Chinese medicine in East Africa and its effectiveness

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 adapting 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 its bodily transformative effects (the body experienced and manifestly effects of a medical intervention). The latter depends on the optimal interplay of the ‘three P’s’ - patients, practitioners and ritual paradigms (like drugs, needles, the physical features of the medical practice, etc.).

Five fields of Chinese medical care in East Africa

Julius Nyere, Tanzania’s first president, (1952-85), 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 dispatched 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 - acupuncture in particular - belonged in the package of world socialism that China then exported. 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 linking Tanzania with Zambia was financed and executed by the PRC). These doctors were fewer in number, probably not as expert in their specialty (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 that the railway project was constructed. 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 Organi- zation (WHO). There are suggestions that the way socialist China dealt with its indig- enous medical tradition and Chinese model in the WHO, (although to my knowledge no one has, as yet, extensively researched this issue), and the modernised traditional Chi- nese approach, rather than the European one, appears to have been implemented in several WHO traditional medicine pro- grammes. Thus, African medicinal plants were recorded and researched according to the criteria of the modern Chinese mate- rial medica, sometimes under the guidance of Chinese experts.

The fourth field of Chinese medical activity in Tanzania arises from Chinese-Tanzanian government collaborations to pro- vide stipends for medical students to train in the PRC. Medical education was based on the Maossi vision of combining West- ern and Chinese medicine, and during six years in China (one year of language learn- ing and five years of medical training), students were obliged to attend a course on acupuncture for at least one semester. In China and in the rest of the world, all students had to attend compul- sory 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 superfluous. In fact, some considered it more ‘advanced’ than biomedical, an attitude which may have reflected political and/or cultural connections that socialism is more advanced than capitalism. Perhaps, such an anti-Imperialist attitude, combined with a certain pragmatism, ignited the collab- oration of the Chinese and Tanzanian Ministries of Health, which in 1989 led to the institutionalization of the traditional Chinese Medicine research pro- grammme on HIV/AIDS at Muhimbili Hos- pital in Dar es Salaam. To date, no results have been published in English. An ear- lier public statement of renowned senior Chinese doctors who lacked in statistical understanding had apparently upset the medical profession. However, although the programme appears to have had an impact insofar as the antiviral drug Abacavir that it developed, which consists only of natural ingredients, is now sold at a very high price in the pri- vate 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 1990’s, as the World Bank put pressure on the govern- ment to privatise health care. The Chinese doctors who, due to these altered health care policies, were attracted into Tanzania differ in important ways from those described previously. Firstly, they are private entre- preneurs. Secondly, their training in Chinese medicine is not as body-based as theirs. By the early 2000’s the majority were “learning by doing”. Thirdly, they operate in fields marked by rigid bureaucratic struc- tures and ‘red tapism’, and this impacts on how they offer their services.


Chinese and cultural patterns

In order to ‘do business’, Chinese medi- cal doctors have to find clients. In con- temporary East Africa, foreign and exotic medicinal practitioners exert a strange attraction. This cultural pattern was described by the anthropologist sociologists David Par- kin (1988) and Susan White (1988) long before Chinese medical entrepreneurs populated the informal sector. White asks what the choices are that people have for managing unmet and illness, and she finds that they basically have two ways. They can take recourse to ‘medicines’ - African herbal remedies, talismans, sorcery formulas 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 prob- lems. Chinese medicine in East Africa falls into the former category.

It is not the Chinese medical decaction of herbal ‘Chinese drugs’ (pharmacology) that East African clients seek but ‘Chinese formula drugs’ (pharmacoeconomics). The latter consist of powdred zhengnoua, 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 zhengnoua needs to immer 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 menstruation, or some aspect of the constitution of a person. In general, the dispensing of ‘Chinese formula drugs’, zhengnengnoua, requires significantly less sophistication than the prescription of ‘Chinese medical drugs’, zhengnoua. How- ever, 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 pla- cebo effect, as it is perceived as an exotic medicine in East Africa. However, many anthropologists have now criticised the ‘placebo’ as a flawed methodological concept for the social sciences; it is an ethnos- necrono- tric tool 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 inher- ent to any medical substance or service regardless of whether the standards of the double-blinded randomised controlled trial have been met. Whitey et al. (2005) emphasise the ‘social efficacy’ of treat- ment 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 her child is not medically efficacious, but it has a social efficacy: the child’s reduced coughing relaxes the husband, and giv- ing her child the same medicine as the neighbours give their children, reassures the mother.5 Hunt & Barker (2001) mention issues of taste and distinction, which determine the choice of any consumer item and commodity, and accordingly also the consumption of medical services and substances.6 In Dar es Salaam, mem- bers 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 out to try this medicine.

The perceived bodily effectiveness of Chi- nese medicine should not be underes- timated (although these effects may be of a different order than the pharmaco- logically active ingredient and often work indistinguishable from the placebo level). ‘Chinese medical drugs’, zhengnoua, sometimes also referred to as ‘the healing properties’. Although initially perceived as a quick fix, Chinese medicines given dur- ing the first consultation are often part of a longer process of healing. Several formula medicines have instantaneous bodily effects: the patient needs to urinate more frequently, or sweats heavily the first night, the colour and/or smell of the urine or feces chang- es. If the doctor predicts this will happen, and then it does, an initial bridge of trust between the Chinese doctor and the patient is built. After a few days, the client may return. The doctor now prescribes a dif- ferent 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 breath- ing. 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 it changes. The site within which the interplay of patients, practition- ers 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 under- standing the phenomenon of Chinese medicine in East Africa. It is a phenom- enon that defies a fully scientific explanation. 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.