

# Unpacking Sino-African Health Diplomacy: Problematizing a Hegemonic Construction

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## ABSTRACT

The practice of health diplomacy aims to prioritize the health care aspects of humanitarian aid as a mechanism for political economic negotiations between donor and recipient nations. Existing research concerning health diplomacy failed to assess the context-appropriateness of the health care aid transferred, the manner in which health diplomacy is implemented, and the political and economic ideologies embedded in such transfers. This paper examines how health diplomacy may be understood in terms of the above-mentioned criteria using specific illustrative examples of Sino-African health diplomacy over the past sixty years. China's health diplomacy is contrasted with examples of that of the US in order to assess whether the former constitutes a distinct alternative to the normative health diplomacy of the global North.

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## *Introduction*

This paper examines the historical trajectory of Sino-African health diplomacy from the Chinese Communist Party's first health care transfers to African states in the 1960s to the present. Previous analyses of health diplomacy have predominantly focussed on health transfers from the global North to the global South. In general, the discourse of health diplomacy appears to assume that all such diplomacy follows a normative, Western paradigm and should be considered beneficent simply by virtue of the transfer of biomedicine. In contrast, by examining China's health aid to African states this paper attempts to provide a more nuanced understanding of health diplomacy through an example of South-South

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health transfers that has provided a mechanism for further political and economic negotiations. In doing so, this paper analyzes if, and how, China's health diplomacy is distinct from Western health diplomacy. More specifically, this paper critically assesses the political and economic ideologies embedded in international health care transfers and the context appropriateness of the types of health aid transferred. By excluding these primary considerations, the existing health diplomacy literature has implied that all health care transfers are inherently beneficent and equivalent. The accuracy of such assumptions is problematized in this paper.

## *Defining Health Diplomacy*

Several definitions of health diplomacy can be identified in the literature.<sup>1</sup> In general, health diplomacy is defined as any health care activity characterized by the underlying intention of improving political, economic, and/or cultural ties between donor and recipient countries in keeping with the foreign policy of the donor state. Health diplomacy is an example of what Nye refers to as "soft power",<sup>2</sup> as health care aid is used to foster international relationships and achieve foreign policy goals.

Although health care transfers have historically been perceived as an inherently beneficent form of diplomacy, it is naïve to assume that all health diplomacy is conducted in the same manner and leads to the same outcomes in different recipient contexts. According to Adams, Novotny, and Leslie, "the most effective international health interventions are carried out in an ethical manner that is sensitive to historical, political, social, economical, and cultural differences between nations and peoples."<sup>3</sup> Hence, regardless of the donor's intentions or the value of the particular health care intervention and/or technological transfer, context appropriateness is a key consideration for effective health diplomacy.<sup>4</sup> Though health care is often represented as a neutral scientific domain, political, economic, and cultural ideologies remain as embedded in international health aid as they are in domestic health care policies. Correspondingly, the range of activities falling under the rubric of health diplomacy should not be understood as a singular, unquestionably beneficent monolith. This point is highlighted by the following comparative and historical analysis of health diplomacy, which problematizes this universalizing conceptualization of health diplomacy.

Some of the first instances of historical health diplomacy were the nineteenth century economic and trade policies relating to maritime quarantines.<sup>5</sup> The focus of these early international health relations concerned “international collaboration to protect human and commercial interests against the spread of particular infectious diseases.”<sup>6</sup> However, these concerns were less a tool for engendering foreign relations than a means of preventing commercial interruptions. Similarly, the colonial legacy of international health can be categorised as “a protectionist response against the importation of foreign-born diseases or a medical defence for colonists, armies, and national commercial interests.”<sup>7</sup> Early health diplomacy can also be identified in historical international missionary work that, despite its often-humanitarian practices, has served as a form of colonial control.<sup>8</sup> In the post-WWII era, health interventions became an increasingly common aspect of international diplomacy through the creation of international development programmes and the growth of organizations such as the European Development Fund (1957), the United States Agency for International Development (1961), and, more recently, the UK’s Department for International Development (1997).<sup>9</sup> Similarly, over the last hundred years, private philanthropic foundations have also played an integral role in health diplomacy. For example, in the early twentieth century, the Rockefeller Foundation used international health as a safe, irrefutable means by which to disseminate an American ideology across the globe and “lay the foundation for American international dominance in trade.”<sup>10</sup> Health diplomacy may thus contain coercive elements intended to foster a donor’s influence over recipient societies.

As argued by Navarro, moreover, power differentials between states may be exacerbated through the transfer of high-technological and expensive medical equipment, which often result in a form of economic and knowledge-based dependency.<sup>11</sup> Similarly, it is essential to question the absorptive capacities of recipient governments in managing health diplomacy. The larger the percentage of government spending supplied by external sources, the greater the chance that “a country may lose control of its priorities, programmes and strategies, yielding all control to the donors.”<sup>12</sup> Hence, in order to safeguard state autonomy and sovereignty, it is crucial to incorporate the concept of recipient government ownership into health diplomacy.

## *Chinese Health Diplomacy: Truly Alternative, or Alternative Packaging?*

China has a long, often unacknowledged history of providing foreign aid to Africa, building upon a common colonial experience to forge what China refers to as mutually beneficial partnerships.<sup>13</sup> The overall amount of this contemporary aid is substantial. In 2009, China pledged a package which included supplying US\$3 billion in soft loans and US\$2 billion in subsidized credit to trade partners; establishing a US\$5 million development fund to encourage Chinese companies to invest in Africa; forgiving the debt of the poorest countries that have diplomatic relations with China; opening the Chinese market to African products through the removal of customs duties on most goods; and opening economic and trade cooperation areas.<sup>14</sup> At the 2012 Forum on China-Africa Cooperation, China doubled its 2009 package, pledging US\$20 billion to Africa over the next three years.<sup>15</sup> This aid will: specifically target the development of infrastructure that facilitates trade within Africa; build agricultural technology centres; support the construction of wells; and train medical and other professional personnel.<sup>16</sup> In 2009, China overtook the United States to become Africa's largest trade partner.<sup>17</sup> If this trajectory continues, China is projected to overtake the World Bank as Africa's most important financier.<sup>18</sup>

Current health sector assistance constitutes more than a quarter of China's foreign aid to Africa.<sup>19</sup> Of the US\$462 million 2006 Sino-African assistance package, \$126 million was specifically targeted for health care.<sup>20</sup> Improving Africa's public health has received particular emphasis from China. In 2006, four health-related priorities were identified, emphasizing: 1) the need to develop and promote effective treatments for malaria; 2) the exchange of medical personnel and information; 3) a commitment to disseminating medical teams and equipment to improve medical facilities and train more doctors throughout Africa; and 4) increased technical support, including research exploring the potential of traditional herbs in treating and preventing HIV/AIDS.<sup>21</sup> In late 2009, China pledged additional measures to strengthen Sino-African health cooperation, including plans to train 3,000 practitioners across Africa and a US\$73.2 million assistance package, facilitating the construction of thirty hospitals and thirty malaria prevention and treatment centres.<sup>22</sup>

Although all donor countries imply their foreign policy and health diplomacy are motivated by the pursuit of mutual benefit for the donor and recipient, China's intentions in Africa have been a source of particular criticism, especially from the West.<sup>23</sup> Brautigam problematizes numerous

aspects of the Western depiction of China's African diplomacy, particularly its presentation of aid as a mere mercenary attempt to exploit the natural resources of Africa.<sup>24</sup> The accuracy of such an assertion is fundamentally challenged by the fact that many of the African countries receiving China's health aid have no natural resources.<sup>25</sup> Furthermore, the Chinese government has explicitly characterized their relationship with African countries as one of "mutual cooperation and benefit," confronting such accusations of harbouring a "hidden agenda."<sup>26</sup> Overall, China's motivations for providing aid are likely similar to those of the US with respect to "strategic diplomacy, commercial benefit, and a reflection of the society's ideologies and values."<sup>27</sup> But, as Brautigam notes, "China's aid and economic cooperation differ [from traditional donors], both in their content and in the norms of aid practice."<sup>28</sup> For the purposes of this paper, however, the question of aid motivation is bracketed in favour of a greater emphasis on the manner in which health diplomacy is conducted and the outcomes of such practices.

Practices of health diplomacy do not share a standardized, systematized, or universalized ideology, meaning that not all health diplomacy is equivalent in terms of perceived appropriateness or effectiveness. The following sections thus analyse whether, and how, China's health diplomacy differs from that of the West: a) ideologically; b) technologically, in terms of specific interventions and technological transfers; and c) structurally, in terms of execution and implementation.

### *Ideology: An Alternative to Western International Development*

China's health diplomacy is undertaken in accordance with a particular ideological understanding of the function, structure and role of aid in diplomatic relations, developed in the 1950s. In general, the ideologies that have become embedded in China's foreign policy and health diplomacy derive from both Beijing's particular political agenda and a distinctively "Asian" perspective on foreign policy. In April 1955, China and other developing countries began to establish both political and economic ties to Africa at a conference in Bandung, Indonesia.<sup>29</sup> One of the primary outcomes of this conference was the development of a novel regional approach, that was to become a normative ideology, characterizing Asian foreign policy and international cooperation, offering a marked alternative to the predominant Western ideology emanating from post-World War II reconstruction and the Truman Doctrine.

Central to this ideology are the so-called “Five Principles of Peaceful Coexistence.” The Five Principles, first articulated by China, India, and Burma, established the foundations of Chinese and Indian foreign policy, as well as Asian regional diplomacy in general, particularly within the Association of Southeast Asian Nations (ASEAN).<sup>30</sup> The Five Principles include: “1) mutual respect for territorial integrity and sovereignty; 2) mutual non-aggression; 3) mutual non-interference in internal affairs; 4) equality and mutual benefit; and 5) peaceful coexistence.”<sup>31</sup> As the Five Principles apply to the conduct of all foreign policy, health diplomacy was to be similarly executed.<sup>32</sup>

The ideological framework for Beijing’s foreign policy, however, extends beyond the Five Principles. For example, China has consistently represented itself as a “natural ally of third world countries in the fight against imperialism and hegemony of the superpowers.”<sup>33</sup> Unlike the Soviet Union, the Chinese government presented itself to African states as a patron that rejected the imperial mandates of Western powers and understood the unique struggles of peasant movements.<sup>34</sup> China successfully characterized its relationships in Africa as equal, strategic partnerships—of similarly-developing “sister” countries—where mutually-beneficial cooperation replaced colonial paternalism.<sup>35</sup>

In 1964, Zhou Enlai announced that Beijing’s policy toward sub-Saharan Africa would be based on both the Five Principles and “Eight Principles of Economic Aid”: equality and mutual benefit; economic cooperation with respect for recipient’s independence; provision of interest-free or low-interest loans; projects with low investment that could be accomplished in a timely manner; provision of quality equipment and resources at market prices; effective technical assistance; fees for experts set according to local standards; assistance in the development of recipient country’s self-reliance; and assistance with no conditions attached.<sup>36</sup> The idea that aid should not violate the recipient’s sovereignty, and offered without conditionalities, has remained the cornerstone of China’s foreign aid practices.

Furthermore, unlike the numerous political and economic conditionalities historically imposed on governments by, for example, the International Monetary Fund and World Bank, no such conditionalities have been attached to China’s loans to African countries. (Indeed, many African debts to China have been forgiven. In 2000, 2003, and 2006, US\$1.2 billion for thirty-one African countries; US\$750 million; and US\$1.3 billion were forgiven respectively.<sup>37</sup> However, to categorize China’s policy as entirely free of conditionalities is not accurate. In order to be considered for Chinese aid, states have been obliged to support the “One China” policy, wherein the Republic of China (Taiwan) is not

recognised.<sup>38</sup> Regardless of the presence of this ideological conditionality within a discourse of “no strings,” China has successfully presented itself as a natural ally of low-income countries, and enhanced its credibility amongst African governments.<sup>39</sup>

### *Technology: Specific Health Diplomacy Interventions*

In addition to these ideological differences, the actual health care interventions and structure of health diplomacy further differentiate Chinese and Western health diplomacy. In order to distinguish the actual health care practices that have been transferred from China to African contexts, unstructured interviews were conducted in Beijing with approximately thirty Chinese and African stakeholders, in conjunction with archival research. The majority of interviews were conducted at the “Third International Roundtable on China-Africa Health Collaboration” in Beijing, from June 12 to June 13, 2012.

The particular interventions and technology transferred from China to Africa have markedly differed from those transferred by the West. Professional human resources have always been a central component of Sino-African health diplomacy. For example, “since the first medical team arrived in Algeria in 1964, more than 15,000 Chinese medical personnel have served in forty-seven different African states and treated at least 180 million patients.”<sup>40</sup> Historically, Chinese Medical Teams (CMTs) have been specifically targeted for rural, under-served communities<sup>41</sup> with limited access to health care.<sup>42</sup> CMTs are also noteworthy for including practitioners of traditional Chinese medicine (e.g. acupuncturists and herbalists), in addition to conventional biomedical personnel.<sup>43</sup>

According to several informants, distinctly “Chinese” health care transfers appear to have been particularly appropriate for local recipient contexts in Africa, and are well utilized by local communities.<sup>44</sup> For example, Chinese herbal remedies were welcomed in most African communities, where many local informal health care economies are dominated by herbal use.<sup>45</sup> Additionally, the Chinese herb *Artemisia annua* provides the starting compound for *artemisinin-combination therapies*,<sup>46</sup> which have proved particularly successful in treating malaria and are endorsed by the World Health Organisation.<sup>47</sup>

In addition to human resources, essential medicines, herbs, and acupuncture, China has also been integral in the development of health care infrastructure, both through the construction of hospitals and clinics throughout Africa and in the on-going training of African medical students in China.<sup>48</sup> According to interviewed informants, these health

care provisions have both enhanced China's image in the eyes of ordinary Africans and engendered a trust in Chinese medical products.<sup>49</sup> Furthermore, preliminary evidence from interviews and the literature suggests a general satisfaction with the outcomes of China's particular health diplomacy in Africa. For example, upon visiting a number of medical clinics sponsored by the Chinese government throughout the continent, it became clear to one researcher that rural CMTs represented one of the most successful forms of current aid to Africa.<sup>50</sup> The Chinese medical teams were noted for focusing on disseminating basic preventative care to rural areas previously lacking proactive public health care.<sup>51</sup> Sustainable health care development is thus promoted in recipient countries' health care infrastructure through the creation of horizontal primary health care programmes, as opposed to the singular focus on vertical programmes for specific disease eradication, as commonly practised in Western health diplomacy.

This contrast illustrates that such interventions cannot accurately be considered independent of their ideological framework. Political, economic, and cultural ideologies embedded within health diplomacy interventions are as relevant to outcomes in local health care systems and population health as the intervention itself. Introducing high-technological health care transfers that are predominantly accessible to elites in metropolitan areas, for instance, may subsequently require a greater allocation of state health care resources to be redistributed toward investment in urban hospitals. The health care budget, resources, and access available for more rural, and often poorer, populations are thereby reduced. Hence, technological transfers that are inappropriate for a given context have the potential to increase disparity and inequity. It is thus imperative to consider these factors in order to improve local health care systems and population health.

### ***Structure: Partnerships in Chinese Health Diplomacy***

There are also inherent structural differences between Chinese and Western health diplomacy. Whereas Western health assistance comes from a combination of public, private, and multilateral sources, China's health diplomacy is almost entirely public in nature, and often decentralized to the level of a Chinese province. Typically, a Chinese province is paired with one or more African countries.<sup>52</sup> Although the Chinese central government negotiates health aid with African states, the implementation of health diplomacy, generally through the deployment of CMTs, is carried

out by individual provinces.<sup>53</sup> According to the Director-General of the Department of International Cooperation of the Ministry of Health of China, this decentralized structure facilitates better recruitment of medical personnel and reduces logistical problems.<sup>54</sup>

Furthermore, the process of health diplomacy is typically initiated by the prospective recipient government. One informant from China noted, “If they don’t ask, we don’t provide.”<sup>55</sup> In general, an African government will propose a health project in accordance with their assessment of the needs of their population. Hence, if the recipient government is seeking CMTs, they will specify what kind of practitioners and specialists they require, and where they wish them to work. The Chinese government then assesses whether it can fulfil the demands of the proposal in terms of human and material resource availability.<sup>56</sup> As a result of this structure, interventions are commonly recipient-led from the onset. They are thus more context-appropriate than if China was to devise a health care intervention according to its own estimation of local need.<sup>57</sup> The greater specificity of this process could serve to inform Western health diplomacy.<sup>58</sup>

China’s health diplomacy is structurally distinct not only in terms of planning, but also in implementation. Chinese medical teams travel as a cohesive group, typically consisting of twenty members, who work together in a single medical facility for a minimum of two years.<sup>59</sup> Furthermore, China’s health interventions are also distinguished by the overall time commitments allotted to projects. Health interventions from the West are usually of a specific duration, and often lack a follow-up from which sustainability can be assessed. Brautigam observes: “For the West, once a project ends, it is turned over to the government, and donor involvement usually ends.”<sup>60</sup> One outcome of the “Western approach” is that even if projects have fulfilled the donors’ specific short-term goals, many are unsustainable in the long term. However, both Chinese and African informants report that China will usually maintain a project until it may be viably assumed by the recipient government.<sup>61</sup> Additionally, follow-ups were considered common, particularly in the case of hospitals in need of repair.<sup>62</sup>

Overall, then, the type of health interventions that China delivers and the manner in which these interventions are carried out may be considered distinct from those of the West. To further illustrate the ways in which the type of health care transfer, manner of delivery, and underlying ideology can impact recipient health care, the paper turns to the case of Chinese and US HIV/AIDS health diplomacy.

## *China and US HIV/AIDS health diplomacy in Africa: A Comparative Case Study*

African countries represented seventy-six per cent of the 2.1 million deaths due to HIV/AIDS in 2007.<sup>63</sup> These deaths were not believed to be a consequence of a lack of viable anti-retroviral (ARV) therapies, but rather due to a lack of accessible and affordable ARV pharmaceuticals.<sup>64</sup> It is estimated that the cost of ARVs would need to be reduced by as much as ninety-five per cent in order to be accessible to all populations.<sup>65</sup>

Unfortunately, as a result of the 1994 World Trade Organization (WTO) Trade-Related Aspects of Intellectual Property Rights agreement (TRIPS), the cost of HIV/AIDS pharmaceuticals is far beyond the income of the average citizen in a low- or even middle-income country.<sup>66</sup> Under TRIPS, a generic product cannot be registered without the patent holder's agreement for the life of the patent, which can last up to twenty years.<sup>67</sup> This policy has been criticized as a globalization of US patent law for the sole benefit of US and European transnational pharmaceutical corporations.<sup>68</sup> TRIPS and US HIV/AIDS policies can be understood as reflections of the so-called Washington Consensus, which is grounded in Western notions of political liberalization and economic reform—such as the radical neo-liberalization of markets and the privatization of public goods.<sup>69</sup> As a result of the Doha Declaration of the Fourth WTO meeting in 2001, developing countries can override drug patents by issuing compulsory licenses to manufacture or import cheaper versions of a pharmaceutical product, if a national health emergency can be justified.<sup>70</sup> It is specified, however, that such a compulsory license would need to “be authorised predominantly for the supply of the domestic market of the Member authorising such use.”<sup>71</sup> Therefore, countries lacking domestic pharmaceutical industries—which includes almost all African countries—do not have the sufficient manufacturing capacity to produce significant quantities of generic pharmaceuticals.

China joined the WTO a month after the Doha declaration was endorsed, but strongly sided with developing countries in criticizing TRIPS and its addendum as perpetuating an imbalance in the rights and obligations of developing countries.<sup>72</sup> China argued that public health rights should take priority over intellectual property rights in government decision-making.<sup>73</sup> Additionally, China had already been active in the African pharmaceutical sector for over three decades, developing pharmaceutical factories in the 1970s that produced drugs for local use in “Zanzibar, Mali, Cote d’Ivoire, Kenya, Egypt, and Sudan.”<sup>74</sup>

Currently, China is the world's largest exporter of active pharmaceutical ingredients (APIs).<sup>75</sup> According to a Chinese informant, low profit margins and regulatory barriers to the production of generic ARVs have resulted in a primacy focus of Chinese pharmaceutical companies on the production of APIs rather than generic ARVs.<sup>76</sup> Informants identified that currently eighty per cent of Africa's ARVs are imported from India, and eighty per cent of the APIs needed for India's ARV production comes from China.<sup>77</sup> In recognizing the capacity of the Chinese pharmaceutical industry to supply generic ARVs, the joint United Nations Programme on HIV/AIDS (UNAIDS) is currently working with the government of China to establish policies that would incentivize Chinese companies to produce generic ARVs for Africa.<sup>78</sup> China is also in the process of developing an alternative to over-dependence on ARVs. There has been a marked interest among a number of African governments in collaborating with China on research exploring the use of African herbal medicines to treat HIV/AIDS.<sup>79</sup> The goal would be to generate sustainable cost-effective HIV/AIDS treatments that offer a viable alternative to cost-prohibitive ARVs, and the many issues noted with generic ARVs production.<sup>80</sup>

Yet, beyond political-economic ideological differences in HIV/AIDS health diplomacy stemming from the divergence between the Washington Consensus<sup>81</sup> and China's economic development model of "a long-term pragmatic strategy, emphasising sustainability and equality, with the ultimate objective of self-determination" (or the Beijing Consensus)<sup>82</sup>—it is also possible to consider the effect of US Christian fundamentalist ideology on the policies of the US HIV/AIDS programme known as the President's Emergency Plan for AIDS Relief (PEPFAR). PEPFAR, though providing the single greatest monetary donation to HIV/AIDS organizations in Africa for counselling, prevention, and treatment, is also replete with conditionalities for African HIV/AIDS patients that may result in different outcomes depending on context. PEPFAR policy has been criticized for insisting that ARV therapies be made available only to those individuals willing to abstain from sex and to those organizations that counsel abstinence and refuse to distribute condoms.<sup>83</sup>

In interviews, informants from local-level African NGOs stated that PEPFAR's demands were unrealistic and counter-productive, often exacerbating the social stigma affiliated with AIDS in local settings and potentially serving to increase the rate of HIV infection via the infeasibility of insisting on abstinence from sex as an effective intervention.<sup>84</sup> Furthermore, a country's eligibility to receive the substantial benefits from PEPFAR is contingent upon their compliance with TRIPS.<sup>85</sup> Thus, health diplomacy that contains conditionalities that are inappropriate for a giv-

en context may result in deleterious outcomes, thus problematizing the normative understanding of health diplomacy as inherently beneficent.

Population perceptions can provide a useful means by which to assess health diplomacy. In 2007, the Pew Trust conducted public opinion polls throughout Africa.<sup>86</sup> This research found that China was perceived as having both a more positive than negative impact on African countries in general, and a more positive impact in Africa overall than the United States in all African countries surveyed, except South Africa.<sup>87</sup> These perceptions may be a result of the particular interventions experienced (e.g. PEPFAR, which was fully implemented by June 2004) and/or may be related to the perceived asymmetry of power between African recipients and the United States. According to Gergen and Gergen: “when a state appears to be highly affluent, its aid is less impressive to the recipient.”<sup>88</sup> However, the Pew Trust findings can be criticized for making statements from highly aggregated averages of the data. Informants interviewed for this paper had numerous criticisms of China’s work in Africa. For example, one African informant reported that “the general opinion is that Chinese products and China’s work are of low quality.”<sup>89</sup> Additional challenges to Sino-African health diplomacy are identified in the following section.

## *Identified Challenges to Sino-African Health Diplomacy*

### *Conditionalities and State Sovereignty*

Technical support, without political “strings attached”—beyond the aforementioned agreement on the “One China” policy—has remained a significant aspect of China’s support for African states.<sup>90</sup> That said, though China’s current policy of non-interference in sovereign states has earned the respect of African leaders, it has consistently received the condemnation of the West for inadvertently perpetuating abuses to human rights through “blind funding.”<sup>91</sup> Similarly, it may be asked whether the requirement of agreeing to a “One China” policy should be categorized as non-interventionist.

It must be recognized, however, that not all conditionalities have the same potential to undermine state sovereignty. Tull suggests that China offers “an attractive alternative to Western governments who undermine the sovereignty of African governments by attaching developmental assistance to reform programmes, such as structural adjustment programmes and democratic reforms.”<sup>92</sup> According to Thompson, China

encourages its African partners to develop their economies through trade and investment in infrastructure and social institutions without demanding particular political or economic reforms.<sup>93</sup> Beijing's patent rejection of the unpalatable aspects of neoliberal development, such as economic "shock therapy"<sup>94</sup> or radical economic and political reform, has made China a welcome partner throughout Africa.<sup>95</sup> Thus, agreeing to "One China" may be considered far less disruptive to state sovereignty than particular economic reforms.

### *True Sustainability*

Attention to the sustainability of health projects has been identified as a strength of Sino-African health diplomacy. And yet, the manner in which China attempts to ensure sustainability may also potentially compromise it. The sustainability of Sino-African health diplomacy can be analyzed and critiqued in several ways, beginning with the locations where CMTs are deployed. Many African countries experience a rural to urban "brain drain." African physicians and medical staff who do not want to work in rural areas are conveniently replaced by CMTs. The CMTs may thus be understood as facilitating this rural human resource migration by making it appear that African governments do not need to seek long-term solutions or create incentives for African health workers to work in rural areas. This situation was reinforced by the Chinese Minister of Health's announcement at the Third International Roundtable on China-Africa Health Collaboration that CMTs would remain in Africa for "as long as they are needed."<sup>96</sup> The prospect may thus be raised that Sino-African health diplomacy may be inadvertently thwarting the development of a sustainable solution to rural health care disparities in African states. Even more so, it is questionable whether the continual provision of Chinese human resources, without the transfer of necessary knowledge to local levels is actually facilitating the sustainability that Beijing advocates, or is, in fact, creating a permanent dependency on China.

These issues of sustainability may, at least in part, result from a lack of focus on the effectiveness of knowledge transfer in Sino-African health diplomacy. For example, many informants noted that true sustainability may be compromised by culture and language.<sup>97</sup> Significant language barriers were identified as detrimental to the sustainability of programmes. One informant noted that in a project in Zambia, instructions for medical equipment were often written in Mandarin, rendering it inoperable for local recipients.<sup>98</sup> Furthermore, although several Chinese informants identified predominant issues in the ability of Africans to maintain projects, it was also observed that mechanisms to foster the transfer of management

skills, necessary for successful project transfers to African stakeholders, were seriously lacking.<sup>99</sup> Neither were there necessarily smooth transfers between the Chinese staff itself, as one informant identified gaps in transitions between old and new medical teams as an issue.<sup>100</sup> Moreover, although CMTs were reported to meet annually in China, it is not clear if the experiences of CMTs and other Chinese participants in health diplomacy are ever utilized to render more effective interventions. Almost all informants lamented the lack of project evaluations.<sup>101</sup>

China's domestic needs were also identified as a potential threat to the sustainability of Sino-African health diplomacy. Firstly, pressures on China's health care system, and the outcome of current health reforms, may prevent provinces from being able to deploy medical teams throughout Africa. Health reforms in China have resulted in marked domestic health care disparities, especially, ironically, with respect to human resources in rural China.<sup>102</sup> Such limitations began to surface when, in 2006, China offered to send medical teams to Africa to the "extent it could."<sup>103</sup> In 2007, approximately 4,000 general medical practitioners were working at community hospitals in China, yet the government estimated that a minimum of 160,000 additional medical personnel were required to meet China's domestic medical needs.<sup>104</sup> Furthermore, provinces are finding it more difficult to assemble medical teams, due to a dearth of volunteers willing to leave their families for a period of two years to be paid the equivalent of local African wages.<sup>105</sup> Thus, in combination with finite medical resources available and a dearth of CMT volunteers, increased domestic demands for health care have the potential to significantly compromise China's ability to send medical personnel to Africa in the future.

According to informants, sustainability is also being threatened by the growing presence of unregulated private Chinese doctors, acupuncturists, and herbalists in Africa, acting as non-state actors and potentially interfering with state-driven health diplomacy. Private Chinese medical, acupuncture, and herbal practitioners have aggressively entered the informal health care economy of many African cities, and are reportedly affecting the cost of, and access to, health care.<sup>106</sup> One informant from Dar es Salaam, Tanzania, reported that acupuncture and Chinese herbs were found in urban areas, and though herbs were identified as especially popular, they were also often expensive.<sup>107</sup>

Finally, sustainability has also been compromised by China's reluctance to engage with local NGOs and other representatives of civil society, by virtue of its adherence to principles of non-interference with governments and the various internal social factions of countries.<sup>108</sup> Interestingly, the intended beneficence of adhering to non-interference

could ultimately thwart sustainability precisely because civil society must be engaged in order to engender sustainable interventions.

### *Structure*

Sino-African health diplomacy can also be critically assessed in terms of structure. The same structure that is so distinct from that of the West is also open to critique. Health care systems are complex and require an holistic analysis, meaning that the effectiveness of a health care system is brought into question when projects are not assessed in conjunction with former and current ones. Chinese informants revealed that projects are often planned in a haphazard manner and are, as mentioned, never evaluated.<sup>109</sup>

Furthermore, a significant strength of historical Sino-African health diplomacy has been its horizontal structure focusing on building infrastructure and establishing primary and preventative health care. However, informants note that China's horizontal focus is currently being compromised by collaborations with Western states, INGOs and multilateral agencies that insist on a more vertical approach to health care.<sup>110</sup> One informant observed that "previously aid from China did not value cooperation with NGOs and other governments."<sup>111</sup> And yet, the Third International Roundtable on China-Africa Health Collaboration appeared to be dominated by organizations such as The Gates Foundation, USAID, and DfID. "We want closer collaboration with WHO and other organizations," offered one Chinese informant.<sup>112</sup> Evidence for this development can be found in the growing focus on health diplomacy projects directed toward, for example, malaria and HIV/AIDS treatment. These distinctively vertical programmes do not effectively strengthen health care systems in general.

Interestingly, this shift toward more Western programming is accompanied by a parallel shift in political economic ideology clearly evident in many of the speeches presented by Chinese representatives at the Third International Roundtable on China-Africa Health Collaboration. One Chinese informant argued: "Our assistance to Africa has been a public economy...we should tap into liberal markets and the private sector."<sup>113</sup> It remains to be seen if what has appeared to be a marked alternative to Western health diplomacy will eventually merge with the Western approach. And yet an African informant representing the African Union asked, "How do we move away from silos [sic] of interventions and begin to address weak health systems?"<sup>114</sup> It is doubtful whether her query will be heard by a China seemingly-eager to forge alliances with Western health and development organizations.

## *Conclusion: Not All Health Diplomacy is Equal*

Although Brautigam argues that “China’s engagement in Africa often simply repeats patterns established by the West, and especially Japan in China,” the Chinese have added their own interpretation to development practices in disseminating what “they believe worked for their own development”.<sup>115</sup> This paper has demonstrated that China’s health diplomacy in Africa does offer an alternative to Western (or North-South) health diplomacy, particularly with respect to the structure of health interventions; the specific kind of interventions; the outcomes of interventions; and the ideological framework underlying such health diplomacy.

Until now, the literature on health diplomacy has been almost singularly concerned with its intentions. However, as illustrated in this paper, the intentions of health diplomacy may not be as relevant to health care systems and population health as the practices being implemented; how they are implemented; and the actual outcomes of such practices. Additionally, any purported beneficence of health diplomacy must be justified with respect to the appropriateness of a particular form of health diplomacy for a given local context. Though somewhat counter-intuitive, preliminary research indicates that “low tech” health care transfers from China may yield more successful outcomes in local African contexts than higher tech Western transfers, primarily due to the context appropriateness of the technology and the corresponding emphasis on building local health care infrastructure.

Further assessments and comparisons of these different approaches will identify the strengths and weaknesses of each, thereby providing an evidence base from which health diplomacy can produce increasingly positive and sustainable outcomes for health care systems and recipient populations. In this manner, donors may begin to learn from one another. Future research should consider the lessons to be learned from China’s experience in health diplomacy (as well as other examples of South-South health diplomacy) with the aim of informing future practice. Interestingly, representatives from the WHO, World Bank, and the Gates Foundation have praised China’s programmes for their positive contributions to African development.<sup>116</sup> On China’s part, as one Chinese informant stated, “We are willing to learn from other countries, from their work in Africa.”<sup>117</sup> Going forward, these differing approaches to health diplomacy need not remain in opposing camps. ■

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## Notes

<sup>1</sup> For example, see Vincanne Adams, Thomas Novotny, and Hannah Leslie, “Global Health Diplomacy,” *Medical Anthropology* 27, no. 4 (2008): 315–23; Harley Feldbaum and Joshua Michaud, “Health diplomacy and the enduring relevance of foreign policy interests,” *PLoS Medicine* 7, no. 4 (2010); David Fidler, “Asia’s Participation in Global Health Diplomacy and Global Health Governance,” *Asian Journal of WTO and International Health Law and Policy* 5, (2010): 269–300; Jeremy Youde, “China’s health diplomacy in Africa,” *China: An International Journal* 8, no.1 (2010): 151–63.

<sup>2</sup> Joseph Nye, “Soft Power,” *Foreign Policy* 80, (1990): 153–71.

<sup>3</sup> Adams, Novotny, and Leslie, “Global Health Diplomacy,” 316.

<sup>4</sup> The author’s research at local levels in the Philippines has identified that global health policies that assume a universalised beneficence can actually wreak havoc at local levels in which the policy is contextually inappropriate. Paul Kadetz, “Assumptions of Global Beneficence: Health care disparity, the WHO, and the effects of global integrative health care policy on local levels in the Philippines,” *Biosocieties* 6, (2011): 88–105.

<sup>5</sup> David Fidler, “The Globalization of Public Health: the first 100 years of International Health Diplomacy,” *Bulletin of the World Health Organization* 79, no. 9 (2001): 842–9.

<sup>6</sup> Youde, “China’s health diplomacy,” 151.

<sup>7</sup> Thomas Novotny, Hannah Leslie, Vincanne Adams, *et al.* *Health Diplomacy: A literature Review*. (Technical report for UCSF/IGCC/CDC Project on Health Diplomacy 2008), 4.

<sup>8</sup> Ka-che Yip, “Health and society in China: Public health education for the community, 1912–1937,” *Social Science & Medicine* 16, no. 12 (1982): 1197–1205.

<sup>9</sup> See European Commission, “European Development Fund,” <http://ec.europa.eu/europeaid/how/finance/edf—en.htm> (accessed December 30, 2012); USAID, “USAID History,” <http://transition.usaid.gov/about—usaid/usaidhist.html> (accessed December 30, 2012); Department for International Development “History,” <http://www.dfid.gov.uk/about-us/history/> (accessed December 30, 2012).

<sup>10</sup> E.R. Brown, "Public Health in Imperialism: Early Rockefeller Programs at Home and Abroad," *American Journal of Public Health* 66, no. 9 (1976): 897-903, 899.

<sup>11</sup> Vicente Navarro, *Neoliberalism, Globalization and Inequalities*. (New York: Baywood 2007).

<sup>12</sup> Novotny et al., *Health Diplomacy*, 4.

<sup>13</sup> For more on the history of China's diplomatic and aid relations with Africa, please refer to Deborah Brautigam, *The Dragon's Gift: The Real Story of China in Africa* (Oxford: Oxford University Press, 2009).

<sup>14</sup> Paola Agnelli, "Chinese Health Cooperation in Africa", in "Global Health and Development Assistance: Rights, Ideologies, and Deceit" (report, Italian Global Health Watch, 2009).

<sup>15</sup> Associated Press. (2012) "China pledges \$20 billion in credit to Africa over the next 3 years," *The Washington Post*, July 19, 2012.

<sup>16</sup> Trade between China and African states reached US\$166 billion in 2011; a three-fold increase from 2006 (Associated Press, "China pledges \$20 billion").

<sup>17</sup> OECD. *OECD Factbook 2011-2012: Economic, Environmental and Social Statistics* (OECD Publishing, 2012). <http://www.oecd-ilibrary.org/sites/factbook-2011-en/04/01/05/index.html?contentType=&itemId=/content/chapter/factbook-2011-37-en&containerItemId=/content/serial/18147364&accessItemIds=&mimeType=text/html> (accessed September 20, 2012).

<sup>18</sup> Associated Press, "China pledges \$20 billion".

<sup>19</sup> Yiding Jiang, *The role of Global Health Diplomacy in China's Health Assistance to Africa* (Unpublished MSc Dissertation. London School of Hygiene and Tropical Medicine and The London School of Economics 2011).

<sup>20</sup> Deborah Brautigam, *China's African Aid: Transatlantic Challenges* (Washington, DC: German Marshall Fund of the United States, 2008).

<sup>21</sup> Youde, "China's health diplomacy".

<sup>22</sup> Lai-Ha Chan, Lucy Chen, and Jin Xu, "China's engagement with global health diplomacy: Was SARS a watershed?," *PLoS Medicine* 7, no. 4 (2010).

<sup>23</sup> For example, see Carola McGiffert, ed., *Chinese soft power and its implications for the United States: competition and cooperation in the developing world: a report of the CSIS smart power initiative*. (CSIS: Washington D.C. 2009); Associated Press, "China pledges \$20 billion"; and Brautigam, *Dragon's Gift*.

<sup>24</sup> Brautigam, *Dragon's Gift*.

<sup>25</sup> Ibid.

<sup>26</sup> The phrase “mutual cooperation” was echoed by almost every Chinese national presenting at the Third International Roundtable on China-Africa Health Collaboration held in Beijing, June 2012. However, it should be noted that according to Brautigam: “aid figures remain state secrets. The Chinese government releases only the barest of information about the quantities of aid it gives” (Brautigam, *Dragon’s Gift*, 12).

<sup>27</sup> Brautigam, *Dragon’s Gift*, 15.

<sup>28</sup> Ibid., II.

<sup>29</sup> Lai-Ha Chan, “China Engages Global Health Governance: A Stakeholder or a System-Transformer?” (PhD dissertation, Griffith University, 2008).

<sup>30</sup> Fidler, “Asia’s Participation.”

<sup>31</sup> Ibid., 272.

<sup>32</sup> Fidler theorizes that consistent application of the Five Principles in practice “strengthened collective action on many global health problems and domestic health concerns” and could be employed “to avoid disputes and controversies on global health issues in relations with non-Asian nations.” See “Asia’s Participation,” 295.

<sup>33</sup> Primarily in reference to the United States and Russia. Chan, “China Engages Global Health Governance.”

<sup>34</sup> Youde, “China’s health diplomacy.”

<sup>35</sup> Chan, “China Engages Global Health Governance.”

<sup>36</sup> Ibid.

<sup>37</sup> Ibid.

<sup>38</sup> Brautigam, *Dragon’s Gift*.

<sup>39</sup> Agnelli, “Chinese Health Cooperation in Africa”. Furthermore, Brautigam notes that the sentiment that “China gives Africans more respect than they get from the West” was shared by several African ambassadors she interviewed in Washington. See Brautigam, *Dragon’s Gift*, 68.

<sup>40</sup> Youde, “China’s health diplomacy,” 151. In 2009, thirty-five Chinese medical teams (CMTs) comprising 860 health care professionals worked in thirty-seven African countries. See Agnelli, “Chinese Health Cooperation in Africa.”

<sup>41</sup> However, informants I interviewed specified that CMTs were currently primarily

being utilised at district hospitals and usually not to be found at primary or secondary level rural health care facilities (Multiple informants. Interview with Paul Kadetz. Beijing, June 12-13, 2012).

<sup>42</sup> Elisabeth Hsu, "Medicine as business: Chinese medicine in Tanzania" in *China returns to Africa : a rising power and a continent embrace*, eds. Christopher Alden, Daniel Large, and Ricardo Soares de Oliveira (New York: Columbia University Press 2008).

<sup>43</sup> Multiple informants. Interview with Paul Kadetz. Beijing, June 12-13, 2012.

<sup>44</sup> Multiple informants. Interview with Paul Kadetz. Beijing, June 12-13, 2012.

<sup>45</sup> Hsu, "Medicine as business."

<sup>46</sup> In the 2006, Forum on China-Africa Cooperation, China promised a grant of US\$38 million toward supplying artemisin to the thirty malarial treatment centres which China proposed to build throughout Africa (Brautigam, "Dragon's Gift," 72).

<sup>47</sup> Elisabeth Hsu, "Chinese Proprietary Medicines: an Alternative Modernity? The Case of the Anti-malarial Substance Artemisinin in East Africa," in *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, eds. Elisabeth Hsu & Gunnar Stollberg, special edition of *Globalizing Chinese Medicine* 28, no. 2 (2009):111-40, Merlin Willcox, "Artemisia species: from Traditional Medicines to Modern Antimalarials – and Back Again," *Journal of Complementary and Alternative Medicine*. 15, no. 2 (2009):101-109.

<sup>48</sup> Youde, "China's health diplomacy."

<sup>49</sup> Multiple informants. Interview with Paul Kadetz. Beijing, June 12-13, 2012.

<sup>50</sup> Youde, "China's health diplomacy."

<sup>51</sup> Ibid.

<sup>52</sup> Ren, Minghui. Interview with Paul Kadetz. Beijing, June 13, 2012.

<sup>53</sup> Jiang, *The role of Global Health Diplomacy*.

<sup>54</sup> Ren, Minghui. Interview with Paul Kadetz. Beijing, June 13, 2012.

<sup>55</sup> Anonymous. Interview with Paul Kadetz. Beijing, June 12, 2012.

<sup>56</sup> However, one informant identified "They all request different teams, but they usually want high tech professionals. They want heart and lung surgeons." However, the informant identified that such requests were usually not feasible for China to provide for more than a short visit. (Anonymous. Interview with Paul Kadetz.

<sup>57</sup> However, it should be noted that depending on a country's financial ability, African countries are currently subsidising expenses for visiting Chinese medical personnel that include: international airfare, stipends for the doctors and support staff, and pharmaceuticals and medical equipment brought by the visiting medical team. See Drew Thomson, "China's Soft Power in Africa: From the Beijing Consensus to Health Diplomacy," *China Brief* 5, no. 21 (2005). Though, China continues to cover many CMT expenses through loans and grants where necessary. See Youde, "China's health diplomacy."

<sup>58</sup> A sentiment echoed in Little's recommendation: "as the United States engages with the developing world, it would do well to cultivate greater receptivity to what country leaders see as vital needs"(Little, "China's Smart Power," 36).

<sup>59</sup> C. Zhang, "Health diplomacy and soft power development — case of Chinese medical teams to Africa," *Contemporary International Relations* 3 (2010).

<sup>60</sup> Brautigam, *Dragon's Gift*, 58.

<sup>61</sup> Multiple informants. Interview with Paul Kadetz. Beijing, June 12-13, 2012.

<sup>62</sup> Multiple informants. Interview with Paul Kadetz. Beijing, June 12-13, 2012.

<sup>63</sup> Chan, "China Engages Global Health Governance."

<sup>64</sup> *Ibid.*

<sup>65</sup> *Ibid.*

<sup>66</sup> TRIPS was aggressively pushed forward by the U.S. pharmaceutical company Pfizer at the Uruguay round of Trade negotiations of the WTO in 1995. See Kelley Lee, Kent Buse, and Suzanne Fustukian, *Health Policy in a Globalising World* (NY: Cambridge University 2002).

<sup>67</sup> Lee, Buse, Fustukian, *Health Policy*.

<sup>68</sup> *Ibid.*

<sup>69</sup> Drew Thomson, "China's Soft Power in Africa: From the Beijing Consensus to Health Diplomacy". *China Brief* 5, no. 21 (2005).

<sup>70</sup> Chan, "China Engages Global Health Governance."

<sup>71</sup> African Union, "Local Pharmaceutical Production in Africa" (Report, 4th Session Of The AU Conference Of Ministers Of Health, Addis Ababa, Ethiopia, 4-8 May 2009), 10.

<sup>72</sup> Chan, "China Engages Global Health Governance."

<sup>73</sup> Ibid.

<sup>74</sup> Lucy Chen and Jin Xu, "The Development of China's Capacity for Supplying Generic Medicines to Africa," in *China-Africa Health Collaboration in the Era of Global Health Diplomacy*, ed. Lucy Chen (Beijing: World Knowledge Publishing House 2012), 124. However, these African factories have been deemed ineffective in producing generic antiretrovirals (ARVs) for HIV/AIDS.

<sup>75</sup> Ibid.

<sup>76</sup> Anonymous, Interviewed by Paul Kadetz. Beijing, June 21, 2012.

<sup>77</sup> Anonymous, Interviewed by Paul Kadetz. Beijing, June 21, 2012.

<sup>78</sup> Anonymous, Interviewed by Paul Kadetz. Beijing, June 21, 2012.

<sup>79</sup> Youde, "China's health diplomacy."

<sup>80</sup> In 2002, China specifically convened a Sino-African forum on traditional medicine and pharmaceuticals, which was attended by participants from 21 African states. See Thomson, "China's Soft Power."

<sup>81</sup> Brautigam observes: "Liberalization, privatization, and structural adjustment never quite achieved legitimacy as a development model in Africa." See *Dragon's Gift*, 16.

<sup>82</sup> Jiang, *The role of Global Health Diplomacy*, 8.

<sup>83</sup> Multiple informants. Interview with Paul Kadetz. Beijing, June 12-13.

<sup>84</sup> Anonymous, Interviewed by Paul Kadetz. Beijing, June 13, 2012.

<sup>85</sup> Chan, "China Engages Global Health Governance."

<sup>86</sup> Andrew Kohut, "How the World Sees China," Pew Global Attitudes Project, 2007, <http://pewresearch.org/pubs/656/how-the-world-sees-china> (accessed November 21, 2011).

<sup>87</sup> Ibid.

<sup>88</sup> Kenneth J. Gergen and Mary M. Gergen, "International assistance from a psychological perspective," in *Yearbook of World Affairs* 25 (1971): 87-103, 101.

<sup>89</sup> Anonymous. Interview with Paul Kadetz. Cambridge, UK, July 14, 2012.

<sup>90</sup> Thomson, "China's Soft Power."

<sup>91</sup> Agnelli, "Chinese Health Cooperation in Africa."

<sup>92</sup> Denis, "China's engagement in Africa: scope, significance and consequences," *Journal of Modern African Studies*. 44 no. 3 (2006): 459-79, 466.

<sup>93</sup> Thomson, "China's Soft Power."

<sup>94</sup> See Naomi Klein, *The Shock Doctrine: The Rise of Disaster Capitalism* (New York: Henry Holt, 2007).

<sup>95</sup> Thomson, "China's Soft Power".

<sup>96</sup> Zhu, Chen, Keynote Speech, Third International Roundtable on China-Africa Health Collaboration, Beijing, June 12, 2012.

<sup>97</sup> Multiple informants. Interview with Paul Kadetz. Beijing, June 12-13, 2012.

<sup>98</sup> Anonymous. Interview with Paul Kadetz. Beijing, June 13, 2012.

<sup>99</sup> Multiple informants. Interview with Paul Kadetz. Beijing, June 12-13. For example, one informant identified that many drugs that were shipped to Zambia remained in a warehouse and were never distributed to their final destinations, because the manpower was supposedly not available to distribute. Anonymous. Interview with Paul Kadetz. Beijing, June 13, 2012. Similarly, another informant identified gaps in the supply chain of drug distribution in Sudan where drugs were stored in a warehouse until they expired. Anonymous. Interview with Paul Kadetz. Beijing, June 12, 2012.

<sup>100</sup> Anonymous. Interview with Paul Kadetz. Beijing, June 12, 2012.

<sup>101</sup> Several informants identified that the lack of evaluations is an outcome of the complex network of ministries through which health aid is channelled in China. (Multiple informants. Interview with Paul Kadetz. Beijing, June 12-13, 2012).

<sup>102</sup> Yuanli Liu, William Hsiao, and Karen Eggleston, "Equity in health and health care: the Chinese experience," *Social Science & Medicine* 49, no. 1 (1999): 349-56.

<sup>103</sup> Youde, "China's health diplomacy."

<sup>104</sup> *Ibid.*

<sup>105</sup> Multiple informants. Interview with Paul Kadetz. Beijing, June 12-13.

<sup>106</sup> Multiple informants. Interview with Paul Kadetz. Beijing, June 12-13.

<sup>107</sup> Anonymous. Interview with Paul Kadetz. Cambridge, UK, July 14, 2012.

<sup>108</sup> Jiang, *The role of Global Health Diplomacy*.

<sup>109</sup> Multiple informants. Interview with Paul Kadetz. Beijing, June 12-13.

<sup>110</sup> Multiple informants. Interview with Paul Kadetz. Beijing, June 12-13.

<sup>111</sup> Anonymous, Interviewed by Paul Kadetz. Beijing, June 22, 2012.

<sup>112</sup> Anonymous. Interview with Paul Kadetz. Beijing, June 13, 2012.

<sup>113</sup> Anonymous. Interview with Paul Kadetz. Beijing, June 12, 2012.

<sup>114</sup> Anonymous. Interview with Paul Kadetz. Beijing, June 12, 2012.

<sup>115</sup> Brautigam, *Dragon's Gift*, 13.

<sup>116</sup> Chan, Chen, and Xu, "China's engagement."

<sup>117</sup> Anonymous. Interview with Paul Kadetz. Beijing, June 13, 2012.