Introduction

Do you enjoy your time here?
It's all the same.
So, why did you come here?
To do business.
Medicine as business?
I first tried growing vegetables . . .
Growing vegetables as business?
All you need is a garage, plastic tubs, water, beans and lots of working hands [to grow bean sprouts or make tofu] . . .
. . . And, I guess, a taste for your produce to have a clientele?
There are too few Chinese restaurants here, that's why I changed to doing medicine . . .

—Excerpt of a conversation with a
Chinese medicine practitioner, 2001

The early twenty-first century has seen an acceleration of movement across national and transnational landscapes. Social scientists speak of hubs and whirls, diversity, superdiversity, mobility, hybridity and assemblages. These 'theoretical minima' refer to the processes of globalisation, glocalisation, creolisation, worlding and entangled histories, which in anthropology and the history of science, technology and medicine used to be discussed in terms of 'cultural exchange' or 'technology transfer' less than half a century ago. Textures of transformation and the social relatedness relevant to the study of medicoscapes, medical diversity, medicine and mobility, alongside the multiple dynamics instigated by body techniques, sensory and other articulations, everyday tactics, and sexual and life history transitions are the focus of this book.

When, between 2001 and 2008, I conducted ethnographic fieldwork on the introduction of 'Chinese medicine' (defined in more

detail below) into East Africa, that is, Tanzania, Kenya and Uganda, I soon realised that this research was not addressing a pressing problem for public health.[1] This was primarily for reasons of quantity. There were too few private Chinese medical practitioners, numbering only about twenty per country, in countries with about 35–42 million people (in Tanzania), 31–37 million (in Kenya) and 25–32 million (in Uganda) at the time. Yet however insignificant they were in number, these private practitioners who styled themselves 'Traditional Chinese Medicine' doctors were culturally visible. The first Chinese medical practices opened as private enterprises in Kenya in the late 1980s, in Uganda in 1995 and in Tanzania in 1996.[2] They catered to a primarily regional, local and transnational East African clientele, men, women, infants and children, and, as this research will show, benefitted from the sterling work of the earlier socialist Chinese medical delegations (for the latter, see e.g. Li 2011, Langwick 2011).

It soon became clear that the phenomenon I focused on was part of a larger social landscape that was not left unaffected by the diplomatic and other relations between China and Africa (e.g. Alden et al. 2008, Bräutigam 2009). As specialised as the topic of 'Chinese medicine in East Africa' would appear, it evidently confronted me with questions fundamental to living beings' entanglement and basic to anthropology as a discipline. Where the media reinforced the view of an unsurmountable 'culture clash' between 'The Africans' and 'The Chinese',[3] this ethnography – with its focus on healing – has drawn inspiration from a principle of intimate co-existence that the evolutionary theoretician and microbiologist Lynn Margulis (1991) emphasised, also known as 'the intimacy of strangers'. The great achievements in evolution, Margulis argued, arose from cooperation and collaboration (further explained in Chapter 6).

Committed to 'slow research' (Adams et al. 2014),[4] I continued post-fieldwork research, not least through e-communication, conference participation, letters of correspondence, brief in-person visits, and exchanges of goods and ideas with African and Africanist anthropologists over more than a decade,[5] such that I felt compelled – as a medical anthropologist – to think about concepts as fundamental to anthropology as that of 'culture'. Specifically, I started to ask: in cases where treatment was successful and led to a recovery of the patient, what instigated this process of healing between mostly

Chinese Medicine in East Africa
An Intimacy with Strangers
Elisabeth Hsu
https://www.berghahnbooks.com/title/HsuChinese

African patients and Chinese practitioners? Is there another way of thinking about these encounters than in terms of a 'culture clash'?

The Core Concern: *Uzima*, Wholeness and Health

'Healing' is linguistically cognate with 'wholeness'. In Swahili, *uzima*, which means wholeness, is the word for health (Iliffe 1998: 11), and for well-being in a broad sense (Obrist 2003: 281).[6] Yet Chinese medicine patients rarely spoke of 'holism'. Meanwhile, their doings were suggestive of a sense of 'incompleteness' (Nyamnjoh 2021).[7] Very evidently, they were searching, open to 'trying out' opportunities on offer.[8] Some were in search of '*words* of wholeness and well-being', what Dilger (2007: 65) calls the neo-Pentecostal 'Gospel of Prosperity (*neno la uzima*) and, intricately related to it, the concepts of "awakening" (*uamsho*) and "salvation" (*uokovu*)'. Others were seeking *dawa*, medicines: 'natural', 'herbal' or 'natural herbal' treatment, paradoxically in modern and 'advanced' Chinese medical clinics in urban East Africa. As we will see later, when they spoke of 'natural herbs', they alluded to a configuration – or according to Norbert Elias (1978) a 'figuration' – of a wholeness that connected the patient to the plant and the plant to the place of their ancestors (Chapters 3 and 8). In a similar vein, 'good health' (*afya mzuri*) was related to place, such as the 'conditions of living' (*hali ya maisha*, cf. Obrist 2003). *Uzima* was also linked to the political anthropologically identified concern with autochthony (Fayers-Kerr 2018),[9] which extended much beyond the idea of a healthy body-enveloped-by-skin, even if it involved becoming entangled with strangers, momentarily, in commercialised and commodified transactions.

The English word *whole* has been etymologically traced to the Middle English *hool*, 'healthy', 'unhurt', 'entire', and mentioned alongside *hale*, 'fresh' and *holy*, 'sacred', 'consecrated'; it comes from Old English *hal*, akin to Old High German *heil*, 'healthy', 'unhurt', and Old Norse *heill* (Oxford English Dictionary, 2nd Edition, 1989). However, neither religious piety, as implied by *Heilung*, *Heiland* and *Heil*, nor a New Age appropriation of this etymology in terms of 'holism' shall provide the framing of this book.

Keeping *the body in balance* (Horden and Hsu 2013) is central not only to European but also to Islamic and South and East Asian

Chinese Medicine in East Africa
An Intimacy with Strangers
Elisabeth Hsu
https://www.berghahnbooks.com/title/HsuChinese

medicines,[10] and has been identified as a concern throughout the vast expanses of Bantu-speaking Africa as well (Parkin 2013; see also Janzen 1992). Although people did not speak much about it, in daily life they did show concern with the regulation of the flow of bodily fluids and other nourishing things. Conversations on the Swahili-speaking East African coastline with the respective medical experts (during fieldwork 2001–5) furthermore brought to the fore Ayurvedic and Arabic medical manuscripts or printed texts, featuring notions of balancing and bolstering, countering and countervailing, and the openings and closings that regulate the flows within the body, as well as into and out of it.

Openings and Closings, Flows and Blockages

Anthropologists of Africa have long noted that 'openings' and 'closings' are a matter of concern, not only for the individual body, but also for the social body and the body politic. This seems to be so particularly in times of rapid changes and exchanges, and also when it comes to questions of fecundity and fertility (which involve an exchange of fluids). Devisch (1993) has vividly demonstrated this in regard to fertility rites among the Yaka of Central Africa, and likewise Boddy (1989) in regard to genital cutting and stitching in Hofriyat in northern Sudan. The closure that keeps the waters in the womb, like in a watermelon, ensures fecund moisture. Bodily regulated openness and closure has been shown to be directly related to enhancing flows of life.

Taylor (1988, 1992) took this preoccupation with openings and closings a step further, and highlighted that body-technological efforts of dancing and cutting would affect the flow of fluids: the flow of water, milk, blood, saliva, urine and sexual fluids. His ethnography went beyond a focus on the body-enveloped-by-skin and highlighted that the transaction of cattle for marriage or the mixing of fluids in sexual intercourse were motivated by a concern with ensuring and instigating flows, as those were considered generative of the matter that perpetuates life. Taylor's fieldwork was in Rwanda, and his concern was not to argue that the healers he worked with were just as concerned with balance and regulation, as Asian medical practitioners are. Rather, he emphasised that the treatment rationale concerned with regulatory efforts towards a harmonious balancing of different components competed with several others.

In a similar vein, Parkin has long lamented the fact that African thought tends to be excluded from the discussion of scholarly medical learning preoccupied with regulatory balancing, when in fact it is also much preoccupied with it. In a paper with subtitle 'The View from the Office, and the Voice from the Field', Parkin (1990) argues that sensory aspects of evidentiality may have caused this bias in anthropological theory, with visually perceived written information being privileged over orally – and aurally – transmitted knowledge. Arguing against taking the 'lack' of a literate tradition as evidence for a 'lack' of complex social stratification and scholarly medico-moral systems that value balance, Parkin (2013) made a case for a 'relational balance' in the cosmologies of Bantu-speaking Africans. His argument presents convincing linguistic evidence for postulating overlapping orally transmitted transregional semantic fields. Yet his focus is on only one sort of social and sexual transgression, called *chira*, and its bodily retribution through wasting; hence considered a case of keeping the body in balance.[11] Indeed, the medico-moral nexus of Asian medical learning advocates avoidance of excessive consumption and immoral conduct too, but mostly through a 'regulatory balancing' of ethnophysiological flows of blood or *qi* (breath, wind or air).

Notwithstanding, the 'difference' between African and Chinese medical cultures has tended to loom large in peoples' perceptions, as well as in the imagination of social and bioscientific researchers, whether 'African', 'Chinese' or 'Other'. Political and economic asymmetries have heightened this difference. However, the difference may not be as pronounced as generally assumed, as hinted at with the above discussion pertaining to openings and closings, flows and blockages, and relational as well as regulatory balancing.

The Spatial Production of Wholeness

This book starts with the usual questions regarding multiple efficacies in general, and in Chinese medical treatment in particular, by asking what sorts of wholeness medical treatment supposedly effects. If an individual in crisis affects and is affected by the surrounding social spaces, is the healing of individual bodies in any discernible way linked to the production of wholeness in social space? And how might a medical encounter's making of wholeness become reflected in a visible and tangible 'production of space' (Lefebvre

1974, [1974] 1991)? Is it possible, by attending to a concerted healing effort to which people from different provenances contribute, that we can start thinking about 'culture' differently? Rather than identifying traits of sameness in provenance to define culture,[12] might such a joint effort towards 'making whole', as represented by healing efforts, be regarded as an intrinsically culture-making process?

Even though 'culture' has become a 'do-not-use-it' taboo word in anthropology, it is in constant use in public life – on the radio, in the newspaper and on TV. Sometimes, it is referred to in ways that cry out for its reappropriation by anthropology, and social anthropology in particular. Here our discipline has created a term central to both its theorising and its method of generating evidence through fieldwork, but we have disengaged ourselves from the term without being able to distance ourselves entirely from the implications for anthropological theory that this entails. As a result, anthropologists today find themselves in the passive position of seeing the concept of 'culture' put centre stage in the public arena but imbued with essentialising meanings that even the inventors of the term had meant to overcome (e.g. Boas 1911: 14). This essentialising tendency comes to the fore particularly when commentators speak of cultural 'difference' and 'other' cultures.[13]

By contrast, already Marcel Mauss suggested that a research focus on technique and technology ([1906] 1979a, [1935] 1979b, [1913–1953] 2006b, [1967] 2007) had the potential to do away with 'sameness' as the defining feature of culture.[14] Admittedly, the remarkable twelve texts, chronologically assembled and thoughtfully edited by Nathan Schlanger (Mauss 2006b), do not form a highly structured argumentative piece. Nevertheless, the messages they contain, alongside insights gleaned from his *Manual of Ethnography* (2007) and a careful reading of his *Seasonal Variations* (1979a) combined with his famous essay on 'Les techniques du corps' ([1936], 1950, [1935] 1973, [1935] 1979b, [1935] 2006a), open up to-date insufficiently explored ways of approaching 'skilled activity' – an apt category for thinking through any medical intervention.[15]

Mauss argued that techniques and skills are partially learned and transferred, adopted piecemeal and transformed. Some can easily be imitated, while others are used in ways that involve skilful fine-tuning. Importantly, such kaleidoscopically assembled techniques, rearranged in consideration of possible complementarity to each

other, can lead to an emerging and mutually negotiated sort of 'wholeness', fundamentally different from the 'wholeness through sameness' that the term 'culture' usually invokes.

This shifting of focus towards an ethnography of hands-on techniques and bodily skills that are always oriented towards being situation-specifically effective takes us away from abstractions like language and religion. Mauss insisted on studying 'social morphology' and material 'objects' in their relation to each other, and rejected the idea that a cartography of the distribution of objects would lead to an identification of 'culture', as any such undertaking was grounded in circular reasoning.[16] The distribution of 'cultural' objects on their own provided no evidence for the expanse of a 'culture'. Rather, it was the responsive interdependency between humans and the materials they engaged with that, as Mauss argued, make culture (inclusive of what some call 'more-than-humans', or what we will refer to below as living *pots*).

Mauss thereby critiqued the homogenising concept of culture that his uncle had formulated. Mauss's focus on technique allowed for a concept of society and culture that was less interested in boundaries and boundary reinforcement, separation and the exclusion of non-members on the grounds of abstract ideas – the well-known 'collective representations', which, thanks to the 'science' of anthropology, would become a scientifically described and lived reality. Rather than studying 'culture', Mauss's attention was on studying specific 'cultural efforts', say, the cultivation and perfection of the craftsman's skills and technologies. This process, he emphasised, involved the 'borrowing' of whatever from whoever. Cultural effort was thus likened to craftsmanship intent on advancing itself, through the making of crafts. It required an attitude of curiosity and openness towards the other and the unknown, we might say, motivated by a sense of what Nyamnjoh (2021) calls 'incompleteness', which in the context of craftsmanship makes probing and 'trying out' into a virtue.

Today we can take the discussion a step further. The Maussian study of concrete 'joint efforts', which involves a focus on both an individual's skills and the material object simultaneously, diverts the researcher's gaze away from the individual. Rather than focusing on the individual body, their gaze actively explores the textures of the spaces that the individual creates and partakes in (Lefebvre 1991),

and these bodily skills and techniques, in turn, can be interpreted as working towards an individual's place-making, emplacement and 'empotment', a process that involves the negotiation of materialities.

China in Africa, Africa in China (CA/AC)

The Chinese government's current 'One Belt – One Road' (Belt and Road Initiative, BRI) project has tended to style the distance between China and Africa as merely geographic, and twenty-first-century Chinese socialism-cum-capitalism was to shrink this geographical distance.[17] Although the rhetoric of South–South win-win commerce committed to technology and engineering that was strangely reminiscent of the nineteenth and twentieth centuries' projects of capitalism and of the North–South colonialism that it claimed to overcome, I saw it proliferate throughout East Africa in the early twenty-first century. The promise of Deng Xiaoping (1904–97) accompanying the endorsement from 1978 onwards of his vision of economic reforms in the People's Republic of China (PRC), which was that they would bring economic prosperity to everyone, and wealth would eventually percolate down from the super-rich, seemed to be embraced by promoters of late liberalism as well. Admittedly, in the early 2000s, the idea of 'development' no longer had the same traction that it had shortly after independence in many African states in the 1950s and 1960s. Nevertheless, the hubs and whirls in the cityscape were able to spur a belief in a better future.

Shortly after I returned from this project's final field trip to East Africa, one of the first edited volumes on China in Africa and Africa in China (CA/AC) relations was to be published (Alden et al. 2008), and would be foundational to a field in area studies that had grown rapidly.[18] Research on CA/AC relations does not generally foreground cultural issues. Rather, education (e.g. student grants for Africans to study in China), finance, health care, technical assistance (e.g. agriculture; see 'growing vegetables' above), material aid and infrastructure figure prominently.[19] Bräutigam (2011: 19) addresses the big questions that loom in everyone's mind: 'Does China's non-interference policy provide cover for pariah regimes in Sudan and Zimbabwe? Has China's growing presence in Africa worsened efforts to build good governance, improve human rights and reduce corruption? Are the Chinese leading a 'race to the bottom'

in social and environmental issues? Does their active support for Chinese business present unfair competition?'

Analysts have differentiated between private and official finance, where the latter comprises two parts: (a) the equivalent to 'official development assistance' (ODA) that China has offered Africa, which consists of grants, zero-interest loans, debt relief and concessional loans; and (b) 'other official flows' (OOF) of specified credits and loans. In contrast to OECD countries, China's OOF finances have generally been larger than the official development assistance (Bräutigam 2011). 'In 2008, China probably disbursed about US$1.2 billion in ODA in Africa, compared with the World Bank (US$4.1 billion), the United States (US$7.2 billion) and France (US$3.4 billion)' (ibid.: 211). These figures referred, however, only to official development assistance spending in that year. Meanwhile, as case studies of large infrastructure projects (dams, railways) have demonstrated, the Chinese investment projects could be financed through different channels. This made it possible to provide ethically questionable levels of debt finance (ibid.). Evidently, China's financial involvement in African nation states was and is complex.

So, how was China's current wave of aid and other economic collaborations to affect African 'development', and how would it affect the 'industrialization challenge'? 'Will China catalyze or crush African manufacturing?' (Bräutigam 2011: 211). Political scientists were and are interested in large-scale aid programmes, public and private, and in public-private investments that overlap in multiple ways. Bräutigam called for a balanced view: 'Why does China give aid?' she asked. 'The conventional answer is: to get access at resources. Yet . . . this is *at best* a partial and misleading answer. Fundamentally, foreign aid is a tool of foreign policy' (Bräutigam 2009: 17). No doubt, China's foreign aid would affect China's health care diplomacy.

The expert on health care diplomacy and Chinese medicine provision in Africa is Li Anshan whose studies on the topic are foundational for anyone entering the field (Li 2006, 2009, 2011, 2021). However, these publications unfortunately did not yet exist at the time of my fieldwork. Studies from the 1970s by Bruce Larkin (1971), Alan Hutchison (1975), Philip Snow (1988) and many others prepared me for the field.

Review of Some Key Texts: From 'Asian Medical Systems' to Their Globalisation

This book traces its genealogy to work that was foundational to medical anthropology as a subdiscipline of social anthropology. Charles Leslie's *Asian Medical Systems* (1976) combined ethnographic and historical research on the 'great traditions', emphasising 'culture' for understanding 'medicine'. It discussed the history, politics and social movements that led to the institutionalisation in modern health care of learned medicine in the Middle East and South and East Asia. These modernist movements reflected an era, after independence, when growing economies inspired confidence.

A second volume, *Paths to Asian Medical Knowledge* (Leslie and Young 1992), on these literate traditions that had been rendered up-to-date and legitimised by scholar-physicians through interpretive and exegetical work, also focused on epistemological questions. Published fifteen years later, this volume contained vintage pieces by the first generation of medical anthropologists who had done long-term fieldwork on the practices of Asian medical 'traditions', spoke the language and had the reading skills to engage with the technical aspects of these traditions' texts.

Another decade later, two further edited volumes on Asian medicines and their globalisation were published: *Countervailing Creativity: Patient Agency in the Globalisation of Asian Medicines* by Elisabeth Hsu and Erling Høg (2002) and *Asian Medicine and Globalisation* by Joseph S. Alter (2005a). Neither volume became as well known as the previous two, but both are relevant for this monograph, as they both engaged with the social dynamics of globalisation. This was when so-called 'international health' care, as moderated by the WHO, had started to be superseded by so-called 'global health' (Brown et al. 2006; Cueto et al. 2019), and when the World Bank was taking increasingly important financial-cum-medical decisions in increasingly commercialised and commodified health markets. The 2002 volume *Countervailing Creativity* discussed countervailing currents to those of the 'Coca-Cola and blue jeans' globalisation that went 'from the West to the rest' of the world, in that these currents – in the editors' framing – consisted of an East-to-South flow (rather than being subsumed into the South–South relations currently discussed in CA/AC circles). *Countervailing Creativity* comprised six

Chinese Medicine in East Africa
An Intimacy with Strangers
Elisabeth Hsu
https://www.berghahnbooks.com/title/HsuChinese

original articles on: Ayurveda in Germany, Tibetan medicine in the USA, Shiatsu practices in the UK and Japan, Korean medicine in Kazakhstan, Chinese medicine in Tanzania and acupuncture in post-socialist Russia, all of which provided ethnographies of 'patient agency'. With its focus on globalisation and patients as actively involved in the shaping of Asian medical practice, *Countervailing Creativity* aimed to complement the earlier two volumes' focus on Asian medical knowledge and doctors in Asia.

The other edited volume, *Asian Medicine and Globalisation*, published a couple of years later, has an introduction by Joseph S. Alter (2005b) that is relevant for us here, as he, like us, was apprehensive of globalised forms of 'Asian medicine' being reduced to TM/CAM.[20] For one thing, as declared in his introduction's first sentence, Alter was interested in how 'coherence' is produced, and how it related to 'health, broadly defined'. Incidentally, Alter's questions resonate directly with our own observations regarding the Swahili word for health and wholeness, *uzima*, which opened this book. Alter's writing must have affected my gaze, as I read it long ago in the field. As stated on the first page, Alter's ultimate concern was with 'culture'. However, although Alter problematised the two themes of 'health and wholeness' and 'medicine and culture' very succinctly in his introductory chapter, these important questions were barely addressed in the book's later chapters.

Alter suggested not to think of 'Asian medicine' as an 'Asian form of medicine' but 'as being various experimental techniques, concerned with embodied life and longevity' (Alter 2005b: 18). As Alter had it, these 'experimental techniques' cannot be studied on their own in a decontextualised way. Rather, they are enacted in fields where they must be legitimised as a 'form of an "Asian medicine"'. The medical fields, as defined by East Africa's governments, insisted on Chinese practitioners being categorised as 'traditional medicine' practitioners selling 'natural herbs'. Meanwhile, the 'worlding' of Chinese medicine through transnational frames (Zhan 2009), regardless of whether it is in Dar es Salaam, Singapore or San Francisco, has meant that the emerging styles of medical practice have transmuted from one into another. They were ever elusive, like quicksilver (Smith 2018). Zhan's and Smith's ethnographies endorse Alter's understanding of Asian medical cultures, beyond the clearly bounded medicalised forms of Asian medical TM/CAM.

These volumes of 1976, 1992 and 2002/2005 form a set because their authors are medical anthropologists and historians, and they reference each other. The first volume focused on social aspects of reformist movements, the second on medical knowledge and epistemologies and the third two volumes on their globalisation. All authors were, broadly speaking, concerned with what Alter called the 'nationalistic politics of culture', the 'when, why and how' of their extension beyond 'bounded frameworks of legitimation' and the 'modernisation' of 'traditional' medical knowledge. This was the state of the art in the medical anthropology of Asian medicines over twenty years ago, when I embarked on my first field trip for this project.

Asian Pharmaceuticals, Acupuncture and the RCT (Randomised Controlled Trial)

Meanwhile, another cluster of medical anthropological literatures would emerge on Asian medical pharmaceuticals with more health-scientific or science studies orientations (or both), starting with Adams (2002), who took issue with the double-blind randomised controlled trials (RCTs) to which Tibetan pharmaceuticals were and still are subject. Alongside several co-authored articles (e.g. Adams et al. 2005), other publications followed suit on Tibetan pharmaceuticals, in particular studies undertaken by social and medical anthropologists (e.g. Craig and Glover 2009; Craig 2012; Gerke 2013, 2021; Saxer 2013; Blaikie et al. 2015; Schrempf and Springer 2015; Van der Valk 2017; Kloos 2010, 2017).

In the field of Chinese medicine, studies on RCTs have been concerned mostly with acupuncture. They no doubt impacted acupuncture practice overseas in important ways, as assessed in the doctoral theses by Iven Tao (2008, 2009) on acupuncture in Germany, Lucia Candelise (2008, 2011) on acupuncture in France and Italy, and Gry Sagli (2003, 2010) on acupuncture in Norway. In line with this trend, Scheid and McPherson (2011) assembled complementary and alternative health research that included articles critiquing treatment evaluation by means of RCTs.

The Chinese medical formulas (*fangji* 方剂), which consist of decoctions (*tangye* 汤液) constituted by carefully selected Chinese *materia medica* (*zhong yao* 中药) and are applied in a personalised way specific to each individual patient's distemper, are still in use today. However, by definition, no legitimation industry has been put in mo-

tion in defence of their efficacy. Conceptualised by some as material culture remnants of bygone times, they have been superseded by industrially produced proprietary medicines, which in this monograph will be referred to as 'Chinese formula medicines' (*zhongchengyao* 中成药; see, in particular, Part III).

Anthropological and historical research on medicine and related practices in South Asia[21] has in recent years led to an outpouring of publications on industrially produced Ayurvedic and other South Asian pharmaceuticals.[22] The most relevant for our purposes will be Pordié and Gaudillière (2014; see Chapter 7).

How a Vietnamese family's medical formula became implicated in industrial production is compellingly documented by Wahlberg (2006, 2008a, 2008b, 2012), and the legendary so-called pharmacy debate in South Korea is discussed in an eight hundred-page thesis by Ma Eunjeong (2008). Wahlberg and Ma have in common that they discuss Vietnamese and Korean medicine as what in Joseph S. Alter's understanding features as a 'medicalised' form of Asian medicine. Theirs are substantial ethnographic studies that masterfully address issues raised in science studies. By contrast, this monograph will emphasise sensory anthropological aspects of Chinese formula medicines and how they have become part of East Africa's urban spatial practices.

In addition to the dyad of patient and practitioner (Chapters 4–5), this research is concerned with the materiality of the medicines (Chapters 6–9). How did patients perceive and handle them, and what made them constitutive of spatial practices in urban East Africa? Rather than providing biographies of each medicine, and investigating their social lives and changing values (Whyte et al. 2003), this research investigates ontological questions regarding body techniques of daily life, more so than hospital technology (Mol 2002), as well as the medicines' sensed materialities and how those made them constitutive of their 'playing fields'. To find answers, we have to become attuned to textured spatialities (Chapters 1–3).

A Not-Untrivial Note on Terminology

In this context, more thought needs to be given to the term 'Chinese medicine'. It provides a literal translation of the Chinese word *zhongyi* 中医. Since *zhongyi* refers to a wide range of different Chinese medical routines, medical anthropologists and historians nowadays use the term 'Chinese medicine' to refer to *zhongyi* in this

broad sense, past and present (as proposed by Farquhar 1994: 1–2; Hsu 1999: 7; Scheid 2002; Zhang 2007: 1). However, the term *zhongyi* came into being only in the nineteenth century (Croizier 1968, 1976), in contradistinction to the newly imported *xiyi*, so-called 'Western medicine' (which was subject to multiple and major paradigm shifts at the time). So, in Republican times (1911–49), the term *Zhonghua yixue* referred to 'Western medicine' as practised and theorised in China (as, for instance, in 中華醫學雜誌, the *National Medical Journal of China*, lit. China's medicine journal). However, after the socialist revolution in 1949, the term *zhongyi* eventually became used to refer to the Chinese medicine that the communist state promoted from the mid-1950s onwards in educational institutions,[23] and publications in Chinese started rendering the term *zhongyi* in English translation as TCM, 'Traditional Chinese Medicine' (Sivin 1987: 429; Hsu 1999: 7, 2022; Taylor 2001, 2005). So, in order to give themselves the prestige of practising a legitimate form of 'Chinese medicine', many Chinese medicine practitioners in Africa said that they were TCM doctors.

Medicine and Migration: A Matter of Creolisation, Hybridity or Superdiversity?

In the public arena, the idea of cultivating an 'accommodating' and 'tolerant' culture towards foreign labourers, refugees, migrants and mobile sojourners tends to be seen as progressive. The phrase certainly expresses a well-meant attitude to the 'other'. However, it also implies a paternalising generosity that is ultimately interested in maintaining asymmetries between 'us' and 'them'. Such 'generosity' helps perpetuate an utterly patronising stance towards the 'other', as it inadvertently endorses the idea that cultural harmony would in an ideal world be ensured by cultural 'sameness' and the cultural 'assimilation' (in the 1950s) of otherness. Although 'hybridisation' (in the 1990s) attends to heterogeneity, the subtext is similar: we live in a world that is messy and not ideal, and hence we should be 'tolerant' of others' otherness.

Such a condescending attitude towards 'the other' not only distorts the potential of a fruitful encounter between self and other. It also perpetuates those aspects of the idea of 'culture' that the discipline of anthropology has so loudly critiqued. A focus on identifying

what stabilises a cultural given will inevitably tacitly 'essentialise' cultural difference.[24]

In globalisation and migration studies a number of analytical terms have been coined with a view to foregrounding cultural diversity and heterogeneity between and within cultures. However, even if we acknowledge that cultures are diverse, this does not do away with the idea of culture defined by sameness, that is, participants sharing the same collective representations.[25]

Terms like 'creolisation' have a several-centuries-old history of celebrating otherness and the mixtures that the engaged self produces in a creative encounter with the other, not only in eroticised colonial settings. 'The creole' often has an intriguing ring, particularly in French literature, being associated with a straddling of boundaries, and their transgression. The word tends to allude to the aesthetic, and can connote striking beauty and unusual novelty in taste. However, when it was introduced into anthropology, the sensuous allusions to aesthetics were kept to a minimum (Hannerz 1987; see also Harré and Rampton 2002).

'Hybridity' is another term that aims to capture the social mixing that mobility and migration entails. The term itself was developed in the context of the natural sciences, in biology. Social scientists will be particularly familiar with its use in Mendelian genetics, where 'hybrids' are mixtures of 'pure races' or varieties. However, there is valuable sociological research on the 'hybridisation' of Chinese medical practices (e.g. Frank and Stollberg 2004). This sociological understanding of hybridisation is vehemently opposed to the idea of any initially pure culture. Pieterse (1994: 80) in particular advanced 'the hybridization of hybrid cultures' and explores creative, playful processes of recombining what is at hand (see also Pieterse 1995). Nevertheless, even if the sociological research undertaken with this terminology is non-essentialising and compelling, the term remains infelicitous due to its Mendelian connotations.

More recently, another term has gained a notable following: 'superdiversity'. Steven Vertovec, who coined the term, notes that he was influenced by the ideas developed around

> cultural complexity as considered by Fredrik Barth . . . and Ulf Hannerz . . . , particularly their thinking about modes of cultural confluence, the coexistence of multiple historical streams and the ways individuals in

> complex settings relate to each other from different vantage points. (Vertovec 2005: 1026)

It was not that the 'new immigrants' were increasing in number. Rather, Vertovec identified various qualitative changes at a time when transnational migration and mobility had become increasingly normative: empirical studies in London showed that while migrants would settle in clusters, they now spread over several boroughs, effecting a high ethnic mix. Furthermore, their degree of staying connected to their homelands was unprecedented, evidenced for instance by the volume of international telephone calls, which facilitated, for example, participation in the development of the homeland or in intermarriages. Vertovec did not identify recurrent patterns of conflict, but acknowledged challenges for policy.

> Compared to the large-scale immigration of the 1950s–early 1970s, the 1990s–early 2000s have seen more migrants from more places entailing more socio-cultural differences going through more migration channels leading to more, as well as more significantly stratified, legal categories (which themselves have acted to internally diversify various groups), and who maintain more intensely an array of links with places of origin and diasporas elsewhere. Super-diversity is now all around the UK, and particularly in London. (Ibid.: 1043)

Superdiversity ranges from culinary adventures, fashion and clothing to multilingualism and experimental architecture. It makes transcultural encounters look exciting, comes across as hype and has a buzz to it. After all, the term was coined when London as the 'world in one city' bid for and got to host the Olympics in 2012. This was in the historically interesting period after the Berlin Wall had fallen in 1989. It was also after the Tian'anmen incident earlier in the same year, 1989, which would lead to the opening up of the PRC to the world, and this, as we will see below in respect to East African health fields, would leave the global economy of late liberalism not unaffected. The encounters between perceived culturally 'other' African patients and Chinese physicians can indeed be studied as an aspect of 'superdiversity'.

Superdiversity, as used in migration and mobility studies, has importantly also inspired linguistic anthropological research (e.g. Blommaert 2013: 44–48, summarised in Parkin 2016). For instance, adverts for accommodation in urban neighbourhoods written in both

simplified and traditional Chinese characters (*jiantizi* 简体字 and *fantizi* 繁體字) would aim to attract 'Chinese' customers from both the PRC and Taiwan. Superdiversity has evidently been accounted for through other inter- and transdisciplinary research as well, not least as it aims to cultivate a speedy critical responsiveness to the ever-changing immigration policies and population movements. However, as fluid, carnivalesque and postmodern as the phenomena that superdiversity studies are, its concept of 'diversity' hinges on its implicit contrast to 'sameness', the sameness implied by the bounded culture concept that we aim to overcome.

Alongside Vertovec's research into superdiversity, medical anthropologists at the Max Planck Institute in Goettingen started pursuing research into 'medical diversity' (Parkin, Krause and Alex 2013; Krause, Parkin and Alex 2014). This happened in an effort to 'update' medical pluralism. The latter is a term coined in the 1970s (Leslie 1980; Nichter and Lock 2002), at a time when information technology and the mobility of labour were not yet as developed as they are today, when overlapping 'medicoscapes' on a global scale are common (Wolf and Hörbst 2003). Whereas the study of 'medicoscapes' was to align itself with science and technology studies on so-called 'boundary objects' (Star and Griesemer 1989) as the locus where different cultures intersected, a sensitivity to 'medical landscapes' (Hsu 2008a) requires medical anthropologists to relinquish the objectifying bird's-eyes view and attend to the moving body's ever-changing horizons in both foreground and background.

The emphasis on fluidity – this rhetoric that cultural processes are always in flow – supersedes the earlier, and in anthropology now historical, concept of 'culture as an enduring unit'. Indeed, in the current, fast-moving, interconnected world, everything is experienced as being in constant flux, looping, braided, transforming and transmuting into other things. Without denying this speed, multiple mixing and complicating of complexity, it nevertheless is worth asking oneself whether there are any limitations to this fluidity.

Re-arranging Kaleidoscopic Refractions

The term 'kaleidoscopic refractions' alludes to solid but fractured pieces. As the kaleidoscope is turned, the pieces will reconfigure. Fractures are more likely along certain lines than along others. As the viewer turns the kaleidoscope, the fractured is reassembled. In

a kaleidoscope this happens in self-symmetrical fashion. The colourful parts that make up the whole are each different, yet each is chunky and solid, and some of these chunky pieces are remarkably long-lived. The chunky fragments do not dissolve entirely into a hydrodynamic whirl of change, nor are they part of a heterogeneous assemblage, a term that despite being ill defined from the start (Phillips 2006) for the lack of a better choice still enjoys great currency (e.g. Kloos 2017).

The notion of kaleidoscopic refractions resonates to a certain degree with recent discussions in medical anthropology on so-called 'transfigurations', which aim to bring Norbert Elias's concept of 'figuration' into conversation with Marilyn Strathern's notion of 'sociality' (for details, see Mattes et al. 2020).[26] Elias (1969) aimed to overcome the impasse within which studies found themselves if they plotted the individual against society. With a study on the nobility in Europe (France, in particular) from the Middle Ages to the early modern period, he laid the foundations for a 'historical sociology' of how people's 'psychological household' changed over time. He found that the psychological household of the individuals studied showed continuities with the sociological milieu in which they lived. The analytic concept of 'figurations' that he thereupon formulated accounted for the melding of sociological milieu and psychological disposition.

In a kaleidoscope, there is a continuity between the chunky glass pieces that remain internally intact and remarkably unaltered when they are reassembled in entirely new reconfigurations: the refractions are self-symmetrical. The becoming they enable would accordingly be that certain chunky pieces are picked up and rearranged in a self-symmetrical manner, much like the bird's nest is built – in a self-symmetrical manner – to the proportions of the bird's body.

Tim Ingold already noted that becoming involves self-symmetrical realignments, although that was not his most central concern in the following quote:

> Imagine a bird's nest, for example. The bird collects twigs and other materials from here and there. In no sense are these materials parts of the nest until they are assembled there. That is to say, they *become* parts in the course of the work, and only as they settle – and as they adjust themselves and progressively hold each other in place. (Ingold 2013: 69)

> Although the nest may subsequently be redone, that work of mutual adjustment can never be recovered. For the coherence of the nest – that *wholeness* which renders its constituents as parts – is no more prefigured in the constituents themselves than is the pattern of a knitted garment prefigured in a hank of wool. . . . Through the bird's own activity, and not through the imposition of any plan or blueprint, the nest is shaped *to the proportions* of its body. (Ingold 2014: 5; italics added)

We see that through the bird's activity the assembled materials became parts of a whole, without themselves having been predestined to occupy the position into which they adjust themselves. Ingold's claim that a cultural constellation is created (or might we say, following Elias, a figuration), shaped to the proportions of the bird's own body, implicitly takes the body as the starting point whence culture is generated and hints at growth along 'automorphic symmetries'.

Herrmann Weyl (1952) long ago suggested that there was a tendency for all living organisms to reassemble themselves according to an 'automorphic symmetry' (regardless of whether they had a radial symmetry like a starfish or a seahorse's bilateral symmetry), and he posited that this re-assemblance applied, regardless of scale and size, even to atmospheric particles. Independently, Benoit Mandelbrot (1983) advanced the concept of 'self-similarity', after identifying an algorithm for how parts relate to wholes with respect to any phenomena in nature, irrespective of scale. Lynn Margulis (1997) became a widely known spokesperson of 'autopoiesis' and spontaneous recalibration; this was in the swinging sixties, and after she joined forces with James Lovelock to advance the Gaia Hypothesis (cf. Onori and Visconti 2012). More recently, Donna Haraway (2016) introduced Margulis's thinking into science and technology studies. However, in the course of doing so, Haraway also added her own ethically guided thinking when she suggested to speak of a process of 'sympoiesis' rather than 'autopoiesis' among higher-order organisms. Meanwhile, it would appear that such a hierarchical differentiation between lower- and higher-order organisms that the concept of sympoiesis draws on is precisely what the research by Weyl, Mandelbrot and Margulis was aiming to overcome.

The above thinkers have in common that they all underlined that there is no hand that turns the kaleidoscope and no creator at the steering wheel. Two were particularly daring, as they suggested that biological organisms, and many if not all phenomena in nature,

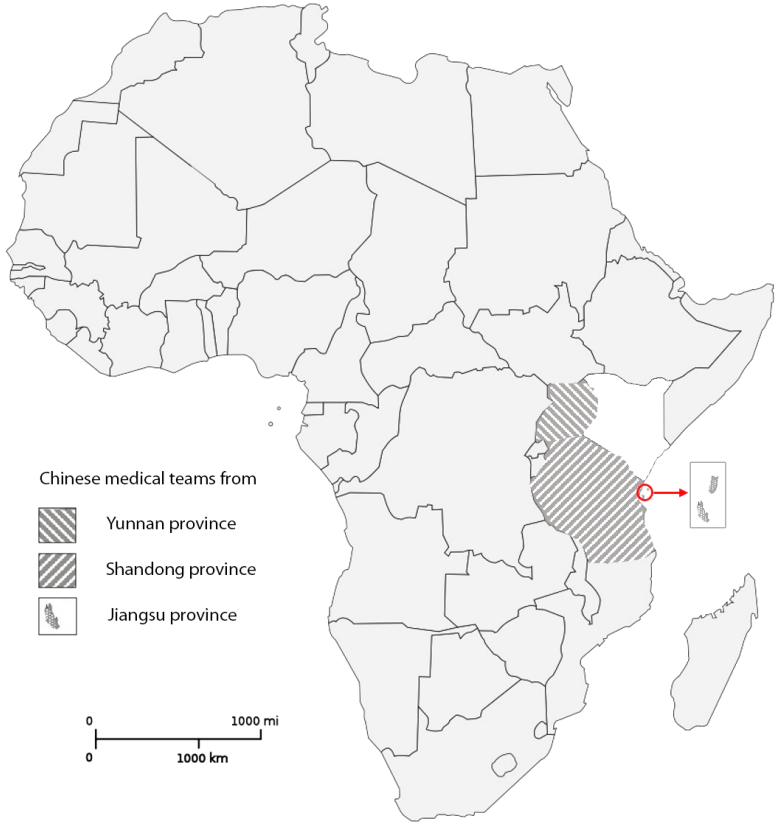
are marked by 'automorphic symmetry' (Weyl) or by 'self-similarity' (Mandelbrot). Although, as we will see, some of the transformations discussed in this book showed traits of self-similarity between the given parts and emergent wholes studied, these ethnographic findings are too fragmented to construct a stringent argument, even if some can be interpreted to point in the direction of an automorphic symmetrical texturing of the emergent socialities and spatialities. Yet as feminist scholarship tells us, such 'situated knowledges', even if fragmented, are valuable and legitimate in themselves (Haraway 1988).

The Fieldwork: Why East Africa?

John Iliffe's *East African Doctors* (1998) was published precisely in the period of preparation for this research. Its superb scholarship, communicated in succinct prose, was one of the main reasons that I started to be drawn to East Africa rather than South or West Africa for my fieldwork. Iliffe states clearly on the first page that his book is not a sociology of the East African medical profession but a 'collective biography' of East African doctors, with a focus on Black Africans, 'covering many aspects of their experience since . . . the 1870s'. This made his study foundational to this medical anthropological project. Iliffe's intricate knowledge of the region and its history, and the questions he brought to it, provided an ideal entry point into the new field site for the novice that I was and still am, and structured my research accordingly.

At the time I had already researched twentieth-century Chinese medicine for over a decade, in regard to 'Westernisation' and 'modernisation',[27] not without contesting those terms (e.g. by replacing discussion of 'modernisation' with that of 'standardisation' as a project that strong government had periodically endorsed in China's history of scholarly medicine). Interested in general epistemic issues, I compared different modes of knowledge transmission.[28] So, the initial question I had for this project was: How would Chinese medical learning affect and be affected by the medical landscapes in East Africa?

'It will be argued', writes Iliffe (1998: 5), 'that modern doctors in East Africa have not been seriously threatened by competition from indigenous medicine, largely because in East Africa, unlike India or



Map 0.1. East Africa and its Chinese medical teams. East Africa comprises the nation states Uganda, Kenya and Tanzania (inclusive of Zanzibar, which includes the two islands Unguja and Pemba). Socialist China despatched and continues to despatch Chinese medical teams from Shandong province to Tanzania, from Jiangsu province to Zanzibar, and from Yunnan province to Uganda. Kenya was a stronghold of the Allied Forces during the Second World War and received no Chinese medical teams (information gathered in fieldwork, 2001–8). Source: Wikimedia Commons, modified by the author, September 2021. https://commons.wikimedia.org/wiki/File:Blank_Map-Africa.svg.

China, that medicine lacked a literate tradition to provide a basis for its modernisation.' Instead, he suggested: 'The real threat to professional medicine, has come from the illicit sale of modern drugs for self-medication, an outgrowth of the dominant position which chemo-therapy has gained within modern medicine.'

Iliffe worked with a concept of 'medical pluralism' that allowed him to differentiate between 'indigenous medicine' and 'self medication'.[29] However, as fieldworkers know, it is sometimes difficult to disentangle the doing of traditional medicine from self-care practices because the two slide into one another.[30] Different forms of indigenous medicine were no doubt a resource that was widely relied upon, starting with home remedies, marketplace purchases and visits to spiritual authorities, diviners, herbalists, astrologers and neighbours who were 'uncles'. Yet medical cultures are not clearly bounded entities, and they are not like tiles making up a mosaic. East African clientele would perceive Chinese formula medicines (*zhongchengyao* 中成药) as 'modern medicines', and their consumption as self-medication; such practices would thus fall into the domain of 'illicit sales'. Following Iliffe's observations, the introduction of Chinese medicine into East Africa would likely accordingly be perceived as a 'real threat' by biomedical professionals. This monograph will provide some evidence in support of this, although the concept of 'threat' will be conceptualised differently, in line with recent work on 'medical diversity' (which adds the spatial to social analysis) and 'medical landscapes' (which comprehends the social through the spatial).

When I started fieldwork in Dar es Salaam in 2001, the 'mushrooming' of Chinese medical practices was a matter of contention among local journalists. This fieldwork finding suggests that they were perceived as a 'threat'. I was also informed by a foreign expert about the killing of a Chinese medical doctor on the doorstep of his home as he was returning from the celebrations of an auspicious event for his business with Tanzanian officials. On my last visit to Dar es Salaam in 2007, I learned that one of the firms that had set up a chain of Chinese medical practices all over the country no longer existed. Its directors were criminals. They had been put on trial the year before, and sent to jail. I am not an investigative journalist. Under the circumstances, I decided not to research whether, and if so to what extent, the sort of private Chinese medical practices that were seen to be 'mushrooming', particularly in Dar es Salaam at the turn of the millennium, posed an enduring threat.

As already stated, this book responds to the general perception of 'culture' as impeding 'transcultural' communication and interaction.

Map 0.2. The People's Republic of China and the Chinese practitioners' provenance. Socialist China despatched and continues to despatch Chinese medical teams from Shandong province to Tanzania, from Jiangsu province to Zanzibar (including Unguja and Pemba islands) and from Yunnan province to Uganda. Kenya was a stronghold of the Allied Forces and received no Chinese medical teams. Enterprising people from Southeast China settled, scattered throughout East Africa, during the interwar years and after the Second World War (e.g. Shunde, * in map). Northeast China became the main sending region of entrepreneurial Chinese medical practitioners about ten years after Chairman Mao's death in 1976, when Deng Xiaoping's reforms started to be implemented more vigorously (information gathered in fieldwork, 2001–8). https://commons.wikimedia.org/wiki/File:Map_of_PRC.svg. Source: Wikimedia Commons, modified by the author, September 2021.

Therefore, I chose to focus particularly on those clinical encounters that were successful insofar as they were perceived to lead to the patient's recovery. I ask which Chinese medical procedures were deemed successful in East African health fields and to what extent

these procedures involved an effort to cultivate sorts of 'wholeness'. For some people, there are more interesting and pressing issues regarding CA/AC, but I chose to design this study so as to better understand what the necessary preconditions are to enable healing to happen, and to what extent healing means making whole, whatever that involves in the concrete situation.

The first hurdle that had to be overcome was posed by the conceptual toolkit with which anthropologists work, namely the concept of 'culture' (see above). However, instead of disengaging with the notion of 'culture' altogether and letting it be appropriated in the public arena in sometimes very uncomfortable ways, anthropologists have a responsibility to hinder its misconceived usage. Since healing is a form of making whole not only the individual body, the focus of this book is on how concerted efforts are mobilised and techniques implemented to cultivate wholeness, and thereby make 'culture'.

Ultimately, I hope that the Chinese medical routines described will not be reduced solely to the 'illicit sale' of sexual enhancement medicines for an aggressively advertised leisure industry. As we will see, 'Chinese medicine' instigated many different bodily routines, which complemented existent practices – or through minor tweaking, could be made to complement them – alongside some newly evolving, sometimes unsettling reconfigurations of Chinese medical treatment with formula medicines.

My focus is on those (rare) moments of medical treatment and healing that can be perceived as a technology for reconfiguring wholeness. Even though there is strife and competition between different medical actors in urban health markets worldwide, and although there is reason to be cynical about them – after all, not all medical treatment is concerned with healing (Lewis 2021: 187) – this book aims to focus in particular on those processes that were observed to be conducive to the recreation of the relation between self and other. To do so, I researched which medical routines made inroads into which urban spaces, and how they modified them and have been modified by them.

The urban spaces into which the Chinese medical practitioners were trying to insert themselves were not 'empty', even if they looked so, but had distinct textures. One such distinctive texturing had arisen from differences in the histories of the medical profession in the three nation states, Uganda, Kenya and Tanzania. As we will

see, these indirectly affected the history of local and regional traditional medical healing practices (e.g. Bruchhausen 2006; Luedke and West 2007; Langwick 2011; Nichols-Belo 2018), and thereby also the ways in which Chinese medicine has been practised in East Africa. Iliffe (1998) highlights with great insight how the different political histories in each of the East African nation states affected their respective medical professions. He does so decidedly indirectly, as his aim has been to focus on the particular, namely the life histories and biographies of East Africa's remarkable health professionals.

Uganda

Iliffe's (1998) study starts with the achievement of higher medical education in Uganda. My fieldwork, by contrast, started in Tanzania and Kenya; Uganda came last. Following Iliffe, I nevertheless introduce Uganda first. For one thing, the sorrow over Makerere University and its decline that I variously encountered during my fieldwork was palpably painful, and conveyed a sense of loss not only of intellectual life and scientific research, but of humanity. The most recent 'killer' of its once rich, strong and even illustrious scholarship was the commercialisation of higher education (personal communication with an expatriate, December 2007). In late liberalism, 'Money making through short-term masters courses' (Mamdani 2007) and certificate-honoured summer schools had become rampant. Notwithstanding, visually and spatially, the sheer size of the university's territory on Makerere Hill imposed itself on central Kampala, its tall trees throwing long shadows, at dusk in particular, reminiscent of its remarkable history in the colonial past.

At this university, East Africa's first medical school was installed in 1923 with standards that outdid similar institutions in the colonies. With its emphasis on practice alongside theory, it apparently rivalled even London's medical education (Iliffe 1998: 127). 'Its medical students were in general exceptionally gifted . . . [and] experienced a rigorous socialisation which left them with strong group solidarity' (ibid.: 60). After the Second World War, in the 1950s, 'the process of professionalisation became part of decolonisation' (Last 1986: 10, cited in Iliffe 1998: 92). In Uganda, these doctors had a public persona that played a significant role both in bringing about independence in political life and in Africanising the colonial medical institutions. However, with the disintegration of the nation state

under Idi Amin in 1971–79, Uganda's visible and strong medical learning, comprising research as well as teaching, which had peaked in the first decade after independence, was shattered. Professionals were divided, internally and in different factions, and a vacuum was created. In the early 2000s, as this vacuum started to be filled and medical institutions were repopulated, there was also an influx of Chinese medical doctors working in private practices in central Kampala.

During my fieldwork in Kampala, I soon became aware of a privately run primary health care station unrivalled in size and significance by others in East Africa. It had been set up about ten years earlier by a Ugandan Western medical physician who had been trained in the PRC. During the five years of his Western medical training in China, he had also received basic training in acupuncture. This had the effect that he became interested in TCM, which he thereupon studied for a further three years in a master's course (*shuoshi* 硕士) before returning to Kampala. In the mid-2000s Kampala had an urban texture marked by small-to-medium-size enterprises and many Christian NGOs. It was in the spirit of Christian aid that caters to the poor that his Christian NGO clinic was founded, stationed in a popular area close to the main bus station. It combined public health services, comprising family planning, vaccination, paediatrics and other aspects, with treatment through Chinese formula medicines and acupuncture. It was in size and structure both exemplary and unique. No other clinic I visited in East Africa integrated Chinese medicine with primary care as successfully. On the one day that I visited, it was heaving with patients and health personnel (for more detail, see Chapter 7). This large private practice, which evidently relieved suffering among the urban poor, provided a vivid illustration of the importance that TM/CAM assumed in the vacuum in Ugandan health care mentioned by Iliffe (1998).

Kenya

Kenyan doctors were not yet sufficiently numerous to form an influential profession at independence. One important Kenyan development during the following thirty years was the expansion of their numbers through the new medical school in Nairobi. In Kenya, the state did not disintegrate, nor did it crush professional aspirations. Rather, state, society and profession experienced a transition to-

wards capitalism that was already under way in the colonial period, and there was also a proliferation of European and Asian biomedical professionals working in private settings. However, the contrast with private practitioners, who formed the majority, became increasingly marked vis-à-vis the discontented minority of doctors in the neglected state sector. Bringing the two together in united professional action posed real difficulties (Iliffe 1998: 169).

Kenya had been the stronghold of the Allied Forces during and after the Second World War and was only indirectly affected by the waves of world socialism with their epicentre in Beijing. In contrast to Uganda and Tanzania, to which the PRC sent expert medical teams, Kenya was never part of this scheme, although diplomatic relations with Beijing existed from independence in 1963. The history of the Kenyan medical profession directly impacted the way that Chinese medicine was perceived among expatriates as TM/CAM catering primarily to a middle-class clientele. A single renowned Chinese medical doctor was the central figure for creating this understanding of the Chinese medical community. He was a 'gatekeeper' for most Chinese who would later open their own medical practices in Kenya. Gatekeepers are a well-known feature of migration studies (Snyder 1976), which need not mean that they socialise exclusively within the boundaries of national identity (Glick Schiller et al. 1995). Ward boundaries can be protective as well as productively negotiated, as the urban anthropologist Aidan Southall (1956) and his student David Parkin (1969) demonstrated long ago, at a time when social anthropologists tended to each study their 'tribe' in rural areas. Once researchers overcome their methodological nationalism (Wimmer and Glick-Schiller 2003), an immigrant's 'mixed embeddedness' and 'cosmopolitanism' – catering to clients beyond their ethnic group – becomes very apparent. This is relevant particularly for 'business migrants' (e.g. Glick Schiller and Çağlar 2013), among whom the Chinese medical practitioners in East Africa belonged. The cosmopolitan urban textures, which for transculturally oriented entrepreneurs offered ideal 'playing fields' (see Chapter 9), afforded outward and upward mobility, and are perhaps best assessed through an anthropology of scale (Glick Schiller 2005; Glick Schiller and Çağlar 2009).

So, this 'gatekeeper' was one of the first Chinese medical doctors to emigrate to Nairobi, albeit not the very first. In the early 2000s his

clinic was thriving and he was in the process of building a factory on African soil to produce Chinese formula medicines. He had also managed to gain recognition in the domain of research and development (R&D), even if only indirectly, by becoming engaged in internationally recognised research. His first widely advertised research project, funded by a respected international funding body, tested a 'herbal tea' that he had developed for treating HIV-infected patients. It involved implementing a double-blind randomised controlled trial (RCT) on a group of women living in Kigera, one of the largest informal settlements of Nairobi. Since the tea would only be effective if the women were adequately nourished, the trial ensured their regular food intake as well. This Chinese medical practitioner had evidently developed his cosmopolitanism to a fine art of health diplomacy, emphasising that business was not actually the motivation of his health enterprise.

Tanzania

By contrast, Tanzania went through what Africanists and historians have called a 'socialist experiment' in 1967/1971–85, initiated by Julius Nyerere (1922–99). 'Tanganyika Territory', which gained independence in 1961, had had this name under British rule (1920–61), after having been part of 'German East Africa' (1880s–1916). Meanwhile, on Zanzibar – which is an archipelago with two main islands, Unguja and Pemba, in the Indian Ocean, not far off the East African coast – independence was obtained in 1963, and a 'socialist revolution' happened early in 1964. The unification of Tanganyika and Zanzibar led to the founding of the United Republic of Tanzania later in 1964.

On Zanzibar, the revolution led to the replacement of an Arab-led government by an African one. Since the medical profession on Zanzibar consisted solely of Arabs, this resulted in the profession's complete annihilation. Zanzibar's medical professionals fled to the African mainland, the Middle East and Britain. Medical and other aid came from communist countries: East Germany, for instance, staffed the hospital in Stone Town on Unguja, and 'the Chinese' built the Abdullah Mzee hospital at Mkoani on Pemba, which was shown to me by Chinese medical team members with pride. Moscow trained medical doctors, one of whom I interviewed during fieldwork. The revolution had apparently abolished private clinics as well

Chinese Medicine in East Africa
An Intimacy with Strangers
Elisabeth Hsu
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as fees at government-funded hospitals, but this was history in the early 2000s when my fieldwork was conducted. Zanzibar still hosted one large Chinese medical team sent by Jiangsu province every two years, which was subdivided into one team stationed at the Mnazi Mnoja hospital in Stone Town and one in Mkoani (Hsu 2007a; Langwick 2011). In regard of some situations observed in Dar es Salaam and Zanzibar, Tanzania was like a post-socialist country: belly up, up for grabs (see e.g. Lindquist 2005), enabling the establishment of unregulated biomedical and TM/CAM businesses.

More on the History of the Tanzanian Health System

Tanzania, following the Arusha Declaration, had seen a period of socialist orientation and a striving for self-reliance called *ujamaa*. Although the Arusha Declaration prioritised agriculture, industry and education, the medical field was also significantly transformed, particularly in comparison with Uganda, Kenya and elsewhere in Africa.

Health expenditure in rural areas increased from 20 to 42 per cent between 1971 and 1981, and by 1983, apparently, 'Some 93 per cent of the people lived within 10 kilometres of a health facility . . . In 1972 the mainland had 99 health centres and 1,501 dispensaries; the numbers in 1980 were 239 and 2,600 respectively' (Illiffe 1998: 205). These numbers are impressive, and they increased in importance. In the nine years between 1961 and 1970, the number of registered medical doctors had risen from twelve to 123 – and it was to rise to 1,060 by 1982, with 72 per cent being Tanzanian in 1984 (ibid.: 208).

The WHO's primary care programme (declared in 1978 in Alma Ata) was remarkably well implemented in Tanzania's mainland, as it is known to have been also in other socialist states in Africa (Bibeau 1985) and beyond, such as in revolutionary Nicaragua (Garfield and Taboada 1984). In Tanzania, it was focused on mass immunisation, tuberculosis control, and maternal and child health clinics, but nutrition and safe water remained a problem. Nevertheless, life expectancy had risen by about 50 per cent in the first thirty years after independence (Iliffe 1998: 206). However, preventive health care remained insufficient in rural and urban areas. '[I]n 1971, some 60 per cent of medical expenditure was still in Dar es Salaam, only 7 per cent was on prevention, and roughly half of the development expenditure was externally financed, despite commitment to self-reliance'

Chinese Medicine in East Africa
An Intimacy with Strangers
Elisabeth Hsu
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(ibid.: 203). To worsen the situation, the level of medical expertise in these health centres started to be loudly questioned by the World Bank, specifically in 1985. Incidentally, at about the same time, the PRC's barefoot doctors scheme started to be dismantled, also due to apparently insufficient expertise, specifically in 'biomedical literacy' (White 1998). It was as though the revolutionary winds had abated worldwide in health fields.

In Dar es Salaam, the population rose 'between 1967 and 1988 from 272,515 to 1,360,850' (Iliffe 1998: 207), and this rapid urbanisation led to a crowding of underfunded health facilities. Simultaneously, hospital admissions due to malaria increased on the mainland 'between 1968 and 1985 from 13 to 25 per cent' (ibid.: 207). Meanwhile, between 1965 and 1988, 'the GNP per capita had fallen by an average of 0.5 per cent per year' (ibid.: 212). 'Poverty' became a pressing issue. Public complaints became louder. So, in 1985, Julius Nyerere stepped down from the presidency, and the socialist experiment was declared a failure by his successors.

Relevant here are two governmental interventions that left their mark on the post-socialist period (see Chapter 8). One concerned the government's attitude to nonbiomedical knowledge. In socialist-oriented Tanzania, the PRC's institutionalisation of Traditional Chinese Medicine was taken as a model, particularly by high-level politicians (Langwick 2010, 2011). This had the effect that in 1974, the Traditional Medicine Unit at Muhimbili hospital was opened. 'By 1991, it [this unit] had identified over 40,000 healers and tested 3,000 herbs' (Iliffe 1998: 211). Memories of this frantic scientific activity, together with unhappy incidents of bioprospecting in the 1990s, had the effect that in the 2000s many local healers, particularly those between Dar es Salaam and Bagamoyo but also others throughout the Tanzanian hinterland, were extremely reluctant to have any contact with pharmacognosists or ethnobiologists, and also medical anthropologists.

The other socialist-oriented governmental intervention still felt in the early 2000s concerned the opening of private practices (Iliffe 1998: 209–12). The Tanzanian government discouraged the opening of private practices by means of heavy taxation, if not at times by outright prohibition. This remained a thorny issue in the 1990s and 2000s, all the more so as doctors working in government institutions had salaries that were disproportionately low (ibid.: 208). In

Chinese Medicine in East Africa
An Intimacy with Strangers
Elisabeth Hsu
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the 1990s there had been a surge of private practices (ibid.: 218), and it was in this period, the late 1990s, that private Chinese medical enterprises started to be set up all over Dar es Salaam.

In the early 2000s the post-socialist health fields of independent commerce and petty enterprise were anything but well established, and the rapid proliferation of Chinese medical practices was perceived as a phenomenon of 'capitalism'. Several Chinese medical practices were staffed either by Chinese families aiming to build up a new livelihood in Africa (e.g. a Chinese practitioner with spouse, child and grandparents who did the childcare) or by enterprising individuals aiming for high profit margins. Furthermore, there were chains of medical practices; one, for instance, was set up by the daughter firm of a construction firm in the PRC that diversified its production lines by transforming rented office spaces into medical consultation rooms. Health personnel working for this chain had been recruited in the PRC and committed to serve in Africa in these rented spaces for two years in the role of 'Chinese medical doctors'. The firm offered what at the time seemed to suburban and particularly rural Chinese with three years of vocational training a good monthly salary (*c.* USD 500), in addition to providing transport and boarding facilities.[31] Overall, petty enterprise, even if undertaken in an as-honest-as-possible manner, was often bound to fail due to cut-throat competition, fraud and crime.

At Makerere University, a biomedical profession of respected size and quality had already been built up in colonial times, and its achievements peaked in the 1960s, before political history effected its destruction. It may not be entirely coincidental that in the vacuum that this created in the health field, an NGO that integrated Chinese medicine into primary care received broad support (see Chapter 7). In colonial Kenya, by contrast, the biomedical profession was by comparison insignificant. It gradually grew after independence, both in an underpaid public sector and in a very large and diverse private sector. The successful Chinese medical business person mentioned above accordingly contributed to the diversification of the private sector (see Chapter 5). In Tanzania, socialist orientation from the early 1960s to the mid-1980s had left a legacy that was still starkly felt in the early 2000s, which fostered unease vis-à-vis both private medical and nonbiomedical practices, and Chinese medical enterprises were both private and nonbiomedical (see Chapter 8). As in

other post-socialist health fields, the competition in the informal sector was treacherous and cut-throat.

Since the mid-2000s, Africa–China and China–Africa relations have been richly documented, particularly in the political sciences (e.g. Alden et al. 2008; on petty entrepreneurs, see e.g. Chatelard 2018). This literature has expanded extremely quickly, but since it proliferated after the period I spent in the field, I have left it basically untapped, alongside that on health diplomacy. Meanwhile, the history by John Iliffe (1998) provided exactly the foundations I needed for studying the processes by which Chinese medical practitioners treated patients on African soil in the early 2000s.

The Theoretical Framing: The Texture of Space, and Its Affordances

Heretofore, we have inadvertently reconceptualised a series of cultural exchanges – otherwise presented as a 'technology transfer' – from the PRC to East Africa as a process by which Chinese medical practitioners *emplaced* themselves into the latter's urban textures. By taking account of the textures of the urban spaces in which the African–Chinese clinical encounters happened, this cultural process can be redefined and analysed as a task of accounting for the retexturing of perceived spatial textures. Self and other are thereby implicated into projects that transform urban spaces. Some of those, as I will argue, can generate a sense of wholesomeness among those participating in the efforts of effecting the transformations involved in healing.

As Lefebvre (1991: 57) put it: 'The texture of space affords opportunities'. This spatial texture is a concrete, tangible and material one, and does not merely arise from texts and 'discourse'. We will ask: which 'textures' of East Africa's 'material spaces' were perceived as conducive to the Chinese medical practitioners' emplacement, and that of their patients? What opportunities did these urban textures afford? What do the actors themselves say, what is said about them in their closer and more distant environs, and what can an anthropologist say about the social processes that they are part of and produce?

Lefebvre explains that there are 'acts with no particular place in it [the texture of space] and no particular links with it', and other

activities that become 'spatial practices' that 'determine' a person's 'individual or collective use' of space (ibid.). Accordingly, one might ask, was the proliferation of Chinese medical practices in Dar es Salaam, Nairobi and Kampala – and other urban areas of East Africa – a before-the-turn-of-the-millennium, short-lived hype that has since abated? Or have some Chinese medical procedures become enduring and meaningful 'spatial practices', and if so, which ones? To identify the 'spatial practices', it is necessary to break them down into 'acts' and examine any odd 'sequence of acts which embody a signifying practice, even if they cannot be reduced to such practice' (ibid.: 57). What Lefebvre says of 'textured spaces' resonates with practice theory (see also the next section).

Meanwhile, most frameworks used in twentieth-century anthropology, from structuralism to the political economy of health, relate to space as a container, a void filled with people and things. Lefebvre begins his project by criticising this view of space:

> Not so many years ago, the word 'space' had a strictly geometrical meaning: the idea evoked simply that of any empty area. In scholarly use it was generally accompanied by some such epithet as 'Euclidean', 'isotropic', or 'infinite', and the general concept of space was ultimately a mathematical one. (Lefebvre 1991: 1)

This abstract conception of space has been foundational to most of the scholarship of the twentieth century. It is ultimately grounded in a Cartesian understanding of the *cogito* versus the *res extensa* that prevails in the natural sciences, and it is also common in social anthropology. However, space-as-an-empty-container is not merely philosophically flawed and not very practical to think with for the fieldworker, it is also ethically problematic. Lefebvre does not say this as blatantly as I have just expressed, but gestures in this direction in another vocabulary:

> ([F]ormal) content and (material) container are indifferent to each other and so offer no graspable difference. Anything may go in any 'set' of places in the container. Any part of the container can receive anything. This indifference becomes separation, in that contents and container do not impinge on one another in any way. . . . The constitution of such a 'logic of separation' entails and justifies a *strategy* of separation. (Lefebvre 1991: 170)

The subtext to the quote above is xenophobia, hostility against the foreigner, the intruder, the stranger. Implicit consequences are

the setting up of walls and boundaries. Needless to say, this subtext is also an important consideration in regard to Chinese medicine practitioners in East Africa. When the media speak of a culture of 'tolerance' and advocate cultural diversity and difference, they allude to a similar space-as-container idiom, where any part of the container can receive anything. However, 'Space is not a pre-existing void, endowed with formal [mathematical] properties alone' (ibid.: 170). This monograph embarks on a project inspired by Lefebvre's approach to reappropriating space, for the humanities and social sciences, as being tangibly textured.

Somewhat paradoxically, Lefebvre's (1991) *The Production of Space* has, in my reading, similar philosophical targets as Ingold's (2009) 'Against Space', which I read as Ingold critiquing Doreen Massey's (2005) *For Space*. However, in this particular piece Ingold somewhat infelicitously conjures up a bucolic *place*, where people live from their *land*, plant their crop in *earth* and harvest it from *fields*, while cattle are grazing in *pastures* (italics added), imagery that links the habits of the organism to a fairly stable, seemingly unchanging ecological habitat.

By contrast, the spaces that interest us here are urban spaces that become implicated in spatial practices. Theoretically, at least, Lefebvre accords seemingly disjointed procedures – say, of distant geographical provenance – the potential to effect a *transformation* of already-given textured spaces (italics added). This view grants Chinese medical procedures the potential to become enduring spatial practices by way of an intricate engagement with East Africa's given urban spaces.

Spatial Textures and Their Automorphic Symmetries

When Lefebvre speaks of 'spatial practices' that are enduring, Bourdieu's 'structuring structures' and the habitus come to mind. Although Bourdieu (1977) speaks of practice without modifying it as 'spatial', his concept of the habitus is closely linked to a spatial dimension, namely that of the 'field'. Hanks (2005) makes this point very convincingly, in a piece that demonstrates how much Bourdieu owes to Erwin Panofsky (1951). Lefebvre and Bourdieu were contemporary Marxist intellectuals in France during the 1960s and 1970s (e.g. Jenkins 2002). Their discussions of 'the production of space' and 'structuring structures' seem to have more in common

than expected. These two analytic concepts both indicate that space is not an empty container but is 'textured', and practice not a voluntary act but a 'structuring' one. Transformations happen not merely within and through, but also with and to those spatial textures and structuring structures. Not everything goes.

As Lefebvre puts it, each living being is space and has its space. As it (re)produces itself in space, it also produces space. This links the body directly to the space surrounding it: 'Can the body, with its capacity for action, and its various energies, be said to create space?' (Lefebvre 1991: 170). Bodies produce space and produce themselves, along with their motions, according to the 'laws of space'. Lefebvre speaks of 'automorphic symmetry', a term he adopted from Herrmann Weyl (1952). Lefebvre, following Weyl, tells us that the spatial body's 'determinants of space' are: 'symmetries, interactions, and reciprocal actions, axes and planes, centres and peripheries, and concrete (spatio-temporal) oppositions' (Lefebvre 1991: 195). Lefebvre stresses, in accord with Weyl, that this is so regardless of scale and domain, regardless of whether the researcher's focus is on crystals or shells, corpuscles or planets, electromagnetic fields or architectural forms. These biologico-spatial realities are 'automorphic', he says, using Weyl's terminology. The spaces that organisms live in and create are not textured in a random way, but in an 'automorphic' way. One is drawn to speak of 'self-symmetrical structuring structures'.

By textured movement, the body creates the spaces around it, and the spaces thereby textured give shape to the body. The signs within these textured spaces may be mutually incomprehensible and multi-layered, but it would be an oxymoron to claim that textures are chaotic or messy. Postmodernism tends to overlook the texture and chunkiness of cultural flows. The acknowledgement that every texture has some sort of symmetry ultimately draws on Lefebvre's engagement with Weyl's 'automorphic symmetry'. It also points towards more recent avant-garde thinking in science studies. Donna Haraway, in particular, has not shied away from engaging with evolutionary biology, in both a critical and creative way, with her thinking about autopoiesis and sympoiesis (Haraway 2016). To a certain extent, this makes her both a follower of Lefebvre, who let his thinking about space be inspired by the symmetries of the life forms of 'more-than-human' organisms, and an innovator who takes this discussion in an entirely different direction (see Chapter 6).

The Structure of This Book

This book is not an ethnography written in one long summer. Rather, diverse 'situated knowledges' have been reassembled and patched together. The field sites were multiple, as were the conditions under which fieldwork was undertaken. Furthermore, starting to rearrange published work, unpublished field notes and unwritten field experiences in a single book, nine years after my last stay in the field, has not been easy.

My fieldwork findings have been published in ten articles on various themes relating to Chinese medicine in East Africa and in about ten other articles on the herbal antimalarial *qinghao* 青蒿. For the writing of this monograph, some of these pieces have been stripped of their theoretical framing and re-embedded in this book's argument. Each of the nine chapters in this book is divided into three sections, comprising the ethnographic core in the middle, preceded by a section on fieldwork methods and concluded by one on theorists. The ethnographic cores in Chapters 1, 3, 4, 5 and 9 draw heavily on published texts (respectively Hsu 2005a, 2017, 2002, 2012a and 2015), while the ethnographic cores of Chapters 2 and 6 are new, and those of Chapters 7 and 8 (based on Hsu 2009a and 2009b) have been thoroughly renewed. The fabric of the text is thus composite. This will convey a sense of the different spatial textures of multisited ethnographic fieldwork stretched out over eight years. There were tensions, fissures and dissonances that have not been foregrounded, yet an effort was made not to eliminate a sense of their existence in the written-up text. It is important to know that this fieldwork, which was grounded in participant observation, entailed moments of both real friendship and heartfelt joy, alongside a lingering sense of uneasiness and sometimes even outright conflict.[32]

As regards ethnographic fieldwork, some generalities need to be voiced here. For one thing, it cannot disregard number or basic quantitative givens. Thus, it is a misnomer to call the ethnographic methods I used merely 'qualitative methods'. No ethnography can be done without a very basic understanding of number and proportion. Stochastic considerations are so basic to everyday life (Lave 1988) that they will inevitably inform ethnographic research. Even if serendipity is an integral aspect of ethnographic fieldwork, good ethnography is not merely a bunch of 'anecdotes'. Ethnographic

fieldwork methods are nowadays discussed didactically and systematically in a range of textbooks. However, fieldwork is part of life, and one learns for life in the field (e.g. Laplante et al. 2020). Textbooks on method tend not to include ethnographic accounts of how a method was applied, and tend not to address the emotional dimension (although there are exceptions, e.g. Davies and Spencer 2010; Elliot et al. 2017). Yet feelings and affective states are undeniably part of fieldwork, as my introductory sections on methods will show. These are on: siting, sensing and mapping the field; language learning in the field; conducting semi-structured interviews; working with narrative; tackling prickly issues; bringing the historical dimension into ethnography; and reflecting on one's mistakes as a fieldworker. Those readers interested in just the ethnographic methods, and not so much in Chinese medicine, may endeavour to read in each chapter only the first section on methods. I have taken extra care to write the texts so as to enable a reader to focus on only the experiences of applying fieldwork methods.

The book is structured in three parts. Part I starts with the medical encounter, moving through space and moved by speech. Part II researches the sociality of different configurations of patients, practitioners and 'pots', as well as the 'para-professionals', that is, the interpreters and lab technicians. Part III engages with the materiality and ontology of the medicine *pots* and their affordances. It investigates the hybridity of the Chinese formula medicines as a manifestation of an 'alternative modernity'; explores sensory aspects of Chinese procedures for enhancing fecundity; and compares the 'Chinese antimalarials' *qinghao* 青蒿 (i.e. the plant and 'natural herb' *Artemisia annua* L.) and *qinghaosu* 青蒿素 (the purified chemical substance artemisinin).

The ethnographic core of each chapter, and how it ties in with medical anthropological debates and theory, is discussed at the end of each chapter, in a section called 'Reflections'. Here in the introduction, I merely point to the range of philosophical and anthropological foundations on which this ethnography is based:

The two sections on 'Reflections' in Part I engage with thinkers who emphasised complementarity and cooperation as foundational to cultural and linguistic encounters, such as Alfred Schütz, who foregrounded the *Thou*-relation, or Paul Grice, who developed the concept of the 'cooperative principle'.

The reflections in Part II shift the focus onto techniques of transformation, skills and body techniques, inspired by Marcel Mauss's insistence on the relevance of studying 'concrete' techniques for understanding cultural relatedness (James 1998). I also engage with Michel de Certeau's (1984) differentiation between strategies and tactics. According to de Certeau himself, the latter resonate with the Chinese philosophical understanding of 'power' as given in the 'propensity of things' (*shi*; Jullien 1995). Both thinkers make us attend to the social through the bodily and material aspects of daily life.

Finally, Part III aims to provide an account of the ways in which the materiality of the 'pots', *pots* and pots (as explained in Chapter 6) can explain their bodily felt efficaciousness by investigating the ontologies of caring that they entail. The book ends by pointing out the revolutionary potential for lasting change that is provided by practical knowledge at the grassroots – what Antonio Gramsci (1891–1937) called 'good sense' or 'common sense' (see Crehan 2002, 2016; Robinson 2005).

The final three chapters, which have been inspired by recent social anthropological research into 'ontologies' (e.g. Willerslev 2004a, b; Holbraad 2007; Holbraad and Pedersen 2017), will focus on intersubjective and inter-corporeally negotiated medical-cum-social efficaciousness. Throughout this monograph, a question will be posed regarding the extent to which the body techniques thereby enacted are perceived by 'the self' and 'the other' to reconfigure the refractions of given spatial textures into novel, but nevertheless automorphically symmetric, wholes.

Notes

1. The ethnographic fieldwork on which this book draws was undertaken in urban areas, specifically urban East Africa (2001–8, *c*. nine months in total), and drew on fieldwork on Chinese medicine conducted in urban China (1988–89, *c*. eighteen months).
2. These are fieldwork-based findings based on interviews with their founders and/or close relatives.
3. Conflicts were multiple, and also existed between socialist-era, pre-socialist and late-liberal Chinese (e.g. Hsu 2007a).
4. 'Slow research' requires reconceptualisations of locality, a sensitivity to 'what is working', the acquisition of knowledge rather than information, and responsiveness to local relevancies (Adams et al. 2014).

5. It would probably be too pretentious to call these efforts 'patchwork ethnography' (Günel et al. 2020), that is, 'research efforts that maintain [. . .] long-term commitments, language proficiency, contextual knowledge, and slow thinking'.
6. Obrist (2003: 281) notes: 'In health explanations, women emphasised that not only conditions of body and mind but also "living conditions" (*hali ya maisha*) have to be favourable in order to achieve good health.' She explains this in terms of *uzima* as a 'broader conception of well-being, vitality and wholeness'. This holistic notion of well-being contrasted with health through hygiene: '"proper food" (*chakula bora*), "clean water" (*maji safi*), "clean environment" (*mazingira safi*) and "cleanliness" in general (*usafi*)' (ibid.: 283). Yet *usafi* has non-dualist connotations too: clear water signifies both the pure and holy (Obrist 2004).
7. A sense of feeling 'incomplete' is a virtue, Francis Nyamnjoh argued in his seminar on proverbs gathered by Achebe Chinuo (on 4 March 2021, University of Oxford), mentioning this deep-seated sense of incompleteness alongside a commitment to 'mobility/motion, encounter, compositeness, debt and indebtedness, and conviviality'.
8. 'Trying out' is a pragmatist stance; see Whyte (1997), Geissler and Prince (2010a), Cooper and Pratten (2015) and many others.
9. On autochthony as a rootedness balanced by a celebration of a 'fundamental alterity', for instance in myths of strangers as the founders of society, see Ceuppens and Geschiere (2005: 388).
10. The term 'scholarly medicine' is adopted from Bates (1995), as the notion of 'humours' and 'humoral pathologies' is too occidental to be applied cross-culturally (Horden and Hsu 2013). See also Köhle and Kuriyama (2018). These three volumes straddle the boundaries of medical anthropology and, in particular, medical history.
11. The wasting illness *chira* has a regulatory function, as do 'taboos' in early anthropology.
12. Durkheim's (1915) 'society', and the 'collective representations' that make up 'culture', draw on a concept of sameness. However, the homogeneous 'cultural representations' of a disembodied collective, combined with the nationalistic focus on one language, one religion and one territory, render his concept of 'culture' inadequate for this project. As many discerning critics have long noted, it is too static, too bounded, too homogeneous and too idealistic.
13. In fieldwork the 'c' word tended to be mentioned mostly after a preceding miscommunication or a clash of blatantly different assumptions and convictions between people of different class, professional, educational or language backgrounds. Sometimes, it appeared to reinforce differences in 'race', as it had done a century ago. At others, it downplayed the determinism of 'genes'.
14. Mauss is rated one of Durkheim's most creative critiques (e.g. James 1998). Consider also Mauss's two students Leroi-Gourhan (1993) and Haudricourt (1987).

15. Currently, the foundational work on the gift by Mauss ([1925] 1954) is much discussed in contemporary African anthropology that is engaged with ethics (e.g. Neumark 2017, Laws 2019). See also the critique of cash economies and the foregrounding of gift economies (Ferguson 2015). However, the focus for us is on Mauss and technology.
16. 'If it [the forthcoming *Historical Atlas of Civilisation* by O. Spengler] is guided by a priori ideas of "*the* culture" or of a priori defined "such and such cultures", this work will only be full of petitions of principle' (Mauss [1929] 2006a: 66).
17. On South–South relations of China in Africa and Africa in China (CA/AC), see Yoon Jung Park's invaluable e-network, accessible at chinese-in-africa africans-in-china@googlegroups.com (accessed 9 December 2021).
18. On the rapid rise of the field of CA/AC in area studies, see, for instance, Petit and Chatelard (2018).
19. Bräutigam (2011) notes that infrastructure made up 61 per cent of all concessional loans granted by China in a year, not only those for Africa.
20. T/CAM or TM/CAM refers to traditional medicines (considered indigenous or local) and complementary and alternative medicines (professionalised local or transnational TMs; 'popular' or folk practices).
21. E.g. Zimmermann (1987), Langford (2002), Frank (2004), Wujastyk and Smith (2008), Hardiman and Mukharji (2013) and Guenzi (2021).
22. E.g. Bode (2004, 2008), Pordié and Hardon (2015) and Coderey and Pordié (2019).
23. In contrast, the various forms of Chinese medicine in Taiwan are either called *guoyi* 國醫, 'the nation's medicine', or *chuantong yixue* 傳統醫學, 'traditional medicine' (anonymous, personal communication, *Aademia Sinica*, Taiwan, September 1999).
24. The idea of the submergence of the 'self' by the invasion of the 'other' – the nationalist stance of xenophobia – is being expressed ever more loudly in Europe (Banks and Gingrich 2006) and beyond. Even if the 'yellow hordes' of Genghis Khan are now part of the European archive and a memory tinged with legend, the 'hydra' of Chinese aid-cum-business was a repeatedly vocalised threat in East African health fields – 'you cut off their head here, they grow another one there' (hospital physician, personal communication, Dar es Salaam, 2007).
25. The exoticising gaze on 'Far Eastern' art and culture, as cultivated in rarefied circles of a wealthy European elite, may have been an instance of 'Sinophilia' (Russell 1922), but cases of 'Sinophobia' have historically been far more frequent, often seizing wide parts of society. It was not merely in nineteenth-century Hawaii that fears of contagion became the main pillars of Sinophobic governmental legislation, as noted in the foundational medical anthropology article 'Learning to be a Leper' (Waxler 1981); they are arguably perpetuated in US legislation for the sake of TB prevention (e.g. Ho 2001, 2003).
26. A focus on 'im/mobilities of and dis/connectivities' throws light on 'the *patternedness* of flows', 'as well as processes of contestation and fragmenta-

tion' (Dilger and Mattes 2018: 272–73, italics added). While referring to 'patterns' instead of 'textures', Dilger and Mattes too aim to give the fluid changes more structure and material solidity by speaking of 'figurations'.

27. E.g. Croizier (1968), Unschuld (1973), Kleinman (1976, 1980), Hsu (2001), Scheid (2002), Rogaski (2004), Zhan (2009), Leung and Furth (2010), Andrews (2014), Lei (2014) and Chiang (2015).
28. See Sivin (1987), Ots (1990a), Farquhar (1994), Hsu (1999), Taylor (2005), Scheid (2007) and Zhang (2007).
29. Iliffe no doubt drew here on the classic work by Last and Chavunduka (1986), which changed for medical anthropology the legacy of Evans-Pritchard (1937, whose focus had been on the *why me?* question) in the direction of research undertaken by van der Geest and Whyte (1988), Comaroff and Comaroff (1992), Pool (1994), Dilger and Luig (2010), Langwick (2011), Prince and Marsland (2013), Laplante (2015), Mattes (2019) and many others.
30. For instance, in order to enhance externally applied herbal medications when packing a wound, the powder taken from antibiotics capsules is sprinkled onto it (Bierlich 2007).
31. In 2001–2, the exchange rates for the Tanzanian Shilling ranged between TZS 1,200 and TZS 1,350 per English pound sterling. One thousand TZS was over one US dollar in 2001, and just about equal to one dollar in 2008. In 2001, the salary of a lowest-grade government employee was *c*. TZS 50,000 per month, around GBP 50.
32. Fieldwork was carried out in March–April 2001, December 2001–January 2002, March–April 2002, July 2002, December 2002–January 2003, April 2003, December 2004–January 2005, April 2005 and December 2007–January 2008. All names of my respondents are pseudonyms.