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Detours on the Road: Unpacking the Lives and Activities of Chinese Medical Teams in Tanzania, 1960s-1970s

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Abstract
Chinese medical teams have had a presence in Africa for several decades, with Algeria being the first country to receive them in 1963. In 1968, following a request from the Tanzanian government, doctors from Shandong province were sent to the country, marking the beginning of the medical team program. This paper examines the general living and working experiences confronted by the medical teams from China, who mainly worked in rural areas of Tanzania, especially during the 1960s and 1970s. It analyses how daunting hurdles such as language barriers, transport and communication breakdowns, fears of dangerous and unaccustomed diseases, frustrating tropical weather, loneliness, and the absence of desired foodstuffs complicated their lives and activities in the country. The paper also discusses the strategies employed by the Chinese government, the host country, and the Chinese doctors themselves to address the challenges they faced. It illuminates that, despite significant challenges, the Chinese doctors persevered, distinguishing themselves and gaining popularity over other medical teams from countries in the Global North and the Soviet Union. Furthermore, the South-South solidarity agenda, the Great Proletarian Cultural Revolution, Cold War politics, and Sino-Soviet disputes largely influenced their resilience. The paper utilises data from pertinent archival sources, oral accounts and published research literature.

Keywords: Chinese medical teams, South-South Cooperation, China, Tanzania.

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Introduction

> "Chinese doctors work in rural areas where health care services are indigent, and patients need the most assistance. Doctors from other countries cannot adapt to such an environment, while Chinese doctors in those places can work enthusiastically. Secondly, they [Chinese doctors] know Tanzania well and understand the people's problems. Working with the people of Tanzania and helping them is both a challenge and a pleasure for Chinese doctors." (Shandong Health Dept. 1998: 32)

The preceding quotation highlights the accolades bestowed upon Chinese doctors in Tanzania, as noted by the Principal Secretary of the Ministry of Health (MoH) in 1975. Such statements suggest that officials from the Tanzanian Ministry of Health recognised the efforts of the Chinese medical teams (CMTs) in rural areas, distinguishing them from other teams whose doctors were unwilling to serve in villages. It is within this context that this article explores the lives and activities of Chinese doctors overseas, using Tanzania as its focal point. Generally, studies on Chinese medical teams abroad are scarce. A few available published works outline the general history and activities of CMTs across various regions of Africa. Studies indicate that Algeria was the first African nation to receive medical doctors from China following an acute shortage of medical personnel after gaining independence (Li 2016; Shu et al. 2019; Yanzhong 2011; Kadetz/ Hood 2017). A severe shortage of medical personnel on the continent affected the type and nature of the activities of Chinese medical doctors in Africa. Alongside attending to patients, Chinese doctors were expected to share their knowledge and expertise with a few local medical workers. Scholars suggest that the exchange of medical knowledge, underpinned by the South-South self-reliance agenda, faced numerous challenges that obstructed the attainment of its intended goals (Kifyasi 2024; Shi et al., 2017).

This article examines how the living and working conditions affected the lives and activities of Chinese medical doctors in Tanzania. It reveals their experiences during the 1960s and 1970s when they were sent to unfamiliar destinations for the first time. The paper indicates that daunting hurdles, such as language barriers, transport and communication breakdowns, fears of dangerous and unfamiliar diseases, frustrating tropical weather, loneliness, and a lack of preferred foods, complicated their lives and activities in the country. Additionally, the Chinese government, the host country, and the Chinese doctors themselves employed various strategies to address these challenges. This paper argues that, despite significant challenges, the Chinese doctors persevered,

distinguishing themselves and gaining prominence over other medical teams from countries in the Global North and the Soviet Union. Furthermore, South-South cooperation, which promoted the exchange of knowledge and resources among Southern countries, enhanced the resilience of Chinese doctors. The Great Proletarian Cultural Revolution, during which Chinese medical doctors were used to export Mao Zedong's political propaganda beyond Chinese borders, was another important factor (Altorfer-Ong 2010: 86). Last but not least, Cold War politics, which hindered the Chinese government's admission to the United Nations General Assembly, prompted China to leverage medical aid as a key bargaining chip to secure allies among independent African nations (Kifyasi 2022: 219).

This article adopts Jean Comaroff and John L. Comaroff's concept of "theory from the south." The Comaroffs explain how Southern countries shifted their economic and technological dependencies away from the Global North. They demonstrate that the Southern world had become centres for the production and circulation of knowledge and innovation within the Global South and beyond (Comaroff/ Comaroff 2012; Mavhunga 2017). The Chinese medical team program was ideally designed to foster medical knowledge exchange with the beneficiaries, aligning with the South-South cooperation agenda. This solidarity movement, which emerged during the Cold War, aimed at creating a strong bloc to address the social, economic, and political challenges facing many countries in the Global South (Blunden 2008: 33; Li 2011: 43). This article employs Comaroff's "theory from the south" to examine how the Chinese government's commitment to dispatching medical teams in Tanzania was, on the one hand, influenced by the Southern solidarity agenda. However, the article also explores other geopolitical factors that led China to send medical teams to numerous African countries during the 1960s and 1970s.

China's medical assistance to countries in the Global South paralleled socialist medical internationalism, which the socialist bloc, including Eastern European states and the Soviet Union, promoted the socialist medicine model as an alternative to the dominant forms of Western medicine. These socialist states forged internationalist solidarity with countries in the Global South and beyond, expanding their missions globally (Vargha 2023: 3; Iacob 2022: 264). Therefore, Chinese medical teams were part of broader professional, political, economic, cultural, and institutional networks that criss-crossed the globe. However, after China's withdrawal from the Soviet Union following the Sino-Soviet disputes in the late 1950s, China's medical missions aimed to gain influence against imperialist nations, the Soviet Union, which it referred to as "revisionist," and

other socialist countries (Huang 2010: 111). In many places where China dispatched its medical teams, its modus operandi attempted to distinguish itself from other medical teams sent by states from both capitalist and socialist blocs (Kifyasi 2021: 152). Thus, while the socialist bloc and China both endeavoured to spread socialist medicine to countries of the Global South, they took different paths, reflecting what can be called the "competing socialist health systems."

The research presented is primarily qualitative, drawing from both written and oral sources. Respondents were identified through the heads of departments at Tanzania's Ministry of Health and the Health Commission of Shandong Province. The informants provided various accounts of the history of the Chinese medical team programme, the challenges faced by medical doctors from China, and the survival strategies they employed while working in Tanzania during the 1960s and 1970s. Some respondents could not recall significant events, particularly those from the late 1960s and 1970s, making archival information necessary to complement their narratives. Most primary sources consist of written documents gathered from archives and libraries. In the archives,[1] I consulted files containing letters, reports, and other valuable information about Tanzania's health situation at independence, as well as the lives and activities of the Chinese doctors in Tanzania. A general challenge with archival materials was the incompleteness of the documents, as some files lacked a sequential link to one another. However, I addressed many of these gaps through the use of alternative sources, including oral historical narratives.

The Emergence of China's Medical Assistance to Tanzania

The South-South Solidarity Agenda and China's Support for Tanzania

The question of why the Tanzanian government sought medical aid from China is significant and warrants an answer. To understand the government's motives, it is vital to consider the geopolitical context of the mid-1950s and Tanzania's economic and social situation at the time of independence. To begin with, the politics of the Cold War gave rise to numerous movements[2] that established South-South cooperation. These movements facilitated the exchange of

[1] Archival information was sought from the Tanzania National Archives (TNA), Zanzibar National Archives (ZNA), Dodoma National Record Centre (NRC), Shandong Provincial Archives (SPA), WHO Archive (WHOA), and various online archives.

[2] The politics of the Cold War divided the world into two power blocs, prompting the Bandung Conference, which took place in Indonesia from April 18 to 24, 1955, the founding of the Afro-Asian Peoples' Solidarity Organization (AAPSO) in 1957 in Cairo, Egypt, and the establishment of the Non-Aligned Movement (NAM) in 1961 in Belgrade, Yugoslavia (Mihyo 1992: 225; Peking Review 1965: 16).

resources, technology, experience, and knowledge on a bilateral, multilateral, regional, and interregional basis among Southern countries, thereby reducing dependence on aid from the countries of the Global North (Bergamaschi/ Tickner 2017: 1-2; Meibo 2019: 1). Through several movements, which brought countries of the Global South together, such as the Afro-Asian People's Solidarity Organisation, the Chinese government forged diplomatic relations with many Southern countries to win their political recognition vital for the admission at the United Nations General Assembly (UNGA) over Taiwan. From its inception in 1945, the UN recognised Taiwan as the legitimate representative of mainland and island China (*Peking Review* 1971: 6). Although mainland China had, since 1949, been under Communist China, the Taipei regime continued to exercise its sovereign rights on Chinese soil. These circumstances escalated the fight for diplomatic recognition between the Beijing and Taipei regimes (Permanent Secr.: 35).

The AAPSO, a prominent SSC movement, pioneered the production and circulation of knowledge in the context of South-South Cooperation. The Second AAPSO Conference, held in Conakry in April 1960, recommended the production and exchange of technical know-how among the peoples of Africa and Asia. The exchange of experts, including teachers, medical doctors, writers, artists, journalists, workers, students, and others, was promoted on the broadest possible scale (Permanent Secr: 12). 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 African and Asian countries were more advanced than others socially, economically, and scientifically (Permanent Secr: 54). In this regard, the AAPSO and other movements that founded the SSC gave rise not only to medical assistance but also economic and political cooperation among member countries in the late 1950s. Under the Southern solidarity agenda, the governments of China and Cuba were among the first countries from the Global South to provide medical aid to Asia, Africa, and Latin America. China, for instance, provided medical services to the freedom fighters in Algeria, Zimbabwe (then Rhodesia), and Mozambique (then Portuguese East Africa). Moreover, it staffed health centres in independent African countries such as Mali, Zanzibar, and Tanzania when colonial medical workers departed after the countries attained political independence (Huish/ Kirk 2007; Blunden 2008).

The Sino-Tanzanian diplomatic relationship, which developed in the late 1950s, had a significant influence on China's assistance to Tanzania. The AAPSO, which brought together independent African and Asian nations alongside prominent

political movements, played a key role in facilitating informal diplomatic relations between China and Tanzania. Before independence, leaders of the Tanganyika African National Union (TANU) engaged with AAPSO delegates from China during several council meetings, thereby establishing informal diplomatic ties (Permanent Secr: 79). So, to speak, the foundation of China's aid programs, including medical aid, precede Tanganyika's independence in 1961 and should be attributed to contacts and exchanges under the umbrella of AAPSO in Cairo. Following the maturation of these informal relationships under the aegis of the AAPSO, the Chinese government formalised diplomatic relations with Tanganyika on the day of independence, December 9, 1961 (Ai 1999: 172). The Tanzanian government was among the first ten African countries to recognise the Beijing regime at the end of 1961. Immediately after independence, the Chinese government opened its embassy in Dar es Salaam, becoming the first in East Africa (*Sunday News* 1962: 1).

Tanzania's Healthcare Situation, Diplomatic Strife, and Its Reliance on China

Tanzania's healthcare situation at the time of its independence was terrifying. A healthcare report covering the period from 1961 to 62 shows that life expectancy was 35 years for men and 40 years for women. The mortality rate was 47 out of 1,000 pregnant women who gave birth. Furthermore, the infant and child mortality rates were 40% to 50% before children reached the age of six (URT 1961-2011: 105; TNA 450/HE/1172). According to a 1964 statement by the Minister for Health, Derek Bryceson, Tanzania's infant and child mortality rates were among the highest in the world (TNA 450/HE/1172). These and many other health challenges prompted Tanzania's President Julius Nyerere to christen diseases among the three main "enemies" to the country's development, next to ignorance and poverty, believing that people would not fully engage in economic activities if chronically sick (Nyerere 1962: I). The healthcare situation was perilous, and the country lacked enough personnel to combat diseases. At independence, it had only had about 549 registered medical doctors, of whom 400 were residents, serving a population of 10.4 million. Many of the registered resident doctors were of Indian origin, while the number of Africans was only twelve (Titmuss et al. 1964: 180; Kifyasi 2025: 7). 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 healthcare personnel who served 98 hospitals, 22 rural health centres, and 975 village dispensaries (Nyerere 1973: 293).

This lack of adequately skilled medical personnel compelled the post-colonial Tanzanian government to rely on expatriates. To begin with, the government retained foreign medical doctors who had 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, the Soviet Union, Yugoslavia, Canada, the USA, Great Britain, and other places (TNA 589/BMC/10/03; URT 1967:4; *Tanganyika Standard* 1962: 3). Indeed, the government perceived hiring expatriates as the only feasible solution to addressing the urgent shortage of medical staff. However, even with its growing economy, it could not afford to employ enough expatriates to meet the needs of the entire healthcare sector.

Tanzania's ability to hire expatriates became even more complicated after the government quarrelled with its traditional donors of the Global North in the mid-1960s. The situation grew more complex in 1964 after the unification of Tanganyika and Zanzibar, which complicated the country's diplomatic relationship with the Federal Republic of Germany (FRG). The government of Zanzibar, which had established diplomatic relations with the German Democratic Republic (GDR), compelled the Tanzanian government to maintain diplomatic relations with the two Germanys, the FRG and the GDR. This was incompatible with the West German Hallstein Doctrine, which discouraged any form of diplomatic recognition for the GDR (Magome 1978: 5-6; Tambila 2010: 82; Rugumamu 1977: 120; Burgess 2021: 176-177). As a result, the FRG withdrew all of its aid to Tanzania, negatively impacting the endurance of the health sector because the FRG had extended part of its aid to healthcare. For instance, Tanzanians pursuing health-related courses in several medical colleges in the FRG under scholarships provided by the Bonn government had to return home, where the government pledged to find alternative colleges and universities to enable them to complete their studies (*Ngurumo* 1965: 1; *The Nationalist* 1965: 1; Nyerere 1968: 90; Lal 2015: 56-57). Furthermore, in 1965, the Tanzanian government entered diplomatic disputes with Britain following the Organization of African Union's (OAU) resolutions against Ian Smith's minority independence in Southern Rhodesia (now Zimbabwe). The OAU wanted the British government to resume constitutional responsibility for Southern Rhodesia and bring down Smith's regime. OAU members threatened to sever diplomatic relations with Britain if it did not meet their demands (Magome 1978: 5-6). However, the voices of these OAU members were not impactful enough since the British government did not take any military action against the Smith regime (Chongo 2022: 5). In response to the OAU declarations, Tanzania was

among the first nine African countries to sever diplomatic ties with Britain. As a result, all London aid to the country was halted. The crisis severely hurt the health sector, since all medical workers from Great Britain who were working in the country departed immediately after the dispute (Magome 1978: 5-6; Iliffe 1998: 200).

As these cases illustrate, dependence on expatriates and graduates from abroad was therefore not feasible following the diplomatic crisis with the traditional donors of the Global North, who were the primary source of expatriates. Instead, the Tanzanian government established medical colleges and universities to train enough experts within the country. The government started a Medical School (now the Muhimbili University of Health and Allied Sciences) at Muhimbili Hospital in March 1963. The nucleus of the school was the Medical Training Centre (MTC), which was built in 1958 jointly with Muhimbili Hospital. Until the 1970s, it could admit at least 30 medical students annually, and the Ministry of Health (MoH) directly employed all graduates (WHOA TAN-HMD-001; *Daily News* 1987: 5; Mkonyi 2012: S47; URT 1964: 71; TNA 589/BMC/10/03). In the decades to come, the school played a commendable role in building the capacity of the health sector. Nevertheless, the number of graduates was insufficient to cater to the demands of the health sector, given the growing population and disease burden. All these circumstances prompted the Tanzanian government to seek medical aid from the Chinese government.

The escalating diplomatic disputes with its traditional donors of the Global North prompted Tanzania's close relations with and reliance on China in the mid-1960s. Before 1965, the Sino-Tanzanian relationship developed slowly. There were a few agreements signed between the two governments. For instance, in December 1962, the Tanzanian government signed a Cultural Agreement with China, followed by an official visit from Tanzania's cultural delegation, led by Minister of National Culture and Youth Lawi Nangwanda Sijaona, in October 1963 (PRC FMA 108-00032-01). 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" (*Peking Review* 1964: 5; Bailey 1975: 39; *Peking Review* 1965: 9). Nyerere's visit boosted Sino-Tanzanian friendship as Premier Zhou visited Tanzania on June 4, 1965 and pledged support for the nation-building agenda (*Peking Review* 1965: 7-8; Mganga 1985: 4). Subsequently, on November 22, 1965, the Second Vice-President of Tanzania paid another visit to China for

negotiations on China's assistance and other diplomatic resolutions (*Peking Review* 1965: 13). The growing Sino-Tanzanian relations led to the opening of the Chinese Economic and Commercial Mission in Dar es Salaam in 1966. The adoption of socialist policies proclaimed with the Arusha Declaration in 1967 further solidified Sino-Tanzanian relations. These events demonstrated the growing political and economic ties between the two nations. Thus, when the Tanzanian government requested the Chinese medical teams (discussed below), it had already established strong diplomatic relations with the Chinese government.

Chinese Medical Teams in Tanzania

Chinese medical teams have a long history in Africa. The medical teams first started in Algeria in 1963, following requests from the Algerian government in 1962 to Northern countries and the Red Cross. This came after Algeria experienced a rapid deterioration in health services following the withdrawal of French medical staff 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, with each of China's provinces dispatching medical teams to two or more overseas countries.[3]

The Tanzanian government began to receive medical teams from Shandong province in 1968 and continues to do so today (TNA 450/HEA/90/5). Against this background, the CMT program aimed not only to rescue the country's medical personnel crisis but also to build the capacity of its health sector. Thus, from its inception, training local medical workers was among the goals assigned to Chinese medical doctors working in Tanzania by the Chinese government (Li 2020: 293; SPA A034-04-085).

The Chinese doctors dispatched to Tanzania possessed specific professional and physical merits, including clinical training with tertiary qualifications, strong professional recommendations with at least five to ten years of work experience, and healthy physiques, with a maximum age of 55. Under such criteria, most doctors sent to Tanzania were older than 30, and many were married, though

[3] 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 received medical teams from Jiangsu province for over 25 years. Unlike countries in the South, China's medical aid to Malta is neither relief nor charity, as Malta's health system is quite robust. China's medical assistance, therefore, aimed to bolster diplomatic relations between the two countries and primarily promote the practice of traditional Chinese medicine. By 2014, Jiangsu province dispatched about 11 batches with 66 medical doctors (see, for instance, Li Bo et al. 2018: 122; Peking Review 1972: 3; Shuang Lin et al. 2016: 1).

they were not allowed to travel with their families (SPA A034-06-0358; Deng interview, 2019). Unlike other socialist states, such as the GDR, which allowed its experts to bring their families along and provided them with suitable housing, domestic workers, and better food supplies (Burton 2021; Harisch 2021: 314), the Chinese government did not permit its medical teams to travel with their families. As a result, most female doctors were unwilling to join the CMT program since they attended more to social responsibilities at home than their male counterparts. Thus, the number of male doctors dispatched to Tanzania surpassed that of females (Qin interview, 2018). 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 was mandated to issue medical doctors with professional working licences, based on the council's promulgated criteria (NRC HC/74/311/02). In the 1960s and 1970s, Shandong province encountered difficulties mobilising qualified medical personnel to participate in the CMT program, especially in gynaecology, anaesthesia, surgery, and other fields that required more skilled personnel, due to a shortage of experts. Unlike the Cuban government, which had an excess of medical personnel from the 1970s (Huish/ Kirk 2007: 82), Chinese provinces suffered a shortage of skilled medical personnel due to their growing population and disease burden (Ge interview, 2016).

The Chinese government dispatched the CMTs to Tanzania at a time when Cold War politics were at their height, and the UN General Assembly did not recognise the Chinese government. Instead, the UN recognised the Taiwanese government as the representative of China. Thus, like the GDR, which sought to compete with the FRG for recognition as the legitimate representative of Germany, China did the same by using medical aid as a tool of influence (Borowy 2018: 3; Kifyasi 2022: 219). Furthermore, this was the period when China, isolated from the Soviet Union, was contending 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 led the fight against "imperialism" and "revisionism" while safeguarding their country's influence and interests (Yanzhong 2010: 111). These contexts informed the recruitment, training, and activities of the CMTs sent to Tanzania. For example, medical doctors dispatched in the 1960s and 1970s were all loyal members of the Chinese Communist Party (CCP), mixing up the medical profession and Chinese politics. Party membership was a crucial selection criterion for recruits since their government assigned them a role to propagate Maoism, enhance Sino-Tanzanian friendship, and preserve China's influence in the region (SPA A034-03-006; Iacob

2022: 277). Generally, deploying medical teams to Tanzania constituted an essential part of China's foreign medical aid, and it was also the longest mission in the history of Shandong province (Che & Ge interviews, 2016). The CMT program made a significant contribution to the development of friendly bilateral relations between the two countries. The dispatch of CMTs by Shandong province has never ceased, despite changes in China's foreign policy. Statistics show that from 1968 to 2017, Shandong province deployed twenty-four batches of CMTs to Tanzania, totalling approximately 1080 medical workers (Wang 2017).

Challenges Encountered by CMTs and Their Approaches to Overcome Them

In 1968, prior to the first deployment of the CMTs to Tanzania, the Chinese and Tanzanian governments, together with Chinese medical doctors, made thorough preparations to ensure the doctors had favourable living and working conditions. For example, Shandong province dispatched a team of doctors to assess the existing healthcare needs, living conditions, work environments, climatic conditions, and political stability in the country, to inform their preparations. Two rounds of visits were conducted: the first preceded the arrival of the whole team, and the second, a follow-up, took place before the teams commenced their work. In January and February 1968, a group comprising five doctors, one nurse, and one interpreter, led by Tsao Yuen-Chung, undertook a 40-day medical tour across 16 districts and one city in Tanzania, investigating the type of medical assistance suitable for those places and the appropriateness of the living and working conditions. The team proposed measures to alleviate hardships and recuperate living and working conditions to ensure effective performance and comfort (SPA A034-03-006; *The Nationalist* 1968: 8; *Ngurumo* 1968: 1). Their reports served as a wake-up call and guided their preparations before travelling to Tanzania. Despite thorough preparations, the Chinese doctors faced numerous challenges while residing and working in Tanzania. The subsequent discussions illuminate the hurdles they confronted and the strategies they employed to mitigate them.

Most personnel from socialist nations working overseas faced language barriers. Available studies show that these experts were sent abroad with little or no language skills in the countries they operated in, which affected their work effectiveness (Harisch 2021: 316). The Tanzanian case demonstrates that Chinese experts received language training before traveling to the country. For example, they took Kiswahili courses at the Communication University of China (CUC),

Tianjin Foreign Studies University (TFSU), and Beijing Foreign Studies University (BFSU) (Kifyasi 2024: 52; Sui interview, 2016). While Tanzania's lingua franca is Kiswahili, many Tanzanians speak and comprehend English at varying levels of fluency. During Mao's regime, proficiency in Kiswahili was imperative since the doctors spent half their time in rural areas where most residents spoke Kiswahili and local languages. Moreover, under Maoism, China sought to spread its influence and political propaganda. Thus, the CMTs needed to interact effectively with political elites and other influential individuals, and such interactions were more operational through Kiswahili (SPA A034-03-006). However, this study has uncovered that most Chinese doctors could not speak Kiswahili or English fluently, indicating that the language training programmes did not adequately equip them with essential communication skills.

As the language barrier persisted, each team included two or more translators who could speak English fluently. In the 1960s and 1970s, the Chinese government dispatched many doctors to Tanzania, who were stationed in various regions and districts. Such distributions necessitated the hiring of more translators, with at least one in each region. For instance, in 1972, 34 doctors were sent to Tanzania and divided into small teams assigned to different district hospitals in the Morogoro, Dodoma, Kigoma, Musoma, and Mbeya regions, where each team required its own translator (TNA 450/HEA/90/5). The language barrier remained unresolved because there were few translators who were often unfamiliar with some medical jargon. Additionally, they could not speak Kiswahili and did not always accompany medical doctors to their work sites (Kisonga interview, 2018). Song Tao, who had served as an interpreter for over eight years, admitted that he primarily translated ordinary conversations, especially when the teams interacted with government officials, and rarely with 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 (Song interview, 2018). Overall, linguistic barriers hindered the effective delivery of healthcare services and thwarted reciprocal learning between Chinese and Tanzanian experts.

Geographically, Tanzania is located 6,710 miles away from China.[4] The long distance between these two countries complicated travel arrangements for Chinese doctors. There were a limited number of air routes available, and these were expensive for the large medical teams, which carried thousands of boxes containing medicine, medical equipment, food, and other necessities. The early

[4] This distance is measured by sea between Dar es Salaam port and the port of Nansha (Guangzhou).

medical teams dispatched to Tanzania travelled by the passenger ships Yaohua, Minghua, and Jianhua to reduce costs. They set sail from Guangzhou's Huangpu port, navigating through the Pacific Ocean, the Strait of Malacca, and the Indian Ocean to reach Dar es Salaam port, with their journey lasting half a month. Most doctors were travelling outside their continent for the first time due to Chairman Mao Zedong's isolationist policies, especially after the Great Proletarian Cultural Revolution (Yan/Gao 1966). Consequently, the foremost challenges faced by the medical teams during their voyage included strong winds and waves, the vastness of the sea, severe seasickness, and the solitude of a long journey covering over 10,799 kilometres.

Transport hurdles complicated not only the medical doctors' voyage from China to Tanzania but also their travels to several workstations. At the outset of the CMT program, over 95% of the Tanzanian population resided in rural areas where healthcare facilities were profoundly needed. Consequently, throughout the 1960s and 1970s, unlike medical doctors from Global North countries, Chinese doctors responded to the country's needs by providing healthcare services in rural areas. The CMTs set up mobile health clinics and spent at least half of their time treating patients in the villages (*Uhuru* 1968: 1; *Tanganyika Standard* 1962: 3; TNA 450 HEA/90/5). However, their rural medical missions were confronted by critical transport breakdowns. 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. Chinese doctors were dispatched to Tanzania two years after the commencement of the Great Proletarian Cultural Revolution in 1966, where it prioritised rural healthcare, sending thousands of its personnel to save peasants and workers in the countryside. The teams dispatched to Tanzania had experience working in hard-to-reach areas. However, China's economic and social infrastructures were somewhat advanced than Tanzania's. They already had passable roads, electricity, and water supplies, and friendly public transport in many places. Thus, the overall economic and social situation in Tanzania was somewhat of a shock to the CMTs, and they took some time to adjust to the new lifestyle (see below) (Deng interview, 2019; Sui interview, 2016).

The Ministry of Health (MoH) of Tanzania provided vehicles to CMTs; however, they did not supply enough for every group, and some of the cars were old, leading to frequent breakdowns (Figure 1). Unreliable transport services compelled the Chinese doctors to trek on foot through forests with dangerous wild animals and mountains, carrying portable medical equipment and medicines, to reach the villages. The Chinese doctors did not hire porters to carry

medical boxes and other equipment. Nevertheless, in some places, village leaders recruited youths to usher the doctors and carry their items (Abedi interview, 2018; Deng interview, 2019). Their response to transport hurdles distinctly contrasted with colonial transport systems, where African porters carried goods and equipment for colonial authorities. Furthermore, Chinese doctors' experience working in rural China after the Great Proletarian Cultural Revolution gave them the expertise and resilience to live and work in Tanzanian villages with minimal complaints (Abedi interview, 2018; Deng interview, 2019). Besides their resilience, inconveniences in transport systems complicated the delivery of food, medicines, and medical equipment, ultimately impacting effective clinical care (SPA A034-06-637).

Figure 1: CMTs heading to the villages in the Mtwara Region, 1971. Source: Health Department of the Shandong Province (1998): The Chinese Medical-Aid Team, 13.

In 1967, Julius K. Nyerere, then President of Tanzania, expressed his frustrations to Consul Zhou Boping regarding the presence of medical doctors from countries in the Global North, such as East Germany, Italy, Israel, Yugoslavia, Canada, and the USA, in Tanzania. He noted they were overly demanding and preferred lavish lifestyles, desiring pleasant living conditions that were costly for the nation. Nyerere anticipated that doctors from China would be different simply because they hailed from a Southern country (Altorfer-Ong 2014: 261). The Chinese teams arrived in Tanzania, aware of the expectations of political elites.

Therefore, they accepted modest living conditions with fewer demands, earning the favour of Tanzania's political elites (*Ngurumo* 1968; 1; Iacob 2022: 277). Undoubtedly, the living and working situations in rural areas were disheartening. However, archival evidence indicates that in some places, the MoH and village leaders tried to accommodate the Chinese doctors better. The Ministry provided safari beds for those working in rural areas. For example, in April 1971, the regional medical officer of Mtwara received four safari beds from the MoH and passed them to Chinese doctors in several villages (TNA 450/HE/90/5). Nevertheless, the efforts of the Ministry and villagers were insufficient to fully address the living challenges faced by the medical teams in the villages. The health department of Shandong province documented reports from the CMTs in rural areas where the doctors voiced their complaints, stating:

> "In December of 1971, ENT [Eye, Nose and Throat] physician Lu Xiuying and I went to [. . .] [one of the villages] for the medical tour. [. . .] [the village was] 300 kilometres away from the medical station. We stayed there for three days, attended to more than 200 people, did minor surgery 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 a church. There is a hole in the roof. At night, I can even see the moon and stars through the hole. The house is filthy because nobody has lived there 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, pigeons, and sparrows on the roof prevented us 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." (Health Dept. 1998: 12)

The complaints from the CMTs highlight some dissatisfaction with their living and working conditions, which stem from Tanzania's underdeveloped rural social and economic environment. Unlike Eastern European medical workers in Czechoslovakia and North Korea, who often felt superior and criticized locals for lacking education, hygiene, and progressive social practices, Chinese doctors generally faced many obstacles themselves. They distanced themselves from the European civilizing mission and instead promoted Maoism and acupuncture as alternatives to Western medical practices (Iacob 2022: 270 & 277; Altorfer-Ong 2010: 86).

The hot climatic conditions in some regions where Chinese doctors worked, particularly in Dar es Salaam and Zanzibar, further complicated their working

and living environments. A document from the health department of Shandong province also noted complaints from the doctors:

> "When our country is in winter with snow, Tanzania is in the rainy season. After the rain, hot sunlight shines in the jungle and 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." (Health Dept. 1998: 12)

However, Deng Shucai and Sui Guangxin, who also worked in Tanzania, remarked that the climate posed a challenge only in the early days, as they gradually acclimatised to it over time (Deng interview 2019; Sui interview 2016). Personnel from other socialist countries working in Eastern and Southern Africa also complained about tough living and working conditions. Immanuel Harisch notes that East German brigades in Angola faced issues like poor food, loneliness, and low wages. These hardships, among others, lowered their morale, and some experts found the conditions so intolerable that they refused to return to Angola after their holidays in the GDR (Harisch 2021: 313). Archival and oral accounts indicate that, unlike the GDR workers in Angola, Chinese doctors remained resilient despite the difficulties and did not return to China before their contracts expired. Instead, some team members worked in Tanzania in multiple batches, thereby playing a vital role in bolstering Sino-Tanzanian diplomatic relations (Health Dept. 1998: 117-122; Abedi interview, 2018).

Chinese medical doctors were sent to Tanzania during the peak of the Cold War. The Chinese government anticipated that capitalist countries would spy on them through Chinese doctors working abroad. As a result, from the outset, the CMTs in Tanzania were prohibited from interfering in the internal affairs of the host country, speaking to journalists, visiting entertainment centres, and disclosing Chinese government secrets to foreigners. Furthermore, the government forbade them from arguing with foreigners or establishing private connections, including romantic relationships and marriages (SPA A034-03-006). Generally, throughout Mao's era, medical doctors working overseas had limited opportunities for interaction with locals and foreigners. While these restrictions served the political devotions of the Chinese government, they complicated the social lives of overseas medical doctors. According to the signed protocol, the Tanzanian government organised tours of several parts of the country, allowing doctors to enjoy annual vacations. After the medical teams had completed twelve months of service, the government arranged a fifteen-day break along

with a seven-day trip to Kilimanjaro, Ngorongoro, the Serengeti, or any other sites of interest suggested by the CMTs for sightseeing and relaxation. The breathtaking natural scenery they experienced left the medical teams with countless treasured memories from their two years engaged in foreign aid work (Health Dept. 1998: 100; NRC BC/74/544/01).

The working environment was perplexing, affecting the effective delivery of healthcare services by the CMTs. Most healthcare facilities in Tanzania faced shortages of medicines, medical equipment, water, and electricity. The Chinese government provided Tanzania with free, ready-made drugs and medical equipment to address these shortages (ZNA DO5/25). For instance, the first team of doctors went to Tanzania with several boxes containing medicines and medical equipment (Figure 2). Similarly, other CMTs brought additional drugs and medical equipment (*Uhuru* 1968: 1; Che interview 2016). However, the medical supplies the CMTs delivered did not adequately meet the demands. Furthermore, the lack of an electricity supply in some hospitals hindered the use of some medical equipment (SPA A034-06-157; Ding interview, 2019). Lu Jianlin, a Chinese medical team leader in Zanzibar, complained: "The most painful thing for us is we know we could save some patients, but because of lack of equipment, we can't" (Ding 2011: 16). In some instances, Chinese doctors resorted to acupuncture, massage, and other methods as alternatives to the missing medicines and medical supplies (Health Dept. 1998: 11). The Tanzanian government grappled with the challenges of providing essential medicines and equipment, yet its economic capacity to achieve this remained limited, complicating the medical delivery by the CMTs. Consequently, it addressed a few areas by supplying generators and other social amenities, such as water and improved road conditions (TNA 450/HEA/90/5).

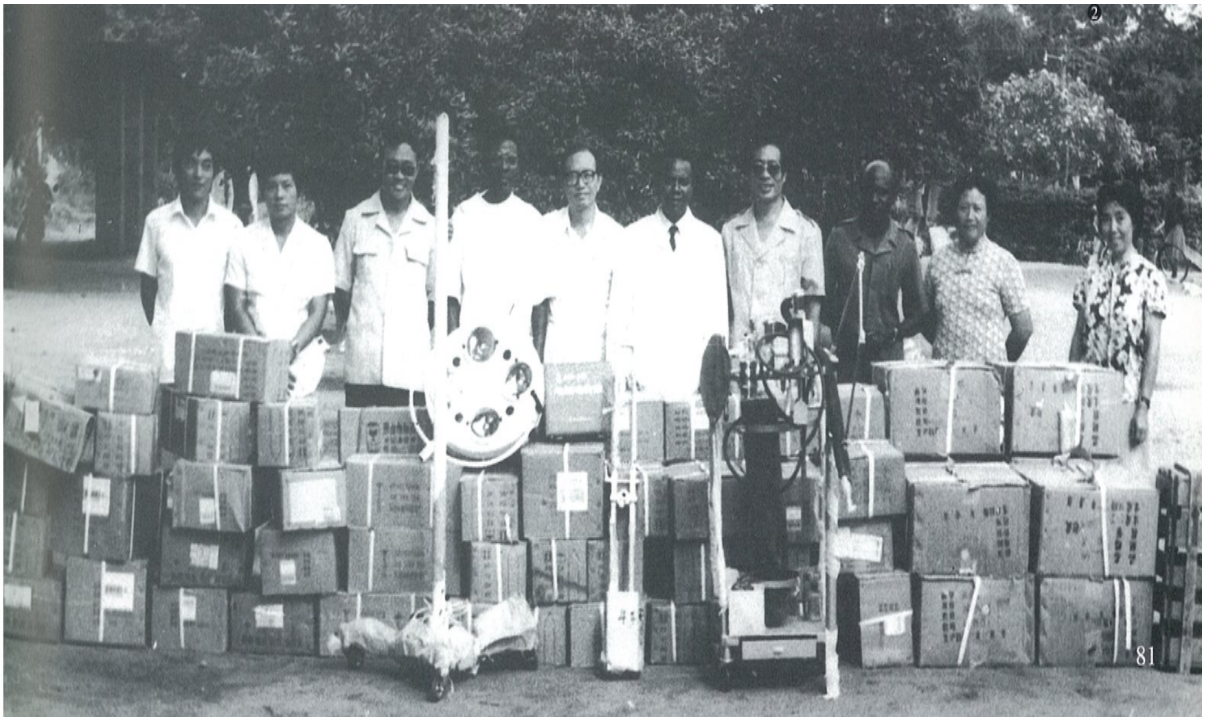

Figure 2: In 1986, CMTs donated medicines and equipment to the Mara Region. Source: Health Department of the Shandong Province (1998): The Chinese Medical-Aid Team, 81.

Chinese medical doctors further encountered unaccustomed diseases, such as trypanosomiasis, trachoma, and others that challenged their expertise. Although they were aware of these illnesses theoretically, they had never confronted them throughout their professional careers in China. Rajabu Kisonga, who worked in the ophthalmology department at Dodoma Referral Hospital, stated that when first-time patients with trachoma consulted the eye department, Chinese doctors were too apprehensive to attend to them before returning to reference books to refresh their medical knowledge. Kisonga added that trachoma was primarily caused by unsanitary conditions resulting from a lack of water, absence of latrines, flies, and proximity to cattle, which, according to the Chinese doctors, were unknown problems in many parts of China (Kisonga interview, 2018). Ding Zhaowei and Jin Xunbo argued that unfamiliar diseases presented both a challenge and an opportunity for Chinese doctors to utilise their medical expertise and acquire new experiences (Ding & Jin interviews, 2019).

Dangerous communicable and non-communicable diseases that were rare in China, such as malaria, trypanosomiasis, typhoid, and cholera, posed a significant threat to Chinese doctors. One doctor involved in mobile medical clinics in rural Tanzania expressed concerns for the teams when they ventured into the countryside. He stated:

> "As we travel [to the villages], we must remain vigilant against an invasion by wild animals. However, what is even more frightening is the tsetse fly, which resembles a gadfly. It can transmit a sleeping sickness, also known as trypanosomiasis. Although the disease has not yet appeared in our country, it is prevalent in Tanzania. So far, the disease has no reliable cure. To prevent tsetse flies from biting, regardless of how hot the weather is, the medical team always ensures that the doors and windows of the car are closed during the journey. That feeling is extremely distressing. Every tour feels akin to a battle." (Health Dept. 1998: 11)

Archival evidence indicates that the Chinese government inoculated CMTs to boost their immunity against diseases such as cholera, tuberculosis, and smallpox (Zhang interview, 2016; TNA 450/HEA/90/5). However, many still contracted illnesses. For example, six out of eight Chinese doctors working in Tabora contracted malaria. The Chinese Embassy in Tanzania repatriated medical workers suffering from serious health issues. A cook, Yu Shanjie, and a doctor, Su Zhongyuan, left the country after encountering grave health problems (SPA A034-06-637). On the one hand, such challenges jeopardised the lives of Chinese doctors; on the other hand, they heightened awareness among both the doctors and the hosting government (SPA A034-06-637). Nonetheless, from the inception of the CMT program to the present day, only two Chinese doctors have died while working in Tanzania.

Furthermore, Chinese medical doctors in Tanzania encountered challenges related to food and its preparation, as they were often compelled to compromise and make do with the local food options available to manage the situation. For the Chinese government, the initial approach to tackling this hurdle was to dispatch a cook with each medical team. However, this did not adequately resolve the challenge, as the Chinese doctors were organised into small groups of five to eight or more, working in various district hospitals. A cook could accompany only one group. Consequently, other doctors had to prepare their meals by themselves, which, in turn, consumed part of their working hours (SPA A034-06-159; Deng interview, 2019). Similarly, some food items desired by the Chinese were either unavailable or in short supply. Traditionally, Chinese cuisine is based on two main components: *fan,* which comprises grains and other starches, and *cai,* which includes vegetables and meat. These two elements form a complete Chinese meal. Essential food items such as noodles, soybean products, some kinds of vegetables, herb-related foods, different types of sauces, and Asian spices were not plentifully available in Tanzania. To remedy this, the Chinese government imported some food supplies, and the Tanzanian

government waived its taxes at the port in Dar es Salaam, demonstrating strong support for the CMT's work (NRC BC/74/544/01). In some places in Tanzania, the CMTs planted various types of vegetables and raised chickens (Figure 3) (SPA A034-04-085). These activities enabled the medical teams to produce essential food items that were either scarce or unavailable in the local market. Furthermore, they improved their leisure time by providing important physical exercise through watering vegetable gardens and feeding chickens, thereby alleviating feelings of homesickness.

Figure 3: A CMT member feeding chickens in the 1970**s.** Source: Health Department of the Shandong Province (1998): The Chinese Medical-Aid Team, 101

Conclusion

Living in an unconventional environment has always been challenging. However, this has been the reality for Chinese medical doctors in Tanzania since 1968. Every two years, a group of doctors with varying specialities is dispatched to Tanzania. The situation was particularly challenging in the 1960s and 1970s when Tanzania's social, economic, and political landscape was utterly unfamiliar to Chinese doctors and most of the Chinese community. This paper has demonstrated that despite adequate preparation, the living and working conditions for Chinese doctors were poor, particularly in rural areas. Transport and communication issues were incredibly frustrating, forcing Chinese doctors to travel to numerous villages on foot while carrying boxes of medicines, medical supplies, and food. Language barriers further complicated their lives, limiting their social interactions. Cultural differences restricted their access to certain Chinese cuisines, encouraging them to try new Tanzanian dishes. Unfamiliar diseases tested their expertise but also familiarised them with practical knowledge and experience in managing tropical diseases. Furthermore, dangerous tropical diseases, particularly malaria, risked their lives and, in some cases, affected their determination to work. Undoubtedly, these challenges were formidable. However, the Chinese government never wavered in sending medical doctors to Tanzania. This paper has illustrated that the Chinese government's commitment to the South-South solidarity agenda, which advocated for the exchange of knowledge and resources among nations of the Global South, reinforced its obligations. Equally important was China's struggle to gain admission to the United Nations General Assembly following Taiwan's recognition as the representative of all of China in 1971. This paper has revealed that medical aid to independent African countries was used as a bargaining chip to secure allies, with only medical teams being dispatched to countries that recognised the "One China Policy". Overall, despite the obstacles, the Chinese doctors played a commendable role in combating diseases, particularly in rural areas where illnesses were prevalent and healthcare facilities were either lacking or understaffed. Their determination endeared them to political elites and the wider community.

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