Chapter Six
Conclusion: The Interface Between China's Medical Assistance and Tanzania's Self-Reliance Agenda

The Bandung Conference of 1955 and other related conferences, including the Afro-Asian Solidarity conferences held in Cairo in 1957, Conakry in 1960, and Moshi in 1963, emphasized self-reliance to countries of the Global South. 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 eliminating exploitation, enhancing the government's control of the major means of production, and its effective use of local resources as primary development agents. The government welcomed assistance, which promised to help the country's transition towards self-reliance.[3] Against such a backdrop, this study has examined the implications of China's medical assistance for the development of Tanzania's health sector under the discourse of the Southern solidarity agenda. 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 Global North in medical aid and knowledge in the Global 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

1 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 "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.

https://doi.org/10.1515/9783112206881-006

light of Tanzania's nation-building agenda and its role in promoting new medical knowledge and self-reliance within Tanzania's health sector.

This research contributes to the existing literature on Sino-African relationships, specifically China's medical assistance to countries of the Global 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 and AIDS research and treatment, have received little or no scholarly attention. Most publications about China's medical assistance to the Global South are not historical studies, but instead come from political science and anthropology, focusing on China's recent medical diplomacy, the practice of traditional Chinese medicine in private clinics, and other contemporary 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 more nuanced historical research.

Despite the existence of Sino-African relations before and during colonization, the relationships became direct and more 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 aid. 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 it influence and recognition from many African and Asian countries, enabling China to maintain its political and economic interests.

China's medical assistance to Tanzania was a reciprocal process. The assistance was executed when both governments needed assistance from each other. As discussed in Chapter 1, at independence, the Tanzanian government lacked skilled medical personnel and imported all pharmaceuticals from abroad. Only

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.

twelve registered Tanzanian 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 countries of the Global North. Such conditions underpinned the Tanzanian government's reliance on Chinese assistance. While external medical assistance was necessary for the Tanzanian government, the Chinese prioritized gaining 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 sought 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 adopted by the Tanzanian government after the Arusha Declaration of 1967 echoed many ideas of the Chinese health system. As elaborated in Chapter 2, Tanzania's Ministry of Health (MoH) sent medical delegates to China to study the practicality of China's socialist health system following its Great Proletarian Cultural Revolution. The delegates recommended that the MoH adopt free healthcare, institutionalize traditional medicine, ban private health services, and promote rural healthcare. The Tanzanian government espoused and practiced the recommended policies in the 1960s and 1970s. I maintain that the adopted policies responded to the needs of the Tanzanian government for healthy people and, thus, human resources. For instance, the extension of rural healthcare was imperative for improving peasants' welfare, which in turn facilitated the effective production of food and cash crops. Additionally, the provision of free healthcare 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". Furthermore, it bespoke the Tanzanian government's endeavor to foster a Southern solidarity agenda by learning from the 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 the key donors.

Questions about the effectiveness of the South-South medical knowledge exchange have 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 Premier Zhou Enlai in

1964.[5] China's aid vision won the trust of 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 with local medical doctors and technical pharmacists. They included both long- and short-term training for Tanzanians in China, as well as on-the-job training. Overall, however, the education and training of local experts did not rank high among the Chinese government's priorities. Following China's Great Proletarian Cultural Revolution, which shut down all higher learning institutions from 1966 to 1970, only a few Tanzanians got Chinese government scholarships to pursue medical education in China. Moreover, the general stereotype about the quality of medical education in China defeated long-term training. Medical graduates from China were deemed incompetent by their colleagues who had been schooled at the University of Dar es Salaam, Makerere University, and other universities in the Global North. Such unevenness and tensions discouraged Tanzanians from accepting Chinese government scholarships for medical training in China, hindering 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 maintain that Chinese experts working in Africa effectively transmitted their knowledge to local workers, my findings suggest that on-the-job training failed in this regard.[7] As discussed in Chapter 5, the production of vaccines at the Mabibo factory stopped immediately after Chinese technicians had left, since the vaccines produced fell below WHO standards. Similarly, Keko Pharmaceutical Industries collapsed because of unskilled personnel and poor management.

5 See *Afro-Asian Solidarity against Imperialism*, 149.

6 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 Li Anshan, "Technology Transfer in China-Africa Relation: Myth or Reality," *Transnational Corporations Review* 8, no. 3 (2016): 186.

Since the country was rich in flora, medicinal herbs were highly used in Tanzania, 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 utilized in traditional medicine practices.[8] The South-South Commission further recommended using traditional medicine as the best way of restoring self-reliance to countries of the Global South.[9] Therefore, traditional medicine is key in addressing global health challenges. Nevertheless, despite the richness of the flora, traditional medicine practitioners utilized only 10% of medicinal plants. I argue that the effective use of herbal medicine in parallel with biomedicine was imperative in addressing global health challenges and maintaining self-support in Southern countries. Regrettably, as Chapter 2 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 normalized 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 in the Global 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 the research and treatment of HIV 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 countries of the Global North. However, traditional medicine researchers from Tanzania were less involved in TCM research and treatment projects because the Chinese disease interventions were often perceived as being empowered by faith and as having superior knowledge and technology. In this vein, they devalued the knowledge and abilities of traditional medicine researchers and practitioners from Tanzania. Such circumstances existed because the 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 Global North and the "poor" countries of the Global South were unbalanced and caused underdevelopment in the Southern

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.

world. They further maintain that countries of the Global North exploited resources and maintained their national interests in the Global 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 the research literature, which maintains 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. The battle over the political recognition of Taiwan in the UNGA influenced political interests. It was further complicated by Mao Zedong's political propaganda against US imperialism and Soviet revisionist policies in the Global South. Therefore, China's assistance throughout the 1960s to 1970s was primarily aimed at winning votes for recognition and admission to the UNGA. However, after the 1978 reform and opening-up policy, its assistance to Africa took a new direction. During this period, the Chinese government reduced foreign assistance in favor of economic relationships with countries of the Global North. For example, it was no longer ready to supply free raw materials to the pharmaceutical factories it funded in Tanzania. Moreover, the activities of the Chinese doctors in Tanzania were restructured to promote and popularize 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 per-

10 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 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 Harshest 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.

ceived medical assistance from China as a stepping-stone towards self-reliance, the Chinese government used foreign aid to pursue both political and economic interests at different historical periods.

The aspiration to make Tanzania self-sufficient had its roots in the mid-1960s, following its diplomatic rifts with traditional donors in the Global North. Like other newly founded African states, Tanzania perceived industrialization as a bridge to self-reliance and a symbol of economic progress. Subsequently, the government established several industries and sought technical and financial support from other countries to achieve its industrialization agenda. I argue that Tanzania's industrialization spirit was an ideological fallout of imperialism since it was equated with development, particularly the development bridging the gap between the already industrialized countries of the Global North and the semi-industrialized countries of the South. Under this strategy, the Tanzanian government aimed to block the massive importation of medicines by establishing pharmaceutical industries that could produce them locally. Such import substitution programs gained support from structuralist and dependency 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 industrialized 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 "Angels" and those from the North as "demons."[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 founding the People's Republic of China in 1949. 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 admired China's development and Maoism. Msekwa said: "You are able to make great political, military, and economic achievements because you have the correct thought guiding you, that is, the

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; Walter Rodney, *How Europe Underdeveloped Africa* (Washington DC: Howard University Press, 1982).

14 Paul Tiyambe Zeleza, "Dancing with Dragon: Africa's Courtship with China," *The Global South* 2, no. 2 (Fall 2008): 174.

thought of Mao-Tse-tung. China has set an excellent example for us in taking the road to 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, as it was believed to 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, respectively. The main reasons behind their collapse included poor management, poor feasibility studies, a lack of qualified local personnel, and insufficient funds to purchase raw materials for pharmaceutical industries. I maintain that the Chinese-funded industrial projects were conceived under ineffective structural settings with a short-trained managerial team, inadequate locally trained personnel, and unsustainable sources of industrial raw materials. All these challenges hampered the local production of pharmaceuticals, curtailing 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 the Tanzanian government's health challenges. Its modes of execution were inconsistent with Tanzania's self-reliance agenda. The Tanzanian government failed to negotiate with the Chinese actors and shape relations in ways that advance the sustainable development of the health sector. As a result, China's assistance created unforeseen dependencies on Chinese medical doctors, pharmaceutical raw materials, traditional Chinese medicine, and pharmaceutical technicians from China. The findings of this study have shown that whenever Chinese assistance was withdrawn, most 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 essential medicines. However, after the Chinese doctors left and the donated medicinal supplies were depleted, the inadequacies of skilled medical personnel and the lack of essential medicines persisted. Similarly, Chinese sponsorship of pharmaceutical industries helped the Tanzanian government kick-start the production of several kinds of medicines. Nevertheless, shortages of pharmaceutical technicians and raw materials resulted in Tanzania's dependency on China. Generally, medical assistance was provided in return for international recognition, political leverage, and economic gains, which served China's national interests in different historical periods.

15 "TANU Team Flies to S. China," *The Nationalist*, December 22, 1967, 1.