

Non-suffering Work: China's Medical Interventions in South Sudan

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Abstract

This paper explores China's mode of medical intervention in South Sudan and compares it with the medical humanitarianism and global health imaginaries and modes of intervention that characterize the activities of the wider international community, especially NGOs and faith-based organizations. In their provision of medical aid to South Sudan, organizations of the international community largely draw on a discourse of suffering and a framework of emergency response to humanitarian crises in post-conflict settings, which often translates into vertical programmes which involve direct governance of the South Sudanese population. In contrast, China's contemporary medical interventions in South Sudan are a mixture of health diplomacy, health infrastructure and development aid, an assemblage which can be understood as a "non-suffering" model of care and a loosely defined apparatus of biopolitics. However, the obvious gap between national goals and the daily experiences of individual Chinese doctors suggests that this will be an uneven process of "becoming."

Keywords: South Sudan; medical aid; biopolitics; global health; medical humanitarianism

China's presence in Africa is a geopolitically significant topic. However, beyond engineering projects, mining and business,¹ China's activities in Africa receive scant attention in the academy, and research on its medical interventions is particularly limited.² Since the mid-20th century, there has been robust movement of medicine, medical care and medical professionals from China to Africa.³ In the 1960s, China started to send medical teams to Africa in support of the continent's newly independent countries, and this mode of aid continues to the present day.⁴ In the 1990s, private doctors and private medical businesses from China started to take a foothold in African countries, constituting another driving force for China's medical presence in Africa.⁵

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1 Driessen 2019; Lee, Ching Kwan 2017; Bräutigam and Tang 2011; Sun 2017.

2 Li 2011; Lin et al. 2016; Huang 2010.

3 Langwick 2011.

4 Hsu 2002.

5 Hsu 2012; Jennings 2005.

This article compares China's medical aid in South Sudan with medical humanitarianism and global health programmes carried out by other international assistance organizations in the country. Medical humanitarianism, understood here as “the field of biomedical, public health, and epidemiologic initiatives undertaken to save lives and alleviate suffering in the conditions of crises born of conflict, neglect or disaster,”⁶ takes centre stage in the contemporary biopolitics of post-conflict regions, centrally influenced by a discourse of suffering⁷ and often manifested by an emergency response and an interventionist apparatus of governance⁸ – increasingly conceptualised as “humanitarian governmentality.”⁹ Such a mode and apparatus of governance tends to respond to a “bare life”¹⁰ model in which people are reduced to the biological dimension or *zoē*. “Suffering bodies” have been invoked as social norms and moral imperatives and are given media visibility, among other considerations, in humanitarian medicine.¹¹ In managing “suffering bodies” there is a clear intersection between “bare life” and biopolitics, following the ethics and practice of contemporary medical humanitarianism.¹²

In South Sudan, this form of biopolitics manifests itself in places such as UN Protection of Civilians (POC) sites and refugee camps. Under this model, medical assistance has been focused on vertical programmes for disease eradication, surgical campaigns and primary care focused on rapid responses.¹³ In a limited capacity, global health programmes also work towards enhancing the health system of South Sudan; but both medical humanitarianism and global health programmes in South Sudan point to a well-structured governance-based mode of intervention.¹⁴

Built on its legacy of medical assistance programmes in Africa dating from the 1960s, China's medical interventions in South Sudan draw on a different discourse. China has not joined the ranks of those in the international community operating under the rubric of what has been termed “minimal biopolitics,”¹⁵ as represented by non-governmental organizations (NGOs) such as Médecins Sans Frontières (MSF), nor it is invested in vertical programmes or direct governance in the health system. Instead, it features a combination of non-interference, a discourse of friendship¹⁶ and a sense of modernity that puts medical infrastructure at its core, thus representing a different form of biopolitics in post-conflict areas. Yet while this represents a distinctive form of medical

6 Abramowitz and Panter-Brick 2005a, 1.

7 Fassin 2012.

8 Good et al. 2010.

9 Jézéquel 2015.

10 Agamben 1998.

11 Calain 2013; Lakoff 2010; Ticktin 2014.

12 Pandolfi 2003.

13 Kadetz 2013; Calain 2007; Wendland 2012.

14 Harman 2012.

15 Redfield 2005.

16 Sautman and Yan 2007.

intervention, China's contribution to global health programmes in South Sudan remains limited in scope.

In summer 2017, I had a conversation with Lu, an orthopaedist, as he smoked a cigarette outside the operating theatre in Juba Teaching Hospital.¹⁷ Chinese medical teams once again began being sent by the PRC to South Sudan following its independence in 2011, and Lu was part of the fourth Chinese medical team sent during that time. He had just removed a bullet from the thigh of a South Sudanese patient, who had been ambushed the night before by two armed rebels on the road to Yei. I asked him what he thought about medical humanitarianism. He hesitated for second, blew a cloud of smoke, and said, "Here in South Sudan, we earn much less than we do in China. Isn't that a form of humanitarianism in its own right?" Lu's words suggest a different understanding of medical aid, one that is marked by practicality rather than the discourse of suffering common to many NGOs working in South Sudan.

For example, World Vision, a global Christian humanitarian organization with an extensive presence in South Sudan, frames its actions as being "dangerously soft-hearted, but just the right kind of dangerous. Going to the ends. Where no one else goes. Because Jesus is alive in the hardest places to be a child."¹⁸ In this context, suffering is closely connected to a sense of universal humanity. In post-conflict South Sudan, the omnipresence of NGOs and faith-based organizations have produced a context in which they are relied upon to perform sovereign functions, encompassing local and transnational actors and institutions responsible for the delivery of public goods and the provision of civilian livelihood.¹⁹

In this article, I take Talal Asad's position²⁰ that a sense of universal humanity is intimately connected to ideologies and practices of governance. Responding to the calls of Joel Robbins, Leslie Butt and Seth Holmes,²¹ I move away from the idea of a single global public whose needs are representable through voices of suffering in order to trace the multiplicity of public discourses in the arena of global health. In doing so, I explore what "another kind of politics" looks like in post-conflict settings.²²

China's contemporary medical interventions in South Sudan represent an assemblage of medical diplomacy, health infrastructure and development aid, which can be understood as a "non-suffering" model of care. Since the 1960s in its medical aid to Africa, China has consistently focused on health diplomacy and health infrastructure. Health diplomacy has always been at the forefront of China's engagement with Africa,²³ with medical teams from China not only providing healthcare services to South Sudanese but also promoting China's

17 Pseudonyms are used for all of the informants in the text.

18 See the "About us" page of the World Vision website at: <https://www.worldvision.org/about-us>.

19 Agensky 2019.

20 Asad 2015.

21 Robbins 2013; Butt 2002; Holmes 2016.

22 Fassin 2009.

23 Youde 2010.

overall foreign policy and international image. Unlike the decentralized medical programmes in remote areas provided by other assistance organizations, China's provision of medical expertise has focused on the public health sector, especially the capacity building of national hospitals. Another focus is on voluntary medical consultations (*yizhen* 义诊). Unlike the vertical programmes and interventions that are commonly practised by global health programmes in South Sudan, *yizhen* focuses on the provision of primary care that is consistent with China's efforts in addressing the imbalance between rural areas and urban areas, thus reflecting an aspiration of modern medicine. The concept of health infrastructure, as another component of China's medical aid, refers to the construction of new hospitals and specialist centres. In South Sudan, this has included the construction and expansion of two major hospitals and a centre for obstetrics and gynaecology. While the international community is hesitant about investing in development projects in a turbulent post-war country, China maintains its long-standing turnkey projects (*jiaoyaoshi gongcheng* 交钥匙工程) in Africa.

Yet, once dispatched to South Sudan Chinese doctors and nurses often feel “stuck” or even “marginalized,” and believe they can only contribute to the public health system of South Sudan on a limited scale. Clearly, there is a gap between the official discourse on medical aid and doctors' practices on the ground, which is attributable to tensions between the different designs and temporalities of China's global health programmes, as well as the challenge of navigating a postcolonial landscape of global health programmes in South Sudan that is inherently colonial in nature.²⁴ All of this limits the scope of Chinese doctors and nurses' care for their South Sudanese patients.

In this article, I will describe the medical humanitarian and global health landscape of South Sudan and discuss the transmission of Maoist medical aid to Africa in the 1960s and its continuation and transformation in subsequent decades. I use Juba Teaching Hospital as a case study to show how Chinese doctors in South Sudan mediate their professional space and the challenges they encounter on a daily basis. To conclude, I examine some of the biopolitical implications of China's medical interventions in South Sudan today.

Medical Humanitarianism and Global Health Programmes in South Sudan

Two of the major features of the international health landscape in South Sudan are medical humanitarianism and global health interventions. Medical humanitarian organizations have a strong presence in South Sudan, due to the country's ongoing wars and conflicts. The First Sudanese Civil War (1955–1972) and the Second Sudanese Civil War (1983–2005), involving Arabs in the north and the Nilotic peoples in the south, claimed over two million lives. The

24 Greene et al. 2013.

independence of South Sudan in 2011 did not bring peace. In the last ten years, millions of people have been displaced by the new conflict, with many fleeing to neighbouring countries.

The *Humanitarian Needs Overview 2018*, produced by the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), estimates that 4.8 million South Sudanese are in need of assistance to access healthcare services.²⁵ “Out of 1,893 health facilities, 419 (22 per cent) are non-functional, and 955 are functioning at 10 per cent of their capacity as a result of extensive looting and vandalization, lack of human resources, and frequent stock outs of drugs and pharmaceuticals.”²⁶ This means that healthcare is increasingly inaccessible in South Sudan where around 70–80 per cent of healthcare services are managed by NGOs and faith-based organizations.²⁷

Conflict and humanitarian aid are closely intertwined in South Sudan. This relationship dates back to 1989, when Operation Lifeline Sudan was launched.²⁸ Under this umbrella, a consortium of United Nations (UN) agencies and NGOs provided humanitarian assistance in war-torn and drought-afflicted regions of southern Sudan. Since then, there has been a pattern whereby emergency responses take centre stage in healthcare services, with less emphasis on development projects. Efforts to build South Sudan’s health system have been compromised by the need to reserve resources for more immediate crises. Given the constant emergencies, donors are used to prioritizing activities such as emergency relief and primary healthcare services delivery that save lives now.²⁹

The provision of the Basic Package of Health Services (BPHS), as a target set by the Ministry of Health of South Sudan, is often contracted out to non-state providers. BPHS refers to essential health services packages or minimum packages of health services,³⁰ which include productive health, community-based health and nutrition, health education and promotion, and monitoring and evaluation. Essential and emergency healthcare are the core components of healthcare services in post-conflict South Sudan.

Nowadays, the UNOCHA’s South Sudan Humanitarian Response Plan is the main initiative coordinating humanitarian work in the country. Over 70 medical partners work with the UNOCHA South Sudan Health Cluster. In neighbouring countries such as Kenya and Uganda, the health sector is coordinated by the countries’ respective health ministries, whereas in South Sudan, the UNOCHA cluster plays a significant role in medical humanitarian affairs. Within this framework, the humanitarian sector has a much larger role and has more say than the development sector.

25 UNOCHA 2018.

26 *Ibid.*, 22.

27 Ministry of Health of South Sudan 2012.

28 Minear 1991.

29 Downie 2012.

30 Ministry of Health of South Sudan 2016.

When it comes to medical humanitarianism, international efforts in South Sudan focus on emergent cases and critical life-saving primary services in remote places, including conflict-ridden areas or UN POC areas. Another focus is on small-scale sanitation and hygiene management in crisis areas. Many NGOs operating in South Sudan today focus on outbreaks of diseases such as malaria and cholera. A representative example is MSF, which worked in 19 project sites across South Sudan in 2019. Their activities ranged from treating gunshot wounds and providing basic medical care in POC sites to vaccinating children against measles and ensuring Ebola preparedness at the border with the Democratic Republic of Congo.³¹

Global health programmes also work in other public health areas to enhance the health system. UNOCHA and its health partners significantly shape the operation of public health in South Sudan. Before South Sudan was divided into 28 states in 2015, each of its then ten states was the responsibility of one health partner. For example, the Health Pooled Fund, a consortium funded by the Department for International Development in the UK (now the Foreign, Commonwealth and Development Office), the United States Agency for International Development (USAID), the Canadian government, the Swedish International Development Cooperation Agency and the Global Alliance for Vaccines and Immunizations, were responsible for states like Unity and Warrap, while the World Bank took charge of the states of Jonglei and Upper Nile.

In some cases, NGOs have been able to directly implement medical projects. For example, Doctors with Africa, a Christian NGO from Italy, supports 11 county health offices, five hospitals, and 150 peripheral health facilities, and provides vaccinations, nutritional screening and ambulance services in the counties of Yirol and Lui.³² Cordaid, an NGO from the Netherlands, provides medical governance in Torit State Hospital in Eastern Equatoria.

Among NGOs, faith-based organizations play a significant role in shaping aid and healthcare. When Operation Lifeline Sudan was born, a number of faith-based organizations were involved, such as Africa Faith and Justice Network, the Association of Christian Resource Organizations Serving Sudan, Bread for the World, the Catholic Fund for Overseas Development, Catholic Relief Services, Dutch Interchurch Aid, the International Catholic Migration Commission, the Lutheran World Federation and World Vision International.³³

The discourse of suffering has largely defined the work of faith-based organizations, given that over 60 per cent of South Sudanese are Christian. Global health and medical humanitarian programmes continue to be shaped by the influence of Christian organizations and doctrines. Medical campaigns,

31 "How we're helping in South Sudan," Médecins Sans Frontières, <https://www.doctorswithoutborders.org/what-we-do/countries/south-sudan>.

32 "Our Work in South Sudan," Doctors With Africa, <https://doctorswithafrica.org/en/where-we-work/in-africa/our-work-in-south-sudan/>.

33 Minear 1991.

for example, often use discourses of “transforming people’s lives” or “marvels of healing”³⁴ that confirm Christian teachings. Samaritan’s Purse, an evangelical Christian humanitarian aid organization that provides medical aid as a key part of its missionary work, summarizes its mission in South Sudan as “helping those in need and proclaiming the hope of the Gospel.” Franklin Graham, the organization’s president, said, “At Samaritan’s Purse we don’t run from disasters – we run to them. We go to help people in Jesus’ Name.”³⁵

This discourse of suffering places Christian organizations within networks of aid and governance, particularly global aid regimes, with which they are increasingly entangled.³⁶ This has created a booming emergency relief industry, including consortiums such as International Orthodox Christian Charities, GlobalGiving, Christian Connections for International Health, the Sudan Council of Churches, the Sudan Conference of Catholic Bishops, Catholic Relief Services and Africa Inland Mission. They form a globally interconnected Christian network of religious actors responding to emergency medical needs. Working together, these transnational networks provide medical ministries such as mobile clinics, basic medical care and complex surgery campaigns including those targeting fistula and cleft lip and palate procedures.

IMA World Health (hereafter IMA), a faith-based organization from the United States, has been offering medical service in South Sudan since 2008. IMA mostly works in the conflict-ridden states of Jonglei and Upper Nile, with a focus on delivering emergency responses to the displaced. In 2016, IMA published a report calling for a transition from NGO-managed to South Sudan Ministry of Health-directed primary healthcare services delivery.³⁷ But in primary healthcare services, IMA’s focus is still on rapid results, especially adaptability and responsiveness in insecure areas, reflecting the strong impact of the emergency response model.

Multilateral funding is a key feature of international assistance organizations’ medical programmes. IMA’s work in South Sudan, for instance, is funded by the Global Fund in partnership with Population Services International and the United Nations Development Programme, the USAID Office of US Foreign Disaster Assistance, UK’s Department for International Development in partnership with Mott MacDonald, the United Nations Population Fund, and the World Bank in partnership with the South Sudan Ministry of Health.

A discourse of suffering is used to justify the work of medical humanitarianism and global health programmes in South Sudan, which is particularly manifested in the omnipresence of NGOs and Christian organizations. The emergency model has created a framework resulting in the “right to interfere,” which

34 Hardiman 2006, 26.

35 “Urgent need: applicants sought for paid positions in South Sudan,” Samaritan’s Purse, 15 May 2019, <https://www.samaritanspurse.org/article/urgent-need-apply-for-paid-positions-in-south-sudan/>.

36 Agensky 2019.

37 IMA World Health 2016.

gives birth to a biopolitical apparatus.³⁸ In a similar fashion, a focus on social suffering has been an inherent feature of contemporary global health programmes, resulting in a soteriological structure of aid work.³⁹ In South Sudan, wars and the rise of Christianity have further enhanced the discourse of suffering that translates into the governance of human life and the operation of a robust business in medical humanitarianism and global health.

China's Medical Aid to Southern Sudan

The discourse of collective suffering has also been used powerfully by China to mobilize a sense of solidarity with Africa. However, unlike the Christianity-informed discourse of suffering, which points to a universal humanity, suffering was initially framed by China as a subject of geopolitical significance bridging the gap between China and Africa.

In 1963, when Mao Zedong 毛泽东 received an African delegation in Beijing, he made the following remarks: "In the fight for complete liberation the oppressed people rely first of all on their own struggle and then, and only then, on international assistance. The people who have triumphed in their own revolution should help those still struggling for liberation. This is our internationalist duty."⁴⁰ Here, Mao positioned China as sharing Africa's experience of suffering, because both had been subjected to colonialism in one way or another. The discourse of collective suffering and collective struggle propelled China's transnational project of promoting solidarity in Third World countries.

Mao's internationalist vision of medical assistance to the Third World reflected his vision of modernity in medicine. According to Mao, China's emphasis would be on the countryside rather than urban areas.⁴¹ In the 1960s, he unveiled a series of nationwide projects supporting such a social movement. For example, the policy of *shangshan xiexiang* 上山下乡, literally "up to the mountains and down to the villages," was designed to re-educate urban youth and intellectuals in the countryside.⁴² During the Great Leap Forward (1958–1962), China started to enhance the delivery of medical services to the countryside by setting up health centres in people's communes (*renmin gongshe* 人民公社), the basic social and economic unit in China at the time.⁴³

Following these guidelines, the emphasis on health in China shifted to the countryside and a "barefoot" programme was launched. Barefoot doctors (*chijiao yisheng* 赤脚医生) who were trained via this model became an important component both of China's health infrastructure in rural areas and of China's medical revolution in the Third World. Barefoot doctors were young farmers with reliable political backgrounds who were selected for intensive

38 Calhoun 2010.

39 Nguyen 2016.

40 Mao 1976.

41 Yao 2007.

42 Lo 1987.

43 Taylor 2005.

practice-oriented training in medicine.⁴⁴ The emphasis was on disease prevention rather than curative medicine. At the centre of this programme was a combination of acupuncture and basic biomedicine. A parallel programme was the mobile medical team (*xunhui yiliaodui* 巡回医疗队), an outside support group formed to promote the development and consolidation of cooperative medicine, which laid the foundation for *yizhen*.

Following the African Independence Movements, China began to reach out to African countries, sending the first medical team to Algeria in 1963 after France pulled its doctors out of the newly independent country. This initiated China's long-standing mission of providing "revolutionary medicine" to the Third World, particularly Africa. Chinese doctors found a new mission overseas in Africa, where they were tasked with "saving the dying and treating the wounded, practising revolutionary humanitarianism" (*jiusifushang, shixing gemingde rendaozhuyi* 救死扶伤, 实行革命的人道主义), a principle prescribed by Mao in the revolutionary period.

In 1970, China started to send medical teams to Sudan. From 1971 to 1973, 48 doctors and nurses from Shaanxi were sent to Sudan for two years' service in places such as Omdurman in the north and Juba, Aweil and Malakal in the south. Many were doctors at the county or township level or were barefoot doctors.⁴⁵ Mao's medical campaigns popularized a simplified form of primary care, making it accessible to China's general population before disseminating it to other parts of the world. In this sense, for the purposes of technical development, Africa was understood in terms of China's rural areas. In doing so, China reconstructed Africa as its target for political and physical intervention by treating the bodies of African people as those of "global peasants."⁴⁶ Under this model, "the poor help[ed] the poor,"⁴⁷ who were framed as members of the same sister/brotherhood.

The view of suffering in this paradigm differs from the discourse of medical humanitarianism, in which external actors witness and respond to the misery of human beings through the practice of advocacy.⁴⁸ In contrast, by identifying common ground between China and Africa – that is, that Chinese and Africans struggle side by side against colonialism and imperialism⁴⁹ – China was able to roll out its biopolitical scheme targeting Africa.

Shifting Grounds for Medical Intervention

This mode of medical aid – responding to political crisis and forging an affective alliance with the international proletariat – slightly changed in the 1980s. The

44 Fang 2012; Sidel 1972.

45 Shaanxi Provincial Revolutionary Committee 1972.

46 Zhan 2009.

47 Snow 1988.

48 Castañeda 2011.

49 Lee, Christopher J. 2010.

work of Chinese medical teams in southern Sudan was interrupted by the Second Sudanese Civil War and the teams were withdrawn from southern Sudan. Meanwhile, as China shifted from a socialist economy to a market economy, it became increasingly difficult for health administrators to recruit medical teams for service in Africa, because doctors preferred to work in China to take advantage of its newly emerging economic opportunities. Due to these considerations, health administrators used a variety of incentives to attract medical professionals to work in Africa, like increased salary and training opportunities. Under these new schemes, junior staff were not considered, with priority being given to mid-career and senior doctors who were selected from the top-ranked hospitals in China. This came at a time when the barefoot doctors were gradually being phased out of China.⁵⁰

Today's Chinese overseas medical teams retain many of the old features. Coordinated by the National Health Commission of China (*guojia weisheng jiankang weiyuanhui* 国家卫生健康委员会),⁵¹ medical teams are posted to recipient countries for one to three years. This form of medical assistance follows the same pattern as partner-assistance programmes in China where economically advanced provinces and municipalities send medical teams to less developed regions in China for one to two years to help with capacity building. For example, Shanghai is responsible for the dispatch of medical teams to Morocco, Yunnan province is in charge of Uganda, Beijing is in charge of Burkina Faso and Henan province is responsible for Zambia, Eritrea and Ethiopia. For French-speaking countries, the medical teams can stay there for three years, but in most cases, medical teams will serve for two years.

China had no further presence in southern Sudan, medical or otherwise, until around 2005, when it started to engage with the region again following the signing of the Comprehensive Peace Agreement between the Sudanese Government in the north and the Sudan People's Liberation Army in the south. Chinese state-owned engineering companies started to make their presence felt in southern Sudan, developing oil fields, digging wells, constructing roads and upgrading power grids. Small businesses from China also swarmed into Juba and other cities in southern Sudan, in particular seizing opportunities in the wake of South Sudan's independence in 2011. At its peak, this trend saw about three thousand Chinese working and living in Juba. Today, roughly one thousand Chinese work and live in the states of Upper Nile and Wau.

In 1995, Khartoum reached an oil agreement with Beijing. In June 1997, the Greater Nile Petroleum Operating Company was established, with the China National Petroleum Corporation (*Zhongguo shiyou tianranqi jituan* 中国石油天然气集团) owning 40 per cent of the company. Most of the oil fields were in

50 Tu 2016.

51 Before 2013, it was called the Ministry of Health. In 2013, it was changed into the National Health and Family Planning Commission. In 2018, it was changed to the National Health Commission.

the south of the country. China invested heavily in Sudan's oil infrastructure, including a pipeline to Port Sudan and several refineries in the north.

After South Sudan gained its independence in 2011, Khartoum withdrew many teachers and medical personnel from the south, plunging the new country into a dire situation. This offered China an opportunity to resume its medical aid programmes in South Sudan. In the same year, China and South Sudan signed a memorandum of understanding on medical assistance. They agreed that 12 doctors from southern China's Anhui province would be dispatched on a one-year mission to staff Juba Teaching Hospital. In 2012, Anhui province sent the first medical team, composed of two physicians, two paediatricians, two gynaecologists, two surgeons, an anaesthetist, an orthopaedist, a translator and a cook. In the following year, they added a Chinese acupuncturist, a dermatologist and a nurse.

Before being dispatched to South Sudan, Chinese medical teams receive six months' training in Anhui province, including cultural courses related to Sudan. Their training ends in Jinzhai 金寨 county, one of China's national-level poverty-stricken counties, located in the mountainous area of Anhui province, where they carry out medical campaigns in assessing the health conditions of villagers and providing primary care services. The rural–urban divide has been the starting point of China's medical aid programmes domestically, a distinction that is also extended to China's medical teams in Africa.

Like their predecessors in the 1970s, the Chinese doctors at Juba Teaching Hospital live in an exclusive compound at the Beijing Hotel (*Beijing fandan* 北京饭店), next to the Chinese embassy compound. Like many employees of the Chinese state enterprises living in the compound, Chinese medical personnel are not allowed to leave their compound without getting approval from their supervisors. Once, a Chinese paediatrician was given a warning for visiting the home of one of her South Sudanese colleagues. One of the few occasions for the medical teams to leave the compound is during the weekend, when they are driven by a Ugandan driver to go shopping in Juba.

Once they arrive at Juba, the medical teams are supervised by the Economic and Commercial Counsellor's Office of China (*jingjishangwuchu* 经济商务处), a local branch of the Ministry of Commerce of China. Many of the Chinese doctors coming to serve in South Sudan have different motives from their predecessors in the 1970s and 1980s. Not only do they receive a generous salary and benefits, but after completing their service in South Sudan they are also eligible to enrol in a three-month exchange programme in Germany for advanced training. Today, many Chinese doctors who travel to South Sudan are motivated less by the mission of "serving the people of the world" than by their desire for a new and refreshing experience overseas.⁵²

52 See Malkki 2015.

This is particularly true of senior doctors, such as my informant Zhuang, an anaesthetist and chief physician in her fifties, who told me, “I was skilled in all areas in my hospital in China. All of the procedures were repetitive. China is developing too fast, leaving little room for people to stay true to themselves. The best thing about being in Africa is that I can spend some time doing what I want.”⁵³ In her spare time, Zhuang read her favourite books, such as *Ten Years in Africa*, a travelogue by a Chinese photographer who travelled extensively across Africa.

Lu, an orthopaedist in his sixties, applied to join a medical team in South Sudan because he regarded it as a “political requirement.” Lu’s parents had been part of medical teams in South Yemen in the 1970s, but for Lu, working in Africa no longer evoked a “revolutionary romanticism.” Many of the doctors recognized that a year’s service in South Sudan could translate into career advancement, public recognition and study opportunities on returning to China.

“Don’t Put Yourself in the Position of an Expert”

Despite these changes, Yao, the economic and commercial counsellor in Juba, still frames the relationship between China and South Sudan as one of the “poor helping the poor,” from a foreign policy point of view. He said, “China is a big nation, but not a powerhouse. For a long time to come, medical teams will be part of China’s South–South collaboration (*nannan hezuo* 南南合作).”⁵⁴

Most of China’s medical interventions in Africa are based on collaborative relationships with national hospitals. For example, the medical teams in Tanzania work with Muhimbili National Hospital, and those stationed in Zanzibar collaborate with Mnazi Mmoja Hospital and Abdulla Mzee Hospital. In South Sudan, they partner with Juba Teaching Hospital. These hospitals serve as a hub for health administrators from China and the Economic and Commercial Counsellor’s Office of China in Juba to coordinate Chinese medical teams, provide medical supplies, and upgrade health infrastructure. Examining these spaces not only offers insights into the how China’s medical interventions are put together, but also highlights the obstacles faced by Chinese doctors on the ground.

Juba Teaching Hospital, the only public referral hospital in South Sudan, was established in 1927, in buildings that had previously served as army barracks. With a lack of proper functioning primary healthcare facilities, many South Sudanese patients end up coming to this hospital.⁵⁵

The hospital is surrounded by a large number of private clinics, pharmacies and testing centres. Due to the lack of medical facilities at the hospital, patients

53 Interview with Zhuang, Juba, 25 June 2017.

54 Interview with Yao, Juba, 30 March 2017.

55 Health services in South Sudan are structured into four tiers: Primary Health Care Units (PHCUs), Primary Health Care Centres (PHCCs), County Hospitals (CH), State Hospitals (SH) and Teaching Hospitals (THs).

often have to go to private clinics to obtain diagnoses and medication. Those who can afford the prices end up traveling to neighbouring countries such as Kenya and Sudan for treatment, with some even travelling as far as India or Jordan.

Power outages at Juba Teaching Hospital are a constant threat to the provision of health services. Many patients and their relatives will wait outside the consultation rooms until the power is back on. Sometimes, the doctors will not show up, or will take tea under the trees until the power is back. In such cases, the patients will have to return the following day, or will not show up until a few days later when they have gotten sufficient money for transportation. Junior doctors and medical assistants often carry out the majority of the work: this is particularly true of the emergency department.

Foreign aid has been a long-standing feature of Juba Teaching Hospital, and the international community plays an active role in this aspect. After the Second Sudanese Civil War, the International Committee of the Red Cross (ICRC) supported Juba Teaching Hospital. At that time, the ICRC set up laboratory facilities and provided an X-ray machine. When the ICRC was involved, the Juba Teaching Hospital had 400 nursing staff including 230 students from the nursing school. Four ICRC head nurses, a teaching nurse and two ward nurses were in charge of the daily coaching of students on the wards.⁵⁶

The hospital was subsequently funded by the Real Medicine Foundation, a US-based non-profit public charity. South Sudan's first college of nursing and midwifery was established by the Real Medicine Foundation in collaboration with the Ministry of Health of South Sudan, UN agencies, and St. Mary's Hospital on the Isle of Wight, UK. Every now and then, retired physicians from St. Mary's Hospital fly to South Sudan to facilitate short-term mental health and basic medical training programmes for the students of the College of Physicians and Surgeons on the southern edge of the Juba Teaching Hospital grounds. Even the *South Sudan Medical Journal* is co-edited by St. Mary's Hospital. St. Mary's Hospital also established Juba Link, which has sponsored a number of visits by senior healthcare professionals from the UK.

Unlike their counterparts from the West, who are actively involved in the management of hospitals and clinics in South Sudan, China's management teams play little role in management. They even intentionally keep themselves away from the role. Wu, who led the fourth Chinese medical team to be sent to South Sudan, said their mission was to do what they can without crossing boundaries. "We are promoting the national image of China. To a certain extent, we are semi-diplomats."⁵⁷ Accordingly, the Chinese doctors in South Sudan modestly position themselves as aides of their South Sudanese colleagues.

In many cases, the Chinese medical teams have to negotiate their own professional space and find a niche. When they first arrived at the hospital, the gynaecologist Xue

56 "Sudan: Juba Teaching Hospital then and now," International Committee of the Red Cross, <https://www.icrc.org/en/doc/resources/documents/feature/2006/sudan-stories-230806.htm>.

57 Interview with Wu, Juba, 23 November 2016.

and her colleague Miao followed the director of the gynaecology department, did rounds in the morning and changed dressings as if they were interns. As Xue said, “Don’t put yourself in the position of an expert. They will not listen to you. You must not break the rules. You can only slowly adapt to them.”⁵⁸

The team now works from Monday to Friday on a half-day basis, between 9 a.m. and 12 p.m. In the 1970s, Chinese doctors at Juba Teaching Hospital used the eye department as their major working space: today their hub is the electronic gastroscopy room. In 2013, the Anhui Provincial Health Department (*Anhuisheng weishengjiankang weiyuanhui* 安徽省卫生健康委员会) donated a gastroscopy machine to Juba Teaching Hospital. After the Chinese doctors arrive at the hospital in the morning, they leave their belongings in this room before going to their respective departments to work.

What they are expected to do on the premises of Juba Teaching Hospital is not clearly stipulated in the memorandum; instead, it is often a matter of improvisation and negotiation, depending on the strategies of each team. “We are not given concrete requirements or guidelines,” said my informant Wu. The biggest challenge is that Chinese doctors are not consistently in charge of beds or outpatient rooms. They have to negotiate with the medical consultants to get clinical spaces, but these spaces are often contingent on availability.

In 2016, the fourth medical team managed to set up a consultation room, but they were only allowed to open for two days per week. Similarly, the fifth medical team collaborated with the director of the surgery department to open a consultation room, but it was soon closed. Chinese surgeons and orthopaedists feel constrained because their South Sudanese counterparts tend to outsource patients to private clinics outside Juba Teaching Hospital. An operation easily costs two to three thousand South Sudanese pounds – a crucial source of income for doctors who have not received salaries from the government for a few months in the wake of a nationwide economic crisis. Many Chinese doctors find it challenging to position themselves within the hierarchical system at the hospital, which is composed of medical consultants, medical assistants and interns, as they do not know how to engage in or influence the decision-making process.

The Chinese doctors generally tend to avoid interfering in the business of their South Sudanese colleagues. On Tuesdays, the orthopaedist Lu goes to the orthopaedic department to help with outpatient services. The consultation room is spacious, with a big flip chart standing against the wall. The big table in the centre is reserved for a medical consultant in the department, and the side table for Deng, a younger medical officer in his early 30s.

Lu partners with Deng, but he remains unobtrusive. Lu said to me, “If the patients have questions, I will help. If Deng does something wrong during the operation, I will correct it directly. I don’t give instructions. I just do it myself. I won’t say that this bone is not clean. Of course, scars should be removed as

58 Interview with Jiang, Wau, 22 March 2017.

much as possible during the operation to facilitate bone growth, but I don't say that in words; instead, I do the scraping myself and return the bone to Deng when I am done."⁵⁹

After the fifth medical team arrived in 2017, they tried to make their work more visible. They created several posters advertising their services and posted them on the gates to a few of the wards. Helen, a South Sudanese nurse who works as a translator for the hospital's Chinese dermatologist and physician, has to fetch patients from the emergency room to be treated by the Chinese doctors. Otherwise, not many patients know that a Chinese medical team is working at Juba Teaching Hospital.

After her work for the Chinese physicians is over, Helen goes back to Ward Five to attend to her daily tasks. I spoke with Helen on the last day of a workshop organized by the Ministry of Health for the staff of Juba Teaching Hospital. Helen, however, had not gone to receive the training, which was held at the distant Freedom Hall conference centre. "Who would pay my transportation fees?" she asked. "Workshops, they happen all the time. What is the way forward? A B C D E, but how can we make things tangible if they remain on paper only? And the *zol kebir* (big men) celebrate it."⁶⁰

Helen identified a difference in the medical aid provided by Chinese medical teams and other foreign actors. The other foreign actors often say nice things, but seldom deliver the actual medical service, but the way the Chinese do things is different. "At least the Chinese are trying to help. In South Sudan, we have a relevant saying: 'the frog jumps according to its strength'." This suggests that the Chinese doctors are doing what they can in spite of the obvious obstacles they face at the hospital.

The senior doctors at Juba Teaching Hospital tend to keep their distance from the Chinese doctors because the Chinese are deemed a threat to their authority in the hospital. Some senior doctors dismiss their Chinese colleagues' work as auxiliary or even useless. They also believe that the Chinese know little about tropical medicine, including the diagnosis and treatment of malaria. A director general of the hospital said that they needed more cosmetic surgeons in post-conflict South Sudan, instead of the general surgeons dispatched by China.

However, young local doctors find their presence beneficial. Every year, Juba Teaching Hospital sends doctors to Anhui Medical University (*Anhui yike daxue* 安徽医科大学) for training. Daniel, an orthopaedist who had studied in both South Africa and China, explained the difference to me as follows. "In China, I worked with two teams. They allowed me to work independently. In South Africa, you can only assist."⁶¹

Every year, the Chinese medical teams also carry out some voluntary medical consultations, or *yizhen*, in a number of states across South Sudan. However,

59 Interview with Lu, Juba, 26 June 2017.

60 Interview with Helen, Juba, 31 March 2017.

61 Interview with Daniel, Juba, 11 July 2017.

unlike other campaigns in South Sudan, which are focused on vertical interventions featuring critical surgical procedures such as fistula surgery, *yizhen* focus on the assessment and treatment of general health conditions, and on preventative medicine. This reflects the continuation of the Chinese medical tradition dating back to Mao's time, both in and beyond China. Through *yizhen*, doctors in city hospitals partner with clinics and hospitals in remote areas to provide the latter with assistance. Mobile medical teams serve as an external support force, promoting the consolidation and development of medicine in the countryside. In this sense, Africa is still largely framed as equivalent to the countryside of China in terms of modes of healthcare delivery.

Since the Chinese medical teams began their service in 2013, they have carried out *yizhen* campaigns two or three times per year, in places such as Yei, Torit, Yirol, Wau and Kuajok. Each campaign lasts for about one to two weeks.

Although China's medical interventions in South Sudan predominantly feature medical teams, they are also characterized by a parallel emphasis on health infrastructure. When international NGOs are hesitant to devote funding on development projects, China moves ahead with its infrastructure projects.

Starting from 2000, China has hosted a series of Forums on China–Africa Cooperation (*Zhong Fei hezuo luntan* 中非合作论坛), with each forum announcing a new medical aid package. In 2015, Xi Jinping 习近平 declared that the Chinese government would construct or upgrade around one hundred medical institutions and facilities in Africa within three years. In the last six years, China has completed two major medical infrastructure projects in South Sudan. The first was the modernization and expansion of Juba Teaching Hospital, which now has a new outpatient and emergency building, an obstetrics and gynaecology building, and a dormitory building for the Chinese medical teams. At the same time, a CT scan machine, electroencephalogram and other medical equipment was installed. Earlier this year, phase two of the expansion project was kicked off, including specialist outpatient, medical technology, inpatient, infectious disease, administration and logistics support divisions. The second project was the construction of the Kiir Mayardit Women's Hospital in Rumbek. South Sudan has also reached an agreement with a Chinese engineering company to construct at least 26 hospitals across the nation.

Through these projects and plans, China continues its long-standing turnkey projects⁶² in Africa, whereby Chinese companies take responsibility for every project stage from design to completion, providing ready-to-use facilities for the governments of African countries. However, as a more recent development, administrators in China are considering moving the housing of Juba Teaching Hospital's medical teams from the exclusive compound to the newly renovated hospital, enabling them to better integrate with their South Sudanese colleagues and patients.

62 Liu et al. 2014.

Towards a Process of “Becoming” in Post-Conflict Settings

China’s contemporary medical interventions in South Sudan suggest a mode of care different from that delivered by medical humanitarianism. They do not originate from a philosophical or religious understanding of human suffering, and they do not end up with a systematic apparatus of biopower and life regulation. Instead, they represent what can be understood as a “non-suffering” mode of care built on an assemblage of values and expertise: a narrative of “poor helping the poor” in the context of the Global South, an alignment with China’s foreign policy of non-interference and a long-standing emphasis on the enhancement of medical systems. Moreover, China has never fully endorsed a human rights discourse emphasizing the alleviation of universal human suffering, but instead has long prioritized a future-oriented developmentalism.

Unlike other global health programmes that are often embedded in multilateral mechanisms and characterised by vertical interventions, China’s bilateral approach and medical interventions in post-conflict South Sudan point to a more loosely defined or structured apparatus. Such developments respond to Joel Robbins’⁶³ call to go beyond the designation of the “suffering subject” often assigned to people in war zones and post-conflict settings. The idea of aid/medical intervention not focused on suffering might also suggest possibilities for Africa’s future.⁶⁴

However, the “non-suffering” model of care is not a consistent and stabilized modality, but rather an unfinished process of “becoming.”⁶⁵ In this process, individual Chinese doctors have to navigate various layers of obligations and expectations, desires and interests, as well as internal and external challenges, which are in themselves reflections of different temporalities. Their experiences at Juba Teaching Hospital are a testimony to the tensions and uncertainties of their work and the discrepancy between ideal and reality.

In formulating its medical aid programmes in South Sudan, the Chinese government adheres to its assumptions of friendship and diplomacy as the basis of a non-interference model of care. Although China has become an economic powerhouse over the years, “Third Worldism” as a powerful vision and discourse has never altogether disappeared from its political agenda and foreign policy. Against this ideological backdrop, Chinese doctors are expected to perform the duties of “semi-diplomats” by promoting China’s national image. Aligning with China’s non-interference foreign policy, they tend to position themselves as medical assistants standing on the sidelines, rather than experts or authorities dictating solutions. While this non-interference mode of care gives more room to the South Sudanese counterparts of the Chinese medical teams, reducing the likelihood of external governance by NGOs, this places the Chinese doctors in a disadvantaged position in the Juba Teaching Hospital, which is heavily influenced by a colonial framework.

63 Robbins 2013.

64 Goldstone and Obarrio 2016.

65 Biehl and Locke 2017.

Moreover, medical aid represents only a small adjunct to China's bigger global engagements,⁶⁶ reflecting China's increasingly pragmatic approach to global health programmes. Unlike the 1970s when much bigger medical teams were sent to Africa in support of decolonization movements, a 15-member medical team rotated on a yearly basis is limited in its provision of healthcare services, and is much smaller than similar direct medical assistance such as that provided by Cuba.⁶⁷ This mode of care sidelines transnational doctors in the public health sector in South Sudan, leaving each medical team to decide the priorities for its one-year term. As a result, Chinese doctors often feel frustrated or disempowered. In the meantime, Chinese doctors are also increasingly driven by self-interest: with junior or mid-career doctors seeking opportunities for promotion, "exploring the world" or finding a new momentum in life as senior professionals.

The landscape of global health programmes in South Sudan poses another layer of challenge. China's medical teams in South Sudan do not engage in much collaboration with global health consortiums. Unlike the missionary doctors and colonial medical officers of the past and contemporary medical NGOs, Chinese doctors in South Sudan are not directly involved in governmentality. Given the current political economy of global health in South Sudan, these medical teams have to constantly negotiate their professional space and even make their work visible to the South Sudanese population they are expected to serve. Chinese doctors in South Sudan face far more challenges in the post-colonial era than they did in the 1970s, when Sudan embraced socialism under the rule of then Sudanese president Gaafar Nimeiry.

Nonetheless, medical aid from China in South Sudan contributes to a new understanding of war zones and post-conflict settings against a background characterized by a great deal of contingency. By comparing the suffering mode that characterizes the activities of international NGOs and Christian charities with the non-suffering framework characteristic of China's medical activities in South Sudan, we can gain a more nuanced understanding of the forms, scope and biopolitical implications of medical humanitarianism and global health programmes in post-conflict areas.⁶⁸

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66 Liu et al. 2014.

67 Brotherton 2013.

68 Fox 2001; Abramowitz and Panter-Brick 2015b.

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Conflicts of interest

None.

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摘要：这篇文章探讨了中国在南苏丹的医疗干预模式，并将其与国际社会——特别是非政府组织和宗教信仰组织——在南苏丹的医疗人道主义和全球健康的想象与干预模式进行了比较。在向南苏丹提供医疗援助时，国际组织很大程度上依托于“苦难”的话语和人道主义危机的紧急响应框架，这些框架通常转化为垂直治理项目。相比之下，中国在南苏丹的当代医疗干预是卫生外交、卫生基础设施和发展援助的混合体，可以理解作为一种“非苦难”的关怀模式和松散的生命政治机制，但国家的目标与中国医生日常经验之间的差距表明，对南苏丹的未来而言，这将是一个不平坦的实现过程。

关键词：南苏丹；医疗援助；生命政治；全球健康；医学人道主义

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