Three's Company: How the US and China's Complementary Competition is Improving African Health

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"Mwana wa Obama?" asked the customs agent.
I gave the same bemused answer I had given the desk clerk at my hotel, the waiter at the restaurant I went to for lunch, the guy who sold me sugarcane juice, the taxi driver on the way to the dock, and the man who had sold me my ticket for the boat that would carry me from Zanzibar to Dar es Salaam: Yes.

That day, July 1, 2013, was the day President Obama arrived in Tanzania on the final stop of his three-country tour of the African continent. As soon as anyone found out I was American, they asked if I was 'mwana wa Obama', the son of Obama. When I spoke in the affirmative, everyone, from the desk clerk to the customs agent, would give me a message to convey to the man they viewed as the father of all Americans. The one message that remains clear in my mind was the customs agent's: "Tell Obama to visit more often, they cleaned all the streets of Dar es Salaam for him."

President Obama's trip to Tanzania was met with much fanfare and celebration by the people. Everyone I spoke to took it as a sign of Tanzania's emergence and increasing influence in the sphere of African affairs. However, his visit was not the only one met with such jubilation. President Obama's visit to Africa shortly followed Chinese President Xi Jinping's visit to the continent, a move rich in symbolism. Africa, specifically Tanzania, South Africa, and the Republic of Congo, was the first state visit President Xi had made as President. President Obama's state visit to Africa came just a month later as he traveled to Senegal, South Africa and Tanzania.

These visits seem to validate much of what has been written in the past few years of the supposed competition between the United States and China for influence and resources in Africa, with many authors proclaiming that the U.S. was losing this competition. Aside from propagating the idea that Africa is some sort of homogenous collection of people, ideas, and cultures, many of these authors view the role of Africa as primarily an economic battleground in which the U.S and China must battle to determine control while ignoring the fact that the differing strengths and focuses of the American and Chinese economies do not lend themselves to any sort of outright competition in Africa.

As much of Chinese foreign interests has been in infrastructure projects and expansion, American interests abroad have focused more on spreading democratic principles, removing trade barriers, and expanding service industries. There seems to be little overlap

and thus, area for competition between the U.S. and China in Africa. Instead, the American and Chinese relationship can be seen not as competitive but as complementary. In what will soon be apparent when considering HIV/AIDS in Tanzania, this dual relationship may not only be sufficient, but necessary for improvement of the quality of care for those affected by this disease.

Sub-Saharan Africa accounts for 69 percent of all people living with HIV/AIDS in 2011 and 70 percent of all HIV/AIDS related deaths.[2] Tanzania is one of the most affected countries in Sub-Saharan Africa, with around 1.6 million of its population living with HIV/AIDS.[12] This means that approximately 3.5 percent of the entire Tanzanian population is infected with the disease and, as of 2012, 5.1 percent of Tanzanians aged 15-49 were infected. This article will examine how policies are impacting the access to and quality of care of the large percentage of the population with HIV/AIDS. Care is defined to not only include healthcare but also mental, physical, emotional and spiritual care. Policies will be divided into two different categories. The first will consist of governmental policies which are directly focused on healthcare and HIV/AIDS such as the National Policy on HIV/AIDS. The second category will consist of governmental policies which are focused on other fields such as education, infrastructure and gender equality. The affect, both direct and indirect, of these implemented policies on the care of people affected by HIV/AIDS (PABH) will be examined. I choose to examine the care of those *affected* by HIV, not just those infected with it. Those who are uninfected yet affected may include patients' families, communities, businesses and the like.

The government's policies on education, along with a lack of resources to improve infrastructure, have led to health worker shortages, inefficient organization and lack of supplies.

Through the examination of various policies which fall into these two categories, it will be shown that policies the government has implemented in healthcare, which directly affect those infected with HIV/AIDS, could use some minor tailoring but are functioning well as a whole. However, policies the government has implemented in other fields, such as education and infrastructure, will be shown to be negatively impacting PABH. Comprehensively, while the government has implemented meritorious healthcare policies, it has faltered in implementing similarly effective policies in other areas, negatively impacting care for PABH.

The government of Tanzania decided to meet the AIDS challenge head on and implemented the National AIDS Control Programme (NACP) to coordinate the response to the virus and established AIDS coordinators in each district in the country. After many medium-term plans, the government found that the instead of halting the spread of AIDS, the plans and NACP had allowed for HIV to reach 8 percent of the population.[6]

At this point, a "war on HIV/AIDS" was declared and the National Policy on HIV/AIDS was developed and implemented by 2001.[13] This policy recognized that HIV/AIDS affected all sectors of the population. It especially highlighted how the impact of having a large percentage of the population, especially those of working age, absent from the workforce due to HIV/AIDS is detrimental to economic

development.[13] The policy was far ahead of its time in relation to past HIV/AIDS policies in the sense that it recognized the key roles played by poverty and stigma in increasing the prevalence of HIV/AIDS in the country, especially among the poor, destitute and uneducated. To combat HIV/AIDS, the government of Tanzania, in partnership with the World Health Organization Global Program on AIDS, started implementing programs which allowed for the education of the general public on the causes and pathways of dissemination of HIV/AIDS.[13] The National Policy also tried to fight the stigma of HIV/AIDS by holding educational seminars and hosting nation-wide rallies.[6]

As effective as the first National Policy on HIV/AIDS was, the government of Tanzania conducted a review of the policies that had and had not worked from the first National Policy and created a second national policy: The Second National Multi-Sectoral Strategic Framework on HIV and AIDS. While the purpose of the second national policy was to improve upon the shortcomings of the first national policy, it failed to do so.[2] While it continued to strengthen what made the first policy so effective, educating the public about HIV/AIDS, combatting stigma and ensuring the availability of protection and treatments, it didn't address the shortcomings of the first national policy.[2] The two national policies improved the care of HIV/AIDS patients not only in healthcare but also mentally and socially. They didn't address other issues which would enable Tanzania's goal of eradicating HIV/AIDS from its population to become reality. These shortcomings in policies dealing with education and infrastructure, the areas not addressed by the national policies, lie within my second category of policies.

There is a serious shortage of health care workers in Tanzania, much worse than most other countries in Sub-Saharan Africa.[5] According to numerous surveys, Tanzania has the absolute worst physicians per 10,000 people ratio in the world at 0.1 doctors for every 10,000 people.[11] The ratio is so low that if you check the 2010 Tanzanian physician per 1,000 people ratio on the World Bank's website, it simply says 0.0.[11] The lack of appropriate personnel becomes clear when compared to the United Nations "Health for All" standard of one physician for every 7,000 people. Many researchers blame this shortage of workers primarily on the educational system.[7] The Tanzanian educational system is setup up in a pyramidal fashion where students have to pass an exam to reach the next level. This weeds out a tremendous number of students from not only pursuing higher learning but from even advancing to the secondary level. Many of the students who are unable to pass are thrust into the world with little to no formal education. Since the pyramidal setup of the educational system allows for few people to reach the level of education necessary to become doctors and nurses, HIV/AIDS patients are forced to depend on traditional healers or health workers who do not have the training necessary to properly help treat those with HIV/AIDS.[7] Further research has found that the negative effects of this lack of training is compounded by the fact that there is very little oversight of the health workers, poor transport and communication infrastructure and an extreme shortage of drugs and medical staff.[5] The lack of training has also led to many health workers themselves getting infected with HIV/AIDS by those they are trying to treat, causing many to miss days from work or quit altogether, further compounding the shortage of health workers.

While attempting to figure out how we came to this dire situation, it's particularly easy to point a finger at educational and economic policies implemented by the government. According to a

piece written by Kwesigabo for the Journal of Public Health:

> "The size of the health workforce (both health professionals and other health workers) has declined in absolute numbers and relative to the size of the population. The decline in absolute numbers was significant during the 1990s when the Government of Tanzania re-entrenched the health workforce and imposed an employment freeze - resulting in a loss of one-third of the health workforce."[5]

The combined effect of the government's policies in education and the health workforce has indirectly harmed those living with HIV/AIDS. Due to a shortage of people to treat those with HIV/AIDS, many people are dying from lack of basic health care services.

The government of Tanzania has tried to combat this by making all drugs necessary for the treatment of HIV/AIDS free to the general public. However, the government's infrastructure policies have severely handicapped the movement of health workers, medicines, and medical equipment from the urban areas to the rural regions. The policies the Tanzanian government has implemented towards the development of the country's infrastructure have limited the gains the country could have made in the fight against HIV/AIDS.

While in Tanzania, I was able to talk to workers at WAMATA, an NGO which helps PABH. They relayed stories of how the mismanagement of government roads, specifically the lack of maintenance, made it difficult for NGOs to connect with their target populations and deliver medicine to villages. Even though the Tanzanian government provides free AIDS medicines, it is extremely difficult for people to obtain. They must travel to these sites, all the while hoping that the health care worker who will treat them is able to show up to work that day. People were dying simply because they lived in places so remote that no roads could reach them, leaving them unable to easily travel for care.

The Tanzanian government, with funding from the United States Agency for International Development (USAID), commissioned a Tanzania HIV/AIDS and Malaria Survey from 2011 to 2012. The Survey resulted in a lot of interesting information: (1) the percent of people with HIV between the ages of 15 and 49 is much higher in the urban sections of the country than the rural sections; (2) the rate is higher for women than for men; and, (3) the percentage of people with HIV/AIDS goes up as age increases with a drastic climb in percentage infected from those aged 25-29 to those aged 30-34. While HIV rates for all genders are decreasing, the Survey revealed that the HIV rate is highest in the Southwestern region of the country and lowest in the Northeastern region of Tanzania. This last point could be seen as a result of where governmental policies have been focused. The government has placed most of its resources to combat HIV/AIDS in the Northern and Eastern regions, which are the tourist and industrial regions of Tanzania.[14] Thus, the Northern and Eastern portions of the country have better infrastructure and higher physician-to-general-population ratios. The mostly rural Western and Southern regions of Tanzania have been largely ignored and undeveloped in all sectors of society, including education, infrastructure, or healthcare.

The policies implemented by the Tanzanian government to increase awareness and knowledge of HIV/AIDS, decrease the stigma surrounding the disease and make medicine available for free have been successful in lowering the rate of newly infected people and providing both financial and mental relief for PABH. However, the

government's policies on education, along with a lack of resources to improve infrastructure, have led to health worker shortages, inefficient organization and lack of supplies. While Tanzania is taking steps to increase the number of new doctors every year, it is proving much more difficult to improve its infrastructure.[9]

As the Survey showed, the HIV/AIDS prevalence is greater in the Southern and Western regions of the country. These are also the regions where infrastructure suffers the most and access to healthcare facilities is nigh impossible. However, just as living on the top floor of an apartment does not make you any more likely to step foot on the moon as someone living on the bottom floor, the infrastructure in much of the Northern and Eastern regions, though better than the South and the West, has much room for improvement. Even basic improvement of roads can help people living in the most rural of areas to better access the same quality of care available in the urban settings.

A country's power, ports, roads, rail, air, water and irrigation will be considered as its infrastructure. Tanzania's potential as a major sea port, handling goods from Africa, the Middle East, the Indian Subcontinent and possibly even the Far East, is apparent to anyone who notes Tanzania's location on a map. This large, stable country can serve as a door through which Africa can exchange goods with the rest of the world. Countries outside of Africa have long been aware of Tanzania's potential and have invested early and often in Tanzania. To this date, China's single largest foreign aid project is a railroad connecting the landlocked nation of Zambia to the Tanzanian port in Dar es Salaam. At the cost of $500 million, China helped build what was, at the time of its completion in 1975, the single longest railway in Sub-Saharan Africa. The question arises however, why must Tanzania rely on other countries to help build its own infrastructure?

According to the African Development Bank Group, infrastructure comprised 1.3 percent to Tanzania's annual GDP growth in the 2000s. If the money spent on infrastructure was raised to the relative level of Mauritius, Africa's leader in infrastructure spending, Tanzania's GDP could increase by an addition 3.4 percent annually.[10] To meet its infrastructure targets, Tanzania needs to increase its current infrastructure spending of $1.2 billion to $2.9 billion annually for the next decade. "Tanzania loses $0.5 billion each year to inefficiencies such as underpricing, undercollection of revenue, overstaffing, and lack of budget prioritization."[10] It is now easy to see why Tanzania brings in foreign investments in infrastructure, agriculture and industry: Tanzania does not have the money to address these issues itself. So Tanzanian infrastructure, one of the areas outlined as most critically needing investment to help PABH, is receiving much of its funding from other countries. The American and Chinese investment strategies in Tanzania vary greatly and are having different effects on the level of care for PABH.

American and Chinese investment in Tanzania can be divided into the two categories from before, one focused on healthcare and AIDS and the other focused on education and infrastructure. As has been seen, the Tanzanian governments fight against AIDS has faltered due to a lack of the necessary resources to invest in, among other things, infrastructure. The United States has invested heavily in the first category while the China has invested in the second.

Under President George W. Bush, the United States invested $15 billion from 2003-2008 through the President's Emergency Plan for AIDS Relief (PEPFAR) in order to combat the global HIV/AIDS pandemic. The program was highly successful and is credited with drastically

cutting infection rates in Africa and saving the lives of 1.1 million people. The antiretroviral treatment funded by the program helped lower the AIDS related death rate in target countries by 10 percent. Tanzania was one of the 15 target countries and benefitted from the program. PEPFAR wished to provide medicines to combat AIDS, prevent new infections thru education and combat social stigma related to HIV/AIDS. All of these goals coincided with initiatives the Tanzanian government had put into place in the late 20th century and was still continuing in the first decade of the 21st. President Bush's program helped Tanzania offset some of the costs of the Tanzanian government's initiatives. While the U.S. investment in combatting AIDS is not nearly at the levels of the Bush administration, the United States had still pledged $4 billion to the Global Fund to Fight AIDS, Tuberculosis, and Malaria for 2011-2013.

Meanwhile, as of 2013, the country with the world's second largest economy has donated a mere $25 million to the Global Fund while receiving close to $1 billion in aid from the Fund. In the first category, relating to investments directly affecting HIV/AIDS, the United States has far outpaced China in donations and investment. However, through earlier analysis, we have learned that free medicines and educating the populace about HIV/AIDS can only have so much benefit without simultaneous investments in infrastructure. It is in this area that the Chinese investments can indirectly be shown to be having a beneficial impact on PABH. While Chinese aid to Tanzania comes with no strings attached, the United States demands economic and social reforms if Tanzania wishes to access U.S. aid. As Rwandan journalist Fred Mwasa stated when asked about the difference between American and Chinese investment in Africa, "America comes with democracy. The Chinese come with roads."[3] Reporter John Rash of the Star Tribune notes that "the United States has been financing health care, education and democratization efforts while the Chinese have focused on infrastructure."[3] This seems to suggest that the American and Chinese relationship in Africa is not one of competition but of complementarity. The United States invests in education and brings democratic ideas which provide a stable region in which China can invest in infrastructure, which results in economic growth, stability, and the spread of democratic ideas.

This is not to say that each country is focusing exclusively on these specific areas however. USAID has an Africa Infrastructure Program which is focused on bringing environmentally sustainable energy to Africa while also funding infrastructure projects which domestic governments may not be fully able to fund. Likewise, China has been funding healthcare projects and been building hospitals in Africa for years. In Tanzania alone, China has been sending medical teams since 1968 to provide healthcare for the local populations. It is the scope of the investment in their respective fields that shows the stark difference in American and Chinese policies.

The entire USAID's Africa Infrastructure Program amounts to a $35 million American investment in Sub-Saharan African infrastructure. While the Chinese, in Tanzania alone, have signed on to provide $412.5 million for a logistics hub next to the port of Dar es Salaam. In April of 2013, a deal was signed between China and Tanzania in which the Chinese agreed to build a $10 billion mega port in the Tanzanian city of Bagamoyo, creating not only the largest port in Africa but one on a scale rivaling the major ports of the Persian Gulf. The Chinese have also agreed to upgrade the existing infrastructure around Bagamoyo while also helping the Tanzanian government build new roads and rail networks in the area. While it is clear that the

Chinese stand to receive significant economic benefits due to their infrastructure projects, it cannot be ignored that they are providing a large amount of funding to improve Tanzanian infrastructure, directly and indirectly improving the healthcare standards of PABH.

As one-sided as Chinese investments in Tanzanian infrastructure seem when compared to similar American investments, the situation is reversed when comparing American and Chinese investment in healthcare, highlighted by the previously discussed PEPFAR program. For both countries to reap the benefits of investment, stable governments with an open political environment, open markets and sustainable infrastructure are required. This is where the need of each country for the other becomes apparent. As U.S. aid comes with requirements to open markets and promote trade amongst African countries, while also necessitating the implementation of democratic changes, Chinese investment comes with little to no requirements. These efforts have led to certain regions of Africa becoming more stable and entering the world economic market. The Chinese have simultaneously invested in both stable (e.g. Tanzania) and unstable countries (Sudan). To protect their investments in unstable countries, the Chinese have been forced to diverge from their usual nonintervention stance and get militarily involved in some African countries. These countries lack the short-term gains provided by American investments and show that successful Chinese infrastructure investment requires both the short-term and long-term benefits of U.S. aid.

Meanwhile, stable African countries such as Tanzania, where the Chinese have invested in infrastructure, have benefitted greatly from additional access to resources and improved stability. This infrastructure investment has allowed such countries to continually expand their role on the global economic and political stage. Now that these countries have expanded their trade with the rest of the world, including China and the West, they also desire a much more stable Africa, helping the U.S. expand its programs into unstable African nations. This simultaneously helps the Chinese, as their investments will be protected over time and continue the cycle of investment and stability

In regards to PABH in Tanzania, China has been helping to build hospitals and sending medical professionals since the 1950s and 60s, but the biggest gains in Tanzanian healthcare and the fight against HIV/AIDS came when the U.S. became involved and provided aid, medicines and funds which directly helped the PABH. Further gain requires investment in infrastructure in Tanzania, which the Chinese are providing. Expanding this strategy across Sub-Saharan Africa, it seems that truly combatting HIV/AIDS requires the continuation of American programs providing funding to programs that directly benefit PABH. These programs need to be complemented by Chinese investments in infrastructure that ensure gains in the fight against HIV/AIDS are sustainable and maintained. The beneficial side-effect of these investments is the democratic and open-market principles introduced by America and the foundational improvements in infrastructure provided by China which, when applied together, may be leading to not only a healthier Africa but one which takes its position on the global stage as a more stable continent with the ability to use its vast resources for the benefit of its own people.

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