation, 2014), 55.

¹⁵⁷ My translation from Kihwahili, "Maswali Bungeni, October 22, 1971, Parliamentary Hansard," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

¹⁵⁸ "Maswali Bungeni, April 22, 1971, Parliamentary Hansard, Madaktari wa Kichina Masasi," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

the competition is rather fierce, our advantage in addition to technical support is a spirit, which is hard-working, fearing neither hardship nor tiredness, being on call, win the trust of the people with technology advantage.”¹⁵⁹ This account confirms oral testimonies I collected in which respondents affirmed that, unlike medical doctors of the North, Chinese doctors worked harder to demonstrate their abilities in clinical care.¹⁶⁰ Apparently, medical doctors from other countries underrated their expertise. In their report to the provincial health department, the CMTs mention that doctors from countries of the North praised the health services that the former provided to patients but not the skills they possessed. Still, a few Northern doctors volunteered to collaborate with Chinese doctors in addressing severe health cases.¹⁶¹

Respondents’ general overview suggests that the health care services provided by the CMTs in Tanzania from the 1960s to 1980s met with overall positive responses. Some Tanzanians who experienced the services from this period gave credit to their expertise.¹⁶² However, responses from Tanzanians who experienced abilities and services by the CMTs from the end of the 1990s to 2000s gave a different response. They claimed that they did not see any extraordinary expertise from the CMTs, underscoring that their abilities were modest and similar to the expertise possessed by many Tanzanian medical workers – even though, they ranked higher the expertise possessed by Cuban and medical doctors of the North.¹⁶³ I argue that Tanzania’s health care situation largely influenced these contrasting perceptions. At independence, the country had only twelve African registered doctors. With the government initiatives, the number rose to 123 in 1971, 356 in 1976, and 782 in 1983 (Chapter 1).¹⁶⁴ Therefore, Chinese doctors came to Tanzania at the moment when the country had a severe shortage of medical personnel. Furthermore, the CMTs dispatched to Tanzania were more qualified than local doctors, which also explains the positive perceptions of the CMTs by

¹⁵⁹ Translated from Chinese by Guo Suhang under my request, Health Department of the Shandong Province, *The Chinese Medical-Aid Team*, 32.

¹⁶⁰ Interview by Andrea Kifyasi with Rajabu Kisonga, April 24, 2018, Dodoma Regional Referral Hospital; Cleopa David Msuya, July 6, 2018, Upanga-Dar es Salaam; Joseph W. Butiku, July 9, 2018, Posta-Dar es Salaam and Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam.

¹⁶¹ Health Department of the Shandong Province, *The Chinese Medical-Aid Team*, 11.

¹⁶² Interview by Andrea Kifyasi with Cleopa David Msuya, July 6, 2018, Upanga-Dar es Salaam; Joseph W. Butiku, July 9, 2018, Posta-Dar es Salaam; Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam.

¹⁶³ Interview by Andrea Kifyasi with Elisiana Danford, April 24, 2018, Dodoma Regional Referral Hospital; Martha Manyirezi, April, 2018, Dodoma Regional Referral Hospital; Simon Ernest, May 7, 2018, MoH Headquarters, Dar es Salaam; Rajabu Kisonga, April 24, 2018, Dodoma Regional Referral Hospital.

¹⁶⁴ JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. C. S. Kabeho, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1990/91*, 45; also see Julius K. Nyerere, *Freedom and Development/Uhuru na Maendeleo: A Selection from Writings and Speeches, 1968-1973* (Dar es Salaam: Oxford University Press, 1973), 293.

patients, political elites, and local doctors. The increased number of trained local medical personnel might have influenced the 1990s and 2000s informants' perceptions that offered a less enthusiastic evaluation of the CMTs.

3.8 “Winning Hearts and Minds”: The Distinctiveness of the Services by the CMTs in Tanzania

Before the onset of the CMT program in Tanzania, there were medical teams from Northern and Southern countries working in the country. In order to distinguish the CMTs from previous approaches, avoid mistakes, and thus win popularity, prospective CMT members went on study tours prior to their dispatch. This confirmed a broader pattern since, as Deborah Brautigam has shown, the Chinese government had been keen to study traditional donors and, on this basis, design aid in a way to bolster its own interventions, acceptance and popularity.¹⁶⁵ In their report of March 1, 1968, they confirmed that donors of the North dominated the provision of clinical care, medicines, medical equipment, and scholarships to medical students in Tanzania. Accordingly, they advised their government to find its own distinct approach towards medical assistance.¹⁶⁶ Indeed, before Tanzania's diplomatic clashes with West Germany and Great Britain in the mid-1960s, the government had hired many medical doctors from Britain, Israel, Yugoslavia, Canada, and the USA (Chapter 1).¹⁶⁷ Nevertheless, the government also received medical workers from different communist countries. For example, in 1964, the Soviet government signed an agreement for the deployment of medical doctors, building hospitals, credit facilities and technical assistance to Tanzania's health sector.¹⁶⁸ Likewise, in 1974, the Cuban government signed a technical agreement with the Tanzanian government, whereby it pledged to deploy 53 medical doctors each year to the country. Subsequently, in 1977, it dispatched 25 medical doctors, nineteen of whom worked in Tanga Region, and the rest remained in Dar es Salaam hospitals.¹⁶⁹ Furthermore, the government

¹⁶⁵ Deborah Brautigam, *The Dragon's Gift: The Real Story of China in Africa* (New York: Oxford University Press, 2009), 11.

¹⁶⁶ “Medical Aid to Tanzania, 1968,” SPA. File No. A034-03-006, Shandong Province Health Bureau.

¹⁶⁷ “URT, President's Address to the National Assembly, Tuesday, June 8, 1965,” TNA. Acc. No. 589 Orodha ya Majalada ya Mtu Binafsi, Bhoke Munanka, File No. BMC. 10/03, Speeches of Ministers and Junior Ministers, 23.

¹⁶⁸ “Bomani to Discuss Aid in Moscow,” *Sunday News*, November 2, 1967, 1.

¹⁶⁹ “Cuba Sends More Doctors,” *Daily News*, September 12, 1977, 3.

received medical doctors and auxiliary staff from Italy. In 1977, for instance, twenty Italian doctors were sent to work in different Tanzanian district hospitals.¹⁷⁰

These medical teams had triggered mixed responses. Nyerere, while talking to Consul Zhou Boping in 1967, complained that medical doctors from countries of the North were so demanding and preferred a lavish life in a low-income country. He grumbled that doctors from the North demanded pleasant expensive houses with air conditions, which cost the country dearly. Nyerere anticipated that doctors from China would be different, simply because they were coming from a Southern country.¹⁷¹ Coincidentally, the Chinese government had pledged in its Eight Principles of overseas aid that: “[T]he experts dispatched by the Chinese Government to help in construction in the recipient countries will have the same standard of living as the experts of the recipient country. The Chinese experts are not allowed to make any special demands or enjoy any special amenities.”¹⁷² Consequently, while other expatriates working in Tanzania enjoyed good salaries and comfortable living environments better than local medical workers with the same level of expertise, the Chinese experts put up with local lifestyle and earnings.

Maoist philosophy manifested itself in Tanzania, for instance, when, in 1970, the Chinese government argued for the reduction of salaries to Tshs. 400 per month for the Chinese experts working in Zanzibar to adjust to local salaries. Part of the letter by Chen Ching, the Chinese Consul in Zanzibar to the First Vice-President, Sheikh Karume read:

On behalf of the Government of the People’s Republic of China, I have the honour to confirm hereby that following the teaching of the great leader of the Chinese people, Chairman Mao, to preserve the style of plain living and hard struggle with a view to reducing Zanzibar’s burden in its national economy through self-reliance, the Chinese Government proposes hereby to lower the standard of living expenses of Chinese experts in Zanzibar.¹⁷³

The argument for “plain living” advocated to the Chinese experts was from a view that countries of the Global South, including China, were equal since at different historical periods they experienced similar social, economic, and political predicaments instigated by the

¹⁷⁰ “Italian Doctors Arrive,” *Daily News*, July 19, 1977, 1.

¹⁷¹ Altorfer-Ong, “Old Comrades and New Brothers,” 261.

¹⁷² Eight Principles for Economic and Technical Aid Contended by Premier Zhou Enlai when Answering Questions from Reporters of the Ghana News Agency on January, 15, 1964 in Ghana, quoted in *Afro-Asian Solidarity Against Imperialism: A Collection of Documents, Speeches and Press Interviews from the Visits of Chinese Leaders to Thirteen African and Asian Countries* (Peking: Foreign Languages Press, 1964), 150.

¹⁷³ Quoted in “Chinese in Zanzibar to Earn Less,” *The Nationalist*, November 20, 1970, 1.

impacts of imperialism, colonialism, and neo-colonialism.¹⁷⁴ This context enhanced the CMTs' acceptance in Tanzania as the government expected them to steer clear of imperialistic lifestyle. In the same vein, Nyerere anticipated that doctors from socialist countries would transmit socialist lifestyles to local doctors through their own positive example. He argued:

Ideally, we also need socialists in every job—which is not necessarily the same thing as wanting a citizen for every job, because not all Tanzanians are socialists. But if a competent doctor also has socialist attitudes, then he is surely an especially great asset to us. And the truth is that the international reputation of Tanzania is such that many socialists from other countries very much want to come and work with us.¹⁷⁵

Alicia N. Altorfer-Ong maintains that CMTs in Tanzania distinguished themselves from medical doctors of the North by living in “dormitory-style sleeping quarters with communal cooking facilities.”¹⁷⁶ Similarly, the Second Vice President of Tanzania, Rashidi M. Kawawa, argued that Chinese doctors were very obliging and capable of living and working in any environment.¹⁷⁷ While the sources used for this study confirm that the CMTs endured modest living and working conditions in Tanzania, CMT members did submit a few complaints to the MoH. For example, they were unhappy with old furniture, and they demanded repair as well as the purchase of some stuff such as curtains, air conditioners, cooking utensils, gas cooker and others which were initially perceived by Nyerere as luxurious amenities. They also complained about old vehicles which the ministry gave them for an upcountry medical tour. Moreover, in some regions, houses rented for the CMTs were not of low quality since the Tanzanian government paid up to USD 1,500 a month per house.¹⁷⁸ Generally, the CMTs living and working environments varied from one region to another, and the MoH addressed several challenges at both national and regional administrative levels to enable the CMTs to live and work comfortably.

CMTs also distinguished themselves from other foreign medical experts through distinct practices, especially acupuncture therapy. Acupuncture was a new and unique way of

¹⁷⁴ Read, for instance, “a speech by Chiao Kuan-Hua, Chairman of the Chinese Delegation and Minister of Foreign Affairs at the 31st Session of the United Nations General Assembly, October 6, 1976,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

¹⁷⁵ Julius K. Nyerere, *Ujamaa: Essays on Socialism* (Dar es Salaam: Oxford University Press, 1968), 148.

¹⁷⁶ Altorfer-Ong, “Old Comrades and New Brothers,” 262.

¹⁷⁷ “Misaada ya China Haina Mirija,” *Ngurumo*, Februari 12, 1968, 1.

¹⁷⁸ “A Memo, 9/4/1974,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China; “Meeting Minutes: 29th February 2008,” NRC. Ministry of Health and Social Welfare, 14/05/03, File Ref. No. HC. 74/311/02 Chinese Medical Team 2007-2010.

addressing several diseases in Tanzania. As essential elements in traditional Chinese medicine, acupuncture and moxibustion had a long history in China. The general practice of traditional Chinese medicine in China paralleled biomedicine from the 1950s. After China's Revolution of 1949, acupuncture and moxibustion were widely used for therapy in China at all levels of health structure by acupuncturists in traditional Chinese medicine, barefoot doctors in the rural areas and medical doctors in urban areas.¹⁷⁹ From its inception in 1968, the CMT program prioritised the practice of acupuncture and moxibustion therapies in Tanzania, where Chinese acupuncturists were dispatched to the country after every two years (Chapter 4). Acupuncture and moxibustion remedies had never been practised before by doctors from neither Western nor Eastern countries. The peculiarity of the therapies and their effectiveness in addressing more than thirty varieties of diseases won the Chinese medical doctors an appraisal from government officers and patients in Tanzania.¹⁸⁰

Working in Ujamaa villages was among distinctive features of the CMTs. Such attempts were in line with the socialist health policies which gave priority to rural health care.¹⁸¹ Consequently, the CMT program came at a moment when Tanzania's health care policy and the political ideology had prioritised rural health care. To become consistent with the government's health policy, the CMTs spent at least half of their time attending patients in villages under their mobile health services.¹⁸² For example, in Shinyanga and Maswa Districts, the doctors attended up to 16,500 patients in 1970. In a single Ujamaa village, the Chinese doctors stayed for more than ten days to take part in village life and work.¹⁸³

The political elites and community at large perceived the Chinese determinations to work in rural areas as unique since even local medical doctors were reluctant to work in villages

¹⁷⁹ "United Nations Development Programme, Project of the Governments of Training Course on Acupuncture Treatment, 17/11/1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

¹⁸⁰ Health Department of Shandong Province, *The Chinese Medical-Aid Team*, 11; Interview by Andrea Kifyasi with Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam.

¹⁸¹ Indeed, rural health care was a priority of both Chairman Mao and Nyerere. It contested the colonial health policies in Tanzania, which had neglected rural health care. Yet, it was not limited to Chinese doctors in Tanzania alone. While Chinese doctors spent half of their time in rural Tanzania, Russian doctors did the same in Ethiopia. For instance, in September 1976, five Russian doctors camped at Durge village, Shoa-Ethiopia, to attend to rural patients. See, "Madaktari Zaidi toka China Watakuja," *Uhuru*, Mei 7, 1968, 1; "'Rash' of Clinics but no Staff, Self-Help Hitch," *Tanganyika Standard*, Wednesday, July 18, 1962, 3; L. Makarenko, "Hospitali Imekuja Kijijini Durge," *Urusi Leo*, September 12, 1976, 5.

¹⁸² "Letter from Daktari Mkuu wa Mkoa, Shinyanga, to Katibu wa TANU, Mkoa wa Shinyanga, August 15, 1974, Madaktari wa Kichina," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

¹⁸³ "A Special Report, Chinese Medical Assistance to Tanzania, May 12, 1972," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

due to several challenges such as unreliable water and electricity supply as well as public transport.¹⁸⁴ In 1975, the Principal Secretary of the MoH applauded the CMTs by saying:

Chinese doctors work in rural areas where the health care services are indigent, and patients are most in need of assistance. Doctors from other countries cannot adapt to such an environment, while Chinese doctors in those places can work with enthusiasm. Secondly, they [Chinese doctors] know Tanzania very well and understand the problems of the people. Working with the people of Tanzania and helping them is both a challenge and a pleasure to Chinese doctors.¹⁸⁵

Such assertions imply that working in rural areas by the CMTs pleased officials in the MoH and differentiated them from other teams whose doctors were scared of working in villages. Providing clinical care to rural patients won them the hearts and minds of rural villagers who were grateful and others presented gifts to the CMTs as an expression of their gratitude (Figure 13). Generally, throughout the 1960s and 1970s, the CMTs gave priority to rural health care. Nevertheless, from the end of the 1980s, their services were primarily based in national and referral hospitals preferably, in Dar es Salaam, Dodoma, Tabora and Musoma.¹⁸⁶ During this period, the roles of the CMTs hardly stressed in spreading communist propaganda; instead, they focused on bolstering the market for Chinese medicines and painting Sino-Tanzanian relationship. Such new roles did not primarily need the CMTs to work in rural areas.

There were structural differences between the CMTs and medical teams from other countries working in Tanzania. Medical assistance from other countries was mainly provided by a combination of public, private, and multilateral foundations. Such structure differed from the Chinese system, which, from its inception, remained public and decentralised at the provincial level. The Chinese central government and African countries negotiated for medical assistance, but the provinces actually deployed the medical doctors to the continent.¹⁸⁷ This structure gave Chinese provinces arguably greater control over the CMT program than the central government. As a result, it maintained relationships between recipient countries and

¹⁸⁴ Interview by Andrea Kifyasi with Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam.

¹⁸⁵ Translated from Chinese by Guo Suhang under my request, Health Department of Shandong Province, *The Chinese Medical-Aid Team*, 32.

¹⁸⁶ Interview by Andrea Kifyasi with Edith Bakari, May 8, 2018, MoH Headquarters, Dar es Salaam. Edith is a Health Service Administrator, Directorate of Curative Services, Ministry of Health, Community Development, Gender, Elderly and Children; Rajabu Kisonga, April 24, 2018, Dodoma Regional Referral Hospital.

¹⁸⁷ Paul Kadetz, "Unpacking Sino-African Health Diplomacy: Problematizing a Hegemonic Construction," *St Antony's International Review* 8, no. 2 (2013): 156.

respective provinces, which, in turn, helped Chinese provinces to swiftly get access to markets and investment opportunities in recipient countries. In Tanzania, for instance, investment in traditional Chinese medicine clinics was mostly occupied by traditional Chinese medicine practitioners from Shandong province.¹⁸⁸ It is, therefore, fair to contend that the CMT program played a soft power role to ease the penetration of provincial hard power through trade and direct investment in Tanzania.

Figure 13: A gift of bananas to the CMT (undated, likely 1970s)



Source: Health Department of the Shandong Province, *Unforgettable Memory*, 71.

Maintenance cost was among the aspects which distinguished the CMTs from medical doctors of other countries working in Tanzania. As hinted earlier, from 1978, following China's open-door policy, recipient countries paid more to host CMTs. However, comparing to medical teams from other countries, the CMTs were cheaper. For example, while the CMTs working in Tanzania received USD 170 a month by 2000s, the Cuban doctors received a living allowance of up to USD 300 per month per person in the same period.¹⁸⁹ In other countries

¹⁸⁸ Interview by Andrea Kifyasi with Sui Guangxin and Chen Zhufeng, March 1, 2016, Jinan.

¹⁸⁹ "Minute, August 31, 2005," NRC. Ministry of Health and Social Welfare, 14/3/04, File Ref. No. BC. 103/544/01 Republic of Cuba Technical Assistance, 2005-2010.

such as South Africa, the Cuban government demanded full salary to its medical doctors where it collected 57% of income tax from doctors' working salaries.¹⁹⁰ Distinctively, throughout the CMT program in Tanzania, the Chinese government paid salaries to its medical workers working in the country. The cheapness of the CMTs further realised in the aspect of flight costs, where the Tanzanian government paid only for the return tickets to the CMTs, but it paid for the round-trip tickets to Cuban doctors.¹⁹¹ Therefore, while Margaret Blunden applauds Cuban medical doctors for their cheap health services to recipient countries,¹⁹² this study upholds that despite the changes in China's foreign policy, Chinese doctors were far cheaper than their Cuban counterparts. Nevertheless, the cheapness of the services by the CMTs does not mean that the Chinese government gained nothing from its medical missions. Instead, as discussed in the previous sections, activities of the CMTs in Tanzania promoted market access for Chinese medicines and bolstered diplomatic relations between the two countries.

3.9 Conclusion

This chapter has unpacked the history of the CMT program in Tanzania. Discussions in the chapter have contended that the CMTs had a long history, and their execution changed consistently with China's foreign policy. The program cherished Mao's political propaganda from the 1960s to 1970s but was adapted to suit China's economic prioritisations in foreign policy from 1978 onwards. Furthermore, the chapter has discussed the ways in which the Chinese CMT program positively distinguished itself from medical assistance provided by other nations, which, in turn, made the Chinese government appear as a more responsible and reliable partner than traditional donors of the North. The analyses made in this chapter add weight to the argument by Jeremy Youde, Olivia Killeen and colleagues who hold that China's medical diplomacy extended both hard and soft power.¹⁹³ The chapter has shown that the CMT program went hand in hand with the donation of Chinese-made drugs which partly assisted Tanzanians in getting access to basic medicines while promoting market access and acceptance

¹⁹⁰ Daniel Hammett, "Cuban Intervention in South African Health Care Service Provision," *Journal of Southern African Studies*, 33, no. 1 (Mar. 2007): 76-77.

¹⁹¹ "Minute, August 31, 2005," NRC. Ministry of Health and Social Welfare, 14/3/04, File Ref. No. BC. 103/544/01 Republic of Cuba Technical Assistance, 2005-2010.

¹⁹² Margaret Blunden, "South-South Cooperation: Cuba's Health Programmes in Africa," *International Journal of Cuban Studies* 1, no. 1 (June 2008): 36.

¹⁹³ Olivia J. Killeen, *et al.*, "Chinese Global Health Diplomacy in Africa: Opportunities and Challenges," *Global Health Governance* 12, no. 2 (Fall 2018): 19; Jeremy Youde, "China's Diplomacy in Africa," *China an International Journal* (March, 2010): 151.

of Chinese medicines in Tanzania. The chapter maintained that the CMT program contributed modestly to promote self-dependence in Tanzania's health sector. The program, which has been in place for more than half a century, did not live up to its claims of capacity building, which would have been key to promoting a sustainable health care system. Dispatching CMTs to Tanzania overwhelmed training programs and joint medical research activities. This situation exacerbated Tanzania's dependence on Chinese doctors up to the present day, as, following Drew Thompson, the Tanzanian health sector is under serious threat by the fact that China's population increase and disease burden will cause some provinces to withdraw their dispatch of medical specialists to Africa.¹⁹⁴

¹⁹⁴ Drew Thompson, "China's Soft Power in Africa: From the "Beijing Consensus" to Health Diplomacy," *China Brief* 5, no. 21 (October 13, 2005): 4.

CHAPTER FOUR:

TAKING TRADITIONAL CHINESE MEDICINE TO POST-COLONIAL TANZANIA

4.1 Introduction

The advent and practice of traditional Chinese medicine (TCM) in Africa has a long history, yet it has been of limited interest to scholars. The existing research literature dwells much on TCM clinics which emerged from the 1990s while neglecting the emergence and practice of TCM from the 1960s onwards.¹ This chapter, therefore, analyses the ways in which TCM was introduced, perceived, practised and developed in post-colonial Tanzania. It shows that TCM was firstly introduced in Tanzania by Chinese navigators in the 15th century. However, it became widespread in 1968 following the dispatch of Chinese medical teams to Tanzania. The chapter goes beyond the previous chapter, which unveiled the history and roles of Chinese medical doctors by unpacking their influence on the emergence and spread of TCM in the country. It shows that TCM experts, who accompanied Chinese medical teams, practised and circulated TCM knowledge among local medical workers. Furthermore, commencements of the HIV/AIDS TCM research and treatment in 1987, as well as the anti-malarial campaign in 2006, further enhanced the acceptance and practice of TCM in the country. This chapter is built on the argument that the practice, spread, and acceptance of TCM knowledge in Tanzania was imperative for the promotion of medical knowledge from the South. In the spirit of Southern solidarity, countries of the South perceived South-South knowledge exchange as an emancipatory undertaking against dependence on the medical knowledge of the North.² Nevertheless, the chapter shows that the execution of TCM services in Tanzania was not only envisioned as an alternative to medical knowledge from the North but also promoted the use

¹ General roles of Chinese medical doctors in transmitting TCM in Africa were outlined by Li Anshan, *Chinese Medical Cooperation in Africa: With Special Emphasis on the Medical Teams and Anti-Malaria Campaign*. (Uppsala: Nordiska Afrikainstitutet, 2011). Traditional Chinese Medicine in East Africa has been broadly studied by Elisabeth Hsu, “The Medicine from China has Rapid Effects: Chinese Medicine Patients in Tanzania,” *Anthropology and Medicine* 9, no. 3 (2002), <https://dx.doi.org/10.1080/13648470216335>; Elisabeth Hsu, “Medicine as Business: Chinese Medicine in Tanzania,” in *China Returns to Africa: A Rising Power and a Continent Embrace*, ed. Alden, C., Large, D. and Soares de Oliveira, R. (London: Oxford University Press, 2008); also Michael Jennings, “Chinese Medicine and Medical Pluralism in Dar es Salaam: Globalisation or Glocalisation?” *International Relations* 19, no. 4 (2005). <https://doi.org/10.1177/0047117805058535>.

² Permanent Secretariat of the Afro-Asian Peoples’ Solidarity Organisations, *Afro-Asian Peoples’ Solidarity Movement*, (Cairo), 12.

of Chinese medicine parallel to biomedicine. Unfortunately, such promotions did not translate into great success in mainstream Tanzanian public health.

4.2 Traditional Chinese Medicine: The History and the Scope of Its Spread

Traditional Chinese medicine relied mostly on herbal medications which were used to prevent and help the human body to fight ailments, relieve pain and restore health. In addition to medication, TCM adopted non-pharmacological therapies such as acupuncture and moxibustion, massage, cupping and spooning.³ Acupuncture was one of the key components of TCM and began in China around 100 BC. Its acceptance and practice fluctuated depending on China's political atmosphere. Its spread to different parts of the world has a long history as well. For instance, acupuncture and moxibustion therapies spread to Korea and Japan in the 6th century AD and Vietnam in the 8th and 10th centuries AD. Acupuncture and moxibustion therapies spread to Europe during the Qing dynasty (1644–1912). The therapies were practised first in France in the 17th century before its spread to Germany, Holland and England by 1700.⁴ Some western physicians adopted acupuncture knowledge and used it to relieve patient pains. By the 1900s, TCM had spread to North America, Asia and several European countries. Portuguese Jesuit missionaries working in Japan and Asian immigrants, especially the Chinese and Vietnamese, were the principal agents for practice, and its spread to Europe, Asia and America.⁵

The advent of biomedicine in the 1900s impacted negatively on the popularity and endurance of TCM not only in Europe but also in China. During this era, acupuncture and moxibustion therapies were perceived as unscientific.⁶ However, after the founding of New China in 1949, the government attached great importance to the development of TCM by laying down policies, principles and strategies to promote its acceptance and practices (see below).

³ The State Council Information Office of the People's Republic of China (PRC), *A White Paper on the Development of Traditional Chinese Medicine (TCM) in China*, 6th December 2016, 4; Interview by Andrea Kifyasi with Jiang Xuan, January 4, 2016, Hangzhou. Jiang is an acupuncturist working at the Department of Acupuncture of the Fenghua People's Hospital at Fenghua, Ningbo in Zhejiang Province.

⁴ A. White and E. Ernst, "A Brief History of Acupuncture," *British Society for Rheumatology* 43, no. 5 (May, 2004): 662.

⁵ Stephen J. Birch and Robert L. Felt, "The Acculturation and Re-Acculturation of Acupuncture," in *Understanding Acupuncture*, ed. Stephen J. Birch and Robert L. Felt (London: Churchill Livingstone, 1999), 45.

⁶ Ernst, "A Brief History of Acupuncture," 663; Paul U. Unschuld, *Traditional Chinese Medicine: Heritage and Adaptation*, trans. Bridie J. Andrews (New York: Columbia University Press, 2018), 1.

Indeed, the government of Mao Zedong promoted TCM within and outside China to preserve the “essence” of Chinese culture and spread its fame to the rest of the world. Above all, the Chinese Communist Party (CCP) endorsed the development of TCM as a valuable inheritance.⁷ The promotion of TCM further aimed at backing up western-based medical care in China. In the 1950s, China had a population of half a billion people who were attended to by fewer than 40,000 biomedical doctors. Consequently, the promotions of TCM partly aimed to enable the Chinese government to utilise about 500,000 TCM practitioners who were at that time disorganised, discouraged and disengaged in the provision of health care.⁸

The promotion of TCM went hand in hand with scientising its knowledge. The Vice-Minister for Public Health, Chien Hsin-chung, confessed that most TCM therapies were unscientific; thus, it was necessary to prove their effectiveness through scientific research. He argued:

The simple yet effective methods of acupuncture and combustion have been known and appreciated by the masses for centuries. Yet much of this skill remained empirical. It lacked a scientifically worked-out theoretical basis. Now the theoretical basis of these methods is being established and it will be possible to attain even better results in medical treatment with these means.⁹

Accordingly, since the 1950s, the Chinese government established TCM schools with a standardised curriculum where TCM students and practitioners studied basic biomedical sciences, traditional pharmacotherapy and acupuncture.¹⁰ The establishment of formal training not only legitimised TCM as a trustworthy practice based on science but also helped the government to unify and regulate the practices of traditional health practitioners. Besides, the government of China vowed to integrate traditional health practitioners with biomedicine. Subsequently, the first Chinese health conference held in 1950, endorsed three principles: firstly, to serve the workers, peasants and soldiers; secondly, the prevention of disease; and thirdly, the integration of traditional Chinese medicine and biomedicine. More importantly, the government stipulated categorically in its constitution that “both modern medicine and

⁷ Chien Hsin-chung, “Chinese Medicine: Progress and Achievements,” *Peking Review*, no. 9, February 28, 1964, 18.

⁸ Birch and Felt, “The Acculturation and Re-Acculturation of Acupuncture,” 51.

⁹ Chien, “Chinese Medicine,” 18.

¹⁰ Birch and Felt, “The Acculturation and Re-Acculturation of Acupuncture,” 52.

traditional Chinese medicine should be developed.”¹¹ Mao was frequently quoted underscoring that “Chinese medicine is a great treasure-house! We must make all efforts to uncover it and raise its standards.”¹² Throughout the 1950s and 1960s, the government stressed training and undertaking research. Thus, it established TCM research institutes in all provinces. Mao endeavoured to see TCM going global and used in parallel with biomedicine for its survival and prosperity. Not surprisingly, from 1956, China made TCM a compulsory course to students trained in biomedicine to enhance their basic knowledge of TCM and promote the use of both medical systems.¹³

While research is scarce, available pieces of information show that the Chinese introduced TCM to the East African coast already in the 15th century through the expeditions by the Ming dynasty diplomat, Zheng He, to the East African coast, composed of 180 Chinese doctors and medical orderlies. The medical doctors took care of the delegates and sought new medical knowledge and materia medica from the coast.¹⁴ In such ways, medical knowledge from the coast flowed to China through direct contact between Chinese medical practitioners and the coastal traditional medicine practitioners during the expeditions.¹⁵

The preceding narratives are significant as they show the interactions, though minimal between traditional medicine practitioners of the two sides. Yet, there is no reliable evidence indicating that Chinese medical doctors extended medical services to the coastal people. Furthermore, there is no plausible information depicting that the coastal medical practitioners adopted some medical knowledge from Chinese medical practitioners. Nevertheless, Li Xinfeng shows that Chinese descendants who were left by Zheng in Mombasa after a shipwreck practised TCM therapies such as massage and cupping. Li adds that Chinese immigrants passed on medical knowledge from one generation to another.¹⁶ Li’s assertions, however, fall short in terms of methodology as he lacked complementary information from archival and archaeological sources. It is, therefore, not known whether the Chinese left were

¹¹ WHO, “Study Tour in China,” *World Health*, November 1977, 23; WHO, *The Role of Traditional Medicine in Primary Health Care in China*, 1985, 1.

¹² Quoted in Birch and Felt, “The Acculturation and Re-Acculturation of Acupuncture,” 52.

¹³ Chien, “Chinese Medicine,” 18; Ling Yang, “Training Medical Workers,” *Peking Review*, no. 46, November 13, 1964, 23.

¹⁴ Abdul Sheriff, *Dhow Cultures of the Indian Ocean: Cosmopolitanism, Commerce and Islam* (New York: Columbia University Press, 2010), 296.

¹⁵ Sheriff, *Dhow Cultures*, 298.

¹⁶ Li Xinfeng, *China in Africa in Zheng He’s Footsteps*, trans. Shelly Bryant (Cape Town: Best Red HSRS 2017), 29-30.

TCM practitioners or ordinary Chinese with varying levels of TCM knowledge. Yet, Li's study brings to light the practice of some TCM therapies on the East African coast before the 1960s. However, their use and spread to other parts of Africa were curtailed by the limited nature of pre-colonial and colonial Sino-African relationships. In the colonial period, for instance, so-called Chinese "coolies" worked in different colonial economic investments in Tanganyika, South Africa and West Africa.¹⁷ However, there is no evidence that these indentured Chinese practised TCM in those colonies.

TCM spread intensely in Africa from the 1960s on. The Chinese medical team (CMT) program played a substantive role in its introduction, practice and spread (see below). Acupuncture therapy was among the first TCM practices introduced in post-colonial Africa, starting gradually in the 1960s and booming in the 1970s. The therapy was credited with relieving pains and treating a wide range of health cases. According to the WHO's acupuncture training program of 1977, acupuncture therapy alone could treat about seventy diseases and some 200 when used in combination with herbal medicines. The acupuncture therapy was especially effective in critical health cases such as bronchitis, bronchial asthma, gastralgia, diaphragmatic spasm, and musculoskeletal problems such as back pain, knee pain and shoulder stiffness.¹⁸

TCM hinges on the philosophy that conceives the human body as maintained by "primordial life energy" called *qi*. This theory explains not only the physiology and pathology of the human body but also underpins the aetiology, prevention, and cure of diseases. TCM practitioners uphold that the *qi* energy flows throughout the human body along several channels called "meridians". Thus, the effective flow of *qi* energy is vital for maintaining a balance between two important natural forces, *yin* and *yang*, which, in turn, is required to maintain the stability of the human body.¹⁹ In this regard, the occurrence of diseases was attributed to the

¹⁷ Read, for instance, Juhani Koponen, *Development for Exploitation: German Colonial Policies in Mainland Tanzania, 1884-1914* (Münster: LIT Verlag, 1994), 336.

¹⁸ Other diseases treated by acupuncture included acute enteritis and dysentery, hypertension, torticollis, malaria, arthritis, lumbago, shoulder pain, acute appendicitis, bile duct disorders, mastitis, urticaria, dysmenorrhoea, menstrual irregularity, hyperemesis gravidarum, abnormal position of the foetus, sequelae of poliomyelitis, acute tonsillitis, toothache, sequelae of apoplexy, headache, trigeminal neuralgia, facial paralysis, intercostal neuralgia, sciatica, neurasthenia, and enuresis. See, for instance, "United Nations Development Programme (UNDP), Project of the Governments of Training Course on Acupuncture Treatment, 17/11/1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China; WHO, "Study Tour in China," 23.

¹⁹ Douglas Allechin, "Points East and West: Acupuncture and Comparative Philosophy of Science," *Philosophy of Science* 63 (Sep. 1996): S109; Jie Wang, Lin-guo Zhang and Wei Jia, "The Rationale of Combination Drug Formulas in Traditional Chinese Medicine," in *Chinese Medicine Modern Practice: Annals of Traditional Chinese*

dominance of either of the forces over the other caused by an imbalanced flow of *qi* along the meridians.²⁰ The balanced state of *yin* and *yang* manifested in three dimensions, which were the harmonisation of physical form and vitality, man and nature, as well as man and society. The outlined dimensions made the TCM theory compatible with the WHO's concept of "health" which defined it as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".²¹

Consequently, according to TCM theory, the imbalanced flow of the *qi* energy which eventually leads to the occurrence of diseases was caused by exogenous factors, epidemic pathogenic factors, parasites, emotional changes, improper diet, maladjustment between work, exercise and rest, trauma and the fluid retention as well as blood stasis. Yet, TCM practitioners did not only rely on symptoms and signs to diagnose diseases. Instead, they employed further diagnostic skills such as observation, listening, smelling, inquiring, and palpation.²² Modes of causations and the types of diseases informed the healing systems. Some patients received herbal doses while others underwent acupuncture therapy. For the case of acupuncture, TCM practitioners (acupuncturists) inserted an acupuncture needle(s) into the skin at specific points of the body (acupuncture points) along the meridian. Inserted needle(s) stimulated sensory nerves under the skin and muscles of the patient's body to restore the usual balance of *yin* and

Medicine Vol. I, ed. Ping-chung Leung and Charlie Chang-li Xue (Singapore: World Scientific Publishing, 2005), 44.

²⁰ The *yin-yang* theory has its background in ancient China. The Chinese believed in the presence of two competing and complementing forces in the universe, the *yin* and the *yang*. In their view, the two forces were in everything, including the human body. See Stefan Jaeger, "A Geomedical Approach to Chinese Medicine: The Origin of the Yin-Yang Symbol," in *Recent Advances in Theories and Practice of Chinese Medicine*, ed. Haixue Kuang (2012), 30; Unschuld, *Traditional Chinese Medicine*, 25.

²¹ WHO, *Constitution of the World Health Organization, 1946*, 1. The harmonisation of physical and vitality includes stamina, physical appearance and all physiological activities of the human body while the harmonisation of man and nature comprises of seasons of the year, climate and geographical environments. Lastly, the harmonisation of man and society describes man's relations with family, workmates and personal relationships. All the mentioned may affect positively or negatively the flow of *qi* energy in the human body. For further details read Li Zhao, Kelvin Chan, Kwok-fai Leung, Feng-bin Liu and Ji-qian Fang, "The Conceptual Framework of the Chinese Quality of Life (ChQoL) Instrument," in *Chinese Medicine Modern Practice: Annals of Traditional Chinese Medicine Vol. I*, ed. Ping.chung Leung and Charlie Chang-li Xue (Singapore: World Scientific Publishing Co. Pte. Ltd, 2005), 189-191. 44.

²² Under the observation method, TCM practitioners observe the patient's expression, body shapes, state of the hair, face colour, the five sense organs, throat, limbs, and skin. Through listening and smelling methods, they take note on how patients speak, breathe, cough and smell. By the inquiring method, they listen carefully to patient's complaints, duration of the illness and the medical history. The palpation method involves feeling the pulse and palpating channels and points. All these techniques have been elaborated on at length by Wen Xuan, "Traditional Chinese Medicine: An Overview," in *Traditional Chinese Medicine*, ed. Chun-su Yuan, Erick J. Bieber and Brent A. Bauer (Washington: CRC Press, 2011), 97-107.

yang for the normal flow of *qi* energy and, hence, restored health.²³ Although TCM theory and practices spread widely, especially from the 1970s (see below), western scientists dismissed its conception of disease and healing, claiming that it was unscientific. The placement of needles, for instance, contrasted with the western scientific conception of cells, nerve pathways, and energy in biological systems. Under such a perception, they categorised TCM therapies as a pseudoscience.²⁴ Nevertheless, the *qi* theory remained fundamental for the practices of TCM in different parts of the world.

Moving away from eastern and western societies to Africa, the Chinese conception of health and diseases varied from the African too. From the pre-colonial period to the present, African societies had a different conception of illness and its aetiology. For instance, in the pre-colonial era, many of the various health practices and epistemologies emphasised that the neglect of ancestral spirits caused illness and other afflictions to individuals, families, and the general community. Furthermore, they supposed that a particular disease was caused by a “sorcerer” when a person died suddenly or had a chronic illness that was unexplainable and progressed rapidly.²⁵ Communities further believed that disrespect of community taboos was capable of causing diseases as a punishment by spirits.²⁶ Moreover, some societies believed that other diseases existed naturally, without any spiritual or social cause.²⁷

African healing systems varied considerably depending on their aetiology, comprising three levels: divination, spiritualism, and herbalism. Some diseases were cured by medicinal herbs and minerals, while others were healed through propitiations or sacrifices to ancestral spirits.²⁸ The healing practices adopted other traditions, including biomedicine, from the late

²³ Lynnae Schwartz, “Evidence-based Medicine and Traditional Chinese Medicine: Not Mutually Exclusive,” *Medical Acupuncture* 12, no. 1 (Spring 2000), 2; Yong G. Wang, “Acupuncture,” in *Traditional Chinese Medicine*, ed. Chun-su Yuan, Erick J. Bieber and Brent A. Bauer (Washington: CRC Press, 2011), 124; Allchin, “Points East and West,” S110.

²⁴ Margaret Lock and Vinh-Kim Nguyen, *An Anthropology of Biomedicine* (Oxford: Wiley-Blackwell, 2010), 40; Allchin, “Points East and West,” S110.

²⁵ Gloria Waite, “Public Health in Pre-colonial East-central Africa,” in *The Social Basis of Health and Healing in Africa*, ed. Steven Feierman and John M. Janzen (Los Angeles: University of California Press, 1992), 213-218.

²⁶ Yusufu Q. Lawi, “Changes and Continuities in Local Articulations of Life, Illness and Healing in Rural Africa: A case of the Iraqw of North-Central Tanzania,” *Tanzanian Journal of Population Studies and Development* 15, no. 1 and 2 (2000): 68.

²⁷ Steven Feierman, “Explanation and Uncertainty in the Medical World of Ghaambo,” *Bulletin of the History of Medicine* 74, no. 2 (2000): 320; Karen. E. Flint. *Healing Traditions: African Medicine, Cultural Exchange and Competition in South Africa, 1820-1948* (Athens: Ohio University Press, 2008), 56.

²⁸ Harald Kristian Heggenhougen, “Health Services: Official and Unofficial,” in *Tanzania Crisis and Struggle for Survival*, ed. Jannik Boesen, Kjell J. Havnevik, Juhani Koponen, and Rie Odgaard (Uppsala: Scandinavian Institute of African Studies, 1986), 312; Megan Vaughan, *Curing their Ills: Colonial Power and African Illness* (Cambridge: Polity Press, 1991), 60; Waite, “Public Health in Pre-colonial East-central Africa,” 214-215.

19th century to the present. Following Stacey A. Langwick, Tanzanian patients and practitioners have regarded biomedical approaches as only part of “a broader therapeutic ecology” up to the present.²⁹ Therefore, although biomedicine became entrenched in the colonial period, Tanzanian communities relied on both biomedical and traditional logics of causality and treatment. Although the colonial administration promoted the use of biomedicine, communities in Tanzania perceived it insufficient in addressing all health problems. Thus, medical pluralism remained the main feature of the Tanzanian health care system in both colonial and post-colonial periods. Accordingly, from the moment TCM was introduced and practised in Tanzania, it met communities used to pluralistic health systems capable of absorbing new medical culture.³⁰ Michael Jennings illustrates how patients in Tanzania were less interested in knowing the philosophical underpinnings of TCM. Instead, they considered mostly the efficacy of their clinical care.³¹

In such pluralistic contexts, acupuncture spread successfully and was practised in some African hospitals. Countries such as Algeria, Republic of the Congo, Ethiopia, Mauritania, Somalia, Togo, Tanzania, and Niger used acupuncture therapies in some government hospitals starting during the 1960s. Moreover, Chinese acupuncturists offered free lessons to local medical workers who performed certain operations using acupuncture anaesthesia.³² The provision of free acupuncture lessons went simultaneously with the establishment of acupuncture departments in some government hospitals in some African countries, including; Tunisia, Cameroon, Lesotho, Namibia, and Madagascar.³³ In the 1990s and 2000s, the Chinese introduced an acupuncture course in some African universities such as Conakry University of Guinea, Universidade Eduardo Mondlane of Mozambique, and Madagascar State Public Health School.³⁴ A milestone for training TCM courses to African doctors was reached in 2000 following the inauguration of a Forum for China Africa Cooperation (FOCAC). The first FOCAC meeting held in Beijing came up with a declaration

²⁹ See, for instance, Stacey A. Langwick, “Articulate(d) Bodies: Traditional Medicine in Tanzanian Hospital,” *American Ethnologist* 35, no. 3 (2008): 428.

³⁰ The reasons why patients in Africa adopted medical pluralism while abstaining from “knowing” their philosophies have been discussed at length in Murray Last, “The Importance of Knowing About Not Knowing,” *Social Science Medicine* 15B (1981): 390.

³¹ Jennings, “Chinese Medicine and Medical Pluralism,” 467.

³² Zheng Yang, “Doctors Bridging Borders: Chinese Doctors Working in Africa Build Cultural Bridges,” (Aug. 2013): 51.

³³ Li Anshan, “From ‘How Could’ to ‘How Should’: The Possibility of a Pilot U.S.-China Project in Africa,” in *China’s Emerging Global Health and Foreign Aid Engagement in Africa*, ed. Xiaoqing Lu Boyton (Washington: Centre for Strategic and International Studies, CSIS, 2011), 42.

³⁴ Li, “From ‘How Could’ to ‘How Should,’” 42.

which, among others, suggested the convocation of the China-Africa Forum on Traditional Medicine and adoption of the Action Plan for the cooperation of traditional medicine between China and African countries.³⁵ The convocation was partly used as a bridge to pass TCM knowledge on to African countries through provisions of scholarships for TCM courses in China and promotion of TCM clinics in Africa. The available evidence generally shows that from the 1960s to 2010, Chinese TCM colleges admitted more than 1,000 African students.³⁶

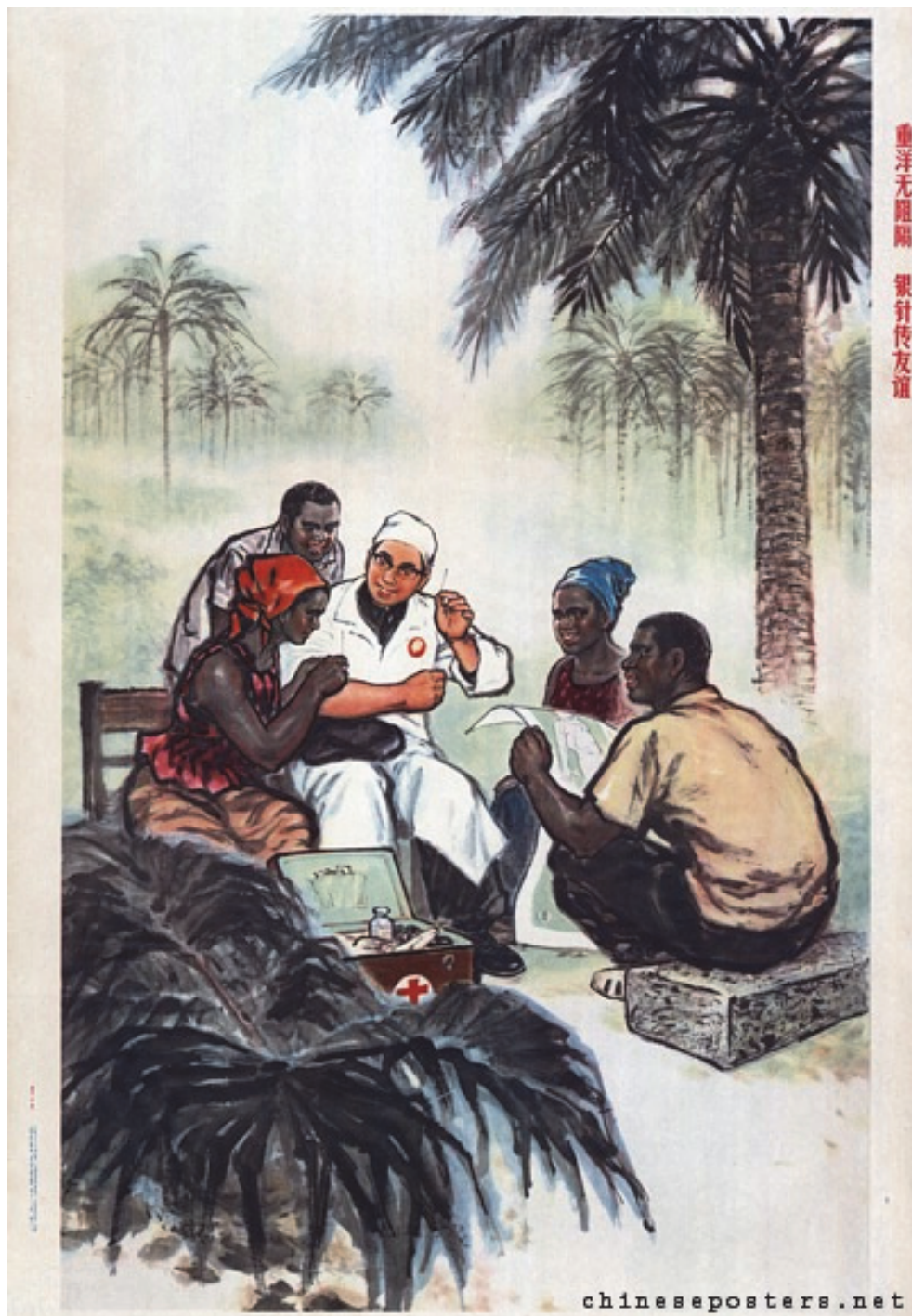
Furthermore, TCM knowledge spread widely and became practised in 183 countries, according to China's 2016 White Paper on the Development of Traditional Medicine. Information by the World Health Organization (WHO) states that about 103 states received international approval to practice acupuncture and moxibustion therapies. Its access to insured patients also progressed since about 18 countries included acupuncture and moxibustion treatment in their medical insurance up to December 2016. The formal training in medical colleges out of China has also had progressive feedback, as more than 30 countries have opened TCM schools to train local TCM practitioners.³⁷

³⁵ Goldon C. Shen and Victoria Y. Fan, "China's Provincial Diplomacy to Africa: Applications to Health Cooperation," *Contemporary Politics* 20, no. 182, (2014): 202, <https://dx.doi.org/10.1080/13569775.2014.907993>.

³⁶ Mu Xueguan, "China's Medical Team in Morocco Runs Free Clinic for Local Chinese," *Xinhua News*, June 18, 2015.

³⁷ The State Council Information Office of the PRC, *A White Paper*, 11.

Figure 14: Chinese propaganda poster of 1971 depicting “friendly” communication of acupuncture knowledge in Africa



Source: Stefan R. Landsberger, and International Institute of Social History, Amsterdam, *Chinese Propaganda Posters*, accessed May 1, 2020, <https://chinese posters.net/>.

4.3 Emergence, Spread and Practice of Traditional Chinese Medicine in Tanzania

The spread of acupuncture in Africa is really closely related to CMT [sic]. Wherever there is a CMT, even if only one medical point with two persons, one of them must be a doctor of acupuncture.³⁸ Wen Hong, a CMT in Cameroon.

The CMT program played a significant role in introducing and popularising acupuncture knowledge. The 2016 China's White Paper on the Development of Traditional Chinese Medicine shows that 10% of the CMTs dispatched to over 70 countries of Asia, Africa, and Latin America comprised TCM professionals.³⁹ Consistently, archival information shows that Chinese doctors have been practising TCM in Tanzania since 1968. The first batch of the CMT included three acupuncturists who worked in Tarime, Mtwara, and Mpwapwa hospitals.⁴⁰ Approximately, every batch of CMT included three or more acupuncturists. In the 1970s, the number of acupuncturists dispatched to Tanzania increased from three of 1968–70 to six in 1971–73. From 1973, the number of acupuncturists sent to Tanzania remained constant around six up to 1978.⁴¹ The increase in the number of acupuncturists went hand in hand with the spread of its services in different places of Tanzania (Table 9). The reasons for this increase were associated with positive perceptions by Tanzanian patients and the Chinese government endeavour to extend TCM knowledge to countries of the South.⁴² However, from 1979 onwards, following the reform and opening-up policy, the number of acupuncturists sent to Tanzania declined to two.

Acupuncture therapy was not swiftly introduced in Tanzania. In the beginning, local medical workers, political elites, and patients had doubts about its efficacy. However, under close persuasion of the Chinese government and the determination of acupuncturists, the therapy began as a trial for a few patients in the 1968 and 1969. Its reception convinced the

³⁸ Li, *Chinese Medical Cooperation in Africa*, 18.

³⁹ The State Council Information Office of the PRC, *A White Paper*, 12.

⁴⁰ "Medical Aid to Tanzania, 1968," SPA. File No. A034-03-006, Shandong Province Health Bureau.

⁴¹ "List of Names of Doctors of the Chinese Medical Team, July 1, 1972," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5; "Technical Assistance China, Medical Aid to Tanzania, Statistics from 1968-1985," SPA. File No. A034-05-366, Shandong Province Health Bureau, Foreign Affairs Office; "Muhtasari wa Mkutano wa Ndugu L. D. Stirling Waziri wa Afya na Madaktari wa Kichina Uliofanyika Tarehe 25 Agosti 1976 Saa 5:30-6:15 Adhuhuri Katika Ukumbi wa Chumba cha Mkutano Wizara ya Afya, Dar es Salaam, Tarehe 7 September, 1976," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5, Technical Assistance China; "Madaktari toka China watambulishwa kwa Waziri wa Afya," *Uhuru*, Agosti 26, 1976, 5.

⁴² Interview by Andrea Kifyasi with Paolo Peter Mhame, May 9, 2018, Dar es Salaam. Mhame is a Director, Department of Traditional and Alternative Medicine in the Ministry of Health.

Chinese government to deploy more acupuncturists to Tanzania beginning in 1971.⁴³ Available workload statistics show that from June 1973 to September 1975, acupuncturists attended to about 36,125 patients. The number of attended patients decreased in 1976, when 10,510 patients were attended. Nevertheless, the number soared in the following years as 36,290 patients were attended in 1977, and about 14,760 patients received acupuncture therapy in 1978. The decline in the number of acupuncturists sent to Tanzania from 1979 resulted in the decline of the number of patients attended. Statistics show that about 2,336 and 1,334 patients were attended in 1982 and 1983, respectively.⁴⁴

Table 9: Distribution of Acupuncturists to Different Working Stations in Tanzania, 1968 to 1985

Years	Number of Acupuncturists	Working Stations
1968–1970	3	Tarime, Mtwara, Mpwawa
1971–1973	6	Morogoro, Kondoa, Tabora, Bukoba, Mtwara, Nachingwea
1974–1975	6	Dodoma, Tabora, Kasulu, Maswa, Morogoro, Mtwara
1976–1978	6	Dodoma, Maswa, Tabora, Kasulu, Morogoro, Mtwara
1979–1982	2	Muhimbili, Dodoma

Source: Created by the author based on data from SPA. File No. A034-05-366, Shandong Province Health Bureau, Foreign Affairs Office.

The above statistics show that from the 1970s, patients perceived the practice of acupuncture therapy positively. Some patients wrote appreciation letters to the Chinese Embassy and Tanzania’s Ministry of Health.⁴⁵ Appreciations went further requesting the dispatch of more TCM experts in the country. Part of the letter sent to the Chinese Embassy by one patient read:

In July 1973, I came to your office inquiring about the famous Chinese “ACUPUNCTURE” treatment for my partially paralyzed right leg after an accident while playing six years ago. I then met Mr Cheng, the Medical Team Manager and also was checked by your physician Dr Leo in Dar es Salaam and they referred me to your medical team in Tabora. I took Acupuncture treatment in Tabora from Dr Lai for a period of three months, and there has been lots of improvement. I can now lift my leg, walk without a stick and I can also drive a

⁴³ “Medical Aid to Tanzania, Work Reports, Job Descriptions and Distribution Table, 1975,” SPA, File No. A034-04-085, Shandong Province Health Bureau, Revolutionary Committee, Policy Office.

⁴⁴ “Medical Aid to Tanzania, Statistics from 1968-1985,” SPA. File No. A034-05-366, Shandong Province Health Bureau, Foreign Affairs Office.

⁴⁵ Appreciation letters were found in TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China. Read, for instance, a letter from Mr. Raza A. Fazal to the Chinese Embassy in Dar es Salaam, of January 2, 1974.

car. During the treatment of three months, four times I went to Bukoba on leave and my family as well and the whole town was surprised at the quick recovery every time I went there. They were all curious and asked me a lot of questions about this treatment [. . .] When I returned at least 12 patients contacted me and would like to take this treatment. I also wish to point out that in Bukoba we have many polio cases and once I have taken this treatment other people will also take the same treatment without hesitation. I am, therefore, requesting you to see if Dr Lai together with a Chinese Medical Team can be stationed in Bukoba. I am sure that the town will appreciate very much the services of your doctors.⁴⁶

The above-quoted accounts from Raza A. Fazal reveal how patients attended by Chinese acupuncturists turned ambassadors, spread news about the efficacy of acupuncture therapy in their respective communities. Similar experiences were reported in many parts of Tanzania. For example, patients from Kasulu-Kigoma, Western Tanzania, reported positively on the Chinese medical interventions regarding the treatment of polio. According to archival information, there were many polio cases in Kasulu throughout the 1970s, which led to the establishment of a special acupuncture centre to tackle the disease. The archival information shows that many patients overcame polio after receiving acupuncture therapies. For instance, a four-year-old child who became paralysed when he was two years old was cured by acupuncturists within three months of the treatment. Similarly, in 1983, a three-year-old child with congenital paralysis was cured after three weeks of attendance at the acupuncture clinic at Muhimbili National Hospital.⁴⁷

Unlike other surgeries, acupuncture surgical treatment is simple but effective. Patients postulated that they could not feel pains when doctors inserted acupuncture needle(s) on their bodies. Furthermore, on some occasions, patients were allowed to eat and drink water, and talk to doctors and their relatives during and/or immediately after the surgery.⁴⁸

Affirmative acceptance of acupuncture treatment influenced local government authorities' requests of acupuncturists in their district hospitals. For instance, the development director of Western Lake Province wrote a letter to the regional medical officer requesting the officer to send a special request to the Ministry of Health (MoH) for the dispatch of

⁴⁶ "Letter from Mr. Raza A. Fazal to the Chinese Embassy in Dar es Salaam, January 2, 1974," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China.

⁴⁷ "Medical Aid to Tanzania, 1975 Work Reports, Job Descriptions and Distribution Table," SPA. File No. A034-04-085, Shandong Province Health Bureau, Revolutionary Committee, Policy Office; "Work Report of 1983," SPA. File No. A034-06-309, Shandong Province Health Bureau, Foreign Affairs Office.

⁴⁸ "Medical Aid to Tanzania, 1975 Work Reports, Job Descriptions and Distribution Table," SPA. File No. A034-04-085, Shandong Province Health Bureau, Revolutionary Committee, Policy Office.

acupuncturists to Bukoba.⁴⁹ The afore-mentioned popularity of acupuncture was, however, not limited to Tanzania. Elsewhere in Africa, acupuncture was credited and endorsed as alternative medicine. In Algeria, for instance, patients perceived acupuncture as an alternative to musculoskeletal health cases which were not efficiently addressed by biomedicine.⁵⁰ This indicates that many patients did not perceive biomedical knowledge as entirely capable of diagnosing and addressing all kinds of health issues since some ailments were perfectly diagnosed and treated by traditional medicines already abundant in Southern countries.⁵¹

The practice and popularity of TCM in Tanzania continued throughout the 1960s, and until the 1980s, but got negatively affected by the liberalisation policies of the 1990s. In 1993, the Bretton Woods Institutions (BWIs) forced the Tanzanian government to adopt a cost-sharing policy in private hospitals and clinics (Chapter 3).⁵² Under the new health policy, patients attended by Chinese acupuncturists and local doctors paid for the services. The implementation of the policy negatively affected low-income patients, who had enjoyed free health services before the 1990s. However, it also led to the establishment of private TCM clinics in major towns and cities of Tanzania. Thus, many patients attended privately established TCM clinics which offered cheaper services than government hospitals.⁵³ However, Elisabeth Hsu noted that an acupuncturist working at Muhimbili National Hospital did not get enough patients to attend in the 1990s. She argued: “Evidently, the socialist fervour with which acupuncture once used to be promoted had cooled down.”⁵⁴

Although the popularity of TCM first developed in public health facilities as indicated above, I argue that the popularity and practice of acupuncture in Tanzania from the 1990s onwards did not diminish as it was cheaply practised in private health centres. Under the cost-sharing policy, patients attending government hospitals paid for the registration fee,

⁴⁹ “Letter from Mkurugenzi wa Maendeleo, Ziwa Magharibi, to Bwana Mganga, Bukoba, January 18, 1974, Utabibu wa ‘Acupuncture’”, TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China.

⁵⁰ Li, *Chinese Medical Cooperation in Africa*, 18.

⁵¹ The limitations of biomedicine have been elaborated at length by Lock and Nguyen, *An Anthropology of Biomedicine*, 53-54.

⁵² JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. Amrani H. Mayagila, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1993/94*, 53; Mboya S. D. Bagachwa, *et al*, *Structural Adjustment and Sustainable Development in Tanzania* (Dar es Salaam: Dar es Salaam University Press, 1995), 66; Biplab Dasgupta, “SAPs: Issues and Conditionalities: A Global Review,” *Economic and Political Weekly* 32, no 21/22 (May, 1997): 1097.

⁵³ Interview by Andrea Kifyasi with Liggyle Vumilia, May 7, 2018, Former Ministry of Health Headquarters, Dar es Salaam. Vumilia is a Coordinator, Department of Traditional and Alternative Medicine, Ministry of Health; Hsu, “The Medicine from China has Rapid Effects,” 299.

⁵⁴ Hsu, “Medicine as Business,” 223.

consultation fee, and costs for prescribed medicines (Chapter 3). To persuade patients, TCM practitioners lowered largely the fees charged to patients in their clinics. For instance, they waived costs related to registrations and lowered those for consultations and medicines.⁵⁵ While TCM practitioners charged Tshs. 2500 for malaria dose, the licensed pharmacy sold a similar dose for Tshs. 6,000.⁵⁶ Additionally, while TCM clinics waived registration fees, government hospitals charged Tshs 1,000 for referral, 500 for regional and 300 for district hospitals.⁵⁷ Edmund Kayombo, who is also the chairperson of the Traditional and Alternative Health Practice Council, argued that TCM clinics offered cheap health services because, in the 1990s, no strict laws were forcing TCM practitioners to register their clinics and pay taxes to the government. This context illuminates why TCM clinics vanished after the Tanzanian government passed the Traditional and Alternative Medicine Act in 2002, which, among other issues, obliged registration of the services and annual fees.⁵⁸ Generally, before the 2000s, patients, especially from low income and ordinary families, preferred attending TCM clinics to government hospitals. The Chinese acupuncturists who worked in Tanzania for several decades created a fertile ground for the favourable acceptance of TCM clinics.

Chinese acupuncturists did not only offer clinical care but also spread TCM knowledge to the local medical workers through on-site training. Despite a limited number of acupuncturists, their role in communicating acupuncture knowledge to local medical workers was commendable. Chinese acupuncturists persuaded many Tanzanians to learn and practise acupuncture therapies. From the 1970s, at least every week, they allocated time to offer free acupuncture training to local medical workers.⁵⁹ Furthermore, a three- to four-month acupuncture-training course was provided in Kasulu, where acupuncturists under cooperation with the MoH established a training centre (Figure 15). In 1975, for instance, about 33 local medical doctors received acupuncture training in Kasulu.⁶⁰ Training local medical workers did

⁵⁵ Jennings, “Chinese Medicine and Medical Pluralism,” 463.

⁵⁶ Hsu, “The Medicine from China Has Rapid Effects,” 304.

⁵⁷ “Principal Secretary, Ministry of Health, Wananchi Kuchangia Huduma za Jamii, Afya, Muhtsari wa Mapendekezo ya Viwango na Maeneo ya Kuchangia, July 1, 1993,” MRC. Acc. No. 30, File No. M.10/1/3, Medical Policy and Instructions General, 1990-2004.

⁵⁸ Interview by Andrea Kifyasi with Edmund J. Kayombo, June 8, 2018, Institute of Traditional Medicine (ITM). Kayombo is a Chairperson of the Traditional and Alternative Health Practice Council of Tanzania and a senior researcher at the Institute of Traditional Medicine of the Muhimbili University of Health.

⁵⁹ Interview by Andrea Kifyasi with Sui Guangxin, March 1, 2016, Jinan. Sui was a Director of a Provincial Hospital and a CMT member from 1995-1997; Chen Zhufeng, March 1, 2016, Jinan. Chen was a Director of Qianfon Mountain Hospital and a CMT member from 2003-2005 and 2007-2013.

⁶⁰ “Medical Aid to Tanzania, 1975 Work Reports, Job Descriptions and Distribution Table,” SPA. File No. A034-04-085, Shandong Province Health Bureau, Revolutionary Committee, Policy Office.

not only enable them to address ailments through acupuncture therapy but also spread Chinese medical culture in the country.

Figure 15: Acupuncture training to local doctors in Kasulu District, 1975



Source: Health Department of the Shandong Province, *The Chinese Medical-Aid Team in the United Republic of Tanzania, 1968–1998* (Shandong, 1998), 74.

While I contended in Chapter four that Chinese medical doctors did not prioritise the training of local doctors, I argue differently for the case of acupuncturists. Their commitment to spreading TCM knowledge stemmed from the fact that TCM drew its background from the Chinese medical philosophy which Chairman Mao vowed to preserve and spread to the rest of the world. Li Anshan states that the advantage which the Chinese government expected from the CMT program was to introduce and spread TCM to recipient countries.⁶¹ The devotion of Chinese acupuncturists in training local doctors in Tanzania was commendable. Li adds that in the 1970s, Tanzanian trainees were allowed to practice on bodies of Chinese acupuncturists and to patients under the supervision of their trainers (Figure 16).⁶²

⁶¹ Li, *Chinese Medical Cooperation in Africa*, 18.

⁶² Li, *Chinese Medical Cooperation in Africa*, 20.

Figure 16: An acupuncture trainee practicing the therapy in Kasulu District, 1975



Source: Health Department, *The Chinese Medical-Aid Team*, 74.

In addition to on-site training, Tanzanians received Chinese government sponsorships for both long and short-term studies to different TCM colleges in China. For instance, from October 1975 to January 1976, 5 Tanzanian medical workers secured three months of training sponsorships about replantation of severed limbs and acupuncture treatment in China. Three doctors (P. M. Sarungi, William Ng’ombe, and Moses Ndosi) registered for a replantation course, two (Hatibu Lweno and Fabian Hoti), admitted for acupuncture.⁶³ The two courses aimed at enabling trainees to acquire new medical knowledge and practice them in Tanzania.

While the Chinese government sponsorship training on acupuncture to Tanzanians sounds altruistic, it gave China an inexpensive opportunity to spread TCM knowledge in the

⁶³ “Letter from the office of the Embassy of the People’s Republic of China in the United Republic of Tanzania, March 8, 1977 to the Principal Secretary of the MoH,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China; “A Report About a Study tour Prepared by Dr P. M. Sarungi, Dr Moses Ndosi, and Dr William Ng’ombe, Our Study Tour on Replantation of Severed Limbs in the People’s Republic of China, October 1975-January, 1976, of January, 1976,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China.

country and establish a market for TCM clinics set up in later years.⁶⁴ Similarly, the spread of acupuncture treatment in Tanzania was an opportunity for China to enhance the market for TCM equipment and drugs. For instance, in 1976, following the completion of training in acupuncture by Tanzanian medical staff, the Chinese government gave the MoH two sets of microsurgical instrument and acupuncture therapy apparatuses.⁶⁵ The donated equipment was necessary for the practice by the medical staff who completed their training. However, more medical equipment was needed, so the Chinese government recommended the MoH to purchase equipment worth £2,200 to enable local acupuncturists to have a complete set of equipment for their practice. The ministry, however, was sceptical of implementing the suggestion. The statement from the ministry showed that it was not sure whether three months of training acquainted trainees with enough medical knowledge to use the equipment correctly.⁶⁶

It is, however, important to note here that campaigns advocating the use of TCM were not restricted to Tanzania but covered many countries of the Global South. The comprehensive promotion of traditional medicine to countries of the Global South in the 1970s gave TCM a chance to penetrate further in Southern countries. During this period, international agencies sponsored medical workers from the South to undertake TCM training in Beijing. In September 1972, the United Nations Development Programme (UNDP) signed the “Basic Agreement” with China, in which it committed to funding projects related to health-manpower development, medical information, traditional medicine, pharmaceutical standards, and primary health care (PHC). The UNDP promoted the South-South exchange of traditional medicine knowledge and effective use of herbal plants to address health challenges.⁶⁷ The PHC and traditional medicine projects funded by the UNDP since 1972 became the basic health theme at the Alma-Ata conference of 1978, which promoted the realisation of the “Health For All” agenda by 2000. Given its long history, TCM and especially its acupuncture and

⁶⁴ Interview by Andrea Kifyasi with Liggyle Vumilia, May 7, 2018, Dar es Salaam.

⁶⁵ “Letter from the office of the Embassy of the People’s Republic of China in the United Republic of Tanzania, March 8, 1977 to the Principal Secretary of the MoH,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China.

⁶⁶ “Letter from the Embassy of the United Republic of Tanzania, Peking China to the Minister of Health, March 16, 1976”; also “Letter from the office of the Principal Secretary, Ministry of Health, April 9, 1976 to Dr P. M. Sarungi, Senior Lecturer and Consultant Orthopaedic Surgeon, Mhimbili Hospital, Vyombo vya Kupasulia kutoka Uchina,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China.

⁶⁷ Yanzhong Huang, “Pursuing Health as Foreign Policy: The Case of China,” *Indiana Journal of Global Legal Studies* 17, no. 1 (Winter, 2010): 110.

moxibustion therapies were endorsed by the UNDP as essential medical knowledge to be communicated to medical doctors of the South.⁶⁸

Although by the 1970s acupuncture was practised in many parts of the world, the UNDP recommended China as a right place for training due to its longstanding practical history. Moreover, outside China, TCM was relatively little practised and few opportunities for studying it existed. Accordingly, China's Ministry of Public Health organised a TCM course in collaboration with the UNDP with the WHO as executing agency.⁶⁹ It is not clear why the WHO promoted TCM training in Global South countries. However, plausible reasons include the existence of many health challenges and disease burden among countries of the South. TCM and especially acupuncture therapy would efficiently address some of such diseases. Moreover, according to David Wondering, acupuncture therapy was cheaper and less demanding in treating the ailments compared to biomedicine. It demanded fewer and cheaper medical equipment and drugs.⁷⁰

The UNDP funded both short- and long-term acupuncture courses, which were arranged under China's Ministry of Public Health through the Academy of Traditional Chinese Medicine in Beijing. TCM institutions from other cities such as Nanjing, Shanghai, and Guangzhou contributed to the training programme, in particular by giving participants a chance to study the practical application of the techniques in rural areas. The training combined theory with practice and stressed the latter.⁷¹ The courses aimed to enable trainees to understand the background of traditional Chinese medicine with the emphasis on acupuncture and moxibustion with in view the practical application of the techniques of treatment in their countries. It further aimed to provide the basic theory of acupuncture and moxibustion in treatment and give practical training in the techniques of needle manipulation and moxibustion through lectures, demonstrations, and practice in specialised institutions, hospitals, and rural

⁶⁸ See, WHO, *Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978*, 63; "Letter from the UNDP Office, 14 April, 1977 to the Principal Secretary Ministry of Health, Multi-Regional Study Tours and Courses in China, 1977-78," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China.

⁶⁹ "United Nations Development Programme, Project of the Governments of Training Course on Acupuncture Treatment, 17/11/1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China.

⁷⁰ WHO, *The Promotion and Development of Traditional Medicine: World Health Organization Technical Report Series 622* (Geneva, 1978), 30; David Wondering, "Acupuncture in Mainstream Health Care," *British Medical Journal* 333, no. 7569 (23 September 2006): 611.

⁷¹ "United Nations Development Programme, Project of the Governments of Training Course on Acupuncture Treatment, 17/11/1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China.

health facilities in different parts of China.⁷² Tanzania, like many other countries of the South, benefited from UNDP sponsorship, and its medical doctors attended both short- and long-term training programs. The backing of TCM training by international agencies did not only legalise its practice but also spread to countries of the South. Additionally, endorsement of the training signalled global acceptance of TCM knowledge.

Generally, from 1968 through the 1990s onwards, the main sponsors of TCM training to Tanzanians were the Chinese government and the UNDP. Local initiatives to spread TCM knowledge started in the 2000s. The Department of Traditional and Alternative Medicine (DTAM) under the MoH proposed to establish a school for alternative healing mechanisms. Acupuncture and moxibustion were among its prioritised courses.⁷³ Similarly, local TCM practitioners showed interest in communicating TCM knowledge to Tanzanians. For example, doctor Rajabu Bakari Mbilo, who also attended a five-year (1989 to 1994) TCM course specialising in acupuncture, moxibustion, and mesotherapy in Beijing, showed interests to establish a TCM college in Tanzania. Mbilo also owned a clinic and had offered TCM services in the country since March 1995.⁷⁴ DTAM and local acupuncturists endeavoured to transmit acupuncture knowledge to a more significant number of Tanzanians who missed sponsorship opportunities from the Chinese government. Unfortunately, for unknown reasons, the aspirations of establishing colleges for traditional medicine did not materialise.

The 2000s further witnessed the engagement of some non-governmental organisations (NGOs) in spreading TCM knowledge, especially acupuncture therapy. Furaha, an osteopathy non-profit organisation, invited two Italian acupuncturists to train local medical doctors in Ilula-Iringa, Tanzania. Italian acupuncturists belonged to the group of Agopuntura Senza Frontiere (ASF)/Acupuncture Without Borders. The doctors trained about twelve local medical doctors within nine days and awarded them certificates.⁷⁵ It is not clear whether the nine days' training course was sufficient for the trainees to practice the acquired medical knowledge.

⁷² "United Nations Development Programme, Project of the Governments of Training Course on Acupuncture Treatment, 17/11/1977," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China.

⁷³ "URT, MoH, The Proposal of Establishing a School for Alternative Healing Mechanisms in Tanzania, February 10, 2000," NRC. Ministry of Health and Social Welfare, 14/6/03, File Ref. No. HF. 458/615/01 Traditional Medicine Research 2004-2009.

⁷⁴ "Letter from Dr Mbilo of November 22, 2004 to Permanent Secretary MoH, Maombi ya Kufungua Chuo cha Mafunzo ya Uganga wa Tiba Asilia," NRC. Ministry of Health and Social Welfare, 14/5/02, File Ref. No. HF. 207/615/01 "A", Traditional Medicine 2005-2008.

⁷⁵ Elisa Rossi, "Chinese Medicine in Ilula Tanzania: An Experience in Learning," *The European Journal of Oriental Medicine*, (January 2012): 27. (26-31.)

Largely, this shows that although traditional methods of treatment were specific to particular communities, a therapy like acupuncture was used globally, and its core was understandable to anyone. Its medical knowledge was not spread by Chinese acupuncturists alone but by other nationals as well such as the Italians. The Italian acupuncturists attended formal training for more than five years, yet and surprisingly they confidently believed that Tanzanian trainees would get acquainted with sufficient acupuncture knowledge within nine days.

I argue that the training arrangements provided by Chinese acupuncturists, the UNDP, and other stakeholders did not help trainees acquire sufficient TCM knowledge to practice effectively and sustainably. By contrast, a study by Li shows that acupuncture therapy was extensively practised by local doctors in government hospitals in Tunisia, Cameroon, Lesotho, Namibia, and Madagascar. The countries mentioned established acupuncture departments in government hospitals that admitted a larger number of patients.⁷⁶ Findings from Tanzania yielded contested results. Despite the efforts invested by Chinese acupuncturists and support initiatives by the Chinese government through scholarships, the practice of acupuncture by local medical doctors in government hospitals was less or not executed at all. Information from the MoH suggests that local doctors favoured biomedicine over TCM. For instance, the two Tanzanian doctors, Hatibu Lweno and Fabian Hoti, each having attended an acupuncture-training course in 1976, did not practise it. Instead, a few months after completion of the acupuncture course in Beijing, they joined Muhimbili Medical College for further studies in biomedicine.⁷⁷

This study further showed that Tanzania's MoH lacked aid use strategy. The ministry sent medical doctors for overseas training without creating favourable plans or conducive environments for trainees to apply the learned medical knowledge after completion of their courses. As shown above, the Chinese government was determined to see the actual practice of TCM medical knowledge by the trainees. It granted Tanzania's MoH two sets of a microsurgical instruments and acupuncture therapy apparatuses for use by the trained medical personnel.⁷⁸ However, Tanzania's MoH did not purchase further equipment as suggested by

⁷⁶ Li, *Chinese Medical Cooperation in Africa*, 19.

⁷⁷ "Letter from the Office of the Principal Secretary, Ministry of Health, April 9, 1976 to Dr P. M. Sarungi, Senior Lecturer and Consultant Orthopaedic Surgeon, Muhimbili Hospital, Vyombo vya Kupasulia kutoka Uchina." TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China.

⁷⁸ "Letter from the office of the Embassy of the People's Republic of China in the United Republic of Tanzania, March 8, 1977 to the Principal Secretary of the MoH," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China.

the Chinese government to enable trainees to practice despite the reminders by Tanzania's Ambassador to China and the trainees.⁷⁹ This circumstance shows that the MoH was hesitant to allow its medical staff to practice TCM in its government-owned hospitals. Gallus Namangaya Abedi, a retired Principal Assistant Secretary of the MoH, claims that some officers in the ministry perceived medical knowledge of Chinese origin as inferior compared to biomedicine. Additionally, Abedi opined that such stereotype was among other reasons which impeded the practice of TCM by the trained medical workers.⁸⁰

Nevertheless, negative perceptions over Chinese medical knowledge by some officers in the MoH does not invalidate the claim that local medical staff received insufficient training which did not equip them with useful medical knowledge to attend patients effectively. A Chinese acupuncturist's oral testimony revealed that acupuncture knowledge was complicated and required a trainee to fully acquire both physical and sensory skills which could not be studied adequately within three months or on site.⁸¹ Training for a fully qualified TCM expert takes up to five years in China to achieve Doctor of Medicine (MD) qualifications. The Chinese government summarised the training to three months or less, which did not work in practice for Tanzania's medical workers.

The failed practice of acupuncture by local medical doctors in Tanzania was noted with frustration by the Chinese government. In her visit to China on October 17, 2004, the Minister for Health, Anna M. Abdallah had to commit that her ministry would promote the practice of acupuncture to regions and hospitals where the CMTs worked. However, its implementation was less promising as local medical workers were unable to apply TCM knowledge to patients. For example, the regional medical officer of Tabora requested further TCM training of his medical workers to implement directives from the ministry.⁸² Thus, despite affirmative acceptance by patients, the practice of acupuncture therapy in government hospitals by local medical doctors remained minimal. From the 1990s on, traditional Chinese herbal

⁷⁹ "Letter from the Embassy of the United Republic of Tanzania, Peking China to the Minister for Health, March 16, 1976," also see "Letter from the office of the Principal Secretary, Ministry of Health, April 9, 1976 to Dr P. M. Sarungi, Senior Lecturer and Consultant Orthopaedic Surgeon, Mhimbili Hospital, Vyombo vya Kupasulia kutoka Uchina," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5: Technical Assistance China.

⁸⁰ Interview by Andrea Kifyasi with Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam.

⁸¹ Interview by Andrea Kifyasi with Jiang Xuan, January 4, 2016, Hangzhou.

⁸² "Letter from Regional Medical Officer, Tabora, September 9, 2005 to the Principal Secretary MoH, Maeneo Mhimu ya Makubaliano Yaliyofanyika wakati wa Ziara ya Waziri wa Afya, Mhe. Anna M. Abdallah Nchini China Tarehe 17/10/2004 Hadi 27/10/2004," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008.

medicine and acupuncture were mostly practised in private-owned clinics by both Tanzanian and Chinese doctors. Yet, Tanzania's historical therapeutic heritage remained stronger and sought by many patients.

4.4 China's Role in Global Health: HIV/AIDS TCM Research and Treatment in Tanzania, 1987–2014

Global-health interventions have been empowered by faith in the superiority of western medical knowledge and technology and a devaluing of the knowledge and abilities of the local populations.⁸³ Randall M. Packard (2016).

From the preceding quotation, it is pertinent to mention that although more than forty years have passed since the 1978 endorsement of traditional medicine by the Alma-Ata Declaration, little has changed. Global health interventions still lean much more on biomedicine than on traditional treatments, and the latter is still less studied.⁸⁴ Similarly, contributions of Southern countries in fighting pandemic diseases such as HIV/AIDS have hardly been uncovered. In contrast, extensive research has been carried out on the roles of traditional partners in global health campaigns, such as the USA, the European Union (EU), the WHO, the World Bank, and the Bill and Melinda Gates Foundation.⁸⁵ The dearth of research related to contributions of Southern countries into global health created the impression that countries of the South had nothing or little to offer to global health challenges. Yet, very little is currently known about China's multilateral engagement in global health from the turn of 21st century onwards, leaving its bilateral health projects unattended.⁸⁶ This section neither intends to undermine the roles of traditional global health partners; nor does it seek to glorify the roles of Southern countries in the fight against pandemic diseases. It, however, advances scholarly attention and discussion on how some Southern countries engaged in the fight against

⁸³ Randall M. Packard, *A History of Global Health: Interventions into the Lives of Other Peoples* (Baltimore, MD: Johns Hopkins University Press, 2016), 9.

⁸⁴ WHO, *Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978*, 63.

⁸⁵ Read, for instance, Amy S. Patterson, *Africa and Global Health Governance: Domestic Politics and International Structures* (Baltimore, MD: Johns Hopkins University Press, 2018); Packard, *A History of Global Health*; John Iliffe, *The African AIDS Epidemic: A History* (Athens: Ohio University Press, 2006).

⁸⁶ Stephen J. Morrison, "The Prospects for Engaging China with Global Health Issues," in *China's Capacity to Manage Infectious Diseases: Global Implications*, ed. Charles W. Freeman and Xiaoqing Lu (Washington: Centre for Strategic and International Studies, 2009); L. H. Chan, P. K. Lee and G. Chan, "China Engages Global Health Governance: Processes and Dilemmas," *Global Public Health* 4, no. 1 (January 2009): 1-30, <https://dx.doi.org/10.1080/17441690701524471>.

deadly diseases such as HIV/AIDS, tuberculosis, smallpox, malaria, Ebola, and the like, using the HIV/AIDS TCM research and treatment in Dar es Salaam, Tanzania as a case study.

4.4.1 The HIV/AIDS Pandemic and the Emergence and Perception of the TCM Clinic

The HIV/AIDS pandemic posed one of the greatest challenges to global health, drawing the world's attention through its rapid spread. Recognising the disease as a serious threat to global health in the 1980s, the WHO prioritised the fight against it. Due to the increasing integration of the world's population, HIV/AIDS spread across the globe at an alarming pace. Yet, AIDS had apparently spread silently from the mid-1970s until 1981 when the first cases were diagnosed in the US. From there on, reports of AIDS patients increased rapidly from different corners of the world.⁸⁷ Sub-Saharan Africa was the world's most severely affected region. By the 2000s, it was home to only 10% of the world's population, yet by 2015, an estimated 36.9 million persons were living with HIV, with over 70% of those individuals located in the region.⁸⁸ Before the turn of the millennium though, in 1983, a surgeon in the Kagera Region of Northwestern Tanzania had recorded Tanzania's first AIDS case. The region was more severely affected than other regions of Tanzania (Table 10). In the 1990s, the region reported about 16% of all deaths while other regions reported less than 3%.⁸⁹ From Kagera, the disease spread to different regions of Tanzania. Up to 1990, about 15,227 Tanzanians died of AIDS, and about 21,208 were identified living with HIV. In 1990, AIDS surpassed malaria as the leading killer among diseases in both adults and children in Tanzania.⁹⁰ Up to the present, the disease has rapidly spread throughout the country, affecting all categories of people in society.

Regrettably, the pandemic plagued the African continent amid a period of economic breakdown, thus many states were financially handicapped and could not afford to fight against the disease. On the other hand, international health agencies focused their attention on primary

⁸⁷ "Health Workers Training Modules on HIV/AIDS, Zanzibar AIDS Control Programme, Ministry of Health, Zanzibar, 1990," WHOA, File No. A20-370-32TAN-JKT1, GPA-Programme on Information, Education and Communication-Tanzania, 1995, 5; Packard, *A History of Global Health*, 273.

⁸⁸ Patterson, *Africa and Global Health Governance*, 32.

⁸⁹ World Bank Report, *Tanzania AIDS Assessment and Planning Study, June 1992*, iii; Maryinez Lyons, "Mobile Populations and HIV/AIDS in East Africa," in *HIV and AIDS in Africa* Ezekiel Kalipeni, *et al.* (Hoboken, NJ: Blackwell Publishers, 2005), 178.

⁹⁰ JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. Prof. Phillemon M. Sarungi, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1991/92*, 12; World Bank Report, *Tanzania AIDS*, iii.

health care (PHC) which had been endorsed by the 1978 Alma-Ata conference. HIV/AIDS was missing in the PHC priorities, and global health agencies perceived it as less dangerous.⁹¹ For instance, the Danish Director-General visited Lusaka-Zambia in September 1985 and warned: “[. . .] if African countries continued to make AIDS a ‘front-page’ issue, the objective of the ‘Health for All’ programs by the year 2000 would be lost [. . .] AIDS is not spreading like a bush fire in Africa. It is malaria and other tropical diseases that are killing millions of children every day.”⁹² His assertions were partly appropriate since malaria was indeed a threat to the continent. In Tanzania, for instance, malaria was the primary cause of deaths throughout the 1980s, accounting for about 10,000 deaths annually.⁹³

Table 10: List of AIDS cases and deaths in Tanzania, 1983–1986

Year	Total Cases	Deaths in Hospitals	Cases in Kagera Reg.	% of Total Cases in Kagera
1983	3	3	3	100
1984	16	16	16	100
1985	266	141	145	54.5
1986	654	170	509	78.0
Total	939	330	673	72.0

Source: “URT, MoH, AIDS Control Programme, Draft Proposal for a 5-Year Plan, 13 March, 1987,” WHOA, File No. A20-181-18-JKT1, TSA with the Ministry of Health and Social Welfare, National AIDS Task Force, Dar es Salaam, Tanzania, in Respect of Strengthening the National AIDS Prevention and Control Programme, 1989, 39.

In this vein, WHO officials dismissed AIDS assistance requests made by Uganda and Sierra Leone by the mid-1980s, claiming that “AIDS was of minor importance compared to other diseases such as malaria.”⁹⁴ It took until January 1986 for the WHO to recognise HIV/AIDS as a major public health concern. In May 1986, the World Health Assembly launched a special programme on AIDS that would later be named the Global Programme on AIDS (GPA). This programme was reconstituted in December 1995 as a new joint United Nations programme on HIV/AIDS (UNAIDS).⁹⁵ Under the GPA, HIV/AIDS was conceived as a behavioural problem caused by having sex with multiple partners and tied to cultural

⁹¹ Read Chapter 8 in Iliffe, *The African AIDS Epidemic*; also see Packard, *A History of Global Health*, 279; and in “WHO yataka Watu Waelimishwe Kuhusu AIDS,” *Uhuru*, Novemba 6, 1985, 5.

⁹² Quoted in Iliffe, *The African AIDS Epidemic*, 68.

⁹³ World Bank Report, *Tanzania AIDS*, 4.

⁹⁴ Packard, *A History of Global Health*, 279.

⁹⁵ WHO, *Global Strategy for the Prevention and Control of AIDS: Report by the Director General, 1988*, 6; Packard, *A History of Global Health*, 282.

practices such as polygamy. Thus, the GPA promptly transmitted behavioural and sex education, and distributed condoms to raise global awareness and reduce the pace at which the disease spread.⁹⁶

Tanzania, like many other African countries, tried several means to get rid of the disease. This included the use of local medical experts, who embarked on extensive research in both traditional medicine and biomedicine to find suitable drugs to cure the disease.⁹⁷ In May 1985, it formed a National AIDS Task Force (NATF) – later renamed the national AIDS Technical Advisory Committee (TAC) – to advise the government on control measures. From March 1987, the committee received financial and technical assistance from the WHO and other donor agencies which enabled the formulation of a medium-term plan (MTP) for dealing with the disease. The MTP aimed to monitor the progression of the disease, decrease the transmission by blood transfusion, reduce mother-to-child transmission, improve diagnostic capabilities, and decrease transmission through education.⁹⁸ These activities were to a large extent undertaken by the National AIDS Control Program (NACP), which was officiated in 1988. Under its four technical units, the NACP dealt with prevention, diagnosis, and research.⁹⁹ The government endeavoured to succeed in the fight against the disease. However, up to the moment when it requested assistance from the Chinese government, the fight against HIV/AIDS had not generated promising results. With the support from the WHO and other traditional donor countries of the North, medical experts in Tanzania were only able to identify affected patients, recognise the HIV/AIDS viruses, and decrease the pace of transmission. Yet, they were unable to treat the disease effectively. Moreover, treatments by both biomedicine and traditional Tanzanian medicine were provided for some opportunistic diseases such as tuberculosis, prolonged diarrhoea, and sexually transmitted diseases (STDs).¹⁰⁰ At this point, the Tanzanian government needed and welcomed support from countries with more advanced and promising medical knowledge to eliminate the disease.

⁹⁶ “MoH, Brief on the NACP,” WHO, File No. A20-370-1TAN-JKT4, GPA-Basic Operations-Tanzania, 1991, 11; “WHO yataka Watu Waelimishwe Kuhusu AIDS,” *Uhuru*, Novemba 6, 1985, 5; Shao, Maselle and Swai, “AIDS,” 14; WHO, *Global Strategy for the Prevention and Control of AIDS*, 5.

⁹⁷ J. Shao, S. Y. Maselle and R. O. Swai, “AIDS,” in *Health and Disease in Tanzania*, ed. G. M. P. Mwaluko, W. L. Kilama, M. P. Mandara, M. Murru, and C. N. L. Macpherson (London: Harper Collins Academic, 1991), 8.

⁹⁸ “URT, National AIDS Prevention and Control Programme, Medium-Term Plan, 15 Dec. 1987-14 Dec. 1988,” WHOA, File No. A20-370-1TAN-JKT1, GPA-Basic Operations-Tanzania, 1989, 3.

⁹⁹ World Bank Report, *Tanzania AIDS*, 136-137.

¹⁰⁰ “URT, MoH, National AIDS Control Programme and Budget for 1.9.1989 - 31.12.1991,” WHOA, File No. A20-370-1TAN-JKT2, GPA-Basic Operations-Tanzania, 1990, 24; Godfrey Mhando, “Historia ya Ugonjwa wa AIDS,” *Uhuru*, Oktoba 4, 1985, 4; Shao, Maselle and Swai, “AIDS,” 8.

The Tanzanian government requested Chinese assistance to fight the HIV/AIDS pandemic in March 1987, following Julius K. Nyerere's trip to China. The positive reputation of the Chinese doctors who had been working in the country since 1968, plus inadequate measures taken by the WHO and other traditional global health partners against the disease, prompted the government to turn to Chinese aid.¹⁰¹ Subsequently, the Chinese President, Deng Xiaoping, accepted the request of the government presented by Nyerere and promptly ordered the Ministry of Health to dispatch medical experts to the country and carry out an anti-HIV/AIDS research and treatment project using TCM. In the absence of therapeutics or a vaccine, Deng hoped traditional herbal medicines would provide an alternative solution to the virus.¹⁰² Indeed, the acceptance of the request rekindled hope that it would be possible to fight HIV/AIDS, since to combat the disease, Tanzania needed both financial assistance and medical knowledge. Moreover, to a large number of traditional medicine researchers and practitioners in the country, the use of traditional medicine was a promising attempt at effective knowledge exchange.

China's assistance for HIV/AIDS research to Tanzania came when its interest in Africa had lessened, following its reform and opening-up policy of 1978. During this period, policies and practices of assistance shifted, and the new relationship was one of investment and profit – the era of Mao and Zhou Enlai was over, even though the theme of “friendship” and the era of cooperation before 1980 were recalled strategically in diplomatic speeches.¹⁰³ Yet, it still became possible for the Chinese government to devote resources to research and treatment of the disease since the project held promising scientific, economic, and political potential for its government. Moreover, the long-term friendship between Nyerere and Deng influenced the Chinese government to accept Nyerere's request.¹⁰⁴ Consequently, in May 1987, Tanzanian and Chinese health authorities signed a cooperation agreement on researching and treating HIV/AIDS. The Chinese government committed to dispatching teams of TCM experts to Tanzania to cooperate with local doctors of Muhimbili National Hospital (MNH) on research

¹⁰¹ Interview by Andrea Kifyasi with Gallus Namangaya Abedi, June 6, 2018, Posta-Dar es Salaam; Joseph W. Butiku, July 9, 2018, Posta-Dar es Salaam. *Mzee* Butiku is an Executive Director, The Mwalimu Nyerere Foundation in Tanzania. He worked at the statehouse as personal research Assistant of Mwalimu Nyerere from 1965.

¹⁰² “URT, Ministry of Health and Social Welfare, the 40th Anniversary on Chinese Medical Team Workers in Tanzania, 1968-2008,” NRC. Ministry of Health and Social Welfare, 14/05/03, File Ref. No. HC. 74/311/02 Chinese Medical Team 2007-2010, also see China Academy of Chinese Medical Sciences, *The 30th Anniversary of China-Tanzania Cooperation on TCM Treatment of HIV/AIDS*, 3.

¹⁰³ See, for instance, Huang, “Pursuing Health as Foreign Policy,” 111.

¹⁰⁴ Interview by Andrea Kifyasi with Joseph W. Butiku, July 9, 2018 Posta-Dar es Salaam.

and treatment. MoUs were signed every three years, based on negotiations that either added or deleted some items according to changing demands.¹⁰⁵

The commencement of Chinese-funded HIV/AIDS research positively influenced the flow of more research projects from local and foreign experts. In 1989, Swiss medical staff and local medical workers conducted joint HIV/AIDS research at Mwananyamala Hospital in Dar es Salaam.¹⁰⁶ While the Chinese research was based on TCM, the Swiss research project centred on biomedicine. Similarly, in 1990, local medical practitioners established a traditional Tanzanian medicine research centre dealing with HIV/AIDS in Tanga. The centre, famously known as Tanga AIDS Working Group (TAWG), was interdisciplinary, comprising conventional physicians, traditional healers, social scientists, and botanists. TAWG researched and treated HIV/AIDS patients with plant-based medicines.¹⁰⁷ In the same period, the Institute of Traditional Medicine (ITM) and traditional medicine practitioners from about eleven regions of Tanzania engaged in research searching for efficacious traditional medicine to cure HIV/AIDS.¹⁰⁸ All of this shows that there were both internal and external initiatives to fight the disease in Tanzania.

The Chinese-funded project officially launched its activities in Dar es Salaam in September 1987. The China Academy of Chinese Medical Sciences (CACMS, formerly the Academy of Traditional Chinese Medicine) was responsible for dispatching experts to run the project together with local doctors from the MNH of Tanzania.¹⁰⁹ TCM experts were recruited from different hospitals and institutes under CACMS, such as Guang'anmen and Xiyuan hospitals, as well as the Institute of Basic Theory for Chinese Medicine (Table 11). The CACMS was established in 1955 and was reputed for hosting famous TCM specialists. It

¹⁰⁵ Interview by Andrea Kifyasi with Liggyle Vumilia, May 7, 2018, Dar es Salaam. For details about the MoU read the "Summarised Minute of Meeting between Ministry of Health and Social Welfare of the United Republic of Tanzania and State Administration of Traditional Chinese Medicine of the People's Republic of China on Continuing Cooperation of Treatment of HIV/AIDS, Beijing, July 17, 2006," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008.

¹⁰⁶ JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. C. S. Kabeho, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1990/91*, 12.

¹⁰⁷ Torunn Stangeland, Shivcharn S. Dhillon and Haavard Reksten, "Recognition and Development of Traditional Medicine in Tanzania," *Journal of Ethnopharmacology* 117 (2008): 296.

¹⁰⁸ JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. Prof. Phillemon M. Sarungi, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1992/93*, 40.

¹⁰⁹ China Academy of Chinese Medical Sciences, *The 30th Anniversary*, 3; also see "Traditional Chinese Medicine has Great Prospects in Dealing with HIV/AIDS," *Xinhua News Agency*, September 25, 2003, accessed May 2, 2016, http://www.chinadaily.com.cn/en/doc/2003-09/25/content_267510.htm.

conducted extensive TCM research for chronic diseases and earned WHO recognition.¹¹⁰ Despite its long history and reputation, prior to 1987, its experts had engaged in neither HIV/AIDS research nor treatment. By that time no HIV/AIDS cases had been officially announced in China; the first cases would only be in 2001.¹¹¹ Tanzania, therefore, marked the first place for CACMS to research and treat HIV/AIDS.

The research team sent to Tanzania comprised up to six experts per batch, which included TCM pharmacists and physicians. Chinese experts worked together with one local pharmacist who was in charge of monitoring the safety of the drugs, and one local physician who was in charge of management and handling patients. A few local nurse assistants were also engaged in the research work assisting the Chinese and local researchers. The TCM experts' tenure was unsystematic; some experts stayed for one year, others for two. Over the 31 years, up to 2018, the CACMS dispatched to Tanzania 16 batches with a total of 66 TCM experts (Table 11). Together, they conducted research and attended to more than 10,000 HIV/AIDS patients in Tanzania.¹¹²

The Chinese Ministry of Finance primarily sponsored the HIV/AIDS research and treatment project. It carried expenses related to the domestic salaries of the experts, travelling expenses from China to Tanzania, language training, medical equipment and medicines.¹¹³ The Tanzanian government met costs related to travelling expenses from Tanzania to China, lodging, house maintenance, water and electricity bills as well as phone expenses. Furthermore, it hired security guards and cleaners for doctors' residence, drivers and 50 litres of fuel every week for vehicles used for the work.¹¹⁴ The Tanzanian government also paid TCM experts

¹¹⁰ "Taarifa Fupi ya Safari ya Jamhuri ya Watu wa China 16-23 Julai 2006," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 7.

¹¹¹ Chan, Lee and Chan, "China Engages Global Health Governance," 7.

¹¹² Charles W. Freeman and Xiaoqing Lu Boynton, "A Bare (but Powerfully Soft) Footprint: China's Global Health Diplomacy," in *Key Players in Global Health: How Brazil, Russia, India, China and South Africa Are Influencing the Game*, ed. Katherine Elaine (Washington, DC: Centre for Strategic and International Studies (CSIS), Global Health Policy Centre, 2010), 17.

¹¹³ "The Agreement Protocol of 2007-2009," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 3.

¹¹⁴ "The Memorandum of Continuing Cooperation on the 7th Period of HIV/AIDS Treatment with TCM between The China Academy of Chinese Medical Sciences, The People's Republic of China and The Muhimbili National Hospital, The United Republic of Tanzania, Beijing, July 18, 2006," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 3.

allowances equivalent of up to USD 170 Tanzanian shillings per head per month.¹¹⁵ Compared to China, the Tanzanian government bore light costs maintaining TCM experts.

Table 11: List of TCM experts dispatched to Tanzania by the China Academy of Chinese Medical Sciences, 1987–2018

Batch	Year	Number of Experts	Undertaking Unit(s)
I	1987–1988	5	Guang’anmen Hospital & Institute of Basic Theory for Chinese Medicine
II	1988–1991	5	Institute of Basic Theory for Chinese Medicine, Guang’anmen Hospital & Xiyuan Hospital
III	1991–1992	6	Institute of Basic Theory for Chinese Medicine, Guang’anmen Hospital & Institute of Information on TCM
IV	1992–1993	6	Guang’anmen Hospital, Institute of Basic Theory for Chinese Medicine, AIDS Centre & Institute of China Medical History Literature
V	1993–1995	5	Institute of Basic Theory for Chinese Medicine
VI	1995–1997	5	Institute of Basic Theory for Chinese Medicine
VII	1998–1999	5	Institute of Basic Theory for Chinese Medicine, Guang’anmen Hospital & AIDS Centre
VIII	1999–2001	6	Guang’anmen Hospital
IX	2001–2003	3	Guang’anmen Hospital
X	2003–2005	3	Guang’anmen Hospital
XI	2005–2006	3	Guang’anmen Hospital
XII	2006–2008	3	China Academy of Chinese Medical Sciences, Xiyuan Hospital & Wangjing Hospital
XIII	2008–2010	3	Guang’anmen Hospital & Xiyuan Hospital
XIV	2011–2012	3	China Academy of Chinese Medical Sciences
XV	2012–2013	2	Guang’anmen Hospital
XVI	2017–2018	3	Institute of Chinese Materia Medica & Guang’anmen Hospital

Source: Modified from China Academy of Chinese Medical Sciences, *The 30th Anniversary*, 22.

The HIV/AIDS outpatient clinic was established shortly after signing the agreements between the CACMS and the MNH.¹¹⁶ Although TCM experts lacked experience in both therapy and research, they promptly started giving clinical care to patients. They imported in

¹¹⁵ “The Agreement Protocol of 2007-2009,” NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 4-5.

¹¹⁶ Information Centre, China Academy of Traditional Medicine (CATM), *Signing Ceremony of Memorandum of Cooperation between China Academy of Chinese Medical Sciences and Tanzania’s Mhimbili Hospital Held in Beijing on March 2, 2011*.

bulk herbal medicines, which were synthesised into powder and liquid forms to ease consumption by patients. An article published on October 15, 2006 in Xinhua News Agency, reported that according to TCM doctors HIV/AIDS was “jointly caused by the invasion of wrong and bad *qi* from outside the human body and unintended discharge of right and good *qi* from within the body.”¹¹⁷ Thus, they believed that patients would recover if several formulae of tested herbs would adequately address the two problems mentioned. Consequently, TCM experts did not begin with an extensive study of the virus and other related scientific procedures. Instead, they directly engaged in trial-and-error practices on patients. They began providing TCM drugs capable of reducing the viral load and maintaining patients’ body immunity while exploring efficacious medicinal herbs for curing the disease.¹¹⁸ Thus, the TCM trial-and-error treatment began before the WHO’s guidelines underscoring clinical evaluation of the safety and possible efficacy of traditional remedies in the treatment of persons with AIDS before any clinical trial. However, the WHO set up new guidelines in 1990, after it had noticed that practitioners used herbal remedies to treat HIV/AIDS patients without any scientific proof that they possessed anti-HIV potency.¹¹⁹ Thus, from 1990, clinical evaluation for the efficacy and safety of the medicine before clinical trial was mandatory. Indeed, clinical trials carried some risk to patients, which would either be caused by adverse side effects or lack of information on the efficacy of the agent under study. Information reporting severe risks encountered by HIV/AIDS patients who used TCM was not available.

As a matter of practice, TCM experts assessed the clinical progress of HIV/AIDS patients by examining physiology, psychology, social relations, and independence. With regard to physiology, they examined the physical discomfort of a patient before and after using TCM by determining whether a patient encountered fever, diarrhoea, cough, headache, weight loss, and other related diseases. The experts examined the psychological status of a patient by considering both negative and positive conditions. They noticed a negative condition if a

¹¹⁷ *Qi* meant the flow of vital energy in the human body, read in “Traditional Chinese Medicine in Tanzania,” *Xinhua News Agency*, October 15, 2006, see also Wei-bo Lu, “Approaches in Treating AIDS with Chinese Medicine,” in *Chinese Medicine Modern Practice: Annals of Traditional Chinese Medicine Vol. 1*, ed. Ping-chung Leung and Charlie Chang-li Xue (Singapore: World Scientific Publishing, 2005), 54-56.

¹¹⁸ Interview by Andrea Kifyasi with Bai Wenshan, May 28, 2019, Guang’anmen Hospital, China Academy of Chinese Medical Sciences, Beijing. Prof. Bai worked at the HIV/AIDS clinic in Tanzania from 2003 to 2005 and from 2008 to 2010; Naomi Vuhahula Mpemba, August 1, 2018, Goigi Mbezi Beach, Dar es Salaam. Dr Mpemba was in charge of management and handling HIV/AIDS patients at the clinic from 1989 to 2010.

¹¹⁹ WHO, “In Vitro Screening of Traditional Medicines for Anti-HIV Activity: Memorandum from a WHO Meeting,” *Bulletin of the World Health Organization* 67, no. 6 (1989): 613; WHO, *Global Programme on AIDS and Traditional Medicine Programme; Report of a WHO Consultation on Traditional Medicine and AIDS: Clinical Evaluation of Traditional Medicines and Natural Products*, Geneva, September 26-28, 1990, 9-10.

patient felt depressed, tense, and depleted. At the same time, they noted a positive state if a patient felt confident with the treatment and was gaining new hope in life. They also examined the patient's social relationships – namely the patient's relationships with doctors, colleagues, and family members at home. Moreover, they examined a patient's ability to act independently through the patient's engagement in daily activities.¹²⁰ These aspects of the assessment imply that TCM experts did not follow a reductionist approach in fighting HIV (as was the case of orthodox health practitioners); instead, they employed a holistic approach viewing the human body and mind in their entirety. The experts designed scoring tables for each patient, detailing clinical progress before and after using TCM under each of the mentioned rubrics. The scores manifested the usefulness of the deployed formulae and were the basis for experts' decisions regarding patients' further clinical treatment.

In the beginning, patients doubted the ability of the Chinese medical team to address HIV/AIDS using TCM. This was because patients had never heard about the engagement of TCM practitioners in any research, nor had Chinese practitioners had previous experience in addressing HIV/AIDS.¹²¹ Furthermore, the clinic was established during a time when suspected patients faced fierce stigma. The community perceived HIV/AIDS as a disease of shame and sin.¹²² This negatively impacted patients' attendance at the clinic. Some patients were afraid that their communities would shun them if they had contact with other patients. This prevented some patients from attending clinical care, while others requested that they attend the clinic secretly. Yet, others preferred visiting private traditional medicine clinics where confidentiality was better guaranteed.¹²³

Clear statistics showing patients' turnout are missing. However, oral testimonies show that many patients attended the clinic over time. Chinese medicines were offered for free, thus many ordinary and low-income patients who were unable to afford private clinics became the

¹²⁰ Interview by Andrea Kifyasi with Bai Wenshan, May 28, 2019, Beijing China.

¹²¹ Interview by Andrea Kifyasi with Naomi Vuhahula Mpemba, August 1, 2018, Goigi Mbezi Beach, Dar es Salaam.

¹²² Read, for instance, how patients were perceived by their relatives and community at large in Deborah Pellow, "Sex, Disease, and Culture Change in Ghana," in *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa*, ed. Philip W. Setel, Milton Lewis and Marynez (New York: Greenwood Press, 1999), 28; also see Frederick Kaijage, "Disease and Social Exclusion: The African Crisis of Social Safety Nets in the Era of HIV and AIDS," In *History of Disease and Healing in Africa*, ed. Y. Q Lawi and B. B Mapunda (University of Dar es Salaam, GeGCA-NUFU Publications, 2004), 117.

¹²³ Interview by Andrea Kifyasi with Naomi Vuhahula Mpemba, August 1, 2018, Goigi Mbezi Beach, Dar es Salaam.

main patients of the clinic.¹²⁴ Most HIV/AIDS clinic patients were women and children. A patient and a doctor whom I interviewed argued that many Tanzanian women were more courageous and caring than men regarding their own health and that of their children. Therefore, the turnout of male patients was less promising, and most of them could not endure regular attendance at the clinic.¹²⁵ Doctor Naomi Mpemba adds that this was a challenge to boosting patients' immunity because patients who did not accompany their spouses to the clinic continued to have sexual relationships with their husbands or wives whose viruses were more active.¹²⁶

When the clinic was founded, attending patients were from MNH, mostly residents of Dar es Salaam City and a few from other regions of Tanzania. Over time, patients from nearby regions, including Coast, Tanga, and Morogoro started attending the clinic. Plans to extend the service to many regions of Tanzania were underway, pending final results of this research. However, throughout its existence, the clinic would not take its services to other regions of Tanzania. These remained solely based at the MNH for further research and clinical trials.¹²⁷

Throughout the 1980s and the 1990s, the TCM clinic was generally positively perceived, and it attended to many patients. Nevertheless, with the advent of western antiretroviral drugs (ARVs) in 2004 the positive reception of the clinic decreased. Many patients left the clinic and opted for ARVs. Other patients went back and forth between using ARVs and receiving TCM clinical treatments.¹²⁸ Generally, patients were looking for a cure, irrespective of whether it would be ARVs or TCM. Some patients who had attended the TCM clinic since the 1980s and the 90s and had experienced few health improvements were tired of TCM and wanted to try a new medication. Therefore, from 2004 onwards the number of patients attending the TCM clinic decreased. This defeated the acceptance and popularity of

¹²⁴ Interview by Andrea Kifyasi with Bai Wenshan, May 28, 2019, Beijing China; Naomi Vuhahula Mpemba, August 1, 2018, Goigi Mbezi Beach, Dar es Salaam.

¹²⁵ Interview by Andrea Kifyasi with HIV/AIDS patient "A" (pseudo name), April 9, 2019, Mlimani City, Dar es Salaam. The patient attended the HIV/AIDS TCM Clinic from 1990 to 2010; Naomi Vuhahula Mpemba, August 1, 2018, Goigi Mbezi Beach, Dar es Salaam.

¹²⁶ Interview by Andrea Kifyasi with Naomi Vuhahula Mpemba, August 1, 2018 at Goigi Mbezi Beach, Dar es Salaam.

¹²⁷ Interview by Andrea Kifyasi with Amunga Meda, July 18, 2018, at Muhimbili National Hospital-Dar es Salaam, Dr Amunga worked with TCM doctors at the HIV/AIDS clinic.

¹²⁸ Interview by Andrea Kifyasi with Naomi Vuhahula Mpemba, August 1, 2018 at Goigi Mbezi Beach, Dar es Salaam.

TCM considerably and contributed largely to the MoH calling off the research project in 2006.¹²⁹

4.4.2 The HIV/AIDS TCM Research and Medical Knowledge Exchange

Chinese medical assistance to Africa was not intended as a simple transmission of funds and personnel but sought to promote self-sufficiency in recipient countries. This is reflected in the fourth of the Eight Principles for Economic and Technical Aid referred to by Premier Zhou in Ghana on January 15, 1964: “in providing aid to other countries,” he said, “the purpose of the Chinese government is not to make the recipient countries dependent on China but to help them embark on the road of self-reliance step by step.”¹³⁰ Nearly two decades later, this was still the publicly proclaimed official policy voiced by Premier Zhao Ziyang during his visit to Africa from December 1982 to January 1983. In his speech made in Dar es Salaam, he reaffirmed that “economic and technological cooperation should contribute to self-reliance on both sides.”¹³¹

Such commitments imply that the HIV/AIDS research and treatment project had a role to play, especially in boosting the capacity of Tanzania’s health sector to enable the country to address the disease independently. This would indeed have been the case if the project had boosted Tanzanian abilities through the exchange of medical knowledge between TCM experts and local medical practitioners. Likewise, since the research focused on exploring efficacious antiretroviral herbal medicines, it had merits in promoting the use of medicinal plants abundant in Tanzania. Consequently, local traditional medicine researchers and practitioners, who were also searching for suitable herbal medicine to suppress the disease, became important stakeholders.

However, from its inception, the research project conformed to neither the South-South knowledge exchange agenda nor to self-reliance commitments. The project denied full inclusion of local medical doctors as well as traditional medicine researchers and practitioners. As mentioned earlier, a team of traditional Tanzanian medicine practitioners and researchers

¹²⁹ Interview by Andrea Kifyasi with Bai Wenshan, May 28, 2019, Beijing China; Naomi Vuhahula Mpemba, August 1, 2018 at Goigi Mbezi Beach, Dar es Salaam.

¹³⁰ Quoted in *Afro-Asian Solidarity against Imperialism: A Collection of Documents, Speeches and Press Interviews from the Visits of Chinese Leaders to Thirteen African and Asian Countries* (Peking: Foreign Languages Press, 1964), 149.

¹³¹ Quoted in Mengua Zeng, “An Interactive Perspective of Chinese Policy: A Case Study of Chinese Aid to Tanzania,” (PhD diss., Graduate School, University of Florida, 1999), 101.

from the ITM conducted their research in Tanga and Dar es Salaam respectively. In contrast, TCM experts conducted their research in Beijing and Dar es Salaam. Regrettably, the groups did not share knowledge. The agreements reached between the two governments contributed to the exclusion of local researchers from the Chinese led research. In response to Nyerere's request to the Chinese government, Deng proposed that TCM specialists lead the fight against HIV/AIDS. Thus, from the beginning, the leadership role assigned to Chinese specialists precluded collaboration on an equal footing between TCM experts and local traditional medicine researchers, a collaboration which was key to promoting South-South production and exchange of medical knowledge. Definitely, the dominance of TCM knowledge in HIV/AIDS research and treatment in Tanzania was more or less comparable to the approach of traditional global health partners whose interventions to pandemics were also powered by their faith in the superiority of their medical knowledge and technology.¹³²

In *Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870–1950*, Helen Tilley shows how colonialists capitalised on Africa's research potential to produce and transmit their medical knowledge on the continent. The colonialists perceived the prevalence of several diseases on the continent as an important asset to clinical trials regarding numerous biomedical formulations.¹³³ Findings from the present study suggest that, paralleling Tilley's conception of "scientific colonialism," the Chinese HIV/AIDS project maintained the supremacy of TCM in Tanzania. The agreements between the Tanzanian MoH and the CACMS denied local medical doctors' opportunities to either gain medical knowledge from TCM doctors or to share such knowledge with TCM doctors. Chinese experts dominated research activities. Under the signed MoU, local personnel were responsible for organising patients, taking serology, diagnosis of patients, clinical observations, and conducting laboratory tests such as routine blood tests. In contrast, TCM experts were tasked with designing a clinical implementation plan, checking the assay report, clinical diagnoses and treatment, as well as filling clinical monitoring forms – jobs which, according to Elisabeth Hsu, were all filled by Chinese people.¹³⁴ Furthermore, the CACMS were in charge of producing and distributing TCM and other medical facilities necessary for research and treatment.¹³⁵

¹³² Packard, *A History of Global Health*, 9.

¹³³ Helen Tilley, *Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870-1950* (Chicago: University of Chicago Press, 2011), 2.

¹³⁴ Hsu, "Medicine as Business," 228.

¹³⁵ "The Memorandum of Continuing Cooperation on the 7th Period of HIV/AIDS Treatment with TCM between The China Academy of Chinese Medical Sciences, The People's Republic of China and The Muhimbili National

According to the agreements, TCM experts were responsible for all activities related to the extraction of chemicals, laboratory experiments, and medicine productions. The local medical doctors were to assist the experts. There was a less tangible scientific investment in terms of laboratory and other medical and research equipment at MNH than in clinical care. TCM herbal formulations were prepared in China and imported into Tanzania for clinical trials.¹³⁶ This dominance of Chinese specialists in research is an instance of what Tilley calls “scientific diaspora”, which refers to the introduction of new scientific knowledge into a foreign land while the convenor’s staff retains total control of it.¹³⁷

This study argues that the failure of Chinese-funded health projects in Tanzania was already rooted in the conception of the projects. The Chinese HIV/AIDS project, as established in the MoU between the MNH and the CACMS, was ill conceived. While CACMS dispatched TCM experts for the research, MNH deployed biomedical doctors to work in the project. Such ill-fated agreements were reached while, in 1974, the government, through the Muhimbili Medical College, established the Traditional Medicine Research Unit (TMRU). The latter was upgraded to an Institute of Traditional Medicine (ITM) in 1991. The institute had a dozen senior researchers including chemists, pharmacologists, botanists and medical anthropologists. Nevertheless, only one pharmacologist from ITM was partially attached to the project, effectively eclipsing the most significant Tanzanian partner.¹³⁸ Undoubtedly, if the partnership between these two institutions (ITM and CACMS) that specialise in the same area had been adequately thought out, the research project on HIV/AIDS would have contributed considerably to the production and exchange of medical knowledge. The MNH would have been engaged only for the clinical trial. Under the Eight Principles of Economic and Technical Aid to overseas countries, the Chinese government pledged: “In giving any particular technical assistance, the Chinese government will see to it that the personnel of the recipient country

Hospital, The United Republic of Tanzania, Beijing, July 18, 2006,” NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 2.

¹³⁶ Interview by Andrea Kifyasi with Rogasian L. A. Mahunnah, July 21, 2018, Tabata Kisiwani, Dar es Salaam. Prof. Mahunnah was the former Director of the Institute of Traditional Medicine (1994), First President of Traditional Medicine in Tanzania and the former Chairperson of the Traditional Medicine Council of Tanzania; Modest C. Kapingu, June 8, 2018, Institute of Traditional Medicine (ITM), Muhimbili University of Health and Allied Sciences (MUHAS), Dar es Salaam. Dr Kapingu worked with the Chinese TCM doctors as a local pharmacist in charge of ensuring the safety of TCM before use by patients.

¹³⁷ Tilley, *Africa as a Living Laboratory*, 8.

¹³⁸ Rogasian L. A. Mahunnah, Febronia C. Uiso and Edmund J. Kayombo, *Documentary of Traditional Medicine in Tanzania: A Traditional Medicine Resource Book* (Dar es Salaam: Dar es Salaam University Press, 2012), 7; Interview by Andrea Kifyasi with Modest C. Kapingu, June 8, 2018, Institute of Traditional Medicine (ITM), Dar es Salaam; Rogasian L. A. Mahunnah, July 21, 2018, Tabata Kisiwani, Dar es Salaam.

fully master the technique.”¹³⁹ Despite such lofty statement of principles, the study upholds that in practice the exclusion of ITM experts and other traditional medicine stakeholders from Tanzania defeated the South-South medical knowledge exchange agenda and turned the pledge into mere rhetoric.

4.4.3 Effectiveness, Distinctiveness and Ending of the Research

The main objectives of the Chinese-sponsored HIV/AIDS project included treating patients and exploring effective TCM capable of curing the disease. Regarding the latter, more than six formulae of herbs were tested up to 2006 – but with little success. The medical analysis showed that many of the formulae were 40 to 50% effective in fighting HIV/AIDS. Nevertheless, the general health status of at least 75% of HIV/AIDS patients using TCM improved.¹⁴⁰ The tested formulations reduced viral loads, thereby improved patients’ body immunity and extended their lives. Doctor Mpemba, who also worked at the clinic for more than twenty years, noted that: “We received patients whose body immunities were severely affected by HIV. However, after they started attending the clinic, their body immunities improved, and others became strong enough to resume their daily activities.”¹⁴¹ She added that: “TCM extended the lives of patients. Others lived for more than ten years, and a few of them are alive. They usually welcome me for friendly talks and family functions, including birthdays and graduation ceremonies of their children.”¹⁴² In addition to enhancing immunity, Doctor Amunga Meda, who also worked at the clinic, reports that Chinese herbs improved patient quality of life by alleviating common diseases such as fever, fatigue, abdomen pains, cough, asthenia and severe diarrhoea.¹⁴³ These assertions corresponded with responses from HIV/AIDS patients who attended the clinic. The patient testified that her immunity improved

¹³⁹ Seventh Principle from China’s Eight Principles of Economic and Technical Aid to Overseas Countries unveiled by Premier Zhou Enlai when answering questions from reporters of the Ghana News Agency on January 15, 1964 in Ghana, quoted in *Afro-Asian Solidarity Against Imperialism: A Collection of Documents, Speeches and Press Interviews from the Visits of Chinese Leaders to Thirteen African and Asian Countries* (Peking: Foreign Languages Press, 1964), 150.

¹⁴⁰ Rodney Thadeus, “China to Help Dar Fight AIDS,” *The African*, February 17, 2003, 3; “Traditional Chinese Medicine in Tanzania,” *Xinhua News Agency*, October 15, 2006; Interview by Andrea Kifyasi with Prof. Bai Wenshan, May 28, 2019, Guang’anmen Hospital, Beijing China; “TCM Explores Treatment Opportunities in Tanzania,” *Xinhua News Agency*, July 15, 2009; Interview by Andrea Kifyasi with Naomi Vuhahula Mpemba, August 1, 2018 at Goigi Mbezi Beach, Dar es Salaam.

¹⁴¹ Interview by Andrea Kifyasi with Naomi Vuhahula Mpemba, August 1, 2018, Goigi Mbezi Beach, Dar es Salaam.

¹⁴² Interview by Andrea Kifyasi with Naomi Vuhahula Mpemba, August 1, 2018, Goigi Mbezi Beach, Dar es Salaam.

¹⁴³ Interview by Andrea Kifyasi with Amunga Meda, July 18, 2018, Muhimbili National Hospital-Dar es Salaam.

after she had started using TCM, which was evident from the fact that she did not contract illnesses such as severe diarrhoea, cough and fever, as frequently as before.¹⁴⁴ Similarly, a patient interviewed by Xinhua News Agency testified that she used TCM for more than 11 years with a noticed improvement of her health. Although the patient was not healed, her immunity was strengthened, and she resumed office work.¹⁴⁵ These testimonies support the conclusion that TCM lengthened lives and reduced death rates of HIV/AIDS patients.

The preceding statements suggest that TCM therapies functioned similarly to western ARVs. However, Doctor Wang Jian,¹⁴⁶ who also worked at the HIV/AIDS clinic in Tanzania, claims that TCM had added merits compared to western ARVs. According to him, the western ARVs focused on getting rid of symptoms; TCM instead addresses the root cause of the disease. Wang added that:

TCM stimulates the patient's own upright *qi* energy that prevents external pathogenic invasions from entering the body, while the goal of western medicine [ARVs] is to kill bacteria or viruses by using chemicals. TCM combines many kinds of herbs to exert [a] greater effect, regulates the body's internal environment [helping it to] regain in its balance in holistic approach.¹⁴⁷

Wang's view implies that TCM intended to increase the defensive capabilities of a patient's immune systems, which were more susceptible to HIV. By contrast, ARVs focused on the suppression of HIV. Bai Wenshan, who also worked at HIV/AIDS clinic in Tanzania, reaffirms that TCM did not focus on ridding the patient of the virus; this shortcoming, in his view, defeated the quick effectiveness of TCM over western ARV. In this vein, HIV/AIDS patients whose body immunities were severely affected did not withstand measures employed by TCM.¹⁴⁸ One patient reported that her husband, who suffered from deficient body immunity, died four years after starting to use TCM, while she herself survived since she started using TCM when her body immunity was still high.¹⁴⁹

¹⁴⁴ Interview by Andrea Kifyasi with HIV/AIDS patient "A", April 9, 2019, Mlimani City, Dar es Salaam.

¹⁴⁵ "Traditional Chinese Medicine in Tanzania," *Xinhua News Agency*, October 15, 2006.

¹⁴⁶ Dr Wang Jian was the Deputy Director of the TCM Centre for AIDS Prevention and Treatment, China Academy of Chinese Medical Sciences (CACMS). He worked on HIV/AIDS Treatment with TCM for more than 22 years, and he spent three years at MNH in the 1990s.

¹⁴⁷ A response by Dr Wang Jian quoted in, Wang Jian, "Fighting AIDS with TCM," China Academic Journal, Electronic Publishing House, 2013.

¹⁴⁸ Interview by Andrea Kifyasi with Bai Wenshan, May 28, 2019, Guang'anmen Hospital, Beijing China; see also Lu, "Approaches in Treating AIDS with Chinese Medicine," 57.

¹⁴⁹ Interview by Andrea Kifyasi with HIV/AIDS patient "A", April 9, 2019, Mlimani City, Dar es Salaam.

The other notable distinction between TCM and ARVs concerned side effects, with TCM associated with fewer side effects than ARVs.¹⁵⁰ Mpemba, who was also responsible for handling all matters related to HIV/AIDS patients, informs that they received fewer complaints from patients regarding side effects of TCM. In her experience, the reported complaints were not only fewer but also less complicated than those observed in patients using ARVs.¹⁵¹ An informant who used TCM therapies from 1990 to 2010 affirmed that she did not incur complicated side effects; she did, however, sometimes experience simple diarrhoea and pruritus.¹⁵² The subjective belief that herbal medicines have fewer side effects than biomedicine influenced such contrast.

Despite its merits, the TCM research project was closed in 2006. The 18 years of research did not produce profound results. Up to 2006, no specific medicine was endorsed for the treatment of the disease. While informants claimed that there were formulae which proved useful in fighting the virus, the CACMS did not approve any of them. Rogasian Mahunnah complained:

The Chinese did not endorse useful formulae for patients' use. Instead, they withdrew the formulations and sent their reports to China for further research. After the withdrawal, new formulations were developed and imported to Tanzania for a clinical trial. Chinese doctors used Tanzanian patients for the trial of their medicines since there were no HIV/AIDS patients in China.¹⁵³

Seemingly, officers at the MoH and local researchers were tired of endless clinical trials with little triumph. Correspondingly, local people mistrusted of Chinese researchers. Criticism like Mahunnah's explains why local traditional medicine researchers perceived Chinese experts only used HIV/AIDS patients in Tanzania as guinea pigs.¹⁵⁴

A further point of the present study is that inadequate transparency in the project prompted local traditional medical researchers to develop negative perceptions of Chinese

¹⁵⁰ Interview by Andrea Kifyasi with HIV/AIDS patient "A", April 9, 2019, Mlimani City, Dar es Salaam. The merits of TCM over orthodox medicine have also been examined by Chong-fen Guan, "Research on Treatment of AIDS in Chinese Medicine," in *Chinese Medicine Modern Practice: Annals of Traditional Chinese Medicine Vol. I*, ed. Ping-chung Leung and Charlie Chang-li Xue (Singapore: World Scientific Publishing, 2005), 147.

¹⁵¹ Interview by Andrea Kifyasi with Naomi Vuhahula Mpemba, August 1, 2018, Goigi Mbezi Beach, Dar es Salaam.

¹⁵² Interview by Andrea Kifyasi with HIV/AIDS patient "A", April 9, 2019, Mlimani City, Dar es Salaam.

¹⁵³ Interview by Andrea Kifyasi with Rogasian L. A. Mahunnah, July 21, 2018, Tabata Kisiwani, Dar es Salaam.

¹⁵⁴ Interview by Andrea Kifyasi with Modest C. Kapingu, June 8, 2018, Institute of Traditional Medicine (ITM), Dar es Salaam; Rogasian L. A. Mahunnah, July 21, 2018, Tabata Kisiwani, Dar es Salaam.

efforts. Tanzanian informants expressed their worries, maintaining that Chinese experts might have developed the tested formulations in China and produced antiviral herbal medicine for sale without acknowledging research partners.¹⁵⁵ These uncertainties were rooted in the fact that the CACMS owned intellectual property rights over the research project. In this regard, Elisabeth Hsu noted that in 2000s, the Chinese globally sold a Chinese-made antiviral herbal medicine with the brand name *Aikeji*.¹⁵⁶ It is not precisely known whether the medicine was produced by CACMS using the formulae they tested in Tanzania or otherwise.

Although the research was officially ended, China and Tanzania agreed to formally commence using the tested medicines. By 2006, the HIV/AIDS clinic tested more than six TCM formulae, with four yielding promising results. Thus, the CACMS endorsed one of the four useful formulae under the brand name *Eling* for patient use. Since the medicines were produced in China, they were regularly imported according to patients' demand.¹⁵⁷ Such imports were consistent with the signed MoU, which allowed the Chinese to produce pharmaceuticals.¹⁵⁸ Agreements like these, however, turned the Tanzanian government dependant on Chinese medicines.

Furthermore, the discontinuation of the research gave birth to the Sino-Tanzanian TCM Centre. The centre, which was housed at MNH, expanded its research on TCM beyond HIV/AIDS. In addition to attending to patients with HIV/AIDS, it also attended to diseases treatable by TCM such as asthma, diabetes, high blood pressure and pneumonia. Also, from 2006, TCM research was conducted for other health cases and not for HIV/AIDS. Under the 2006 agreement, since the laborious HIV/AIDS research work had ended, the number of TCM experts dispatched to Tanzania was reduced to three.¹⁵⁹ The establishment of the centre was another attempt at promoting the use of TCM in Tanzania. The agreements reached in 2006

¹⁵⁵ Interview by Andrea Kifyasi with Febronia C. Uiso and Edmund J. Kayombo, June 8, 2018, Institute of Traditional Medicine (ITM). Uiso and Kayombo are senior researchers at the Institute.

¹⁵⁶ Hsu, "Medicine as Business," 228.

¹⁵⁷ "Taarifa Fupi ya Safari ya Jamhuri ya Watu wa China, 16-23 Julai 2006," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 7; "Letter from Permanent Secretary, MoH to Katibu Mkuu Kiongozi, July 25, 2006, Taarifa ya Safari ya China 16-22, 2006," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 2.

¹⁵⁸ "The Memorandum of Continuing Cooperation on the 7th Period of HIV/AIDS Treatment with TCM between The China Academy of Chinese Medical Sciences, The People's Republic of China and The Muhimbili National Hospital, The United Republic of Tanzania, Beijing, July 18, 2006," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 2.

¹⁵⁹ "Letter from Permanent Secretary, MoH to Katibu Mkuu Kiongozi, July 25, 2006, Taarifa ya Safari ya China, July 16-22, 2006," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 2.

stated that: “Both sides [Tanzania and China] will support and promote the establishment of a Traditional Chinese Medicine Centre in the Muhimbili National Hospital to provide Traditional Chinese Medicine services to the Tanzanian people.”¹⁶⁰ Again, as it was with the preceding HIV/AIDS research, the 2006 MoU assigned most of the research activities to Chinese experts who were in charge of diagnosis, treatment and distribution of medicines. In contrast, local medical workers were responsible for the managerial activities of the Centre.¹⁶¹ Undeniably, TCM research projects influenced the adoption and use of a new medical culture rather than empower the development of local medical knowledge. That several TCM formulations were trialled on Tanzanian patients shows that the country was a captive subject to scientific experiments in both the colonial and post-colonial periods.

Furthermore, the TCM centre promoted a market for Chinese herbal medicines. Under the 2006 MoU, the Chinese government provided free medicine to HIV/AIDS patients while charging patients suffering other diseases including asthma, blood pressure, diabetes, and rheumatism. In the MoU, the Chinese government committed itself to charging patient fees for the basic cost of medicines only, “without any purpose of making a profit”.¹⁶² However, the basic cost of medicines was left to be determined by the Chinese side since its government was responsible for the purchase, transport, and storage. It is, therefore, difficult to determine whether they made profits out of the fees charged or not. Distribution of revenues shows that the Tanzanian side benefitted from registration and consultation fees, while the Chinese benefitted from medicine fees charged to patients.¹⁶³ While this sounds like a win-win deal, its execution supported the use and market for Chinese herbal medicines.

¹⁶⁰ “Summarisantalared Minute of Meeting between Ministry of Health and Social Welfare of the United Republic of Tanzania and State Administration of Traditional Chinese Medicine of the People’s Republic of China on Continuing Cooperation of Treatment of HIV/AIDS, Signed in Beijing on July 17, 2006,” NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 2.

¹⁶¹ “The Memorandum of Continuing Cooperation on the 7th Period of HIV/AIDS Treatment with TCM between The China Academy of Chinese Medical Sciences, The People’s Republic of China and The Muhimbili National Hospital, The United Republic of Tanzania, Beijing, July 18, 2006,” NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 3.

¹⁶² “The Memorandum of Continuing Cooperation on the 7th Period of HIV/AIDS Treatment with TCM between The China Academy of Chinese Medical Sciences, The People’s Republic of China and The Muhimbili National Hospital, The United Republic of Tanzania, Beijing, July 18, 2006,” NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 3.

¹⁶³ “The Memorandum of Continuing Cooperation on the 7th Period of HIV/AIDS Treatment with TCM between The China Academy of Chinese Medical Sciences, The People’s Republic of China and The Muhimbili National Hospital, The United Republic of Tanzania, Beijing, July 18, 2006,” NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 3.

Although it served Chinese interests, the centre did not survive long and was closed eight years later in 2014. The closure of the centre limited access to data, so it is difficult to find data related to the reasons for its decline. However, information I have, shows that the contract for the centre was not renewed because the Dar es Salaam port authorities detained Chinese medical equipment and herbal medicines imported to Tanzania.¹⁶⁴ Respondents did not openly mention the reasons behind this confinement. Nevertheless, from 2016, the MNH and CACMS agreed to promote institutional relationships through exchanging medical experts to ease the sharing of medical knowledge. The CACMS agreed to send TCM experts to Tanzania to train local traditional medicine researchers and practitioners, but this plan did not come to fruition as the two sides voiced disagreements over the terms of its execution in 2018.¹⁶⁵

4.5 TCM and China’s Anti-malaria Campaign in Tanzania, 2006–2010

Malaria is the primary killer disease on the African continent. According to the WHO’s World Malaria Report of 2005, about 107 countries and territories were malaria epidemic areas, with countries in Sub-Saharan Africa, South-East Asia, Pacific, and Latin America being the most vulnerable to the disease. The report added that the disease infected about 500 million people and caused 3 million cases of death annually, 80% of which occurred in Africa and most of them were pregnant women and children under five years. Moreover, low-income families in Africa spent one-fourth of their annual income on malaria treatment. Malaria consumed 1.3% of annual GDP of African countries.¹⁶⁶ This situation implies that malaria has been a consistent major threat to public health and a barrier to the economic development of African countries. In Tanzania, for instance, the 1999 MoH information shows that about 4,000,000 malarial cases were reported each year which was equivalent to 34.2% of

¹⁶⁴ Interview by Andrea Kifyasi with Hedwiga Swai, July 18, 2018, Muhimbili National Hospital (MNH), Dr Swai is a Director of Medical Services at MNH; Amunga Meda, September 19, 2018, Muhimbili National Hospital.

¹⁶⁵ Interview by Andrea Kifyasi with Bai Wenshan, May 28, 2019, Guang’anmen Hospital, Beijing China.

¹⁶⁶ “Memorandum of understanding between Department of Aid to Foreign Countries, Ministry of Commerce of the People’s Republic of China and National Malaria Control Program, Ministry of Health and Social Welfare of the United Republic of Tanzania, April 19, 2006,” NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008.

all outpatient health cases. The 2000 information added that malaria accounted for about 100,000 Tanzanian deaths annually.¹⁶⁷

China was one of the most severe epidemic areas affected by malaria. During the 1960s and 1970s, there were two epidemic outbreaks which infected more than 20 million people. The malarial epidemics endowed China with experiences in the prevention and cure of malaria using TCM. Artemisinin and its semisynthetic derivatives were discovered in 1972 by Tu Youyou, a Chinese scientist and 2015 co-recipient of Nobel Prize in Medicine. The therapy contained four derivatives; dihydroartemisinin, artesunate, artemether, and arteether, which effectively worked against malaria parasites. The WHO officially approved the medicine in 1993. Artemisinin was extracted from Chinese herbal plant, *Artemisia annua*, and was used for curing several ailments, including malaria since ancient times.¹⁶⁸ Artemisinin was efficacious against all forms of malaria parasites. In the 1990s, it surpassed sulphadoxine-pyrimethamine (SP) in treating malaria.¹⁶⁹

China's rich experience, professional personnel, and anti-malarial medicine had benefitted the anti-malarial campaign in Tanzanian and Africa at large. After the WHO approval of artemisinin, China sought to popularise the therapy on the African market in several ways. For example, in the 2000 Forum on China Africa Cooperation (FOCAC) held in Beijing it came up with the Beijing Declaration of the Ministerial Forum on China-Africa Health Development. Under the Declaration, health ministers and officials from China and African countries committed to embarking on new efforts of finding and implementing sustainable health solutions for several health cases, malaria being in the front.¹⁷⁰

China's anti-malaria campaign in Africa increased in 2006, when it built thirty hospitals, provided renminbi 300 million yuan of grant for purchasing Chinese-made

¹⁶⁷ "National Institute for Medical Research (NIMR), The Commercialization of Local Production of Artemisinin, 2006," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 2.

¹⁶⁸ "National Institute for Medical Research (NIMR), The Commercialization of Local Production of Artemisinin, 2006," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 1; WHO, *Meeting on the Production of Artemisinin and Artemisinin Based Combination Therapies, June 6-7, 2005, Arusha, Tanzania*, 12-22; Elisabeth Hsu, "Chinese Propriety Medicines: An "Alternative Modernity?" The Case of Anti-Malaria Substance Artemisinin in East Africa," *Medical Anthropology* 28, no. 2 (2009): 112, <https://dx.doi.org/10.1080/01459740902848303>.

¹⁶⁹ "National Institute for Medical Research (NIMR), The Commercialization of Local Production of Artemisinin, 2006," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 3.

¹⁷⁰ Forum on China-Africa Cooperation (FOCAC), *Programme for China-Africa Cooperation in Economic and Social Development, (October 2000)*, 16.

artemisinin, and established 30 malaria prevention and treatment centres.¹⁷¹ The establishment of anti-malaria centres was followed by training opportunities for Africans medical personnel at the Jiangsu Centre of Verminous Control and Prevention. More than 60 Africans from different recipient countries, including Tanzania, attended the ten-day course.¹⁷² In the FOCAC meeting of 2009, the Chinese government committed to providing Ren Minbi 500 million yuan worth for medical equipment and other materials for fighting against malaria to thirty hospitals and thirty malaria prevention and treatment centres (Table 12).¹⁷³

At FOCAC meetings, the use of artemisinin became an agenda where African leaders were informed of its efficacy. The Chinese government donated the Chinese made anti-malaria drugs after almost all FOCAC meetings. Indeed, compared to other diseases, malaria received a higher preference in the Chinese health development assistance to Africa from the 2000s to 2013.¹⁷⁴ I argue that China's anti-malaria campaign partly helped Africans to fight malaria. However, on the other hand, it promoted the use and superiority of Chinese-made anti-malaria therapies in Africa, which, in turn, enabled Chinese pharmaceutical companies to compete closely with the western-made anti-malaria therapies for the African market.

China's anti-malaria campaign in Tanzania was officiated in 2006. On April 19, 2006, an MoU was signed between the Department of Aid to Foreign Countries under the Ministry of Commerce of China and the National Malaria Control Program (NMCP) under the MoH of Tanzania. The campaign aimed to introduce comprehensive Chinese experience in malaria control and set up a malaria control demonstration centre. It intended to reduce malaria morbidity by responding to the local situation under the instruction from and experience of Chinese experts. The Chinese government pledged to assign experts on tropical diseases to exchange ideas with Tanzanian professionals to analyse the malarial situation and draft a feasible scheme on malaria prevention and cure in combination with the treating policy recommended by the WHO.¹⁷⁵

¹⁷¹ Address by Hu Jintao, President of People's Republic of China at the Opening Ceremony of the Beijing Summit of the Forum on China Africa Cooperation, Beijing November 4, 2006, 4.

¹⁷² Li, *Chinese Medical Cooperation in Africa*, 17.

¹⁷³ Liu Jian, "A Healthy Relationship: China-Africa Medical Cooperation still going strong after 50 years," (August, 2013): 15, also see, Li, *Chinese Medical Cooperation in Africa*, 13.

¹⁷⁴ Mohon Shajalal, *et al.*, "China's Engagement with Development Assistance for Health in Africa," *Global Health Research and Policy* 2, no. 24 (2017): 4.

¹⁷⁵ "Memorandum of understanding between Department of Aid to Foreign Countries, Ministry of Commerce of the People's Republic of China and National Malaria Control Program, Ministry of Health and Social Welfare of

Table 12: Anti-malaria centres in Africa sponsored by China from 2007 to 2009

Country	Date	Location of the Centre/Hospital Name
Liberia	1 February 2007	Monrovia
Chad	28 December 2007	N'Djamena (N'Djamena Freedom Hospital)
Senegal	2007	Dakar
Burundi	17 March 2008	Bujumbura
Uganda	15 May 2008	Kampala (Mulago Hospital)
Congo Brazzaville	13 August 2008	Brazzaville
Gabon	28 September 2008	Libreville (China-Gabon Cooperation Hospital)
Benin	10 November 2008	Lokosa
Guinea-Bissau	10 December 2008	Bissau
Ethiopia	26 December 2008	Aoluo Mo, Naz
Togo	7 January 2009	Lomé
Mali	13 February 2009	Bamako (Kadi Hospital)
Cameroon	26 March 2009	Yaoundé (Women's and Children's Hospital)
Cote d'Ivoire	7 April 2009	Abidjan
Rwanda	8 May 2009	Ki Gu Ki Jo
Equatorial Guinea	7 June 2009	Bata
Zambia	26 June 2009	Lusaka
Comoros	July 2009	Moheli
Madagascar	6 October 2009	Tananarive (Infectious Disease Hospital)
Sudan	14 October 2009	Ad Damazin
Central African Rep.	25 October 2009	Bangui
Ghana	28 October 2009	Accra
Angola	23 October 2009	Luanda
Guinea	6 November 2009	Conakry (Kona Correa Steen Hospital)
Mozambique	25 November 2009	Maputo
Sierra Leone	30 November 2009	Friston Hospital
Tanzania	30 November 2009	Leah Amana Hospital

Sources: Modified from Li Anshan *Chinese Medical Cooperation in Africa*, 14; Xia Zhi-Gui, *et al.*, "China-Africa Cooperation Initiatives in Malaria Control and Elimination," *Advances in Parasitology*, 86 (2014): 334–335.

China's anti-malaria campaign in Tanzania focused more on curative than preventive measures. The only preventive initiatives mentioned in the MoU was its devotion to providing long-lasting insecticide-treated nets and a pledge to facilitate two to three times more public

the United Republic of Tanzania, April 19, 2006," NRC. Ministry of Health and Social Welfare, 14/05/03, File Ref. No. HC. 74/311/02 Chinese Medical Team 2007-2010.

education in forms of scientific popularisation exhibition and lectures on malaria prevention and cure for the local people.¹⁷⁶ I argue that this was done deliberately to boost the market for China's pharmaceutical factories producing anti-malaria medicines. This claim is justified by the engagement of Chinese pharmaceutical company in the Sino-Tanzanian anti-malaria programme. The MoU consigned the Beijing Holley-Cotec Pharmaceutical as the coordinator responsible for the management and implementation of the China-Tanzania anti-malaria programme.¹⁷⁷ This context gave a chance to the company to coordinate and boost the market for its anti-malaria drugs in Tanzania. For instance, in 2007, the company purchased shares from a Chinese provincial government which co-owned Tanzansino United Pharmaceuticals, a joint venture industry with the Tanzanian military. This firm produced and exported artemisinin-based combination therapies for malaria within and outside the country.¹⁷⁸

Although, since the 1960s, Chinese officials sang the song of self-reliance, findings of this study show that its approach to the anti-malaria campaign hardly boosted Tanzania's capacity to eliminate malaria sustainably. In contrast, the assistance prompted the country's dependency on Chinese-made anti-malarial therapies. Instead of investing in preventive measures, the Chinese government preferred donating anti-malaria drugs. For instance, in May 2006, the MoH of Tanzania was given a chance to choose efficacious artemisinin therapy made in China of which it was ready to donate. Part of the letter read:

In order to strengthen the friendship and help more local patients to get rid of malaria suffering, the Chinese Government wishes to donate some Chinese anti-malaria medicine when the high-level Chinese Delegation visits Tanzania this June [of 2006]. It would be highly appreciated if the esteemed Ministry could nominate the species of medicine which is acceptable to your Government and inform the Representation at your early convenience.¹⁷⁹

¹⁷⁶ "Memorandum of understanding between Department of Aid to Foreign Countries, Ministry of Commerce of the People's Republic of China and National Malaria Control Program, Ministry of Health and Social Welfare of the United Republic of Tanzania, April 19, 2006," NRC. Ministry of Health and Social Welfare, 14/05/03, File Ref. No. HC. 74/311/02 Chinese Medical Team 2007-2010.

¹⁷⁷ "Memorandum of understanding between Department of Aid to Foreign Countries, Ministry of Commerce of the People's Republic of China and National Malaria Control Program, Ministry of Health and Social Welfare of the United Republic of Tanzania, April 19, 2006," NRC. Ministry of Health and Social Welfare, 14/05/03, File Ref. No. HC. 74/311/02 Chinese Medical Team 2007-2010.

¹⁷⁸ Geoffrey Banda, Samuel Wangwe and Maureen Mackintosh, "Making Medicines: An Historical Political Economy Overview," in *Making Medicines in Africa: The Political Economy of Industrializing Local Health*, ed. Maureen Mackintosh, Geoffrey Banda, Paula Tibandebage and Watu Wamae (England: Palgrave Macmillan, 2016), 16.

¹⁷⁹ "Letter from Chief Representative, The Economic and Commercial Representation of the People's Republic of China in the United Republic of China, May 24, 2006 to the Permanent Secretary, Ministry of Health,

Donations of anti-malaria therapies were not limited to Tanzania alone. Since official recognition of artemisinin by the WHO, donation of anti-malaria medicines to Africa became a priority to the Chinese government. Anti-malaria drugs became an important gift of Chinese officials who visited Africa. For example, in his visit to Africa in 2002, President Jiang Zemin presented cotexcin to Nigeria as his gift to the Children's malaria project. Similarly, state visits to Africa by Chinese National Congress chair Wu Bangguo in 2004 and the visit by President Hu Jintao in 2006 donated anti-malaria drugs made in China as their exceptional contribution to the fight against malaria.¹⁸⁰ While such donations improved access to anti-malarial medicine for many patients, they also promoted Chinese drugs on African markets while falling short of the declared aim of promoting sustainable malaria control.

It was regrettable that anti-malaria therapies made from artemisinin were mainly sourced from China. Archival information suggests that such therapies could have been possibly produced in Tanzania. From the 1990s, *Artemisia annua* was commercially produced in Njombe, Arusha, Mara and Kagera Regions of Tanzania.¹⁸¹ Local production of anti-malaria raw materials was an imperative step toward producing anti-malaria therapies within the country. Nevertheless, the Tanzanian government and other stakeholders did not utilise the available raw materials to produce locally anti-malaria drugs. The extracted raw materials were shipped for overseas consumption. For example, in 2002, about 28 tons of artemisinin was destined for shipment overseas.¹⁸² Assistance from China and other countries of the North did not promise to utilise locally grown *Artemisia annua* for local production of anti-malaria therapies, nor did they prioritise preventive measures. Instead, they tied the government to foreign-made anti-malaria therapies through grants. Such attempt provided a short-time relief in the fight against malaria while worsening Tanzania's dependence on imported drugs.

Cooperation on Malaria Control," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008.

¹⁸⁰ Li, *Chinese Medical Cooperation in Africa*, 16.

¹⁸¹ "National Institute for Medical Research (NIMR), The Commercialization of Local Production of Artemisinin, 2006," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 3.

¹⁸² "National Institute for Medical Research (NIMR), The Commercialization of Local Production of Artemisinin, 2006," NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 7.

4.6 Conclusion

Discussions in this chapter unveiled that despite its entanglements, TCM knowledge was spread and practised in Tanzania. Its practice and acceptance added value to the strength of medical knowledge from the South. It further implied that there were potentials for South-South medical knowledge production and circulation as an alternative to North-South. The current trend further suggests the possibility of South-North medical knowledge exchange. Global health players relied on biomedicine in the fight against pandemic diseases while excluding traditional medicines. TCM intervention in HIV/AIDS and malaria treatment was an attempt to promote innovation in and practice of medical knowledge from the South. Findings from the present study suggest that the Chinese-Tanzanian HIV/AIDS research was not particularly successful regarding eradicating the disease and only marginally contributed to boosting the medical knowledge of local researchers and practitioners. Nevertheless, TCM became widely practised and accepted in Tanzania. This did not come without self-interests, however, as Chinese engagement in African countries yielded tangible benefits in terms of market access and scientific achievements.

CHAPTER FIVE
**“TEACH A MAN HOW TO FISH, AND YOU FEED HIM FOR
A LIFETIME”:**
**THE ENTANGLEMENTS OF CHINESE-FUNDED
PHARMACEUTICAL FACTORIES
IN POST-COLONIAL TANZANIA**

5.1 Introduction

During the Cold War era, the Eastern and the Western blocs provided different forms of assistance to African countries depending on their respective priorities. For example, donors from the West gave priority to projects with immediate and tangible results. In contrast, donors from the East gave prominence to long-term development projects such as basic industries, scientific and educational facilities, and health care.¹ Assistance from both parties aimed to win allies in Africa. In post-colonial Tanzania, donors of the North, such as the International Monetary Fund (IMF) and the World Bank, assisted the government with medicines and funds to purchase drugs and medical equipment.² By contrast, the Chinese government provided grants and sponsored long-term projects which promised to trigger local production of pharmaceuticals. Its assistance was framed in the moral lesson from the ancient Chinese proverb, which goes: “*Give a man a fish, and you feed him for a day. Teach a man how to fish, and you feed him for a lifetime.*”³

The high costs of imported drugs and medical supplies were obstacles to improved health and wellbeing in Africa. Such challenges burdened health care systems and limited effective health care delivery on the continent. Local production of pharmaceuticals, by contrast, would maintain the country’s self-sufficiency, reduce medical imports, and prevent the loss of foreign currency. This chapter surveys the emergence and development of Chinese-funded pharmaceutical industries in post-colonial Tanzania, tracing their history and

¹ Randall M. Packard, *A History of Global Health: Interventions into the Lives of other Peoples* (Baltimore, MD: Johns Hopkins University Press, 2016), 114.

² “United Nations Aid,” *East African Standard*, Nairobi, January 12-19, 1967.

³ Quoted in Menghua Zeng, “An Interactive Perspective of Chinese Aid Policy: A Case Study of Chinese Aid to Tanzania” (PhD diss., University of Florida, 1999), 98.

implications for Tanzania's health sector. It also discusses, in brief, the colonial attempt at establishing pharmaceutical factories in the territory, chronologically tracing the evolution of pharmaceutical industries from the colonial to post-colonial periods. It further examines the extent to which Chinese sponsored pharmaceutical factories promoted self-sufficiency and how it implicated the Sino-Tanzanian pharmaceutical knowledge exchange under the spirit of Southern solidarity. While pharmaceutical companies held great potential in view of Tanzania's self-reliance agenda, I argue that the Chinese-sponsored factories rather created new forms of dependency in terms of the importation of raw materials and foreign technical experts.

5.2 Prelude to Post-Colonial Pharmaceutical Factories, 1902–1948

Industrialisation in the colonial territories was less encouraged in Africa since the colonies produced agricultural raw materials such as sisal, cotton, tea, and the like for the metropolitan industries. At the same time, colonialists turned the colonies into a market for the consumer and producer products of the colonial powers.⁴ Generally, the colonial economy was geared towards serving the interests of the colonial states and the metropolitan nations. Nevertheless, pharmaceutical manufacturing companies set up production facilities and started manufacturing medicines in Africa already during the colonial period. Investment in pharmaceuticals became visible in the 1930s, concentrating in Tanganyika, Kenya, South Africa, Zimbabwe and Nigeria. Throughout the colonial period, investment in pharmaceutical industries was linked to multinational European companies that set up subsidiaries in colonies. For instance, in 1930, Glaxo Company set up its base in Kenya. Likewise, in 1935, the Abbott companies established a pharmaceutical industrial base in South Africa, while in Nigeria, May and Baker companies established their firms in 1944.⁵ Pharmaceutical factories in some African countries were established and run by the colonial authorities. Tanganyika was a good example of such investments (see below). The establishment of pharmaceutical industries in some African countries went hand in hand with colonial economic investments. The colonial governments encouraged the establishment of pharmaceutical industries in settler colonies to

⁴ URT, *Report on the Fifty Years of Independence of Tanzania Mainland, 1961-2011*, 104; also read Chapter 5 in John Iliffe, *A Modern History of Tanganyika* (Cambridge: Cambridge University Press, 1979).

⁵ Geoffrey Banda, Samuel Wangwe and Maureen Mackintosh, "Making Medicines: An Historical Political Economy Overview," in *Making Medicines in Africa: The Political Economy of Industrializing Local Health*, ed. Maureen Mackintosh, Geoffrey Banda, Paula Tibandebage and Watu Wamae (London: Palgrave Macmillan, 2016), 8.

meet the demands of pharmaceuticals for settlers and labourers. Moreover, import challenges necessitated that the colonial authorities built pharmaceutical industries during the world wars to meet the local supply of medicines to military men and African troops.⁶ However, throughout most of the colonial period, there were few initiatives promoting the local production of medicines in Africa. The administrations mostly sourced medicines from abroad, preferably from the respective colonial authorities' metropolises.

The history of pharmaceutical industries in colonial Tanganyika dates back to the German colonial era. The Amani Tropical Agricultural Research and Biological Institute, founded by Franz Ludwig Stuhlmann, and developed later into the East African Malaria and Vector-Borne Diseases Institute, eased the establishment of the industries. Moreover, the establishment of cinchona trees plantation at Bomole (Tanga) between 1902 and 1906 by the German colonialists gave a chance to the emergence of a simple pharmaceutical factory in 1914. Cinchona trees were originally grown by indigenous communities in South America (Peru) and Java (Indonesia) under the Dutch. The seeds for cinchona trees grown in Tanganyika territory were imported from Java. The indigenous people of Peru initially employed the bark for the treatment of malaria. The bark was first utilised in European medicine in the early 17th century.⁷

The colonial chemists exploited the bark of cinchona to manufacture quinine sulphate used for anti-malaria in colonial Tanganyika. The first alkaloid to be isolated from the bark in the pure state was quinine. The curative effect of the bark was due to the presence therein of several alkaloids, of which the four main ones were quinine, cinchonidine, cinchonine, and quinidine.⁸ In colonial Tanganyika, Germans planted about four varieties of cinchona, namely *Cinchona ledgeriana*, *Cinchona succirubra*, *Cinchona* hybrid (ledgeriana and succirubra), and *Cinchona robusta*. In sum, there were more than 75 acres of German-planted cinchona trees at

⁶ Amon J. Nsekela and Aloysius M. Nhonoli, *The Development of Health Services and Society in Mainland Tanzania: A Historical Overview-Tumetoka Mbali* (Dar es Salaam: East African Literature Bureau, 1976), 8; Banda, Wangwe and Mackintosh, "Making Medicines," 10.

⁷ Nsekela and Nhonoli, *The Development of Health Services*, 14; Stefanie Gänger, "World Trade in Medicinal Plants from Spanish America, 1717-1815," *Medical History* 59, no. 1 (January 2015): 47, <https://doi.org/10.1017/mdh.2014.70>.

⁸ "Curing Malaria with Locally-Produced Totaquina," *The Tanganyika Standard*, July 18, 1946, TNA. Acc. No. 450, Ministry of Health, File No. 1063, Cinchona, 1944-1949.

Bomole-Tanga up to 1914. German authorities extended several acres of cinchona tree farms to Kilosa-Morogoro.⁹

The German's initial goal of planting cinchona trees was not meant for its raw materials to be locally used for the production of quinine. Instead, it was grown to satisfy German needs for industrial raw materials and research by the Amani Institute. Germany's Imperial policy for the Tanganyika territory gave little priority to the establishment of pharmaceutical industries. Thus, its investment in the territory aimed to serve the interests of the metropolitan nations.¹⁰ However, the advent of the First World War (1914–1918) forced Germans to establish a simple pharmaceutical industry in the territory. During the War, local supplies of quinine were running short because of the insecurity that prevented the Germans from importing more quinine from abroad. Quinine factories were opened in Kilosa and at the Veterinary Laboratory located at Mpapua (Tanga). The factories exploited cinchona barks grown in Kilosa and at Amani Institute respectively. Production trials commenced on a small scale in January 1914, when about 10 kilos were produced a month by the officer in charge. The factories at Kilosa and Tanga continued to operate throughout the War (1914–1918), producing quinine and other medicines.¹¹ The little remaining source material suggests that the German administration terminated their cinchona farms by the end of the First World War.

After the British takeover of the colony in 1918, the new colonial administration inherited the remains (ratoons) of the German cinchona trees. Tanganyika being a “conquered” territory, the League of Nations mandate was less valued for industrial investment by the British colonial government. In East Africa, British colonial policy preferred to establish industries in Kenya, which was a settler colony.¹² However, in the 1920s, the British government showed an interest in using cinchona for manufacturing quinine in Tanganyika. To achieve this, it extended the plantations of cinchona trees in Tanga between 1922 and 23 by using the seeds they obtained from the existing trees. The British government anticipated that the manufacture of quinine in the territory would cost less than the money it used to purchase

⁹ “Report on Alkaloid Content of Amani Cinchona Trees, 1931,” TNA. Acc. No. 450, Ministry of Health, File No. 174, Cinchona, 1920-1935.

¹⁰ C. E. Barker, M. R. Bhagavan, P. V. Mitschke-Collande, and D. V. Wield, *African Industrialisation: Technology and Change in Tanzania* (England: Gower Publishing Company, 1990), 40.

¹¹ “Letter from the Acting Chief Secretary, September 20, 1922 to the Principal Medical Officer, Tanganyika Territory,” TNA. Acc. No. 450, Ministry of Health, File No. 174, Cinchona, 1920-1935.

¹² Rune Skarstein, “Growth and Crisis in the Manufacturing Sector,” in *Tanzania Crisis and Struggle for Survival*, ed. Jannik Boesen, Kjell J. Havnevik, Juhani Koponen, and Rie Odgaard (Uppsala: Scandinavian Institute of African Studies, 1986), 79.

quinine from abroad.¹³ Moreover, it planned to extend the production of cinchona to meet the demands of quinine for the whole of East Africa. Thus, in the early 1930s, the colonial administration opened more farms for cinchona and encouraged peasants' plantations. To trigger further production, the colonial authorities sanctioned a grant from the Colonial Development Fund to plant 100 acres of cinchona at the Amani Station. The plans by the British colonial government were to reach 1,200 acres required to feed a large-scale quinine factory.¹⁴

The League of Nations Malaria Commission further advocated the production of cinchona trees in colonial Tanganyika. The commission endorsed the production of cinchona in the malarial tropical countries where the cost of imported drugs prohibited their use.¹⁵ During the 1930s, the malaria rate in Tanganyika amounted to 228 patients per 1,000 population. On the population figure of 5,022,640, the number requiring treatment became 1,145,162. The quantity of quinine thus required was estimated to be about 78,525 lb. (1,145,162 x 480 grains), equivalent to 35 tons per year.¹⁶ Indeed, the demand for quinine was higher and would cost the colonial government dearly if it committed itself to providing malarial treatment to all patients exclusively via imported quinine. However, the director of medical services in the territory declared that the amount required for African prophylaxis in Tanganyika would be much less than actual demand. His assertions were rooted in the fact that quinine salts would only be exhibited for the specific purpose of protecting a small aggregation of people such as labour units, or others for whom the benefit to be derived from the expenditure had positive economic significance to the British Crown.¹⁷ Thus, despite malarial contexts in Tanganyika, the production of cinchona was meant to only save a few categories of people with economic importance to the colonial government. Chiefly, the promotion of cinchona production was aimed at supplying quinine factories established in Europe.

Despite the successful extension of cinchona plantations in Tanganyika, the colonial government did not establish a quinine factory throughout the 1920s and early 1930s. Yet, in

¹³ "Letter from Principal Medical Officer, Tanganyika Territory, October 5, 1920 to Prof. Dunstan, Imperial Institute, London," TNA. Acc. No. 450, Ministry of Health, File No. 174, Cinchona, 1920-1935.

¹⁴ "Colonial Advisory Council of Agriculture and Animal Health Report of the Sub-Committee Appointed to Consider the Question of the Cultivation of Cinchona in the Colonial Empire, October 7, 1935," TNA. Acc. No. 450, Ministry of Health, File No. 174, Cinchona, 1935-1936.

¹⁵ "Conclusions of the League of Nations Malaria Commission Sub-Committee of Experts on Quinetum, 1931," TNA. Acc. No. 450, Ministry of Health, File No. 174, Cinchona, 1920-1935.

¹⁶ "Remarks to the Article on "Quinine", *Tanganyika Standard*, June 16, 1936," TNA. Acc. No. 450, Ministry of Health, File No. 1063, Cinchona, 1944-1949.

¹⁷ "Remarks to the Article on "Quinine", *Tanganyika Standard*, June 16, 1936," TNA. Acc. No. 450, Ministry of Health, File No. 1063, Cinchona, 1944-1949.

the mid-1930s, the British government came up with a new plan of establishing a totaquina factory. Totaquina consisted of a mixture of quinine, cinchonine and cinchonidine, with a trace of quinidine, and about 15% to 20% of amorphous alkaloids, together with a limited amount of inorganic matter and moisture. Its test showed that it was equal to quinine in therapeutic value. Totaquina was capable of destroying malarial parasites of all forms except the gametocytes of subtertian and schizonts.¹⁸

The plans for the totaquina factory received significant consideration after 1936. However, it took until 1941 for the British government to allocate funds for the factory. Bark from the old half-forgotten plantation and the cinchona just reaching maturity planted in different parts of the territory enabled the totaquina factory to commence at Dar es Salaam in 1942.¹⁹ The British needed to establish the factory during the Second World War period because Java, which was the leading supplier of quinine to the British colonies, had been occupied by the Japanese in February 1942. This deprived the British and its allies of the primary source of global quinine supply.²⁰ To alleviate the situation, the British government encouraged the production of drugs locally in the colonies. Hence, Tanganyika's existing cinchona plantations gained favour with the British.

The production rate of totaquina at the Dar es Salaam factory, which rose from 640 lbs. in 1942 to 8,900 lbs. in 1945, was promising. Colonial officials led the factory, yet a few Africans were employed to work in a lower cadre such as foreman and other assistants (Figure 17). Many Africans did not qualify for jobs that required more expertise as the colonial system denied their access to formal education.²¹ However, the colonial officials promoted to higher-ranking jobs such as tablet making a few Africans who showed higher ability. For instance, in 1944, the factory hired one African to work as a tablet maker after he had served for two and a half years as an assistant to a British expert.²² Generally, many Africans worked in the lower

¹⁸ "A Memorandum on Cinchona Development and Research on Totaquina, 1944," TNA. Acc. No. 450, Ministry of Health, File No. 174, Cinchona Products, Maintenance and Supplies, 1943-1945

¹⁹ "A Memorandum on Cinchona Development and Research on Totaquina, 1944," TNA. Acc. No. 450, Ministry of Health, File No. 174, Cinchona Products, Maintenance and Supplies, 1943-1945

²⁰ "A Memorandum from the Colonial Office of April 1, 1942," TNA. Acc. No. 450, Ministry of Health, File No. 174, Cinchona Products, Maintenance and Supplies, 1941-1942.

²¹ "Curing Malaria with Locally-Produced Totaquina," *The Tanganyika Standard*, July 18, 1946, TNA. Acc. No. 450, Ministry of Health, File No. 1063, Cinchona, 1944-1949; Kjell J. Havnevik, *et al.*, *Tanzania: Country Study and Norwegian Aid Review* (Moss: A/S Repro-Trykk, 1988), 15.

²² "Curing Malaria with Locally-Produced Totaquina," *The Tanganyika Standard*, July 18, 1946, TNA. Acc. No. 450, Ministry of Health, File No. 1063, Cinchona, 1944-1949.

cadre and their supervisors assigned them mainly to unskilled jobs. Such occupations did not acquaint them with enough knowledge to enable them to run the factories after independence.

Figure 17: African workers assisting the totaquina factory manager to examine a newly arrived consignment of cinchona bark, 1945



Source: TNA. Acc. No. 450, Ministry of Health, File No. 1063, Cinchona, 1944–1949.

Notwithstanding the good quality of totaquina produced in Dar es Salaam, the British colonial government ceased its production in October 1947, followed by two years of decline after the end of WW II. The cessation implies that the operation of the factory was wartime expedient. It was, instead, a simple short-term factory since long-term and sophisticated factories were inconsistent with the imperial policy.²³

After the cessation of production, the colonial government proposed to dispose of the factory to the Association of Cinchona Growers (peasants) who previously supplied the factory with bark. However, by the time the agreements were reached, the association had ceased to

²³ “Letter from the Member for Finance, Trade and Economics, December 18, 1948 to the Director of Medical Services,” TNA. Acc. No. 450, Ministry of Health, File No. 1063, Cinchona, 1944–1949.

exist, and growers were asked to form one if they wished to negotiate for the factory. An elected committee of representatives of the cinchona estates concerned proposed the formation of a syndicate comprising three leading growers in Tanganyika who had for several years produced over 75% of the total cinchona bark grown in the territory, to whom the factory was to be handed over.²⁴ However, information concerning the progress of the factory after it had been handed over to the syndicate disappears from the colonial files in Tanzania archives.

The preceding assertions show that both Germans and the British colonialists did not prioritise the establishment of pharmaceutical industries in Tanganyika territory. The emergence of pharmaceutical factories during the WW I and II aimed at addressing the challenges of the availability and supply of drugs temporarily during the war periods, as seen in the rapid closure of the industries shortly after the end of the Wars. Moreover, encouragement of the production of cinchona trees by both Germans and the British colonialists aimed to ensure constantly the supply of raw materials to European based pharmaceutical industries. Despite all that, colonial pharmaceutical industries constituted a founding stone for their development in the post-colonial period. The establishment of several hectares of cinchona plantations was an important foundation. Post-colonial Tanganyika had an opportunity to take over from where the British colonialists ended by establishing not only plantations for quinine raw materials but also investing in other sources of raw materials for the sustainable development of its post-colonial pharmaceutical industries. However, discussions in the subsequent sections show that the post-colonial government abandoned the colonialists' cinchona farms in favour of imported pharmaceutical raw materials.

5.3 Health Challenges and Post-Independence Government Interventions for Pharmaceuticals

Tanzania's health care situation at independence was terrifying. A health care report covering the period from 1961 to 62 shows that life expectancy was 35 years for men and 40 years for women. The death rate was 47 out of 1,000 pregnant women who gave birth. Furthermore, infant and child mortality rate was 40% to 50% before children reached the age

²⁴ "S. M. P. 27509, Memorandum No. 3 for Executive Council, Totaquina Factory, January 6, 1949," TNA. Acc. No. 450, Ministry of Health, File No. 1063/3, Cinchona-Manufacture of including Construction and Equipment of Factory and Assays Connected with Process of Manufacture, 1946-1953.

of six.²⁵ According to a 1964 statement of the Minister for Health, Derek Bryceson, Tanzania's infant and the child mortality rate was one of the highest in the world.²⁶ These and many other health challenges prompted President Julius Nyerere to christen diseases among three main "enemies" to the country's development next to ignorance and poverty, believing that people would not fully engage in economic activities if they were chronically sick (Chapter1).²⁷

However, the government lacked essential "weapons" for its battle. Indeed, successful preventive measures required the spread of sufficient preventive health education to the population as well as vaccination against diseases such as tuberculosis and smallpox. Yet, the government depended on the acquisition of all of its vaccination therapies from overseas. Similarly, curative measures could not attain tangible achievements without an adequate supply of medicines and medical equipment.

The post-colonial government attempted various ways to provide policy guidelines by which it would disengage itself from such neo-colonial economic entanglement and thereby hasten its progress to achieve self-reliance. It realised that the importation of medicines from abroad was the main cause of the scarcity of foreign currency. This, in turn, placed a heavy brake on the speed of development.²⁸ Thus, in its First Five Year Development Plan (FYDP) covering the period 1964–69, the Ministry of Commerce and Industries pledged to convert Tanzania from an agrarian and weak country, dependent upon the caprices of other countries, into an industrial and powerful country, fully self-reliant, and independent of exploiting countries.²⁹ To achieve this objective, the ministry, in its development plans, laid a firm industrial base.

²⁵ URT. *Report on the Fifty Years of Independence of Tanzania Mainland 1961-2011*, 105; "A Speech by Honourable D. N. M. Bryceson, M. P., Minister for Health, 1962," TNA. Acc. No. 450, Ministry of Health, File No. HE. 1172, Medical Development Plan.

²⁶ "Letter from the Minister for Health, Honourable D. N. M. Bryceson to all Ministry Employees of May 18, 1964," TNA. Acc. No. 450, Ministry of Health, File No. HE. 1172, Medical Development Plan.

²⁷ Julius K. Nyerere's Foreword in a book by David F. Clyde, *History of the Medical Services of Tanganyika* (Dar es Salaam: Government Press, 1962), I.

²⁸ URT, *Second Five-Year Plan, 1969-1974, Programme for Industrial Development, Part I, July 1969*, 9; Interview by Andrea Kifyasi with Cleopa David Msuya, July 6, 2018, Upanga, Dar es Salaam. Honourable is a former Prime Minister of Tanzania (1980-1983 and 1994-1995), Minister for Finance (1972-1975 and 1983-1990), and Minister for Industries and Commerce (1975-1980 and 1990-1994).

²⁹ "Ministry of Industries, Mineral Resources and Power, Budget Speech. The Fundamental Task of the Five-Year Plan and the Path of its Fulfilment," TNA. Acc. No. 469, Ministry of Commerce and Industries, File No. CIC 70/12 Speeches-Material, 1962-64, 1.

Consequently, the establishment of pharmaceutical industries was a part of the government's long-term plans, premised on the FYDP. These industries were founded at the moment when the government placed priority on expanding health care to serve basic needs, raise life expectancy, and foster healthy communities. On the other hand, the government's stress on pharmaceutical industries aimed at remedying the state of the country's dependency on imported drugs which became expensive and unsustainable to manage for a growing economy.³⁰ Indeed, the establishment of pharmaceutical factories presented an opportunity to save lives while creating jobs and improving the local economy. The industries anticipated and prompted local production of packing materials, containers, boxes, printing work, medical literature, and other products demanded by the factories. Above all, these production jobs would also increase the country's export volume, creating industries that would ensure constant production for domestic needs and surplus for export projected to boost the country's economy.³¹ This indicates that pharmaceutical industries were vital for the nation's development and at improving the standard of peoples' health, which assured a vigorous labour force for the development of a sound economy.³²

Concrete steps to implement the government's plans to set up pharmaceutical industries were envisaged in the Second Five Year Development Plan (SFYDP) projected for 1969–74. The government envisioned establishing three government-owned pharmaceutical factories.³³ Such commitment was bound by the government statement which outlined its intent to practise the national politics of self-reliance through local production of pharmaceuticals.³⁴ Therefore, Mabibo Vaccine Institute and Keko Pharmaceutical Industries (discussed below) were established under the country's scheduled development agenda. These two factories supplemented the existing privately owned Mansoor Daya Industries, founded in 1962 (see below).

³⁰ "Proposal for the Setting up of a Factory to produce Pharmaceutical Products in Tanzania, 1964," TNA. Acc. No, 596, National Development Cooperation, File No. D/3522/2, Pharmaceutical Project, 1966-1966.

³¹ Interview by Andrea Kifyasi with Cleopa David Msuya, Upanga, Dar es Salaam; "Memorandum, Tegry-Assia Pharmaceutical Ltd, April 20, 1966," TNA. Acc. No, 596, National Development Cooperation, File No. D/3522/2, Pharmaceutical Project, 1966-1966.

³² Relationship between health and labour power is discussed in Michel Foucault, *The Birth of Biopolitics: Lectures at the College De France, 1978-79*, trans. Graham Burchell (New York: Palgrave Macmillan, 2008), 230; Quentin T. Wodon, *et al.*, "Tanzania Economic Update: Human Capital – The Real Wealth of Nations (English)," *Tanzania Economic Update*, no. 12 (July 2019): 4.

³³ URT, *Second Five-Year Plan, 1969-1974, Programme for Industrial Development, Part I, July 1969*, 38.

³⁴ JMT, *Mpango wa Maendeleo wa Shughuli za Afya na Ustawi wa Jamii kwa Kipindi cha Miaka Mitano Kuanzia Julai 1, 1969 Mpaka Juni 30, 1974*, 18.

Before the assistance from the Chinese government, the Tanzanian government encouraged both locals and foreigners to invest in pharmaceutical industries. Through its Three-Year Development Plan (TYDP) of 1961–64, the government created favourable conditions for foreign capital by offering tariff protection and tax incentives. For instance, the Foreign Investment Act of 1963, among other commitments, gave immunity to the foreign capital from nationalisation without compensation. Furthermore, in January 1965, the government established the National Development Cooperation (NDC), which was responsible for the promotion of both private and public investments in the industrial sector.³⁵ Subsequently, both Tanzanians and foreigners showed interest in investing in pharmaceutical industries. For instance, Mansoor Daya, a pharmacist who engaged in a retail pharmacy in Dar es Salaam since 1959, collaborated with the Tayford Laboratories of England to establish the Mansoor Daya Chemicals Limited in 1962. The industry, which was the first to be established in post-colonial Tanzania, started its production in May 1965.³⁶ Though it was a small-scale unit, with the establishment cost of Tshs. 1,500,000, its inauguration was an important milestone in the fight against diseases and for the local production of pharmaceuticals. The unit manufactured drugs for both preventive and curative measures targeting the demands and consistent with the existing health challenges.³⁷

Nevertheless, production at Mansoor Daya Chemicals Limited was not enough to satisfy the needs of the whole country. Hence, the government signed an agreement with investors from Israel, Tegry-Assia Pharmaceutical Factory, to establish another factory in Dar es Salaam. The plant was to be co-owned by the NDC.³⁸ However, the investors and the

³⁵ URT, *Ministry of Industries Mineral Resources and Power, Budget Speech. The Fundamental Task of the Five-Year Plan and the Path of Its Fulfilment*, 3; Rune Skarstein and Samuel M. Wangwe, *Industrial Development in Tanzania: Some Critical Issues* (Uppsala: Scandinavian Institute of African Studies, 1986), 4; Idrian N. Resnick, *The Long Transition: Building Socialism in Tanzania* (London: Monthly Review Press, 1981), 27; Jeannette Hartmann, “The Two Arusha Declarations,” in *Re-Thinking the Arusha Declaration*, ed. Jeannette Hartmann (Copenhagen: Axel Nielsen and Son A/S, 1991), 113.

³⁶ Sudip Chaudhuri, Maureen Mackintosh and Phares Mujinja, “Indian Generics Producers, Access to Essential Medicines and Local Production in Africa: An Argument with Reference to Tanzania,” *European Journal of Development Research* 22, no. 4 (2010): 8; also see Banda, Wangwe and Mackintosh, “Making Medicines,” 19.

³⁷ Lawrence Mabele, “Kiwanda cha Madawa,” *Tanzania Nchi Yetu*, November 1977, 12-13. Its products up to 1966 included: APC-tablets analgesia, aspirin tablets, anti-malaria tablets (chloroquine phosphate), ferrous Sulphate tablets, codeine tablets, penicillin, sulpha imidine tablets, sulpha quinidine, sulpha thiazole, multivitamins and sulpha meltes peridrazine, also refer to, “Industrial Studies and Development Centre, Some Facts about the Market for Medicinal and Pharmaceutical Products in Tanzania, 1965,” TNA. Acc. No. 596, National Development Cooperation, File No. D/3522/2, Pharmaceutical Project, 1966-1968.

³⁸ “Letter from Deputy General Manager, NDC, April 5, 1968 to the Principal Secretary, The Treasury, Certificate of Approved Enterprise No. 117-Tanzania Industrial Centres LTD. And Certificate of Approved Enterprise Tegry-

government ended with misunderstandings, which unfortunately discouraged its establishment. The investors wanted the Tanzanian government to commit itself to purchasing the produced medicines per prices fixed by the industry, which the Tanzanian government did not accept. As the two parties failed to meet consensus, the board of NDC cancelled its certificate on April 5, 1968.³⁹

Chinese-funded pharmaceutical industries in Tanzania were established shortly after the government had endorsed the Arusha Declaration in 1967, which defined a socialist course of development. Under the declaration, the state controlled the economy to overcome dependence over private parastatals. Thus, it nationalised privately owned industries to enable the government to own basic means of production (Chapter 2). Such policies discouraged local and foreign investment in pharmaceutical industries.⁴⁰ Consequently, pharmaceutical industries funded by the Chinese government were compatible with the government's endeavour to have state-owned enterprises. In Africa, Tanzania was the first to get assisted by the Chinese government where two industries, Mabibo Vaccine Institute (MVI) and Keko Pharmaceutical Industries (KPI), were built in 1968 (discussed below). Algeria followed Tanzania in line to receive Chinese assistance, and on December 22, 1976, consented with China to construct a factory for surgical instruments in Middiyyah.⁴¹

China's commitment to technical and economic assistance to Tanzania in the 1960s astounded Nyerere who still perceived China as a technologically and economically low-income country. He openly confessed: "It did not occur to us that the great, but poor, Third World country of China, would be able to help, even if it was willing to do so. So, when in 1965, I first talked on this project with the Chinese leaders, I was doing so as one who talks about his ambitions to a sympathetic but equally powerless friend."⁴² From the preceding

Assia Pharmaceuticals Ltd," TNA. Acc. No, 596, National Development Cooperation, File No. D/3522/2, Pharmaceutical Project, 1966-1968.

³⁹ "Letter from General Manager National Development Cooperation, December 24, 1966 to Assia Chemical Laboratories (1964) Limited," TNA. Acc. No, 596, National Development Cooperation, File No. D/3522/2, Pharmaceutical Project, 1966-1968.

⁴⁰ For general information about nationalisation policy read Kjell J. Havnevik, "A Resource Overlooked-Crafts and Small-Scale Industries," in *Tanzania Crisis and Struggle for Survival*, ed. Jannik Boesen, Kjell J. Havnevik, Juhani Koponen, and Rie Odgaard (Uppsala: Scandinavian Institute of African Studies, 1986), 269.

⁴¹ "WHO, National Health Planning in Tanzania: Report on a Mission, August 1, 1973-April 28, 1974," WHOA, File No. TAN/SHS/002, 1972-1974-SHS/NHP, National Health Planning, 7; Gail A. Eadie and Denise M. Grizzell, "China's Foreign Aid, 1975-78," *The China Quarterly*, no 77 (Mar., 1979): 228.

⁴² Julius K. Nyerere, "TAZARA- from a Caricature of a "Chinese" Railway to "Our" Railway," A Speech at the Handing-over of the Tanzania-Zambia Railway (TAZARA) to Tanzania and Zambia Kapiri Mposhi, Zambia: July 14, 1976, in *Freedom and Liberation: A Selection from Speeches 1974-1999*, ed. The Mwalimu Nyerere Foundation (Dar es Salaam: Oxford University Press (T), 2011), 96.

quotation, it seems Nyerere underestimated the state of the Chinese economy. Yet, Hua Hsin discloses that up to the mid-1960s, the Chinese government had attained a healthy economic and technological development. After the 1949 liberation movement, China embarked vigorously on the establishment of industries for hospital equipment. The industries enabled the government to have enough Chinese-made equipment that was used to diagnose and treat diseases as well as facilitate surgical operations. Such investments transformed China's dependency on imported hospital equipment. By the 1970s, it imported only 1,500 types of medical equipment in 5,000 specifications to meet its domestic needs. The Chinese government further established research institutes of medical equipment and built big factories in Beijing, Tianjin and Shanghai, and in the provinces of Shaanxi and Sichuan to produce enough medical equipment to cater to the needs of the whole China.⁴³ These examples imply that the moment China pledged to assist Tanzania in terms of equipment and experts for the pharmaceutical industries, it had already made a step in producing them at home.

5.4 Mabibo Vaccine Institute (MVI), 1968–1984

The most effective way to prevent many infectious diseases is through vaccination, but for now, all inoculated medicines are imported from abroad. With the help of a friendly country [China], [Tanzania] seeks to establish a vaccine factory to manufacture locally two kinds of vaccine drugs before the end of 1969.⁴⁴

The preceding quotation underscores the government's commitment to establishing a vaccine plant to conform with its self-reliance agenda and the preventive health care campaign endorsed in TYDP for 1961–64 and FYDP for 1964–69. The campaign stressed the dual approaches of hygiene and vaccination to address diseases such as tuberculosis and smallpox.⁴⁵ Undoubtedly, the establishment of a vaccine factory challenged the colonial health policies, which gave less prominence to preventive measures. During the colonial era, both Germans and the British established simple vaccine factories in Tanganyika. The smallpox lymph vaccine was produced in Dar es Salaam by Germans until they fled the territory during the WW

⁴³ Hua Hsin, "Chinese Factory's Long March from Dustpans to Hospital Equipment," *Daily News*, October 19, 1977, 4.

⁴⁴ My translation from Kiswahili in JMT, *Mpango wa Maendeleo wa Shughuli za Afya na Ustawi wa Jamii kwa Kipindi cha Miaka Mitano Kuanzia Julai 1, 1969 Mpaka Juni 30, 1974*; also see URT, *Second Five-Year Plan for Economic and Social Development July 1, 1969-June 30, 1974, Volume I: General Analysis, 1969*, 173.

⁴⁵ URT, *Tanganyika, Development Plan for Tanganyika, 1961/62-1963/64, Dar es Salaam, 1962*, 18; URT, *Tanganyika, Five-Year Plan for Economic and Social Development, July 1, 1964-June 30, 1969, Volume II: The Programmes, 1964*, 118.

I. In 1926, the British colonial government took over the production of a vaccine for smallpox at the Veterinary Research Laboratory in Mpwapwa-Dodoma. The production of vaccines by the British stopped at the outbreak of WW II in 1939. Therefore, from WW II to independence, vaccines were sourced from Nairobi, where they built a large and sophisticated vaccine factory.⁴⁶ Importing vaccines from Nairobi led to an unavoidable delay, and sometimes vaccines were spoiled while on the way to Tanganyika. Compatibly, its distribution to the interior was challenging because of the unfavourable transport system. These hurdles discouraged the extension of inoculation services to the interior of Tanganyika territory.⁴⁷ Consequently, China's assistance in the restitution of the vaccine factory was not only an imperative attempt in challenging the colonial policies but also emancipation from dependence on imported vaccines from countries of the North.

The Mabibo plant was co-financed by the Tanzanian and the Chinese governments. Tanzania received China's support in the form of "Technical Assistance", whereby the Chinese government covered expenses related to experts for technical work and all equipment needed for production and construction work. In return, the Tanzanian government provided funds for the erection of the plant buildings, worth Tshs. 1,000,000.⁴⁸ The plant was located at Mabibo, a few miles outside the city centre of Dar es Salaam in the Kigogo area. President Julius K. Nyerere officially inaugurated the plant on April 23, 1971.⁴⁹ About 70 Tanzanians manned the factory under the supervision of Chinese experts who taught them the art of vaccine manufacturing (Figure 18). Production commenced in January 1971, and the first production was issued to Kisarawe District in March 1971 for TB prevention. Up to 1972, about 500 people were vaccinated at Kisarawe District.⁵⁰ Regrettably, some industrial equipment sourced from China was found unsuitable in hot climate regions such as Dar es Salaam. The hot weather lowered the quality of the liquid produced vaccine. As a result, in 1974, the plant changed its products from a liquid form into tablets and procured new equipment for drying the liquid made

⁴⁶ Nsekela and Nhonoli, *The Development of Health Services*, 9.

⁴⁷ "Letter from Senior Medical Officer, Western and Central Province, Tabora, December 24, 1949 to the Director of Medical Services, Small Vaccine Lymph," TNA. Acc. No. 450, Ministry of Health, File No. 204, Vaccine Lymph- Local Manufacture and Distribution of, 1946-1952.

⁴⁸ "A Special Report, Chinese Medical Assistance to Tanzania, May 12, 1972," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China; "Dar to Have a Vaccine Plant, Government Moves to Combat Smallpox, Tuberculosis," *The Nationalist*, August 22, 1970, 8.

⁴⁹ Marcelino Komba, "Tanzania takes a Step Towards Self-Reliance in Drugs," *The Nationalist*, May 4, 1971, 3.

⁵⁰ "A Special Report, Chinese Medical Assistance to Tanzania, May 12, 1972," TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China.

vaccines to tablet mode (Figure 18). The MVI produced not only enough vaccines to satisfy the needs of the country but also a surplus which was sold to nearby countries. Its production capacity was 1.5 million doses of freeze-dried vaccine for smallpox and 250,000 doses of Bacillus Calmette-Guérin (BCG) vaccine for TB per year.⁵¹

Figure 18: Chinese and local workers standing by a newly imported vaccine dryer, 1977



Source: Ellen Rhobi Binagi, “Madawa ya Kinga Yatengenezwa Mabibo,” *Tanzania Nchi Yetu*, Novemba 1977, 13.

Local production of vaccines rekindled hope that it would be possible for the government to combat TB and smallpox successfully. Prior to its establishment, the government relied on imported vaccines and grants. For example, from 1968 to 71, the United Nations International Children’s Emergency Fund (UNICEF) and the WHO provided vaccines, transport facilities, vaccine kits, and medical equipment to support smallpox and tuberculosis eradication campaigns.⁵² Yet, the granted vaccines did not cover the needs of the country. As a result, throughout the 1960s, the government spent more than Tshs. 2,000,000 each year for purchasing vaccines from abroad.⁵³ Indeed, reliance on grants and imported vaccines was

⁵¹ “A Special Report, Chinese Medical Assistance to Tanzania, May 12, 1972,” TNA. Acc. No. 450, Ministry of Health, File No. HEA/90/5 Technical Assistance China; Ellen Rhobi Binagi, “Madawa ya Kinga Yatengenezwa Mabibo,” *Tanzania Nchi Yetu*, Novemba 1977, 13.

⁵² “Addendum to the Plan of Operation for the Development of Public Health Services in the United Republic of Tanzania (Tanganyika): BCG Vaccination, 1970,” WHOA, File No. TANZANIA/UNICEF-5, 1968-1972-SHS, Development of Public Health Services; URT, *Ministry of Health and Social Welfare, Annual Report of the Health Division, 1967 Volume I*, 6.

⁵³ Komba, “Tanzania takes a Step Towards Self-Reliance in Drugs,” 3.

irreconcilable with the government's self-reliance agenda. Accordingly, local vaccine production anticipated preserving foreign currency and triggering the country's medical self-reliance.

The MVI began with the production of BCG for TB, followed by the freeze-dried vaccine for smallpox. The government dearly needed these two vaccines to curb smallpox and TB, which were spreading at an alarming rate (see below). The incidences of smallpox and TB were not only a threat to the Tanzanian population but to many countries of the South. For instance, in 1958, the World Health Assembly endorsed the Smallpox Eradication Programme (SEP) to fight the epidemic. With the frightening rate of its spread, the WHO gave much attention to SEP from 1966.⁵⁴ The production of vaccines at MVI was, therefore, responding to the global health challenges. Back in Tanzania, incidences rose during the WW II and accelerated further after independence. The WW II military requirements caused a considerable dislocation of the rural epidemiological services, which, allowed smallpox cases to increase markedly in many parts of the country, particularly south and east of Lake Victoria (Table 13). Yet, it took until 1968 for the Tanzanian government to launch a robust campaign against smallpox and ensure that all newborns were inoculated.⁵⁵ The government's regulation was obligatory given the mounting incidences of smallpox. The 1965 annual report of the Health Division shows the incidences of smallpox more than doubling from 1,461 cases in 1964 to 3,017 cases in 1966 (Table 13). Such a rise occurred despite the vaccination campaign, which was underway. In 1964, for instance, the government inoculated about 1,500,000 people. The number of inoculated Tanzanians rose to 3,131,555 out of more than 11,000,000 people by 1965.

⁵⁴ Packard, *A History of Global Health*, 129-145.

⁵⁵ URT, *Ministry of Health, Annual Report of the Health Division 1965 Volume I*, 6; W. I. Kilama, A. M. Nhonoli and W. J. Makene, "Health Care in Tanzania," in *Towards Ujamaa: Twenty Years of TANU Leadership*, ed. Gabriel Ruhumbika (Dar es Salaam: East African Literature Bureau, 1974), 212.

Table 13: Annual returns of smallpox cases and deaths in Mainland Tanzania, 1937–67

Year	Notified Cases	Deaths	Cases/Mortality Per cent
1937	1,478	31	2.1
1938	1,095	27	2.4
1939	579	27	4.7
1940	156	5	3.2
1941	92	6	6.5
1942	90	4	4.4
1943	201	2	1.0
1944	5,755	38	0.6
1945	12,285	1,815	14.7
1946	12,671	1,935	15.2
1947	2,960	616	20.8
1948	1,206	209	17.3
1949	10,45	169	16.1
1950	6,390	345	21.0
1951	855	139	16.2
1952	370	34	9.2
1953	1,200	54	4.5
1954	928	28	3.0
1955	542	15	2.8
1956	605	21	3.5
1957	856	38	4.4
1958	1,176	94	7.9
1959	1,442	158	10.9
1960	1,584	83	5.2
1961	914	45	4.9
1962	1,048	53	5.0
1963	867	49	5.6
1964	1,461	102	7.0
1965	2,759	213	7.7
1966	3,017	171	5.7
1967	1,629	150	9.2

Source: URT, *Ministry of Health, Annual Report of the Health Division, 1965*, Volume I, 7; “WHO, Smallpox Eradication: Assignment Report, 1972,” WHOA, File No. TANZANIA-1801, 1970-1974-CDS2, Smallpox Eradication, 21.

Yet, the 1965 report shows that smallpox epidemics affected dearly several regions such as Mwanza, which reported 490 cases, Mbeya 475, Kigoma 407, Shinyanga 354, and

Iringa, which recorded 309 cases. Other regions such as Tabora, Singida, and Mtwara reported not more than 100 cases while the incidences in other regions were less sporadic.⁵⁶ This increasing smallpox epidemic in the mid-1960s incited the importation of vaccines and made the need for the local production of vaccines an appealing.

Furthermore, TB was also a serious threat to the Tanzania government. The 1967 annual report of the Health Division shows that TB incidences were rampant in all regions of Tanzania. Numerous TB cases among both outpatients and inpatients were reported in Mwanza, Tanga, Kilimanjaro, and Arusha Regions (Table 14).⁵⁷

Table 14: Tuberculosis incidences by 1967

Region	Population	Total No. T.B. Beds	Total No. B.C.G. Vaccinations	Outpatients	Inpatients	Total
Arusha	601,515	84	198,822	672	1,054	1,726
Kilimanjaro	650,533	246	37,670	629	1,329	1,958
Coast	781,267	230	24,475	647	678	1,958
Dodoma	708,422	84	856	178	182	360
Iringa	683,555	102	1,565	299	468	767
Kigoma	470,773	-	40	132	130	262
Mara	535,882	60	2,503	559	242	801
Mbeya	955,891	120	65,114	42	218	260
Morogoro	683,061	100	-	97	487	584
Mtwara	1,032,896	226	-	432	1,442	1,874
Mwanza	1,057,965	170	112,439	452	2,569	3,021
Ruvuma	392,812	100	8,540	733	587	1,320
Shinyanga	888,209	95	-	297	113	410
Singida	454,749	-	-	582	320	902
Tabora	552,339	73	-	149	36	185
Tanga	769,304	196	3,955	960	1,084	2,044
West Lake	658,079	120	314	183	1,429	1,612
Totals	11,876,982	2,016	456,343	7,043	12,368	19,411

Source: URT, Ministry of Health and Social Welfare, Annual Report of the Health Division, 1967 Volume I, 10.

⁵⁶ "WHO, Smallpox Eradication: Assignment Report, 1972," WHOA, File No. TANZANIA-1801, 1970-1974-CDS2, Smallpox Eradication, 22; URT, *Ministry of Health, Annual Report of the Health Division 1965 Volume I*, 2.

⁵⁷ URT, *Ministry of Health and Social Welfare, Annual Report of the Health Division, 1967 Volume I*, 10.

Undoubtedly, the production of vaccines at the MVI was auspicious. Nevertheless, in 1979, the WHO declared the eradication of smallpox, and subsequently, the MVI condensed the production of the freeze-dried vaccine. At the same time, 50 employees from a total of 70 left the plant. The production of BCG vaccine continued, but after the Chinese experts left, the quality of the vaccines produced by local workers no longer met the WHO requirements. It was in such a context that the production of BCG vaccine halted in 1982, and a few remaining personnel, left unoccupied, abandoned the factory.⁵⁸ In 1980, Mabibo was handed over to the National Chemical Industries (NCI) through the Ministry of Industries with a view of rehabilitation. In 1984 it was considered as the most suitable site for housing the Extended Program of Immunisation (EPI) in Tanzania. As a result, all but three of the buildings were handed over to the Ministry of Health for the use of EPI. In July 1986 the remaining three buildings were handed over by NCI for the use of EPI. Thus, Mabibo has not been available for vaccine production ever since.⁵⁹

5.5 Keko Pharmaceutical Industries (KPI) and the Production for Self-Sufficiency 1968–1997

The Keko plant was established in 1968 as a unit under the Ministry of Health and Social Welfare. It was a medium-scale unit with facilities for the production of tablets, capsules, and infusions for curative purposes. Its foundation stone was laid in 1973 by the first Vice President Aboud Jumbe. The construction of KPI was divided into two phases. Phase one was completed in 1972, while the second phase was done in July 1975. Trial production started immediately after the completion of civil works and installation of machinery.⁶⁰ KPI was built under the assistance of the Chinese government following the request by Tanzania's Ministry of Health in 1967. The plant was built at the cost of Tshs. 9.9 million, the government of Tanzania contributing a sum of Tshs. 5.1 million for civil works and the remaining Tshs. 4.8 million, which was in the form of machinery, raw materials and technology, were provided by

⁵⁸ United Nations Industrial Development Organization (UNIDO), *Programme for Production of Vaccines in Africa, Technical Report: Programme for Production of Vaccines in Tanzania, Prepared for the Government of the United Republic of Tanzania, on January 6, 1986*, 5.

⁵⁹ UNIDO, *Establishment of a Formulation-Filling Plant for Bacterial Vaccines for Veterinary Application Technical Report, Findings and Recommendations, Prepared for the Government of the United Republic of Tanzania, on November 13, 1991*, 9.

⁶⁰ "A Special Report, Chinese Medical Assistance to Tanzania, May 12, 1972," TNA. Acc. No. 450, File No. HE/I/10/15, Pharmaceutical Plant (Keko); "Kiwanda cha Dar Kutoa Madawa Mwaka Ujao," *Uhuru*, Novemba 3, 1973, 1.

the Chinese government. From its inception, KPI was a production wing of the Ministry of Health. However, in May 1980, the plant was transferred to the Ministry of Industries under the newly established parastatal, the NCI. As a parastatal, KPI began to produce on a commercial basis rather than a non-profit making unit.⁶¹

From its commencement, KPI vowed to maintain the government's policy of socialism and self-reliance by substituting imports of pharmaceuticals with local production. The factory had a production capacity of 105 million tablets, twelve categories of injections contained in 10 million ampules, and five categories of intravenous infusions contained in 40,000 vials per year. At its early stage, the plant committed to producing highly needed drugs consistent with the existing health challenges. Its trial production list included about 35 varieties of medicines.⁶² However, in 1977, production was reduced to 25 products. The management realised that there was little demand for some products, while others were uneconomical. For instance, eye drops were in less demand due to fewer eye cases. The production of some drugs was phased out, as they were perceived to be unpopular with many users. Among the 25 listed products, not all were routinely produced. Some drugs were produced only on special requests.⁶³ There was an increase in production for the seriously needed medicines at the plant. The available figures show that aspirin and dextrose were in high demand. Thus, production of these drugs rose tremendously. For instance, the production of aspirin rose from 20 million tablets in 1975 to 35 million in 1977. Similarly, the production

⁶¹ "National Chemical Industries, Brief Notes on Keko Pharmaceutical Industries Limited, 1981," TNA. Acc. No. 638, Chemical Industries, File No. GM/6/F/80, Keko Pharmaceutical Industries Ltd, 1985, Special Surveys and Reports.

⁶² "Letter from the Office of Planning and Development Department of the Tanzania Investment Bank to the Director, Keko Pharmaceutical Plant, March 18, 1978, Production of Keko Factory," TNA. Acc. No. 450, File No. HE/1/10/15, Pharmaceutical Plant (Keko); "Kiwanda cha Madawa Kitajengwa Mjini Dar," *Uhuru*, Septemba 21, 1972, 5. The early 35 varieties produced by KPI at its trial stage included; Ferrous Sulphate (Ctd) 300 mg, Aspirin 300 mg, APC 420 mg, Yeast 300 mg, Tetracycline 250 mg, Phenobarbitone 30 mg, Vitamin C 100 mg, Vitamin B1 10 mg, Vitamin B2 5 mg, Vitamin K4 4 mg, Ephedrine Hcl 30 mg, Aminophylline 100 mg, Isoniazid 100 mg, Chloroquine DO4 250 mg. The production further included the following types of injections; Vitamin B1 2ml x 100 mg, Ephedrine 1ml x 30 mg, Reserpine 1ml x 1 mg, Aminophylline 2ml x 500 mg, Procaine 2ml x 40 mg, Vitamin B12 1ml x 0-1 mg, Chloramphenicol 2ml x 250 mg, Nikethamide 1.5ml x 375 mg, Sodium Bicarbonate 10ml x 500 mg, Tetracaine 10ml x 50 mg, Atropine SO4 1ml x 0.5 mg, Distilled Water for Injection 5 ml, Glucose 500 ml x 5%, Normal/Saline 500 ml x 0.9%, Glucose/Saline 500ml (5% Glucose Nacl), Dextran 500ml 6%, Mannitol 100ml x 20%. It further included the following list of eye drops; Neomycin Sulp 5ml x 5%, Neomycin Sulp 10ml x 5%, Sulphacetamide Sod. 5ml x 10%, and Sulphacetamide Sod. 10ml x 10%.

⁶³ "Pharmaceutical Plant, Keko, Production List," TNA. Acc. No. 450, File No. HE/1/10/15, Pharmaceutical Plant (Keko). Drugs produced on special request included; Mannitol Injection, Chloramphenicol Injection, Sodium Bicarbonate, Distilled Water and Procaine. The following kinds of medicines were no longer in production by 1977; Neomycin Sulp 5ml x 5%, Neomycin Sulp 10ml x 5%, Sulphacetamide Sod. 5ml x 10%, Sulphacetamide Sod. 10ml x 10%, Isoniazid 100 mg, APC 420 mg, Yeast 300 mg, Vitamin B2 5 mg, Reserpine 1ml x 1 mg, Tetracaine 10ml x 50 mg.

of dextrose rose from 2,000 tablets in 1975 to 15,000 in 1977.⁶⁴ These few glimpses reveal that the production focus responded to the economic demands following the most common diseases.

The Chinese pharmaceutical technicians handed over the plant to Tanzanians in June 1976. Regrettably, shortly after the handover, the production trend began to contract. The financial statistics of 1977 show that the plant did not make any profit, but rather lost Tshs. 90,673.83. The factors that led to this loss included an inadequate supply of raw materials, poor management, and the lack of enough skilled personnel.⁶⁵ Such shortfalls reveal that the conditions for a successful handover have not been satisfied. The production trends show that the target of production was not realised throughout the period when the plant was under close eyes of the Chinese government (Table 15). It was not until 1981 that tablet production reached 130 million, and in 1983 when the production of infusion turned 125,000 litres. The production target at KPI was realised and exceeded its initial capacity at a period when the government turned to the loans and grants from Nordic countries and others of the North. Donor countries from the North provided loans and grants to purchase raw materials and modern equipment which replaced Chinese production technology (see below). The new machines re-installed in the plant were mostly sourced from England and Germany.⁶⁶ This increase in production in the 1980s implies that the availability of enough raw materials and modern machines were imperative for the efficiency and sustainable development of pharmaceutical industries.

Nevertheless, from the early 1990s, donors from Nordic countries and others from the North reduced their loans and grants to the Tanzanian government, which, in turn, led to a severe decline in the production of pharmaceuticals. The government lacked enough foreign currency to purchase raw materials for these industries.⁶⁷ Reductions in loans and grants were prompted by liberal politics, which promoted a free-market economy and privatisation of government enterprises. Such policies in favour of privatisation and private corporations discouraged financial and material support to government-owned factories. As a result, under

⁶⁴ “Pharmaceutical Plant, Keko, Production List,” TNA. Acc. No. 450, File No. HE/I/10/15, Pharmaceutical Plant (Keko).

⁶⁵ “Pharmaceutical Plant, Keko, Production Report Year July 1977-June 1978,” TNA. Acc. No. 450, File No. HE/I/10/15, Pharmaceutical Plant (Keko).

⁶⁶ “Letter from the Secretary, Central Tender Board, February 5, 1979 to the Director, Keko, Pharmaceutical Plant, request for Purchase of Oil-Fired Steam Boiler and Pressure Vessel,” TNA. Acc. No. 450, Ministry of Health, File No. HE/I/10/15, Pharmaceutical Plant (Keko).

⁶⁷ JMT, *Hotuba ya Mheshimiwa C. D. Msuya (MB.), Waziri wa Viwanda na Biashara, Akiwasilisha Bungeni Makadirio ya Matumizi kwa Mwaka 1994/95*, 15.

the free market economy, the government-owned pharmaceutical industries failed to keep pace with imported pharmaceuticals, which were cheaply sold, and hence collapsed.⁶⁸ Production records available shows that in 1989 the KPI and the Tanzania Pharmaceutical Industries Ltd (TPI)⁶⁹ produced a total of 621,531 million tablets. Its production dropped to 602 million tablets in 1990. The only advantage of the time was that while government-owned pharmaceutical industries registered little success, privately owned industries supplied the market requirements to a more considerable degree. For instance, the Mansoor Daya and Shellys Ltd. pharmaceutical industries increased their production of tablets from 35,535 million tablets in 1989 to about 47,596.7 million tablets in 1990.⁷⁰

Production trends at government pharmaceutical factories continued to drop extremely. The production of tablets fell to about 12%, from 463 million tablets in 1991 to 407.2 million tablets in 1992.⁷¹ The situation was worse in 1993, when the production of the two government-owned pharmaceutical industries dropped at 51%; that is, from 407.2 million tablets in 1992 to 198 million tablets in 1993. These drops imply that the assistance which the Tanzanian government received from the Nordic and other donor countries in the 1980s did not sustainably enhance the operational capacities of pharmaceutical industries. Moreover, the promising performance of the privately-owned pharmaceutical industries justified the need for privatisation of government-owned pharmaceutical industries. As a result, in 1997, the government sold off Keko to a private investor who owned 60% of shares with the remaining 40% retained by the government. However, since then, Keko has come under the administration and management of a private investor.⁷²

As the Tanzanian government had thus failed to develop an integrated and coordinated policy, local pharmaceutical industries failed to produce enough pharmaceuticals to meet demand and foster self-dependency. As a result, local pharmaceutical industries contributed marginally to the country's medical self-reliance aspirations. For example, in the late 1970s and early 1980s, local production never accounted for more than 5–7% of the country's total

⁶⁸ Interview by Andrea Kifyasi with Cleopa David Msuya, July 6, 2018, Upanga, Dar es Salaam.

⁶⁹ Tanzania Pharmaceutical Industries Ltd (TPI) was the third government-owned pharmaceutical industry after MVI and KPI. TPI was established under the sponsorship of the Finish government in 1976.

⁷⁰ JMT, *Hotuba ya Mheshimiwa C. D. Msuya, (MB.), Waziri wa Viwanda na Biashara, Akiwasilisha Bungeni Makadirio ya Matumizi kwa Mwaka 1991/92*, 13-14.

⁷¹ JMT, *Hotuba ya Mheshimiwa C. D. Msuya (MB.), Waziri wa Viwanda na Biashara, Akiwasilisha Bungeni Makadirio ya Matumizi kwa Mwaka 1993/94*, 13.

⁷² Robert M. Mhamba and Shukrani Mbirigenda, "The Drugs Industry and Access to Essential Medicines in Tanzania," *EQUINET Discussion Paper Series*, 83 (July 2010): 14.

demand. Yet, the 1990 information shows that the government imported medicines and equipment from abroad at a rate of about 95%.⁷³

Table 15: Production trends at KPI, 1976–90

SN.	Year	Tablets (Millions)	Infusions Litres (Thousands)
1	1976	83.13	25.69
2	1977	85.36	27.75
3	1978	66.37	24.93
4	1979	100.00	24.93
5	1980	103.45	25.00
6	1981	130.00	37.15
7	1982	200.00	26.78
8	1983	180.00	125.00
9	1984	335.31	185.57
10	1985	44.23	202.77
11	1986	276.98	494.43
12	1987	371.77	398.92
13	1988	201.62	630.79
14	1989	362.73	376.89
15	1990	305.89	500.78

Sources: Created by the author based on data from TNA. Acc. No. 638, Chemical Industries, File No. KPI/8, Keko Pharmaceutical Industries Ltd, Company Plan, 1985, 38; File No. KPI/6, Keko Pharmaceutical Industries Ltd, 1988, Company Plan, 1, and File No. KPI/5, Keko Pharmaceutical Industries Ltd, 1991, Company Plan, 44.

The failure of KPI and other domestic pharmaceutical industries to meet national demands made the government spend most of its foreign currency on purchasing drugs and other medical equipment from abroad. Available financial information discloses that the total costs of imported medicinal and pharmaceutical products rose with time. For instance, the costs surged from USD 0.9 million in 1964 to USD 4 million in 1968. Then costs swelled again from Tshs. 34 million in 1971 to Tshs. 120 million in 1977.⁷⁴ Inevitably, the mounting costs for

⁷³ Economic Commission for Africa, *Chemical Industry Development Programme*, 107; “World Drug Market Manual, 1982,” TNA. Acc. No. 450, File No. HE/I/10/15, Pharmaceutical Plant (Keko); JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. C. S. Kabeho, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1990/91*, 21-22.

⁷⁴ “The Pharmaceutical Industry, 1970,” TNA. Acc. No. 596, National Development Cooperation, File No. D/1000/4, Vol. 1 Projects General, 1969-1974; “JMT, *Mpango wa Pili wa Maendeleo wa Shughuli za Afya na Ustawi wa Jamii kwa Kipindi cha Miaka Mitano Kuanzia Julai 1, 1969 Mpaka Juni 30, 1974*,” TNA. Acc. No. 589, Orodha ya Majalada ya Mtu Binafsi, Bhoke Munanka, File No. BMC. 10/03, Speeches of Ministers and

drugs and equipment overwhelmed the Tanzanian government's budget. For example, in 1990/1991 financial year, the funds required for the purchase of medicines amounted to Tshs. 6.2 billion. Yet, the government afforded only 35% of it; relying for the rest on loans and grants from multilateral lenders and donor countries.⁷⁵ In 1990, the government predicted that the costs for the purchase of medicines and medical equipment would shoot to at least Tshs. 8 billion by 2000. However, the actual cost turned out to be Tshs. 10 billion, Tshs. 2 billion higher than the government's forecasts. Worse still, the costs further increased to Tshs. 30 billion in 2004/2005 and to Tshs. 53 billion in 2008/2009, respectively.⁷⁶

5.6 The Raw Materials for Pharmaceutical Industries

As seen in the previous section discussing the British colonial government's efforts to plant cinchona trees, access to raw materials was at the heart of the industry. As in other industrial undertakings, a constant supply of raw materials was imperative for the pharmaceutical industry. Yet, investment in the production of pharmaceutical raw materials was not taken seriously by many African countries at independence. As a result, the production of pharmaceuticals in the continent leaned towards the secondary and tertiary levels, meaning that the industries produced finished dosage forms from imported raw materials and excipients (inactive substances) as well as packaging and labelling finished products.⁷⁷ With limited exceptions for South Africa, Egypt, and Ghana, production at the primary level, which involved manufacturing active pharmaceutical ingredients (APIs) and intermediates⁷⁸ from basic chemical and biological substances, did not exist. Up to 2012, 95% of APIs were imported to Africa.⁷⁹ Thus, many post-colonial African industries produced generic medicines, which means the copies of original or innovating branded medicines. The enterprises purchased

Junior Ministers, 18; "Kiwanda cha Madawa Kitajengwa Mjini Dar," *Uhuru*, Septemba 21, 1972, 5; "Arusha Drug Plant to Save 48m/-" *Daily News*, November 9, 1977, 3.

⁷⁵ JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. Prof. Pillemon M. Sarungi, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1992/93*, 30.

⁷⁶ JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. Anna Margareth Abdallah, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 2005/2006*, 8; JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. Prof. David Homeli Mwakyusa, (MB.), Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 2008/2009*, 68.

⁷⁷ African Union (AU), *Pharmaceutical Manufacturing Plan for Africa, Third Session of the African Union Conference of the Ministers of Health: Strengthening of Health Systems for Equity and Development in Africa, April 9-13, 2007* (Johannesburg: African Union 2007), 7; East African Community, *East African Community Regional Pharmaceutical Manufacturing Plan of Action (2012-2016)*, 17.

⁷⁸ APIs were the therapeutic component of the drug, and excipients were pharmacologically inactive substances used as a carrier for the active ingredients of medication or as lubricants during the manufacturing process. See, for instance, Banda, Wangwe and Mackintosh, "Making Medicines," 11.

⁷⁹ UNIDO, *Pharmaceutical Manufacturing Plan for Africa: Business Plan* (Addis Ababa: UNIDO, 2012), 54.

chemicals in bulk and turned them into a form suitable for administration to patients. The medicines produced contained the same form of dosage, therapeutic effect, delivery route, known risks, and side effects as the originator drug.⁸⁰ This situation limited the development of pharmaceutical knowledge and innovations to many African countries. It further aggravated the dependency on foreign brands and prompted repatriation of the economy through the purchase of APIs.

While the first pharmaceutical industry established in the country (Mansoor Daya Chemicals Ltd.) utilised raw materials from overseas and mainly from England, the first Chinese-funded vaccine plant (Mabibo Vaccine Institute) depended on China for its raw materials.⁸¹ The Chinese themselves did not produce all vaccine-related raw materials during that time. Instead, a few of them were bought from Holland and exported to Tanzania based on the factory's demand. Imported raw materials for the vaccine factory were specifically for manufacturing TB vaccines while the production of vaccines for smallpox utilised locally produced raw materials.⁸²

The availability of raw materials for the Keko plant was also problematic. KPI began its production by using a stock of raw materials provided by the Chinese government as a grant.⁸³ While this grant facilitated the launch of the production, it also constituted a market entry strategy for Chinese pharmaceutical raw materials in Tanzania. It is evident that KPI utilised raw materials it received from China for a while and promptly began purchasing such raw materials largely in China.⁸⁴

⁸⁰ Banda, Wangwe and Mackintosh, "Making Medicines," 11; also see J. V. S. Jones, *Resources and Industry in Tanzania: Use, Misuse and Abuse* (Dar es Salaam: Tanzania Publishing House, 1983), 95; Mhamba and Mbirigenda, "The Drugs Industry," 9.

⁸¹ Mabele, "Kiwanda cha Madawa," 12-13.

⁸² Binagi, "Madawa ya Kinga Yatengenezwa Mabibo," 11.

⁸³ A grant of raw materials for KPI included; Aminophylline (tablets), Activated Charcoal, Caffeine Medicinal, Phenobarbitone, Aluminium Hydroxide, Magnesium Stearate, Dried yeast, Ferrous Sulphate, Thiamine hydrochloride, Aminophylline Injection, Isoniazid, and Anhydrous Caffeine. Read "Ripoti ya Quality Control, 1976/77," TNA. Acc. No. 450, Ministry of Health, File No. HE/I/10/15, Pharmaceutical Plant (Keko).

⁸⁴ "Ripoti ya Quality Control, 1976/77," TNA. Acc. No. 450, Ministry of Health, File No. HE/I/10/15, Pharmaceutical Plant (Keko).

Table 16: Varieties of raw materials imported for KPI and the importing countries, 1977

SN.	Name of Raw Material	Importing Country
1	Thiamine Hydrochloride	China
2	Chloramphenicol	China
3	Neomycin Sulphate	China
4	Procaine HCL	China
5	Phenobarbitone	China
6	Sulphacetamide Sodium	China
7	Ascorbic Acid	China
8	Ephedrine HCL	China
9	Glucose Oral	China
10	Mannitol	China
11	Magnesium Stearate	China
12	Aspirin	China
13	Vitamin C	China
14	Dextrose Monohydrate	India
15	Dextrin	India
16	Aminophylline	India
17	Ferrous Sulphate	India
18	Starch	Holland
19	Talcum Powder	Holland
20	Indigo Carmine	Holland
21	Lemon Yellow	London-UK
22	Cochineal	London-UK
23	Tetracycline HCL	Geneva-Switzerland

Source: “Ripoti ya Quality Control, 1976/77,” TNA. Acc. No. 450, Ministry of Health, File No. HE/I/10/15, Pharmaceutical Plant (Keko).

Some pharmaceutical raw materials for KPI were purchased in other countries including India, Britain, Switzerland, and the Netherlands, since, by the 1970s, Chinese enterprises did not produce every kind of raw materials needed.⁸⁵ Anecdotal evidence shows that the Chinese government was privileged for imports by its aid recipient countries. For instance, in Zanzibar, a government official assured the Deputy Ambassador of China to Tanzania saying that: “Often when we want to order [products] we first ask China and if they

⁸⁵ “Ripoti ya Quality Control, 1976/77,” TNA. Acc. No. 450, Ministry of Health, File No. HE/I/10/15, Pharmaceutical Plant (Keko).

do not have, we inquire to other countries.”⁸⁶ The dominance of Chinese-made pharmaceutical raw materials throughout the 1970s implies that the procurement processes favoured Chinese companies. Such privileges were inconsistent with China’s “Eight Principles” of economic cooperation and foreign aid, whereby in its second principle, the Chinese government promised to honour the sovereignty of the recipient countries while providing aid with no strings attached or asking for any privileges.⁸⁷ Indeed, in the 1970s, it was diplomatically difficult for the Tanzanian government to import raw materials for MVI and KPI from Europe, America, or elsewhere so long as Chinese firms produced similar kinds of raw materials. Such an attempt would have deterred the bilateral relationship between the two countries. Consequently, the execution of China’s assistance in pharmaceutical industries created a market for Chinese raw materials. A grant of raw materials offered by the Chinese government immediately after the handover of MVI and KPI persuaded the managements to place the orders for their raw materials with China. Thus, by 1977, China dominated the supply of pharmaceutical raw materials to KPI, as shown in Table 16.

From the above table, it is apparent that KPI imported more than 60% of raw materials from China and purchased a few in India, Holland, London, and Geneva. Yet, the 1977 report from the department of quality control shows that the plant utilised a few varieties of raw materials such as laboratory chemicals which were locally produced.⁸⁸ Unfortunately, I could not get more information detailing the quantity and quality of the produced chemicals. Moreover, information showing the progress of the production of the chemicals mentioned above could not be found. As there were no implemented plans for the local production of pharmaceutical raw materials, local production continuously depended on overseas imports.

Findings of this study show that the necessary purchase of pharmaceutical raw materials made the government spend considerably large sums of foreign currency not allocated in its budget. Investment in pharmaceutical industries reduced the government’s spending on imported medicines from abroad but increased demands for foreign currency used to purchase pharmaceutical raw materials. The available financial reports show that from 1981

⁸⁶ My translation from Kiswahili in “Mazungumzo na Balozi wa China, August 7, 1970,” ZNA. Group Index. DO. Ministry of Trade and Industry, File No. DO10/4, 1969 April to 1970 August, Maelezo ya Mkutano na Balozi wa Uchina.

⁸⁷ Andrea Azizi Kifyasi, “The Goals of China-Africa Medical Cooperation: A Case Study of Tanzania, 1960s-2010” (Masters diss., Zhejiang University, July 2016), 19.

⁸⁸ “Ripoti ya Quality Control, 1976/77,” TNA. Acc. No. 450, File No. HE/I/10/15, Pharmaceutical Plant (Keko).

to 1985 the funds spent on the purchase of pharmaceutical raw materials rose tremendously. For instance, the costs for pharmaceutical raw materials at KPI rose from Tshs. 19 million in 1981 to Tshs. 24.7 million in 1982. Furthermore, they increased from Tshs. 30.13 million in 1983 to Tshs. 37.66 million in 1984. On the other hand, the grant for raw materials that the KPI received from Nordic countries in 1984 lowered the costs of importing raw materials from Tshs. 37.66 million in 1984 to Tshs. 20.05 million in 1985.⁸⁹ This implies that the local production of raw materials for pharmaceutical industries was essential in saving costs related to higher demands of foreign currency.

Dependence on imported raw materials for pharmaceutical industries was challenging. In addition to the costs incurred, and as raw materials were transported by a ship, it took a minimum of three months to receive the goods in the Dar es Salaam port. Procurement processes were usually bureaucratic, which further discouraged purchases and delayed importation.⁹⁰ Moreover, imported raw materials raised production costs, which led to higher prices for Tanzanian-made drugs. Yet, fewer initiatives were made by the Tanzanian government to encounter import-dependence to its local industries. In his address to the national conference of the ruling political party Chama Cha Mapinduzi (CCM), Chairman Julius K. Nyerere confessed: “We have paid little attention to the possibility of the local development of these minor but essential inputs [industrial raw materials] [. . .] The problem of the import-dependence of our industries has never been given sufficient weight in our decisions [. . .]”⁹¹

Disappointments of *Mwalimu* Nyerere prompted the Ministry of Industries and Commerce to develop a plan to tackle the question of obtaining raw materials. Subsequently, in its Third Five Year Development Plan, the ministry proposed to increase the production of pharmaceutical industries to reach at least 40% of the actual needs of medicines in the country using locally produced raw materials and vowed to reduce the importation of pharmaceutical raw materials and promote local production. Yet, the ministry planned to consent to the

⁸⁹ “Brief Notes on Keko Pharmaceutical Industries Limited, 1981,” TNA. Acc. No. 638, Chemical Industries, File No. GM/6/F/80, Keko Pharmaceutical Industries Ltd, 1985, Special Surveys and Reports; also see TNA. Acc. No. 638, Chemical Industries, File No. KPI/8, Keko Pharmaceutical Industries Ltd, Company Plan, 1985, 8.

⁹⁰ “Letter from the Director, Pharmaceutical Plant, Keko, July 24, 1978 to the Manager of Import Licencing Department, July to December Foreign Exchange Allocation of Industrial Raw Materials,” TNA. Acc. No. 450, File No. HE/I/10/15, Pharmaceutical Plant (Keko).

⁹¹ URT, *The Address Given to the National Conference of Chama cha Mapinduzi by the Chairman, Ndugu Julius K. Nyerere, on October 20, 1982 at Diamond Jubilee Hall, Dar es Salaam*, 44.

importation of a few varieties of raw materials which could not possibly be produced in Tanzania. With such projections, the government anticipated producing locally more than 80% of the demand for medicines by 1986.⁹² Unfortunately, such dreams did not materialise. The importation status after 1986 remained similar to the previous years, with the government importing more than 90% of medicines and all of its raw materials for chemical industries.

Undeniably, the question of raw materials posed a great challenge to the development of pharmaceutical industries. Some scholars argue that the production of pharmaceutical raw materials in Africa – and Tanzania, in particular – was impossible. For instance, J. V. S Jones maintains that the production of commonly used drugs in Tanzania such as aspirin and chloroquine demanded a large bank of intermediate chemicals such as sulphuric acid, caustic soda, and chlorine. It also needed reagents such as acetic acid, acetic anhydride, benzene, ethylene, alcohol, and others, the production cost of which a non-industrialised and a low-income country like Tanzania could not afford. He added that the country further lacked a strong quality control team to guarantee a high standard of purity for the chemicals.⁹³ Despite the merits of Jones' observations, I argue that Tanzania had the potential to produce some pharmaceuticals using locally produced raw materials while importing a few which could not be produced in the country. For instance, the production of quinine could have been eased by the presence of cinchona plantations established during German and British colonial periods. Suleiman Mbenea Mlungwana, a long-time employee at KPI, admitted that local production of some raw materials was possible, but the goodwill of political elites and donors was missing.⁹⁴

The possibilities of producing raw materials locally would have been learnt from Congo (DRC), where a Belgian-established pharmaceutical factory, Regie Congokina (now Pharmakina), produced quinine using cinchona barks yielded at Kivu and Ituri provinces. The factory commenced the manufacturing of quinine using the locally grown cinchona barks from 1944 to the present.⁹⁵ Mzee Mlungwana contended that the Pharmakina fed KPI with quinine

⁹² URT, *Hotuba ya Ndugu Basil P. Mramba, (MB.), Waziri wa Viwanda na Biashara, Akiwasilisha Bungeni Makadirio ya Matumizi kwa Mwaka 1981/82*, 19.

⁹³ Jones, *Resources and Industry in Tanzania*, 97.

⁹⁴ Interview by Andrea Kifyasi with Suleiman Mbenea Mlungwana, June 6, 2018, KPI Headquarters, Mzee Mlungwana is a Quality Assurance Manager at KPI. He works with KPI from 1984 to the present.

⁹⁵ "Letter from the Director of Regie Congokina, June 30, 1945 to Medical Department of Tanganyika Territory," TNA, Tanganyika Secretariat, File No. 32780, Manufacture of Quinine in Tanganyika Territory, 1944-1945.

salts from the 1990s to the present.⁹⁶ As seen above, the quinine salts which KPI imports from DRC had been locally produced during German and British colonialism as well as the post-colonial periods. Information from the MoH shows that up to 1985 cinchona was grown in Tanga Region, especially at Amani in Lushoto and Handeni Districts. For instance, there was a large-scale production of cinchona in Dindira, which had 940 acres and produced 36 tons each year. Similarly, Balangai cinchona farm with 700 acres produced 62 tons each year. At the same time, in Moga where 24 acres of cinchona was planted produced at least 756 kilograms of cinchona bark annually.⁹⁷ Nevertheless, the cinchona bark produced in the post-colonial period was not locally utilised. Instead, the bark was exported overseas. In February 1985, the Principal Secretary of the Ministry of Health, Julius Sepeku, complained to medical researchers over the repatriation tendencies and vowed to encourage the use of cinchona bark for the local production of quinine.⁹⁸ Yet, records documenting the local use of cinchona following the Ministry's commitments could not be found.

Furthermore, in 1990, the government attempted to utilise medicinal plants as an alternative source of pharmaceutical raw materials. Although it took 23 years to implement, this intention had first been pronounced on May 6, 1967, by Tanzania's Minister for Health:

Most of the medicines that are needed for curing our normal day-to-day diseases can be obtained from various local plants. Of course, there are some drugs which are of a highly sophisticated nature, whose raw materials cannot be produced locally or whose production costs far exceed the cost of importation. Such drugs will continue to be imported for a long time.⁹⁹

Commitments by the Minister for Health stemmed from the fact that Tanzania had the richest flora in tropical Africa. In June 1985, the Minister for Health Aaron Chiduo informed the parliament that the country had more than 215 plants species which were effective in addressing several diseases.¹⁰⁰ Chiduo's statement was complemented by the findings from the Institute of Traditional Medicine (ITM) which reaffirmed that the country had about 12,667 plant species of which 1,267 were utilised in traditional medicine.¹⁰¹ Yet, these species

⁹⁶ Interview by Andrea Kifyasi with Suleiman Mbonea Mlungwana, June 6, 2018, KPI Headquarters,

⁹⁷ "Mimea ya Quinine ipo Mingi," *Uhuru*, Februari 28, 1985, 3.

⁹⁸ "Wizara yataka Quinine Itengenezwe," *Uhuru*, Februari 27, 1985, 3.

⁹⁹ "Shortage of Doctors," *Standard*, Dar es Salaam, June 18-24, 1967.

¹⁰⁰ "Mitishamba 215 Inafaa kwa Matibabu - Chiduo," *Uhuru*, Juni 25, 1985, 4.

¹⁰¹ Rogasian L. A. Mahunnah, Febronia C. Uiso and Edmund J. Kayombo, *Documentary of Traditional Medicine in Tanzania: A Traditional Medicine Resource Book* (Dar es Salaam: Dar es Salaam University Press, 2012), 8.

represented only 10% of the country's flora. This context gave more opportunities for effective utilisation of an almost untapped wealth of medical flora by traditional medicine practitioners and pharmaceutical industries. More importantly, the stress on the production of medicines using medicinal herbs was among recommendations made in 1990 by the South Commission. Under the Chairmanship of *Mwalimu* Nyerere, the commission encouraged countries of the South to fully utilise medicinal plants to reduce dependence on imported drugs and pharmaceutical raw materials from abroad.¹⁰² Consequently, the 1990's attempt by the Tanzanian government was partly responding to the call by the Southern Commission.

Subsequently, in early 1990, the KPI made several steps to execute the government's ambitions of utilising medicinal plants. It firstly collaborated with the Traditional Medicine Research Unit (TMRU), which was under the Muhimbili University of Health and Allied Sciences (MUHAS), to launch joint research project on useful medicinal plants as well as production processes. The general projections were to warrant effective supply of medicinal plants at KPI and modernise the production of traditional medicines in the country.¹⁰³ However, there was poor coordination and the project lacked clearly defined roles for the two institutions, TMRU and KPI. TMRU failed to secure outlets for the products, presumably due to the non-existence of a clear-cut national policy on the production and utilisation of plant-derived pharmaceuticals.¹⁰⁴ The coordination between KPI and TMRU was vital for effective utilisation of medicinal plants in the health care system. Fortunately, at the end of 1990, the government restored the proper coordination between the two institutions, and TMRU submitted herbs to KPI for production trial.¹⁰⁵ The TMRU anticipated that KPI would commence production trial immediately upon the receipt of the raw materials. Nevertheless, the production trial delayed due to bureaucracies in the Ministry of Health, which complicated the issuance of the policy. Up to the end of 1991, there was no policy guiding the production and utilisation of drugs extracted from locally grown plants. Hence, the project collapsed. Informants claimed that external forces from countries importing pharmaceutical raw materials

¹⁰² The South Commission, *The Challenge to the South* (United States: Oxford University Press, 1990), 102.

¹⁰³ TNA. Acc. No. 638, Chemical Industries, File No. KPI/5, Keko Pharmaceutical Industries Ltd, 1991, Company Plan, 38.

¹⁰⁴ TNA. Acc. No. 638, Chemical Industries, File No. KPI/5, Keko Pharmaceutical Industries Ltd., 1991, Company Plan, 38.

¹⁰⁵ The submitted herbs included: 102 kg. of *Cinchona succirubra* cortex, 21 kg. of *Calendula officinalis*, 68 kg. of *Sybilium marianum*, 154.5 kg. of *Saponaria officinalis* radix, 35 kg. of *Datura innoxia*, 50.5 kg of *Thymus vulgaris* herba, 65 kg. of *Tagetes patula* and, 53.4 kg. of *Coriandrum sativum*, TNA. Acc. No. 638, Chemical Industries, File No. KPI/4, Keko Pharmaceutical Industries Ltd, 1990, Company Plan, 7.

were behind the delay for the issuance of the policy in favour of their imports.¹⁰⁶ Yet, strong evidence is missing to substantiate this claim. Regardless, unnecessary delays in the issuance of the policy provide grounds to accept that there were internal and external forces which compromised initiatives invested in producing drugs using locally grown plants.

Ineffective utilisation of medicinal plants by local pharmaceutical industries prompted their export out of Tanzania. For instance, *Artemisia annua* plant (which was commercially produced in Southern Highlands, Northeastern, and Northwestern parts of Tanzania in the 1990s) was extracted and shipped to Europe and Asia. In 2002, about 28 tons of artemisinin was destined for shipment to Europe.¹⁰⁷ The *Artemisia annua* plant produces artemisinin raw materials necessary for the production of anti-malaria medicines. The extracted raw materials were consumed by industries abroad that produced drugs and then exported them to Tanzania. Worse still, local pharmaceutical industries purchased APIs for artemisinin from European and Asian companies for the production of anti-malarial therapies.¹⁰⁸ Stacey Langwick adds that in the 1990s and 2000s, more herbs from Tanzania were transferred to China and other countries. Traditional Chinese medicine practitioners imported efficacious medicinal herbs from Tanzania and mixed with other Chinese herbs to produce medicines which were used in China and elsewhere, including Tanzania.¹⁰⁹ Thus, the Tanzanian government failed to promote adequate utilisation of medicinal herbs as an alternative source of raw materials in pharmaceutical industries, which negatively affected the efficient production of pharmaceutical industries.

¹⁰⁶ Interview by Andrea Kifyasi with Suleiman Mbonea Mlungwana, June 6, 2018, KPI Headquarters, Silver Sendu, June 12, 2018, Kimara Bonyokwa, *Mzee* Sendu is a former employee at KPI. He worked in the Maintenance Department from 1987 to 2003.

¹⁰⁷ “National Institute for Medical Research (NIMR), The Commercialization of Local Production of Artemisinin, 2006,” NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 7.

¹⁰⁸ “National Institute for Medical Research (NIMR), The Commercialization of Local Production of Artemisinin, 2006,” NRC. Ministry of Health and Social Welfare, 14/7/01, File Ref. No. BC. 74/544/01, Technical Aid China 2005-2008, 7.

¹⁰⁹ Stacey A. Langwick, *Bodies, Politics, and African Healing: The Matter of Maladies in Tanzania* (USA: Indiana University Press, 2011), 77.

5.7 The Implications of Tanzania's Economic Crisis and China's Open-Door Policy to Chinese-Funded Pharmaceutical Industries, 1978–1990s

The period from the late 1970s and through the 1980s was memorable in Tanzania's history. The country's economy suffered under several predicaments, including the Uganda-Tanzania War or Kagera War of 1978 to 79, which, in turn, affected the survival of several local industries.¹¹⁰ The government faced a severe deficit of foreign currency during and especially after the war. Admitting to the prevailing situation, Nyerere contended:

Yet it still true that to a large extent, at our present level of development, it is unavoidable that our industries should be import-dependent. And for the last two years, they have been starved of foreign exchange. As a result, our industrial production has dropped drastically. Measured in constant prices, our industrial output in 1979 was valued at Shs. 1,092 million. In 1980 it had dropped to Shs. 648 million. The industrial sector accounted for 10.4% of our Gross Domestic Product in 1977; in 1981 it accounted for only 5.8% of a smaller GDP.¹¹¹

The crisis severely affected the pharmaceutical industries. For instance, production at KPI dropped from 335.31 million tablets in 1984 to 44.23 million in 1985.¹¹² It was ill fated that the crisis occurred at a moment when China's assistance to Tanzania was less forthcoming. At the end of the 1970s, China lost interest in Africa following its reform and opening-up policy adopted in 1978. Projects funded by the Chinese government in Africa were abandoned, with China providing neither guidance nor financial assistance. From 1978 onwards, the Chinese government did not pledge to sponsor huge projects as it used to in the previous decades.¹¹³ The Chinese government established a new way of assisting a few countries with which it had developed a close friendship, including Tanzania. A letter from the Ministry of Foreign Affairs of Tanzania disclosed that: "[...] China, as she is now, cannot undertake very big projects as she used to do in the past. Hence [the] Chinese [government] suggest that we could identify

¹¹⁰ T. L. Maliyamkono and M. S. D. Bagachwa, *The Second Economy in Tanzania* (London: James Currey, 1990), 4.

¹¹¹ URT, *The Address Given to the National Conference of Chama cha Mapinduzi by the Chairman, Ndugu Julius K. Nyerere, on October 20, 1982 at Diamond Jubilee Hall, Dar es Salaam*, 44.

¹¹² TNA. Acc. No. 638, Chemical Industries, File No. KPI/6, Keko Pharmaceutical Industries Ltd, 1988, Company Plan, 1.

¹¹³ Yanzhong Huang, "Pursuing Health as Foreign Policy: The Case of China," *Indiana Journal of Global Legal Studies* 17, no. 1 (Winter, 2010): 111; Li Anshan, "China's New Policy toward Africa," in *China into Africa, Trade, Aid, and Influence*, ed. Robert I. Rotberg (Washington, D. C: Brookings Institution Press, 2008), 7.

small medium size projects which could be run on joint venture basis.”¹¹⁴ The Chinese government preferred small-scale projects such as furniture, garment, leather, and soap factories, to name just a few.¹¹⁵

For a project to qualify as a joint venture with the Chinese government, it had to possess many of the following criteria: Firstly, projects were to be of small or medium scale. Secondly, raw materials were to be locally available to avoid the high costs of imports. Thirdly, China’s portion of profits had to be remitted to China in foreign exchange. Fourthly, China’s contribution to a joint venture was to be less than 50% of the total investment. Fifthly, China’s investment was to be in the form of equipment and technical expertise. Above all, the recipient country had to provide land, factory premises, raw materials, operating funds, and other necessary facilities.¹¹⁶ Thus, the Chinese authorities had set aside ideological and political interests in favour of economic gains. Besides the HIV/AIDS research and treatment project funded in 1987 (Chapter 4), the Chinese government did not back the establishment of any meaningful project in Tanzania from the period of 1978 to 1995.

Under the joint venture policy, the Chinese government devoted to taking control of projects established under its sponsorship. Accordingly, it assisted Chinese enterprises to penetrate the African market, invest, and run the enterprises under the government’s sponsorship.¹¹⁷ Some Chinese-funded projects in Tanzania, such as the Friendship Textile Factory and Ubungo Farm Implements, were taken over by Chinese enterprises in the 1990s as the Tanzanian government possessed less than 50% of the shares, which enabled Chinese enterprises to exercise the management of the industries entirely.¹¹⁸ I could not find out the reasons that prevented Chinese enterprises from taking control of pharmaceutical industries. However, profit return was the determining factor for China’s commitment to a joint venture, and the Chinese government did not see any potential from the pharmaceutical industries. Thus,

¹¹⁴ “Letter from Principal Secretary, Ministry of Foreign Affairs, November 30, 1982 to the Assistant Minister, Ministry of State (Planning) of Zanzibar, Joint Venture with China,” ZNA. Group Index. DO. Ministry of Trade and Industry, File No. DO5/25, 1976 March to May 1983, Mahusiano na Nchi za Nje-China.

¹¹⁵ “Letter from Principal Secretary, Ministry of Foreign Affairs, November 30, 1982 to the Assistant Minister, Ministry of State (Planning) of Zanzibar, Joint Venture with China,” ZNA. Group Index. DO. Ministry of Trade and Industry, File No. DO5/25, 1976 March to May 1983, Mahusiano na Nchi za Nje-China.

¹¹⁶ “Letter from Principal Secretary, Ministry of Foreign Affairs, November 30, 1982 to the Assistant Minister, Ministry of State (Planning) of Zanzibar, Joint Venture with China,” ZNA. Group Index. DO. Ministry of Trade and Industry, File No. DO5/25, 1976 March to May 1983, Mahusiano na Nchi za Nje-China.

¹¹⁷ See, Menghua, “An Interactive Perspective,” 198.

¹¹⁸ Menghua, “An Interactive Perspective,” 198.

the Chinese government effectively abandoned the pharmaceutical companies it had helped establish.¹¹⁹

China's reduction of assistance to Africa and Tanzania in particular weakened the economic and political strength of Nyerere's government. Moreover, *Mwalimu* Nyerere, who was also a close friend of Mao Zedong, perceived the open-door policy as an open betrayal of Maoism.¹²⁰ Before official endorsement of the policy, Nyerere sent to China a delegation led by Prime Minister, Edward Moringe Sokoine, in September 1978, to negotiate the new forms of Sino-Tanzanian diplomatic relationship. Chinese officials told Sokoine that their economy was affected by several predicaments such as earthquakes and the decline in the production of coal and iron. Thus, while the Chinese government focused on reviving the declining economy, it allocated limited resources to foreign assistance. In 1978 the government also projected reaching the highest level of development similar to superpower nations by 2000. Hence, the government of China utilised most of its resources internally to promote economic growth.¹²¹ To this end, it is apparent that the reform and opening-up policy targeted China's development into an economic superpower more than Maoism, which stressed political hegemony.

The hardships outlined above no doubt weakened China's economy. Nevertheless, as this study has shown, international aid had also been motivated by the struggle for diplomatic recognition between Mainland China and Taiwan, which, following China's admission had come to a satisfactory end. Thus, diplomatic support from African countries was not a motivation to provide aid; instead, Chinese authorities desired to obtain sophisticated industrial technology, which African countries could not provide (Chapter 1). The Chinese authorities found it imperative to reconcile with the United States and attract foreign direct investment (FDIs) to obtain advanced technologies and capital for its diffusion to domestic firms, and only industrialised countries in the North could provide that. It was not until the mid-1990s that China acquired technology and advanced industries that seemed to promise their elevation to

¹¹⁹ Some scholars claim that the Chinese government never abandoned projects it funded in the country, see Rwekaza Mukandala, "From Proud Defiance to Beggary: A Recipient's Tale," in *Agencies in Foreign Aid: Comparing China, Sweden and the United States in Tanzania*, ed. Goran Hyden and Rwekaza Mukandala (New York: St. Martin's Press, 1999), 55.

¹²⁰ Interview with Joseph W. Butiku, Executive Director, The Mwalimu Nyerere Foundation in Tanzania on July 9, 2018 at The Mwalimu Nyerere Foundation Headquarters, Posta-Dar es Salaam. Mr Butiku worked at the statehouse as personal research Assistant of Mwalimu Nyerere from 1965.

¹²¹ "Ziara ya Waziri Mkuu ndugu E. M. Sokoine, Mb. Katika Jamhuri ya Watu wa China kati ya Tarehe 12/9/1978 hadi 15/9/1978," ZNA. Group Index. DO. Ministry of Trade and Industry, File No. DO5/25, 1976 March to May 1983, Mahusiano na Nchi za Nje-China.

“superpower” that Africa, once again, become of great importance – but this time, only because it had abundant raw materials needed for Chinese industrial development.¹²²

China’s abandonment of pharmaceutical industries prompted the Tanzanian government to turn to donors of the North. From the 1980s, countries such as the United Kingdom, Denmark, Sweden, Finland, Norway, and Netherlands emerged as major donors and technical advisers to the industrial sector (Chapter 1).¹²³ Their interventions decreased China’s influence on pharmaceutical industries. For instance, they advised and formatted KPI with new European-made machines and technologies. The machines installed by Chinese technical experts were perceived to be of small-scale, crude, outdated and unable to keep pace with the growing technology and production demands. Thus, in 1980, Chinese production technology at KPI was phased out and replaced by European technology.¹²⁴ The phasing out of Chinese technology was a big blow to the South-South knowledge production and exchange. Yet, China’s abandonment of Africa in the period from 1978 to 1995 influenced some countries, including Tanzania, to reorient their economic destiny toward the North.

In the course of these diplomatic shifts, Tanzania’s industries came to rely increasingly on raw materials from Northern countries, while imports from China decreased. For example, in 1984, the government of Norway donated to KPI raw materials for aspirin, chloroquine phosphate, chloramphenicol levo, tetracycline hydrochloride, mebendazole, and paracetamol. In 1987, Norway donated again to KPI 80,000 kg of granulated aspirin, tablets auxiliary materials, and equipment for the tableting unit.¹²⁵ Furthermore, in 1990, the government of Sweden donated to KPI six million Swedish kronor for the purchase of raw materials.¹²⁶ Some traditional donors of the North attempted to rescue Tanzania’s pharmaceutical industries through loans. For instance, in 1990, the World Bank gave Tanzania

¹²² Read, for instance, Peter J. Buckley, Jeremy Clegg and Hi Tan, “Knowledge Transfer to China: Policy Lessons from Foreign Affiliates,” *Transnational Corporations* 13, no. 1 (April 2004): 31; Huang, “Pursuing Health as Foreign Policy,” 111.

¹²³ Alf Morten Jerve, “The Tanzanian-Nordic Relationship at a Turning Point,” in *Re-Thinking the Arusha Declaration*, ed. Jeannette Hartmann (Copenhagen: Axel Nielsen and Son A/S, 1991), 171.

¹²⁴ Interview by Andrea Kifyasi with Suleiman Mbonea Mlungwana, June 6, 2018, KPI Headquarters, Silver Sendeu, June 12, 2018, Kimara Bonyokwa.

¹²⁵ TNA. Acc. No. 638, Chemical Industries, File No. KPI/8, Keko Pharmaceutical Industries Ltd, Company Plan, 1985, 39; TNA. Acc. No. 638, Chemical Industries, File No. KPI/6, Keko Pharmaceutical Industries Ltd, 1988, Company Plan, 6.

¹²⁶ Under SIDA, Sweden purchased 16 tonnes of chloroquine DC, 33 tonnes of paracetamol, 30 tonnes of Dextrose, 419,680 pieces of polypropylene bags and various raw materials for the production of infusions at KPI, TNA. Acc. No. 638, Chemical Industries, File No. KPI/5, Keko Pharmaceutical Industries Ltd, 1991, Company Plan, 6.

a loan of USD ten million for the purchase of basic medicines and pharmaceutical raw materials.¹²⁷ In 1993, the World Bank again lent the Tanzanian government USD 26.5 million for the purchase of medicines, medical equipment, and pharmaceutical raw materials.¹²⁸ Donation of pharmaceutical raw materials and medicines to Tanzania was beneficial on the one hand since it invigorated production activities of the government pharmaceutical factories. However, on the other hand, it covertly paved the way for the prompt penetration of such goods in the Tanzanian market.

The preceding exposition illustrates attempts by countries of the North to revitalise local pharmaceutical industries through loans and grants. However, such assistance did not sustainably maintain the efficiency of the government-owned pharmaceutical industries. The question of pharmaceutical raw materials was answered by loans for the purchase of raw materials and through grants of raw materials purchased from abroad, preferably from donor companies.¹²⁹ Additionally, the insufficient production of medicines by local pharmaceutical factories was addressed through loans for the purchase of medicines abroad and by donations of some basic medicines.¹³⁰ I maintain that these kinds of assistance did not provide a lasting solution to the existing drug shortages, and the production of pharmaceutical industries collapsed. Instead, they exacerbated the government's debt burden. Loans received by the government from the World Bank and other multilateral lenders were meant for consumption and not for production. Bought medicines and equipment were consumed or used, and once finished, the government applied for the next supply. Donors' assistance was less extended to projects capable of building and maintaining the ability of the Tanzanian government to produce pharmaceutical raw materials and enough medicines through its local industries.

5.8 China's Role in Pharmaceutical Knowledge Transmission

On June 16, 1964, the Chinese and Tanzanian governments signed agreements on economic and technical cooperation in which the government of China pledged to offer

¹²⁷ JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. C. S. Kabeho, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1990/91*, 21-22.

¹²⁸ JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. Amrani H. Mayagila, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1994/95*, 38.

¹²⁹ TNA. Acc. No. 638, Chemical Industries, File No. KPI/6, Keko Pharmaceutical Industries Ltd, 1988, Company Plan, 6.

¹³⁰ JMT, *Wizara ya Afya, Hotuba ya Waziri wa Afya Mhe. C. S. Kabeho, MB. Kuhusu Makadirio ya Matumizi ya Fedha kwa Mwaka 1990/91*, 21-22.

economic aid and transmit its production technology to Tanzania in the form of equipment, goods, and technical experts.¹³¹ The modes of the knowledge exchange were through long- and short-term training of Tanzanian technicians in China, as well as short-term training via special classes in Tanzania and through on-the-job training.¹³² Accordingly, the Tanzanian government anticipated that the signed cooperation agreements would address the shortfalls of skilled personnel.

The Sino-Tanzanian technical cooperation was established at the peak of Cold War politics. During this period, several countries of the North believed that Africans were unable to master technology; thus, development projects requiring advanced technology had to be discouraged on the continent. For instance, in the mid-1960s, when Tanzania and Zambia were struggling to get funding for the Tanzania-Zambia Railway (TAZARA) project the US government officials declined the project arguing that “Africans [were] too backward to master [its] technology.”¹³³ In contrast, some Southern countries did not hesitate to support technologically based projects on the continent. In this vein, the Chinese government’s transmission of pharmaceutical knowledge to Tanzania was imperative to challenging racist presumptions and the hegemony of the knowledge from the Global North.¹³⁴ Nevertheless, I argue that the *modus operandi* in which China’s pharmaceutical knowledge exchange was executed failed to equip local workers with sufficient technical knowledge and managerial skills, which, in turn, retarded efficiency and survival of the pharmaceutical factories (see below). I maintain that the collapse of Chinese-funded pharmaceutical factories was partly caused by problems with imported technology and the dependency created by it.

At its establishment, MVI and KPI recruited Tanzanians to work with the Chinese technical experts for the sake of knowledge sharing. Many of the recruits were graduates from the University of Dar es Salaam majoring in chemistry, engineering, and biology.¹³⁵ Recruits for the MVI worked with Chinese technical experts from 1971 to 1979. For the case of KPI,

¹³¹ Menghua, “An Interactive Perspective,” 179.

¹³² Li Anshan, “Technology Transfer in China-Africa Relation: Myth or Reality,” *Transnational Corporations Review* 8, no. 3 (2016): 186, <http://dx.doi.org/10.1080/19186444.2016.1233718>.

¹³³ Jamie Monson, “Freedom Railway: The Unexpected Successes of a Cold War Development Project,” *Boston Review* (December 2004/January 2005): 2.

¹³⁴ Comaroff and John L. Comaroff, “Theory from the South: Or, How Euro-America is Evolving Toward Africa,” *Anthropological Forum* 22, no. 2 (July 2012), <http://dx.doi.org/10.1080/00664677.2012.694169>. For more details read their book, Jean Comaroff and John L. Comaroff, *Theory from the South: Or, How Euro-America is Evolving Toward Africa* (London: Paradigm Publishers, 2012).

¹³⁵ Interview by Andrea Kifyasi with Suleiman Mbonea Mlungwana, June 6, 2018, KPI Headquarters; Silver Sendeu, June 12, 2018, Kimara Bonyokwa.

the recruits joined thirteen Chinese technical experts in 1975, and they worked together until 1976. Archival and oral testimonies show that neither the training of technical students in China nor training in the formal classes at the factory premises was provided. Instead, on-the-job training was privileged. The Chinese government assumed that pharmaceutical knowledge and skills would be swiftly learnt by local workers while on the job.¹³⁶ Effective on-the-job training involves both theory and practice, which integrates trainers and trainees. Consequently, language as a medium of communication was a valuable training tool. Yet, Chinese technical personnel could neither speak fluently the English language nor Kiswahili. Thus, they mostly passed pharmaceutical knowledge to the locals through gesture.¹³⁷ Such a technique was further used by Chinese technician working in other Chinese-funded projects. Philip Snow writes that in the Tanzania-Zambia Railway (TAZARA) project, Chinese technician “would assemble and dismantle a piece of machinery and encourage his African apprentices to follow suit until they got the procedure right.”¹³⁸ This informal way of transmitting knowledge to Tanzanian staff lasted up to June 1976 for the KPI and until 1979 for MVI. On September 8, 1976, and in 1979, Chinese technical personnel completed their assignment and left the country. Since then, the management and production activities at KPI and MVI was left to Tanzanian personnel.¹³⁹

Scholarships, which had for certain periods allowed Tanzanian students to train at Chinese universities, were not a solution. It took until 1972 when about 200 Tanzanian and Zambian students received Chinese government scholarships to pursue their studies in transportation, locomotive speciality, and railway engineering.¹⁴⁰ The scholarships for other specialities and to other countries resumed in 1974, three years after the handover of the MVI and two years before the handover of the KPI to Tanzanians. Furthermore, in 1978, two years after the handover of KPI, China adopted the open-door policy where it lost interests in Africa. Indeed, the new policy affected the Chinese government scholarships to African students. For instance, scholarship opportunities dropped from 121 in 1978 to 30 in 1979.¹⁴¹ Thus,

¹³⁶ “Ripoti ya Quality Control, 1976/77,” TNA. Acc. No. 450, File No. HE/I/10/15, Pharmaceutical Plant (Keko), Interview by Andrea Kifyasi with Suleiman Mbonea Mlungwana, June 6, 2018, KPI Headquarters; Silver Sendeu, June 12, 2018, Kimara Bonyokwa.

¹³⁷ Interview by Andrea Kifyasi with Suleiman Mbonea Mlungwana, June 6, 2018, KPI Headquarters.

¹³⁸ Quoted in Li, “Technology Transfer in China-Africa Relation,” 186.

¹³⁹ “Ripoti ya Quality Control, 1976/77,” TNA. Acc. No. 450, File No. HE/I/10/15, Pharmaceutical Plant (Keko).

¹⁴⁰ Li, “Technology Transfer in China-Africa Relation,” 186.

¹⁴¹ Li Anshan, “African Students in China: Research, Reality and Reflection,” *African Studies Quarterly* 17, Issue 4 (Feb. 2018): 11 (5-44.)

opportunities for pharmaceutical technicians from Tanzania to get trained in Chinese pharmaceutical colleges were very limited. In contrast, the Chinese government channelled its scholarships to students studying for the TAZARA project since, compared to other projects, the prosperity of TAZARA had a higher geopolitical value in the eyes of the Chinese government. While previous scholarship has used the TAZARA case to draw a sweeping conclusion that Chinese sponsored projects in Africa went hand in hand with adequate knowledge transmission to the personnel of the recipient country, the MVI and KPI cases show that there was no effective means of knowledge exchange to the local personnel.¹⁴²

The management and production at KPI and MVI by Tanzanian staff were a crucial assignment to test the efficiency of the on-the-job training. Unfortunately, from the beginning, the factories faced technical and managerial hurdles, which signalled that local personnel were unable to run the factories effectively. The two factories faced a severe shortage of experts and updated knowledge on the part of the existing personnel. For instance, soon after the Chinese left, the production of vaccines at MVI was found to be below WHO standards. This context discouraged the government and closed the factory shortly.¹⁴³

Passing on pharmaceutical knowledge through on-the-job training was insufficient. Such challenges were the result of feebleness in structural and systematic processes in the establishment and operation of the factory. Pharmaceutical industries utilised equipment and machines that demanded a higher level of expertise to operate effectively. They, therefore, required highly trained and experienced personnel. Nevertheless, the government established the industries while lacking industrial (technical) pharmacists and experienced managerial personnel. Graduates who took over the industries from the Chinese experts lacked effective production and managerial skills. This was because the relevance of the science and engineering knowledge produced at local universities was limited at grounding scientific theories, which were, of course, vital for the founding of pharmaceutical industries. Yet, the knowledge produced lacked application skills. Thus, college graduates who took over the production and managerial activities needed specific industrial training to gain production

¹⁴² In this article, the author applauds China's role in knowledge transfer to China aid recipient countries. Li "Technology Transfer in China-Africa Relation"; also see, Liu Haifang and Jamie Monson, "Railway Time: Technology Transfer and the Role of Chinese Experts in the History of TAZARA," in *African Engagements: Africa Negotiating an Emerging Multipolar World*, ed. Ton Dietz, et al. (USA: Brill, 2011).

¹⁴³ UNIDO, *Programme for Production of Vaccines in Africa, Technical Report: Programme for Production of Vaccines in Tanzania, Prepared for the Government of the United Republic of Tanzania, on January 6, 1986*, 5.

skills through formal short training and further studies. In 1959, Richard Turnbull, then governor of Tanganyika, projected that it would take up to 20 years for the country to have a “sufficient number of Africans of experience, ability and integrity to fill posts in the public service, and in commerce and industry.”¹⁴⁴

Pharmaceutical manufacturing was a complicated process involving a wide range of stakeholders whose investments needed financial and technical preparations before embarking on the production and commercialisation. An effective manufacturing system required specialised skills in several disciplines such as pharmacy, chemistry (analytical, organic, synthetic and medicinal), biological sciences (biochemistry, microbiology and molecular biology), life sciences (medicine, pharmacology and toxicology), management (strategy, financial and management accounting, operations, logistics and commercial laws), and information and communication technology (ICT).¹⁴⁵ These specialisations were dearly missing in post-colonial Tanzania. Moreover, successful pharmaceutical services included both clinical (hospital, retail pharmacies) and industrial (technical) pharmacy. Regrettably, during both German and the British colonial era, Tanganyika developed these services in one-way traffic, namely clinical pharmacy. Throughout the colonial period, medical training focused on a few cadres such as dispensing auxiliaries and rural medical aids. It was not until 1940 that the British colonial government introduced courses in chemical analysis and pharmacy assistantship. Moreover, such attempts were interrupted by the WW II and thus were in the end in vain. Thus, the colonial medical schools trained pharmaceutical cadres for hospital and retail pharmacies only.¹⁴⁶ In the post-colonial period, the Tanzanian government did not shift the paradigm. Instead, it proceeded from where the colonialists ended by adding training schools for the same medical cadres. The post-colonial government failed to realise the need for industrial (technical) pharmacists who were the pillars of the development of pharmaceutical

¹⁴⁴ Quoted in Sebastian Edwards, *Toxic Aid: Economic Collapse and Recovery in Tanzania* (Oxford: Oxford University Press, 2014), 66.

¹⁴⁵ UNIDO, *Programme for Production of Vaccines in Africa, Technical Report: Programme for Production of Vaccines in Tanzania, Prepared for the Government of the United Republic of Tanzania, on January 6, 1986*, 41.

¹⁴⁶ “Letter from the Director of Medical Services, June 5, 1946 to the Chief Secretary, Dar es Salaam,” TNA. Acc. No. 450, Ministry of Health File No. 675 Medical Training Centres; also see Nsekela and Nhonoli, *The Development of Health Services*, 40.

industries. Pharmaceutical technicians were responsible for drug discovery and manufacturing as well as quality control and utilisation.¹⁴⁷

Up to 1972, Tanzania had only 5 African pharmacists who had trained abroad and were hired by the Mansoor Daya and Mabibo Vaccine plants. It was not until 1974 that the MUHAS launched the School of Pharmacy. The school began as a department in the Faculty of Medicine of the Medical College. Subsequently, from July 1974, the school commenced a three-year course on pharmaceuticals with an annual intake of 16 students. It was established with the assistance of the British Council, United Nations Development Programme (UNDP), and the WHO. They assisted in the form of experts, equipment, and fellowships.¹⁴⁸ Consequently, the school was established three years after MVI has been handed over to the Tanzanian government, and two years before the handover of KPI. Not surprisingly, the industries faced technical challenges caused by the lack of skilled local personnel shortly after the handover. Archival sources show that many job applicants lacked the required qualifications. For instance, KPI advertised a vacancy for production auxiliaries in June 1976, but up to June 1978, there were no qualified applicants.¹⁴⁹

The ways in which the Chinese technical experts shared pharmaceutical knowledge with Tanzanians resembles and differs slightly from the Finnish technical experts. In April 1976, the Tanzanian government signed Tripartite Agreement with the National Development Corporation, M/S Orion Yhtymä (OY) Corporation of Finland, and the Finnish Ministry of Foreign Affairs for the establishment of Tanzania Pharmaceutical Industries (TPI). According to the agreement, the M/S Orion Yhtymä had to provide continuous on-the-job training for the local staff in Tanzania and advanced three-month training for two experienced pharmacists in Finland at Orion's premises.¹⁵⁰ This attempt, however, did not address the challenge of skilled

¹⁴⁷ "Pharmaceutical Production Technician Training, June 15, 1978," TNA. Acc. No. 450, File No. HE/I/10/15, Pharmaceutical Plant (Keko).

¹⁴⁸ "WHO, Assignment Report: Medical School, Dar es Salaam, July 1968-August 1974," WHOA, File No. TAN-HMD-001, 1974-1979-HMD 5, Training of Health Personnel, 5; "WHO, National Health Planning in Tanzania: Report on a Mission, 1st August 1973-28th April 1974," WHOA, File No. TAN/SHS/002, 1972-1974-SHS/NHP, National Health Planning, 16; Charles A. Mkonyi, "Emergence of a University of Health Sciences: Health Professions Education in Tanzania," *Journal of Public Health Policy* 33, no. 1 (2012): S54; Interview by Andrea Kifyasi with Rogasian L. A. Mahunnah, July 21, 2018, Tabata Kisiwani, Dar es Salaam. Professor Mahunnah worked at the Institute of Traditional Medicine of the Muhimbili University.

¹⁴⁹ "Pharmaceutical Plant, Keko, Production Report Year July 1977-June 1978," TNA. Acc. No. 450, File No. HE/I/10/15, Pharmaceutical Plant (Keko).

¹⁵⁰ "National Chemical Industries, Request Document for Technical Services Assistance to Tanzania Pharmaceutical Industries Limited," TNA. Acc. No. 638, Chemical Industries, File No. NCIC/8/G/80, Tanzania Pharmaceutical Industries, Proposals, Negotiations and Contracts.

personnel at the TPI. After three years, the trainees had not acquired sufficient knowledge to carry over the factory. Admitting the shortage of personnel, the Director of National Chemical Industries (NCI) asserted:

[. . .] as we do not have the experienced technical personnel at the Company, NCI's urgent requirement is to have a competent firm which can provide the necessary technical backup services to TPI for a given period at the same time training the present technical staff. We are therefore requesting the Ministry of Industries and Ministry of Finance to request the Finnish Government to provide us [with] the suggested expatriates possibly from ORION to provide the required technical services up to the end of 1984 and then request UNICEF to take over from ORION for five years thereafter.¹⁵¹

Given that the Chinese and Finnish experts themselves had spent more than five years studying to qualify, it does not seem altogether surprising that a few months of training and on-the-job observation proved insufficient. The 2012 United Nations Industrial Development Organization (UNIDO) report affirms that pharmaceutical knowledge is complicated and would take at least three years or more to train a college graduate who has a basic qualification in relevant disciplines and to convert the trainee into a skilled pharmaceutical operator.¹⁵²

The findings of this study support Jamie Monson's observations on the TAZARA project. She contended that the project suffered technical failures because "the Chinese [technical experts] did not achieve their goal of training and supervising enough African technicians to take over the management of TAZARA after their departure."¹⁵³ She further noted that the railway authority continued to rely on Chinese technical experts after the handover. Yet, Nyerere was overly optimistic that technicians from the South would be cheap yet effective compared to experts from the North. In his words:

My own country has a recent experience of what this can mean [South-South technical assistance]. All the technicians in our cement works were from Europe. They were highly paid, with expensive leave and other benefits. But, when they objected to our new Income

¹⁵¹ "National Chemical Industries, Request Document for Technical Services Assistance to Tanzania Pharmaceutical Industries Limited," TNA. Acc. No. 638, Chemical Industries, File No. NCIC/8/G/80, Tanzania Pharmaceutical Industries, Proposals, Negotiations and Contracts.

¹⁵² UNIDO, *Programme for Production of Vaccines in Africa, Technical Report: Programme for Production of Vaccines in Tanzania, Prepared for the Government of the United Republic of Tanzania, on January 6, 1986*, 42.

¹⁵³ Monson, "Freedom Railway," 2.

Tax Laws, we were able to replace them with technicians from India, who were less expensive to employ, and more understanding of our needs and circumstances.¹⁵⁴

Thus, the failure of Chinese technicians to equip local pharmacists with enough production and managerial expertise was a big blow to Nyerere's optimism. Moreover, reliance on foreign technicians was inconsistent with Tanzania's socialist policies, which upheld self-dependency. In this way, the Chinese pledge of "teaching Tanzanians how to fish and not giving them a fish" did not yield sustainable results.

5.9 Conclusion

This chapter has shown how China, an emerging donor of the Global South, pledged to assist Southern countries distinct from traditional donors of the Global North. Its assistance was expected to promote self-dependency in African countries since it was executed under the framework of the South-South cooperation, which perceived economic and technological self-sufficiency as the primary weapon in the fight against imperialism, colonialism, and neo-colonialism. Nevertheless, this chapter has shown that China's assistance to the establishment of pharmaceutical industries in Tanzania rather sustained the country's dependency on pharmaceutical raw materials and technicians from China. Such dependencies were caused, for instance, by the ill-conceived mechanisms of knowledge exchange, which failed to pass on sufficient technical knowledge and managerial skills to local personnel. Moreover, capacity building for the local production of pharmaceutical raw materials remained marginal while the country relied heavily on periodic imports. The chapter has maintained that aid provided only short-term relief to technological, economic, political, and social challenges facing recipient countries. In the absence of loans, grants, and technical experts from the donor countries, production and management of the government-owned pharmaceutical industries declined.

¹⁵⁴ Julius K. Nyerere, "Third World Unity," in *Freedom, Non-Alignment and South-South Cooperation, A Selection from Speeches, 1974-1999*, ed. The Mwalimu Nyerere Foundation (Dar es Salaam: Oxford University Press (T), 2011), 25.

CONCLUSION

CHINA'S MEDICAL ASSISTANCE VERSUS TANZANIA'S SELF-RELIANCE AGENDA

The Bandung Conference of 1955 and other related conferences, including the Afro-Asian Solidarity conferences held in Cairo 1957, Conakry 1960, and Moshi 1963, emphasised Southern countries' self-reliance. They further denounced assistance with strings attached, which would perpetuate dependencies.¹ Consistently, in 1964, the Chinese government formulated principles governing its economic and technical aid to foreign countries, which resonated with the priorities advocated by African and Asian countries.² In the same vein, following the Arusha Declaration of 1967, the Tanzanian government set itself an agenda of socialism and self-reliance. With these two principles, it anticipated getting rid of exploitation, enhancing the government's control of the major means of production and its effective use of local resources as primary agents of development. The government welcomed assistance which promised to help the country to move through a transition towards self-reliance.³ Against such backdrop, this study has examined the implications of China's medical assistance for the development of Tanzania's health sector under the discourse of Southern solidarity. It specifically aimed at assessing the extent to which China's medical assistance reflected the Southern agenda of promoting self-reliance and lessening the dominance of countries of the North in medical aid and knowledge to the South. After exploring the social, economic, and political contexts that gave birth to China's medical assistance in Tanzania, this study discussed several major Chinese-funded health projects in independent Tanzania, assessing them in the light of Tanzania's nation-building agenda and its role in promoting new medical knowledge and self-reliance within Tanzania's health sector.

¹ See, for instance, The Ministry of Foreign Affairs, Republic of Indonesia, *Final Communique of the Asian-African Conference of Bandung, April 24, 1955*; Executive Committee of the Afro-Asian Peoples' Solidarity Organisations, *Afro-Asian Peoples' Solidarity Movement* (Cairo), 8.

² Read, for instance, Eight Principles for Economic and Technical Aid Contended by Premier Zhou Enlai when Answering Questions from Reporters of the Ghana News Agency on January 15, 1964 in Ghana, in *Afro-Asian Solidarity Against Imperialism: A Collection of Documents, Speeches and Press Interviews from the Visits of Chinese Leaders to Thirteen African and Asian Countries* (Peking: Foreign Languages Press, 1964), 149.

³ URT, *The Arusha Declaration and TANU's Policy on Socialism and Self-Reliance* (Dar es Salaam: Publicity Section, 1967); Julius K. Nyerere, *The Arusha Declaration and TANU's Policy on Socialism and Self-Reliance, February 5, 1967*, 7.

This research contributes to the existing literature on Sino-African relationships and specifically on China's medical assistance to the South. Some studies have examined the activities of Chinese medical doctors in Africa without fully establishing the contexts that gave rise to such programs. Additionally, some medical aid projects funded by the Chinese government in Africa, such as pharmaceutical industries, HIV/AIDS research and treatment, and the anti-malaria campaign have received little or no scholarly attention. The majority of the publications about China's medical assistance to the South are not historical studies but are from fields of political science and anthropology focusing on China's recent medical diplomacy, the practice of traditional Chinese medicine in private clinics and other current issues. Such works do not show the subtle changes in the projects over time nor their implications in promoting self-reliance and South-South medical knowledge exchange. Yet, available primary sources allow for a more nuanced historical research.

Despite the existence of Sino-African relations before and during colonisation, the relationships became direct and robust during the 1950s, prompted by Cold War politics, which called for the Bandung Conference in 1955.⁴ The conference gave rise to the Afro-Asian Peoples' Solidarity Organisation (AAPSO) in 1957, which spearheaded Southern solidarity, thereby underscoring the need for African and Asian countries to assist one another economically, politically, socially and technologically. As shown in Chapter 1, China's medical assistance to Tanzania was partly influenced by the ideal of Southern solidarity, and the "Eight Principles" governing economic and technical assistance to the South articulated by Premier Zhou Enlai in 1964, which became a blueprint for bilateral medical assistance. However, I argue that China's assistance was motivated by its aspirations to attain political and economic power in a global context. Indeed, China's dominance in the AAPSO won the country influence and recognition by many African and Asian countries, which, in turn, enabled China to establish grounds for political and economic hegemony.

China's medical assistance to Tanzania was a reciprocal process. The assistance was executed at the moment when both governments needed assistance from each other. As discussed in Chapter 1, at independence, the Tanzanian government lacked skilled medical personnel and it imported all pharmaceuticals from abroad. Only twelve registered Tanzanian

⁴ For more on the pre-colonial China-Africa relations, see: Abdul Sheriff, *Dhow Cultures of the Indian Ocean: Cosmopolitanism, Commerce and Islam* (New York: Columbia University Press, 2010); For more on China-Africa relations during the colonial period, see: Juhani Koponen, *Development for Exploitation: German Colonial Policies in Mainland Tanzania 1884-1914*, (Hamburg: LIT Verlag, 1994), 348.

medical doctors were on record, and the disease burden outweighed their capacity. Furthermore, in the mid-1960s, the country encountered diplomatic rifts with West Germany, Britain, and the USA, which limited assistance from the North. Such conditions underpinned the Tanzanian government's reliance on Chinese assistance. While external medical assistance was a necessity to the Tanzanian government, the Chinese prioritised getting recognition in the United Nations General Assembly (UNGA). Upon learning about the influence of Tanzanian President, Julius K. Nyerere, in Africa, Chinese diplomats lobbied so that Nyerere and his delegate would contribute votes that would grant China recognition in the UNGA. Eventually, while the Tanzanian government needed China's medical assistance to enhance the capacity of its health sector, the Chinese government needed Tanzania's support in the UNGA.

Yet, diplomacy and politics were not the only binding factors that aligned Tanzania's interests with those of the Chinese. Instead, the socialist health policies which the Tanzanian government adopted after the Arusha Declaration of 1967 echoed many ideas of the Chinese health system. As elaborated at length in Chapter 2, Tanzania's Ministry of Health (MoH) sent medical delegates to China to study the practicality of China's socialist health system. The delegates recommended the MoH to adopt free health care, institutionalise traditional medicine, ban private health services and promote rural health care. The recommended policies were espoused and practised by the Tanzanian government in the 1960s and 1970s. I maintain that the adopted policies responded to the needs of the government for healthy people and thus human resources. For instance, the extension of rural health care was imperative to improving the welfare of peasants for effective production of both food and cash crops. Additionally, the provision of free health care was conducive to sexual reproduction and reduced mortality and morbidity rates which, in turn, would boost the nation's economy. The adoption of Chinese health policies contested the conceptions about the production and transmission of knowledge and experiences from the Northern "core" to the Southern "periphery" and bespoke the Tanzanian government's endeavour to foster Southern solidarity by learning from so-called peripheral countries. I argue that China's economic, political and social influences on Southern countries should be perceived as a "paradigm shift" since it challenged the core countries and reduced their ability to remain as the key donors.

Questions about the effectiveness of the South-South medical knowledge exchange has been discussed in Chapters 3, 4 and 5 of this study. Knowledge exchange was the main agenda of the African and Asian countries since it was the central means of attaining self-reliance. Moreover, it was the seventh of the "Eight Principles" of China's foreign aid

proclaimed by Zhou in 1964.⁵ China's aid vision won trust from the Tanzanian government, which perceived its assistance as a bridge to self-reliance.⁶ The Chinese government employed different means to foster exchanges of medical knowledge to local medical doctors and technical pharmacists. They included long and short-term training of Tanzanians in China and on-the-job training. Overall, however, the education and training of local experts did not rank high among the Chinese government's priorities. The Chinese government did not provide enough scholarships for Tanzanians to pursue medical and pharmaceutical studies in China during the period from 1968 to 1990. While few short-term training programmes were offered to local medical doctors in Beijing, similar training was not offered to pharmaceutical technicians nor traditional Tanzanian medicine researchers and practitioners. Moreover, the Cold War politics defeated long-term training since medical graduates from China were deemed incompetent by their colleagues schooled at Makerere University and universities located in the North. Such unevenness and tension discouraged Tanzanians from accepting Chinese government scholarships for medical training in China and hindered the production of medical knowledge and exchange.

Furthermore, the modus operandi of knowledge exchange was unsustainable. The Chinese government mostly preferred on-the-job training, expecting local workers in hospitals and pharmaceutical industries to acquire adequate medical knowledge while collaborating with Chinese experts. Moreover, language barriers impeded training and exchange, as many Chinese experts neither spoke fluent English nor Kiswahili. Instead, as shown in Chapter 3, Chinese medical doctors spent most of their time providing clinical care instead of training local medical doctors. Contrary to most scholarly accounts, which maintained that Chinese experts working in Africa transmitted the knowledge effectively to local workers,⁷ my findings suggest that on-the-job training failed in this regard. As discussed in Chapter 5, immediately after Chinese technicians had left, the production of vaccines at the Mabibo factory stopped since the vaccines produced fell below WHO standards. Similarly, the Keko Pharmaceutical Industries collapsed because of unskilled personnel and poor management.

⁵ Read, for instance, *Afro-Asian Solidarity against Imperialism*, 149.

⁶ Read a speech by President Julius K. Nyerere, "TAZARA- from a Caricature of a "Chinese" Railway to "Our" Railway," A Speech at the Handing-over of the Tanzania-Zambia Railway (TAZARA) to Tanzania and Zambia Kapiri Mposhi, Zambia: July 14, 1976, in *Freedom and Liberation: A Selection from Speeches 1974-1999*, ed. The Mwalimu Nyerere Foundation (Dar es Salaam: Oxford University Press (T), 2011), 95.

⁷ See, for instance, Li Anshan, "Technology Transfer in China-Africa Relation: Myth or Reality," *Transnational Corporations Review* 8, no. 3 (2016): 186.

Medicinal herbs were highly used in Tanzania since the country was rich in flora, and its citizens used herbal medicines long before colonial rule. Up to 2012, the country had about 12,667 plant species of which 1,267 were utilised in traditional medicine practices.⁸ The South-South Commission further recommended the use of traditional medicine as the best way of restoring self-reliance to countries in the South.⁹ Therefore, traditional medicine had a key role to play in addressing global health challenges. Nevertheless, despite the richness in flora, traditional medicine practitioners utilised only 10% of medicinal plants. I argue that effective use of herbal medicine in parallel with biomedicine was imperative in addressing global health challenges and in maintaining self-support in Southern countries. Regrettably, as Chapter 5 reveals, several political and technical bureaucratic impediments hampered attempts to use local medicinal plants to produce medicines at Keko Pharmaceutical Industries. By contrast, medicinal herbs from Tanzania were exported overseas, and the government normalised the importation of pharmaceutical raw materials for its industries.

Furthermore, the emergence and practices of traditional Chinese medicine (TCM) had a vital impact on promoting medical knowledge from the South. As described in Chapter 4, TCM gained influence during the 1960s and was positively received by different groups of Tanzanians. Moreover, China's engagement in research and treatment of HIV/AIDS using TCM was an essential contribution to global health. The Tanzanian government hoped that TCM practitioners could boost medical knowledge exchange with local traditional medicine researchers and practitioners while reducing the country's dependency on medicine and medical knowledge from the North. However, traditional medicine researchers from Tanzania were less involved in TCM research and treatment projects because the Chinese interventions in diseases were empowered by faith and perceived TCM knowledge and technology superiority. In this vein, they devalued the knowledge and abilities of traditional medicine researchers and practitioners from Tanzania. Such circumstances existed because achievements of the research and treatment projects would have triggered scientific, economic, and political consequences of significance to the Chinese government.

Dependency theory has maintained that economic and political relationships between the "rich" countries of the North and the "poor" countries of the South were unbalanced and

⁸ Rogasian L. A. Mahunnah, Febronia C. Uiso and Edmund J. Kayombo, *Documentary of Traditional Medicine in Tanzania: A Traditional Medicine Resource Book* (Dar es Salaam: Dar es Salaam University Press, 2012), 8.

⁹ The South Commission, *The Challenge to the South* (New York, NY: Oxford University Press, 1990), 102.

caused underdevelopment in the Southern world. They further maintain that countries of the North exploited resources and maintained their national interests in the South through different means, including foreign assistance.¹⁰ However, I argue that a “national interest” agenda attached to foreign assistance can be exercised by any donor country, regardless of its economic, political, technological or social achievements, with assistance directly or indirectly projecting the interests of donor countries onto recipient countries.

The major findings of this study departed from those of research literature which maintain that Southern countries assisted one another altruistically.¹¹ Discussions in Chapters 3, 4, and 5 showed that the Chinese-funded health projects intertwined political and economic interests. For instance, from the inception of the medical cooperation in 1968 to 1977, the Chinese government pursued more political and less economic interests through its assistance extended to Tanzania. Political interests were influenced by its battle over political recognition against Taiwan in the UNGA. It was further complicated by Mao Zedong’s political propaganda against US imperialism and Soviet revisionist policies in the South. Therefore, China’s assistance throughout the 1960s to 1970s primarily aimed at winning votes for recognition and admission in the UNGA. However, after the reform and opening-up policy of 1978, its assistance to Africa took a new direction. During this period, the Chinese government reduced foreign assistance in favour of economic relationships with countries of the North. For example, it was no longer ready to supply free raw materials to pharmaceutical factories it funded in Tanzania. Moreover, the activities of the Chinese doctors in Tanzania were restructured to promote and popularise the use of medicines manufactured in China. Under the new policies, economic interests overwhelmed geopolitical interests since the Chinese government intended to become an economically powerful nation by the year 2000.¹² Therefore, while the Tanzanian government perceived medical assistance from China as a

¹⁰ Read, for instance, Dambisa Moyo, *Dead Aid: Why Aid Is not Working and How There Is a Better Way for Africa* (New York, NY: Farrar, Straus and Giroux, 2009); Sebastian Edwards, *Toxic Aid: Economic Collapse and Recovery in Tanzania* (Oxford: Oxford University Press, 2014).

¹¹ See, for instance, Li Anshan, “China-Africa Medical Cooperation: Another form of Humanitarian Aid,” accessed May 1, 2016, <http://www.doctorswithoutborders.org/china-africa-medical-cooperation-another-form-humanitarian-aid>; Ding Ying, “Healing Angels from China: Medical Teams from China Fight Death and Disease in the Harshes Environments in Africa,” *Beijing Review*, September 22, 2011.

¹² “Ziara ya Waziri Mkuu ndugu E. M. Sokoine, Mb. Katika Jamhuri ya Watu wa China kati ya Tarehe 12/9/1978 hadi 15/9/1978,” ZNA. Group Index. DO. Ministry of Trade and Industry, File No. DO5/25, 1976 March to May 1983, Mahusiano na Nchi za Nje-China.

stepping-stone towards self-reliance, the Chinese government used foreign aid to pursue political and economic interests at different historical periods.

The aspiration to make Tanzania self-dependent had its roots in the mid-1960s, following its diplomatic rifts with traditional donors of the North. Like other newly founded African states, Tanzania perceived industrialisation as not only a bridge to self-reliance but also a symbol of economic progress. Subsequently, the government established several industries and sought technical and financial support from other countries to achieve its industrialisation agenda. I argue that Tanzania's industrialisation spirit was an ideological fall-out of imperialism since it was equated with development, particularly the development bridging the gap between the already industrialised Global North countries and the semi-industrialised countries of the South. Under this strategy, the Tanzanian government aimed to block the massive importation of medicines by establishing pharmaceutical industries which could produce them locally. Such import substitution programs gained support from structuralist and dependence theorists who have explained poverty in Southern countries as the result of the relationship between European and North American nations with so-called underdeveloped countries. These theorists, however, have overlooked the role played by less industrialised but powerful countries such as Cuba, India and China in retarding development in Southern countries.¹³ From this misconception, political elites in Africa perceived donors from the South as "saviours" and those from the North as "exploiters".¹⁴ Yet, such conceptions maintained the trust of political elites in Tanzania in Asian and Latin American governments. Similarly, government authorities in Tanzania perceived China's sponsorships for the establishment of pharmaceutical industries as emancipatory.

Undeniably, with its socialist ideology, the Chinese government attained a considerably higher level of self-dependency soon after the 1949 revolution. It was, therefore, regarded as a development model in several Global South countries, including Tanzania. In December 1967, a delegation led by Pius Msekwa, (then Tanganyika African National Union (TANU) Executive Secretary), visited China and showed admiration of China's development and Maoism. Msekwa said: "You are able to make great political, military and economic

¹³ Randall M. Packard, *A History of Global Health: Interventions into the Lives of other Peoples* (Baltimore, MD: Johns Hopkins University Press, 2016), 239; also see Edwards, *Toxic Aid*, 24-25. For more detailed information about this structural relationship, see; Walter Rodney, *How Europe Underdeveloped Africa* (Washington DC: Howard University Press, 1982).

¹⁴ Read, for instance, Paul Tiyambe Zeleza, "Dancing with Dragon: Africa's Courtship with China," *The Global South* 2, no. 2 (Fall 2008): 174.

achievements because you have the correct thought guiding you, that is, the thought of Mao-Tse-tung. China has set an excellent example for us in taking the road of self-reliance. Tanzania must take this road too. It's the only road to make our country strong and prosperous."¹⁵ From this perception, China's pledge to support the establishment of pharmaceutical industries was positively hailed, believing that it would reduce the country's dependence on imported pharmaceuticals. However, as presented in Chapter 5, the pharmaceutical industries of Keko and Mabibo failed to promote the country's self-reliance agenda since they faced managerial and technical challenges, which led to their decline in the 1980s and 1990s consecutively. The main reasons behind their collapse included poor management, poor feasibility studies, lack of enough qualified local personnel, and lack of sufficient funds to purchase raw pharmaceutical materials. I maintain that the Chinese-funded industrial projects were conceived under ineffective structural settings with a short-trained managerial team, inadequate local trained personnel, and unsustainable sources of industrial raw materials. All these challenges hampered the local production of pharmaceuticals, which, in turn, curtailed Tanzania's aspirations for self-reliance.

In closing, this research has shown that China's medical assistance to post-colonial Tanzania hardly functioned as a solution to health challenges that faced the Tanzanian government. Its modes of executions were inconsistent with Tanzania's self-reliance agenda. The assistance created unforeseen dependences on Chinese medical doctors, pharmaceutical raw materials, traditional Chinese medicine, and pharmaceutical technicians from China. Findings of this study have shown that whenever Chinese assistance was withdrawn, most of the medical projects declined. Such circumstances warrant the conclusion that Chinese aid only offered short-term relief to several challenges facing the health sector in Tanzania. For instance, under the Chinese medical team program, Chinese doctors saved the lives of many patients and donated drugs, which, in turn, assisted Tanzanians in getting access to basic medicines. However, after Chinese doctors left and the donated medicinal supplies were depleted, inadequacies of skilled medical personnel and the lack of basic medicines persisted. Similarly, Chinese sponsorship of pharmaceutical industries helped the Tanzanian government to kick-start the production of several kinds of medicines. Nevertheless, shortages of pharmaceutical technicians and raw materials resulted in Tanzania's dependency on China.

¹⁵ "TANU Team Flies to S. China," *The Nationalist*, December 22, 1967, 1.

The medical assistance was provided in return for international recognition, political leverage, and economic gains which served China's national interests in different historical periods.

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Interviews

No.	Name	Date	Place
1	Jiang Xuan	January 4, 2016	Hangzhou
2	Ge Yonghe	March 1, 2016	Jinan
3	Che Yansong	March 1, 2016 & May 23, 2019	Jinan
4	Qin Shanbo	March 1, 2016	Jinan
5	Chen Zhufeng	March 1, 2016	Jinan
6	Sui Guangxin	March 1, 2016	Jinan
7	Sun Yazhou	March 1, 2016	Jinan
8	Zhang Jing	April 11, 2016	Hangzhou
9	Song Tao	March 16, 2018	Posta, Dar es Salaam
10	Rajabu Kisonga	April 24, 2018	Dodoma Regional Referral Hospital
11	John G. Myonga	April 24, 2018	Dodoma Regional Referral Hospital
12	Elisiana Danford	April 24, 2018	Dodoma Regional Referral Hospital
13	Martha Manyirezi	April 24, 2018	Dodoma Regional Referral Hospital
14	Liggyle Vumilia	May 7, 2018	Posta, Dar es Salaam
15	Simon Ernest	May 7, 2018	Posta, Dar es Salaam
16	Edwin Mng'ong'o	May 7, 2018	Posta, Dar es Salaam
17	Edith Bakari	May 8, 2018	Posta, Dar es Salaam
18	Paolo Peter Mhame	May 9, 2018	Posta, Dar es Salaam
19	Gallus Namangaya Abedi	June 6, 2018	Posta, Dar es Salaam
20	Suleiman Mbonea Mlungwana	June 6, 2018	Keko, Dar es Salaam
21	Edmund J. Kayombo	June 8, 2018	Muhimbili University, Dar es Salaam
22	Modest C. Kapingu	June 8, 2018	Muhimbili University, Dar es Salaam
23	Febronia C. Uiso	June 8, 2018	Muhimbili University, Dar es Salaam

24	Silver Sendeu	June 12, 2018	Kimara Bonyokwa, Dar es Salaam
25	Cleopa David Msuya	July 6, 2018	Upanga, Dar es Salaam
26	Joseph W. Butiku	July 9, 2018	Posta, Dar es Salaam
27	Amunga Meda	July 18, 2018	Muhimbili National Hospital, Dar es Salaam
28	Hedwiga Swai	July 18, 2018	Muhimbili National Hospital, Dar es Salaam
39	Rogasian L. A. Mahunnah	July 21, 2018	Tabata Kisiwani, Dar es Salaam
30	Qin Chengwei	July 22, 2018	Posta, Dar es Salaam
31	Ramadhan Machano	July 24, 2018	Stone Town Zanzibar
32	Naomi Vuhahula Mpemba	August 1, 2018 & April 9, 2019	Goigi Mbezi Beach, Dar es Salaam
33	HIV/AIDS Patient, A	April 9, 2019	Mlimani City, Dar es Salaam
34	Deng Shucaï	May 23, 2019	Jinan
35	Ding Zhaowei	May 23, 2019	Jinan
36	Jin Xunbo	May 23, 2019	Jinan
37	Bai Wenshan	May 28, 2019	Guang'anmen Hospital, Beijing