The East to South transfer of Chinese medical technologies, people and know-how counters usual globalisation trends from the West to the rest.

Chinese medical doctor and Kenyan patient (Nairobi, 2005). Courtesy Elisabeth Hsu

Chinese medicine in East Africa and its effectiveness

Elisabeth Hsu

The current practice of Chinese medicine in East Africa takes place primarily in the informal sector and has a short history of one or two decades. It coincides with economic reforms in the People's Republic of China (PRC). If not a consequence of these reforms, Chinese medicine certainly feeds both African and Chinese economies. The practice of Chinese medicine in East Africa is primarily a cultural phenomenon, as it has, as yet, little relevance for public health. In Tanzania and Kenya it is currently offered in about forty medical practices, mostly in the suburbs of Dar es Salaam and Nairobi. There is an historical context and also a local cultural pattern that works favourably towards adopting it into the multi-cultural fabric of East Africa. Furthermore, we should consider the medicine's effectiveness, its meaning response (the effects of the symbolic on the physiological in the treatment of an illness), its social efficacy (the effects the medicine has on the social environment), and ritually induced body transformative effects (the bodily experienced and materially manifest effects of a medical intervention). The latter depends on the optimal interplay of the 'three Ps' - patients, practitioners and ritual paraphernalia (like drugs, needles, the physical features of the medical practice, etc.).[1]

Five fields of Chinese medical care in East Africa

Julius Nyerere, Tanzania's first president, (1962-85), was socialist in orientation and cultivated contacts with the People's Republic of China (PRC) in collaborations that extended to the medical field. At one stage, the PRC despatched over two hundred expert teams of Chinese biomedical doctors to government hospitals in the country's major cities on an annual basis. Most teams included an acupuncturist, since Chinese medicine - and acupuncture in particular - belonged in the package of world socialism that China then exported.[2] However, by 2001, the number of Chinese medical teams had diminished to only about four in Tanzania.

The Chinese doctors who have lived on most vividly in the memory of Tanzanians, are the general practitioners on the Tazara railway project. (The project to build a railway line from Dar es Salaam to Lusaka was financed and executed by the PRC). These doctors were fewer in number, probably not as expert in their speciality (they were employees of the Ministry of Railways and not of the Ministry of Health), and they worked in Tanzania for one or two year spells from 1965 to 1976, the decade in which the line was constructed.[3] Their main objective was to guarantee the health of the Chinese railway workers but they did not shy away from treating the locals too.

A third and less well-known Chinese medical impact on African health care has been mediated through the World Health Organisation (WHO). There are suggestions that the way socialist China dealt with its indigenous *materia medica* became a model for the WHO, (although to my knowledge no one has, as yet, extensively researched this issue), and the modernised traditional Chinese approach, rather than the European one, appears to have been implemented in several WHO traditional medicine programmes. Thus, African medicinal plants were recorded and researched according to the criteria of the modern Chinese *materia medica*, sometimes under the guidance of Chinese experts.[4]

The fourth field of Chinese medical activities in Tanzania arises from Chinese-Tanzanian government collaborations to provide stipends for medical students to train in the PRC. Medical education was based on the Maoist vision of combining Western and Chinese medicine, and during six years in China (one year of language learning and five years of medical training), students were obliged to attend a course on acupuncture for at least one semester.[5] In contrast to any other country in the world, all students had to attend compulsory courses on traditional medicine. As a result, some returned to Tanzania with an entirely different attitude to traditional medicine: it need not be backward and superstitious. In fact, some considered it more 'advanced' than biomedicine, an attitude which may have reflected political convictions that socialism is more advanced than capitalism.[6] Perhaps, such an anti-Imperialist attitude, combined with a certain pragmatism, ignited the collaboration of the Chinese and Tanzanian Ministries of Health, which in 1989 led to the institutionalisation of a long term Traditional Chinese Medicine research programme on HIV/AIDS at Muhimbili Hospital in Dar es Salaam. To date, no results have been published in English. An earlier public statement of renowned senior Chinese doctors who lacked in statistical understanding had apparently upset the medical profession. However, although discredited in research, the programme appears to have had an impact insofar as the antiviral drug *Aikeji* that it developed, which consists only of natural ingredients, is now sold at a very high price in the private sector.

This brings us to the fifth field of Chinese medical doctors' activities in Tanzania, which since 1996 is mostly in the private sector. Restrictions on private practice had been removed in the early 1990s,[7] as the World Bank put pressure on the government to privatise health care. The Chinese doctors who, due to these altered health care policies, immigrated into Tanzania differ in important ways from those described previously. Firstly, they are private entrepreneurs.[8] Secondly, their training in Chinese medicine varies: some are highly qualified but in the early 2000s the majority were 'learning by doing'. Thirdly, they operate in fields marked by rigid bureaucratic structures and 'red tapism', and this impacts on how they offer their services.

Cultural and consumer patterns

In order to 'do business', Chinese medical doctors have to find clientele. In contemporary East Africa, foreign and exotic medicines exert a strange attraction. This cultural pattern was described by the Africanist anthropologists David Parkin (1968) and Susan Whyte (1988) long before Chinese medical entrepreneurs populated the informal sector.[9] Whyte asks what the choices are that people have for managing misfortune and illness, and she finds that they basically have two. They can take recourse to 'medicines' - African herbal remedies, talismans, Koranic spells and/or the ingestion of holy water as well as Western pharmaceuticals – or to 'the healing powers of elder kin, ancestors, and spirits'. The former provides a quick fix, the latter gets at the root of the problem. Chinese medicine in East Africa falls into the former category.

It is not the Chinese medical decoction of herbal 'Chinese drugs' *(zhongyao)* that East African clients seek but 'Chinese formula drugs' *(zhongchengyao)*. The latter consist of powdered *zhongyao*, usually a mixture of several different kinds, to which further ingredients, like vitamins or steroids, are sometimes added. Some come as tablets or capsules, others as tiny seeds or pellets. While a patient who takes *zhongyao* needs to simmer them over a small fire for about twenty minutes twice a day, formula drugs are easy to consume. Some are swallowed, others are dissolved in water and imbibed. They are designed to treat 'complaints' – pain in the joints, irregular menses - not the constitution of a person. In general, the dispensing of 'Chinese formula drugs', *zhongchengyao*, requires significantly less sophistication than the prescription of 'Chinese medical drugs', *zhongyao*. However, to understand the recent popularity of Chinese medicine in East Africa one has to go beyond the patients' perceptions and their attraction to the exotic.

Questions of effectiveness

One could say Chinese medicine has a placebo effect, as it is perceived as an exotic medicine in East Africa. However, many anthropologists have now criticised the 'placebo' as a flawed analytical concept for the social sciences; it is an ethnocentric tool fit for answering questions raised by the medical profession. Within limits, it suits biomedical criteria but it cannot explain social phenomena. Moerman (2002) proposed instead to investigate the 'meaning response', which is inherent to any medical substance or service regardless of whether the standards of the double-blinded randomised controlled trial have been met.[10] Whyte et al. (2003) emphasise the 'social efficacy' of treatment choices as people tend to resort to a certain therapeutic service or substance because of its effectiveness from the point of view of maintaining unstrained social relations. For example, a mother may be fully aware that the cough syrup she gives her child is not medically efficacious, but it has a social efficacy; the child's reduced coughing relaxes the husband, and giving her child the same medicine as the neighbours give their children, reassures the mother.[11] Hunt & Barker (2001) mention issues of taste and distinction, which determine the choice of any consumer item and commodity, and accordingly also of the consumption of medical services and substances.[12] In Dar es Salaam, members of the upwardly mobile urban middle classes, caught between a critical stance towards tradition and an anti-Imperialist sentiment, distinguished themselves from others by venturing into trying out this medicine.

The perceived bodily effectiveness of Chinese medicine should not be underestimated (although these effects may be of a different order than the pharmacologically active ingredient and often work 'indirectly', by for instance enhancing what biomedicine calls 'self-healing properties'). Although initially perceived as a quick fix, Chinese medications given during the first consultation are often part of a longer process of healing. Several formula medicines have instant bodily effects: the patient needs to urinate more frequently, or sweats heavily the first night, the colour and/or smell of the urine or faeces changes. If the doctor predicts this will happen, and then it does, an initial bridge of trust between the Chinese doctor and the client is built. After a few days, the client may return. The doctor now prescribes a different medicine. It may look different and have another taste, and it may be meant to evoke different bodily effects: increased sleep, feelings of relaxation, deeper breathing. As doctor and patient embark on a journey of several stages, the effect of a Chinese medical treatment, - which the doctor often assesses primarily in terms of *qi* - which means breath, vapour, energy etc. - can easily be mapped onto the patient's subjective self-assessments of treatment. I noted that the locals are very much aware of their bodies and have a remarkably fine perception of its changes. The site within which the interplay of patients, practitioners and their paraphernalia is experienced is the body.

There is no doubt that history and culture, politics and socio-economics, as well as the ritually induced, body transformative effects within the patient, are key to understanding the phenomenon of Chinese medicine in East Africa. It is a phenomenon that is not entirely uncontroversial. If Chinese medicine in East Africa is to make a valuable contribution to health care in the future, the ways in which it is regulated must account for the multiple layers of its effects. ■

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Notes:

1 Fieldwork was carried out in eight visits each of about one month between 2001-06.

2 Hutchinson A. 1975. China's African Revolution. London: Hutchinson, p. 222; quoted by Zhan M. 2002. The Worlding of Traditional Chinese Medicine: a Translocal Study of Knowledge, Identity and Cultural Politics in China and the United States. Ph D thesis in Social and Cultural Anthropology, Stanford University, p. 45.

3 See also Monson J., 'Liberating Labor? Constructing Anti-Hegemony on the TAZARA Railway in Tanzania, 1965-76', in D, Large & al. (eds). China Returns to Africa: A Superpower and a Continent Embrace. Hurst. To be published February 2008.

4 Ethnobotanical fieldtrip to Ghana, June 2000 and fieldwork in Tanzania at the same institution as that discussed in Langwick, S.,The Matter of Maladies: Ontologicial Politics in Postcolonial Healing in Tanzania (forthcoming), chapter 3.

5 Taylor K. 2005. Medicine of Revolution: Chinese Medicine in Early Communist China. London: Routledge.

6 Hsu E. 2002. "The medicine from China has rapid effects": Patients of Traditional Chinese Medicine in Tanzania". In E. Hsu & E. Høg (eds) Countervailing Creativity: Patient Agency in the Globalisation of Asian Medicines, Anthropology and Medicine 9 (3), Special Issue, 291-314.

7 Iliffe, J. 1998. East African Doctors, Cambridge: Cambridge University Press, p. 218.

8 On this distinctively Chinese mobility, see for instance Pieke F. 2007. Editorial Introduction: Community and Identity in the New Chinese Migration Order. Population, Space and Place 13: 81-94.

9 Parkin D. J. 1968. Medicines and Men of Influence. Man 3 : 424-39. Whyte S.R. 1988. The Power of Medicines in East Africa. In S. van der Geest & S.R, Whyte (eds) The Context of Medicines in Developing Countries. Dordrecht: Kluwer, 217-233.

10 Moerman D. 2002. Meaning, Medicine and the 'Placebo Effect'. Cambridge: Cambridge University Press.

11 See Whyte S. & al. 2002. The Social Life of Medicines. Cambridge: Cambridge University Press.

12 Hunt G. & Barker G.C. 2001 Socio-Cultural Anthropology and Alcohol and Drug Research: Towards a Unified Theory. Social Science and Medicine 53: 165-188.