Development Aid and Solidarity Work: East and West German Health Cooperation with Low-Income Countries, 1945 to 1970

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Summary

Between 1949 and 1989, both the Federal Republic of Germany (FRG) in the West and the German Democratic Republic (GDR) in the East, engaged in health-related relations with low-income countries in the global South. The strong position of the churches in West Germany and the dominant position of the state in the East provided the preconditions for diverging international health activities, as did differences in ideology and economic status. Activities entailed similarities (an initial focus on clinical therapy and material donations) and differences (in scale, composition of actors and conceptualization). Programs evolved gradually, reacting to circumstances rather than a master plan. By the late 1960s, international health assistance was mainly organized as a component of “development aid” in the FRG, while regarded as “solidarity” in the GDR, in both cases designed to spur changes in recipient countries according to the respective Northern models as components of a perceived direct, global East-West confrontation.

Keywords: Federal Republic of Germany; German Democratic Republic; health development aid; health solidarity assistance; humanitarian emergency assistance

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Between their foundation in 1949 and the end of the German division in 1989/90 both German states, the Federal Republic of Germany (FRG) in the West and the German Democratic Republic (GDR) in the East, engaged in health-related relations with low-income countries in Africa, Asia and South America. The two countries shared the same tradition of health and social policies and the same prewar history of using health as part of their foreign policy, including and especially within a colonial past, which was still present in racist attitudes of their outgoing citizens despite official claims to the contrary.¹ After 1949, they differed in their political affiliations, their attitudes towards health policies and their general political, economic and social circumstances. They also differed in the way they conceptualized international cooperation in the health field as either part of development and humanitarian aid or part of solidarity. This paper explores how this combination of similarities and differences played out in the health-related cooperation of the two Germanies with low-income countries between the late 1940s and the mid-1960s and how it led to similar but not altogether identical practices.

The Background

After World War II, both German states vehemently rejected the health system of National Socialism and its underlying basis of biologism, but came to very different conclusions about various aspects of central state control, an influential role of doctors, medicalization of societal life and a concept of health as a collective good. Overall, differences showed primarily in the position of doctors (strong in FRG, weak in GDR), in the perceived primary responsibility for health (individual in FRG, collective in GDR), the organizers of most health facilities (university, communal, charitable or private in FRG, governmental in GDR), in the administrative format (federal in FRG, central in GDR), and in the prioritization of their health care focus (separation of primary prevention and therapy in FRG, integration in GDR).²

For cooperation with foreign countries, this meant that while in the FRG doctors, churches and universities were important actors in addition to government agencies, in the GDR all activities took place under the central authority of the state which, in turn, was largely controlled by the Socialist Unity Party (SED) whose Political Bureau was more influential than the

¹ Büschel 2008.

² Schleiermacher 2004, 171–177; Nagel 2007, 31–32, 67–118 ; Moser 2002, 15–18, 203–207; Harsch 2012.

nominal GDR government, the Council of Ministers.³ Politically, the affiliation of both states with different ideological blocks played out especially in the competition between recognition as “Germany.” Until the early 1970s, West German governments claimed a status as the only legitimate representation of the German people, underscored by the Hallstein Doctrine, which involved the threat to reduce or sever relations with any country that extended diplomatic recognition to the GDR. Conversely, recognition as an independent German country was the central goal of all foreign policy of GDR governments.⁴

Economically, the impressive recovery in West Germany after the onset of Marshall Plan Aid in 1948 contrasted with a less fortunate situation in the GDR, which not only did not receive foreign aid but had to make substantial reparation payments, in money and in kind, to the Soviet Union.⁵ Inevitably, West German actors could make use of far more resources for health-related activities in low-income countries, both generally, since there was more money, and in kind, since much of the medical and pharmaceutical industry was located in the West.⁶ In addition, West German organizations could tap into a far larger pool of medical personnel, notably doctors since after 1945 the country saw an influx of doctors from former German territories such as Silesia, from overseas regions like war-ravaged China and also, until 1961, from the GDR. Doctors left the GDR in large numbers, drawn to the West by the promise of higher living standards, more personal and professional freedom, higher status, better medical facilities, the perception of less stringent de-Nazification and easier access to medical schools for their children. In 1961, 10267 doctors in West Germany were of East German origin, while only 14592 doctors were left in the GDR, so that an oversupply of doctors in the West contrasted with scarcity in the East.⁷

Collectively, these circumstances shaped the preconditions for the engagement of the two German states in Asia, Africa and Latin America: the situation in West Germany was characterized by comparatively abundant financial and material resources, both public and private, a functioning pharmaceutical industry, a diversity of actors (including churches, individual doctors, medical associations, and government agencies) and a large number of doctors looking for work. Preconditions in the GDR consisted of very limited resources, particularly scarce money in non-convertible currency, very lim-

3 Möller 2004, 37.

4 Spanger 1987, 161–163.

5 Karlsch 1993, 228–240.

6 Weber 1999, 53–54.

7 Schagen 2004; Spaar and Funke 1996, 5–11.

ited medical and pharmaceutical production, and the centralization of foreign assistance work under state responsibility, controlled by the communist party. Both German states would seek contact primarily with countries of their own ideological block, though options were limited for the GDR, given its political isolation. In both countries, political and economic motivations mixed with the humanitarian impulse, though the respective mix is impossible to quantify and, depending on actors, presumably varied.

The Beginnings of Health-related Engagement in Africa and Asia: West Germany

In West Germany, the two churches (Roman Catholic and Protestant), who could build on their long tradition of missionary medical work, were the first to engage systematically in health work in Southern countries again. By cooperating with remote mission stations and increasingly national churches, they circumvented colonial and independent governments and predominantly reached marginalized rural populations. Far from being a disappearing phenomenon, missionary medical societies gained new medical and nursing members after the churches regained their freedom of action after 1945. A key institution in this regard for the Roman Catholic side was the *Missionsärztliches Institut Würzburg*, which would send out over one hundred doctors to Southern countries after 1945.⁸ In the Protestant church, institutes such as the *Hermannsburger Mission*, the *Rheinische Mission* or the *Bethel-Mission* continued their prewar medical work in Subsaharan Africa, to a certain degree guided by the *Deutsches Institut für ärztliche Mission* (Difäm) in Tübingen. By the late 1950s, the various German mission societies had employed 39 doctors, one dentist, 110 nurses, three technical assistants and one pharmacist.⁹ Other German mission doctors worked for foreign missionary societies such as the London Salvation Army or Methodist, Lutheran or Presbyterian Communities from the USA. This upsurge in activities pitted an older generation of mission doctors, nurses and other missionaries, who had been sceptical of perceived materialist tendencies of modern bio-medicine, against younger colleagues, who whole-heartedly embraced this modernity, albeit with a Christian foundation. Gradually, the latter gained ground and thus facilitated closer cooperation with the West German and the host country's government.¹⁰

8 Egg 2015.

9 Müller 1960, 241.

10 Bruchhausen 2009, 177; Egg 2015, 97–101.

Other German doctors, facing limited and often poorly paid job opportunities in the FRG and seizing the opportunity for a stay away from the war-time devastation of their home country in exotic regions, continued or started work in Africa and Asia in the service of governments or institutions in non-colonial foreign countries like China, Yemen, Iran, or Ethiopia.¹¹ Several hundred doctors from Germany and Austria worked in Indonesia in the 1950s and early 1960s after the Dutch doctors left the country and the West German Medical Association entered into an agreement with the Indonesian government to recruit suitable candidates.¹² Such an international career path was further facilitated when the FRG joined the WHO in 1951 enabling West German doctors to act as WHO Senior Advisors in countries like Iraq.¹³

For years, the West German government played virtually no direct role in these developments. Only in 1952, the government became active, initially by paying contributions to health activities of international organizations such as the UN Expanded Programme of Technical Assistance (EPTA) and WHO.¹⁴ Government involvement increased in the mid-1950s after the US administration urged a more active FRG role in bolstering the Western world in Southern continents. In response, several ministries developed plans for West German engagement in “underdeveloped countries” including technical aid and/or projects of economic cooperation, which contained health as a field of action.¹⁵ Church agencies and their established network of people and contacts in target countries were among the foremost beneficiaries of these funds. Soon, state funds financed half of the costs for those projects that had been negotiated with the institutions which both churches had founded in order to support and coordinate development activities in low-income countries: *Misereor* for the Roman Catholic (1958) and *Brot für die Welt* in the Protestant church (1959).¹⁶ The rest of these expenses and the other projects were covered by private donations and (government collected) church taxes. In addition, the churches established their own institutions to conduct the assignment of personnel to countries in Africa, Asia and South America

11 Jachertz 1982; Hoeck 1998; Anonymous 1965; Jäger 1963.

12 Brüning 1954, 119; Freisleben and Petersen 2016, 205.

13 Virnich 1977.

14 BMZ 1977, 18.

15 “Einschaltung der westlichen Welt in die Entwicklung der ‘unterentwickelten’ Gebiete und Beteiligung der Bundesrepublik im Sinne einer längerfristigen Förderung der Wirtschaftsbeziehungen”, 2, BAK B 136/2519; Anlage I/4 “Das erweiterte technische Hilfsprogramm der Vereinten Nationen” (Fußnote: Nach einem Memorandum des Auswärtigen Amtes vom 26.4.58); Auswärtiges Amt, Abt. 4, Ref. 400, “Streng vertraulich”, “Zusammenarbeit mit entwicklungsfähigen Ländern (Bestandsaufnahme und Möglichkeiten)” 26.4.56.

16 Bruchhausen 2016.

(*Arbeitsgemeinschaft für Entwicklungshilfe*, AGEH, 1959; *Dienste in Übersee*, DÜ, 1960) and to organize fellowships for students from these countries (*Katholischer Akademischer Auslandsdienst*, KAAD, 1958). These new institutions resulted mainly from activities of lay church members and their emphasis on long-term developmental goals, aiming at the tangible improvements of material living conditions of populations in poor countries. They shifted church health work away from older concepts of medical work as charitable activity supporting spiritual advancement.¹⁷

Medical activities of West Germany in Southern countries underwent some changes when Chancellor Adenauer visited the USA in April 1953 and, faced with US demands for support in the Korean War, promised a Red Cross field hospital. However, the war ended while the hospital was on the way so that, upon arrival, it was redefined as a hospital for the port city of Pusan.¹⁸ It was a large-scale project, running for five years with an annual budget of 3.6 million marks and, initially, a German staff of 86 people.¹⁹ It was also a politically difficult project. There were rumours of Nazi attitudes among the staff, and two doctors accused the senior surgeon of having misstated the cause of death of patients in order to cover up the unsuccessful outcomes of surgery, an accusation that caused international embarrassment when it was picked up by the Australian press.²⁰ Nevertheless, West German and South Korean representatives considered the project a success: treatment was eagerly sought, especially by the local poor, and in total, the German staff trained 60 Korean doctors and numerous nurses.²¹ Other Korean voices, however, complained about the long use of an urgently needed school building and about the alleged exploitation of Korean doctors and nurses.²²

The Beginnings of Health-related Engagement in Africa and Asia: the GDR

In the GDR, health-related cooperation with countries in Africa and Asia similarly developed in piecemeal fashion. Given the difficult circumstances in the country, early plans of international health work focused on cooperation with Socialist partner countries. Assistance projects only emerged when prompted by the Korean War. In 1950, the National Front, an association of

17 Berg 1980; Otto 1959; Teusch 1976; Osner 1961; Toscer 1997.

18 Germer 1954, 1303.

19 Huwer 1985; Huwer 2007; Escher 1959.

20 Anonymous 1959.

21 Dauth 1985, 170; Anonymous 1955.

22 Hong 2009; Hong 2015, 100.

parties and mass organizations founded in 1949, created a commission for assisting Korea (“Korea-Hilfsausschuß”), designed both to coordinate aid programs and to make political use of the event by denouncing “US imperialism.” Until 1953, this commission provided 16 million marks worth of aid, including some 300,000 pounds of drugs, and two ambulances.²³ Though the commission had been meant to be temporary, it was renamed “Solidaritätsausschuß für Korea und Vietnam” (Solidarity Commission for Korea and Vietnam) when the end of the first Vietnam War promised a chance for reconstruction. Collectively, these events created a crucial precedent of conceptualizing health programs in Southern countries as acts of “solidarity” with people suffering as a result of perceived Western aggression. Thus, these programs were framed as part of an East-West rather than a North-South dichotomy.

From November 1954 to the end of 1955, the Solidarity Committee sent over two million marks worth of material to Vietnam. Shipments in 1956 included drugs, two dispensaries and equipment for an orthopedic ward and for a surgical hospital.²⁴ The latter was part of the reconstruction of and assistance for the hospital of Phu Doan, originally built by the French and destroyed during the war. In one of the largest GDR solidarity projects ever, a team of thirty-three people, including doctors, nurses, a pharmacist and translators, worked in the hospital between February and November 1956. Their task was to install the donated technical equipment, to introduce East German work plans, to train Vietnamese staff and to set up the dispensaries.²⁵ Officially the project was a great success, but internal criticism by the embassy was scathing: purportedly, several members of the team were unqualified, two people had an extramarital affair (which made them unacceptable in the eyes of the reporting embassy official), others acted in overly authoritarian manners, and the party secretary never succeeded in “making the party organization the leading and mobilizing force of the group.”²⁶ Nevertheless, Vietnamese patients appear to have made ready use of the hospital, and the Vietnamese partners expressed gratitude for this medical support, particularly for the orthopedic ward, mainly designed to

23 Spanger and Brock 1987, 215; Armstrong 2005, 164.

24 Bericht über die Tätigkeit des Solidaritätsausschusses für Korea und Vietnam beim Nationalrat der Nationalen Front der DDR im Jahre 1956, undated, Politisches Archiv des Auswärtigen Amtes (PAAA) MfAA A, 8.436.

25 Sperker, Bericht über die Tätigkeit der Medizinischen Arbeitsgruppe des Solidaritätsausschusses, 14.8.1956, PAAA, MfAA A, 8.505; Tung an Nationalrat, 8.6.1956; Nationalrat der Nationalen Front an Botschaft Hanoi, 27.6.1956, beide PAAA, MfAA A, 8.455.

26 Sperker, Bericht über die Tätigkeit der Medizinischen Arbeitsgruppe des Solidaritätsausschusses, 14.8.1956, PAAA, MfAA A, 8.505, 5. Translation Borowy.

help people who had lost limbs during the war.²⁷ Similarly, East German donations of artificial eyes and the training of orthopedic specialists, of six doctors and three pharmacists aimed at meeting war-related needs.²⁸

These activities were integrated into East German foreign policy and propaganda, but at this point they were not meant to become a permanent feature, since the official standard form of cooperation in the health field was still the concept of cooperation between equal partners, designed to benefit both sides. This type of cooperation was formalized in a system of bilateral health agreements between governments of the Socialist block, which evolved during the 1950s. Agreements typically foresaw an exchange of literature, visits, students and patients and cooperation in policies against epidemics.²⁹

This format guided cooperation with the People's Republic of China during this period. Several brief projects regarding a possible anti-leprosy drug and iron lung machines combined humanitarian and economic motives. Lengthy negotiations eventually led to a bilateral health agreement in 1957.³⁰ Cooperation was never big, and in the wake of the Sino-Soviet rift it effectively ended.

This mixture of purposes caused some tension between different ministries. In the mid-1950s, the GDR Ministry of Health complained that the Foreign Ministry frequently proposed projects which were financially impossible and did not necessarily make medical sense.³¹ The conflict of goals increased when the wave of decolonization in Africa increased the number of potential partners for cooperation and potential diplomatic recognition, none of whom fit the format of cooperation for mutual material benefit. In response, the National Front created a new "Committee for Solidarity with the Peoples of Africa", renamed "Afro-Asian Solidarity Committee" in 1964 and eventually known simply as "Solidarity Committee." It became an important source of financing for projects in low-income countries, including those regarding health, from funds it gained from "solidarity stamps" whose purchase was semi-mandatory. In the process, it transferred the concept of "solidarity" assistance to (health) cooperation with countries in Africa and Asia in general.

27 Kirsch, 1963, 79.

28 Botschaft Hanoi an MfAA, 23.11.1956, PAAA MfAA A, 8.436; Engelhardt an Botschaft Hanoi, 16.11.1956, PAAA, MfAA A, 8.408; Bericht über die Tätigkeit des Solidaritätsausschusses für Korea und Vietnam beim Nationalrat der Nationalen Front der DDR im Jahre 1956, undatiert, PAAA MfAA A.

29 Positionspapier des MfG, ohne Titel, undated, ca. mid-1957, BArch DQ 1/1955.

30 Kulitzka, Aktenvermerk, Arbeitspläne zum Gesundheitsabkommen für die Jahre 1958/1959, 27 Dec 1957, PAAA, MfAA A, 9957.

31 Position Paper of the Ministry of Health, undated, ca. mid-1957, BArch DQ 1/1955, 3.

A crucial asset for broadening international health activities was the Museum of Hygiene in Dresden. Rooted in the popular health exhibitions in the interwar period, this museum now offered the opportunity to provide exhibitions to other countries on topics ranging from anatomy to malaria.³² Between 1957 and 1966, exhibitions were sent, at least, to Indonesia, North Vietnam, Burma, Algeria, India, Egypt, Tanzania and Mali. Though shipments were repeatedly planned to be on a commercial basis, eventually most or all exhibitions seem to have been given for free. These exhibitions served a mixture of educational, political and economic purposes, in that they provided platforms for the GDR to showcase their public health achievements and their exportable medical and pharmaceutical products. But in practice, exhibitions were challenging. Often, partner governments desired exhibitions on just those topics relevant to tropical conditions on which there was no expertise in the GDR, or recipients found the technical quality of the exhibitions disappointing.³³ Nevertheless, these exhibitions remained generally well received measure that added an element of public health education into the range of cooperative activities, that otherwise focused on therapy.

Health-related Cooperation: the Consolidation

Overall, by the early 1960s, both German states had established a certain routine of health cooperation with countries in Africa and Asia. By that time, there were approximately eighty West German health projects, mainly in Africa. The range of activities included the donation of institutes, hospitals, medical equipment, staff aid (43 countries), the assignments of clinicians to teaching hospitals (Ethiopia, Togo, Senegal, Algeria), the donation of twelve mobile clinics, 50 ambulances and several X-ray convoys (often including the service by technicians) as well as the training of medical assistants (from Tanganyika) and specialists for tuberculosis (from all over the world) in West Germany.³⁴ A new feature after 1960 was the establishment of national or university institutes for public health, hygiene and/or parasitology in Afghanistan, Togo, Thailand, Egypt and Indonesia, supported by German academic staff often over ten years.³⁵ The East German program

32 Lienert 2009.

33 Hong 2006, 90.

34 DMI 1964.

35 Seeliger 1963; Fritz Fühner, "IV. Hygiene der Entwicklungsländer," *Arbeitsbericht des Direktors der Lehranstalt für Allgemeine und Sozial-Hygiene*, ed. Hygienisches Institut der Freien und Hansestadt Hamburg. Jahrgang 1966, BArch B213/4960 Fragen des Gesund-

also entailed the donation of medical institutions such as the hospital mentioned (Vietnam), a tuberculosis dispensary (Egypt) and orthopedic centers (Vietnam, Cuba, Guinea), the assignment of medical professors to teaching hospitals (Iraq, Ghana, Guinea, Mali), health exhibitions and the training of students. The number of expatriate health workers from East Germany remained rather limited, with a total of 17 doctors and 21 nurses sent by the GDR into “Third World” countries until 1963.³⁶

The inter-German tension also showed during assignments within conflicts influenced by Cold War rationales. During the Congo Crisis of 1960/61, both West Germany and the GDR responded to calls by the WHO and the International Red Cross and sent small medical teams to the region. There was a clear element of competition, as both groups compared their performance to that of the other side, tallying material and personnel provided.³⁷ Some years later, during the Vietnam War, German doctors were found on both sides of combatant lines. The West German side sent a Red Cross hospital ship for the treatment of civilians and commissioned the aid organization of the Roman Catholic Order of Malta with providing health services in the region of Danang, employing more than 500 German aid workers over a period of five years.³⁸ By comparison, activities of the GDR appear very restricted, apparently limited to supplying information and equipment regarding bacteriological and toxicological analysis (responding to growing concerns regarding the health effects of herbicides and insecticides, sprayed by the US military) and to training Vietnamese experts in orthopedic care.³⁹

Similarly, East German representatives in Egypt in the early 1960s found that they had nothing to match West German offers of equipment and pesticides to fight bilharzia and malaria.⁴⁰ For years they tried to find alternatives, which would be cheaper but sufficient to ensure Egyptian support for the acceptance of the GDR into the WHO.⁴¹

Meanwhile, overall health cooperation with Southern countries increased, and there was a growing recognition in both German states around the middle of the 1960s that these activities had gone beyond ad-hoc projects, giving rise to some reconsiderations of principles and structural changes. In

heitswesens 1970/71, File Projektleitertagungen Gesundheitshilfe – 1968 – und Fachtagung(en) (Niger); Müller-Oelinghausen 1970; Holz 1971; Rensch, Bruchhausen (2017).

36 Hong 2008, 206.

37 Seyfert, MfG, internal circulation, Einsatz der medizinischen Hilfsgruppe im Kongo, 12.8.1960, MfAA C 801/74; Weitbrecht 1964.

38 Riemann 2009; Kröger 1970; Kurylo 1973.

39 Bericht über den Besuch der DDR-Regierungsdelegation in der DRV, 19.10.–30.10.1965, undatiert, BArch DQ1/5171.

40 Krebs to Deutsche Export- und Importgesellschaft, 23 Dec 1960, BArch DQ 1/22006.

41 See documentation 1963-65, PAAA, MfAA A, 16.764.

West Germany, the government established a Ministry for Economic Cooperation (BMZ) in 1961 to take charge of this task. In 1963, it was followed by a volunteer service (DED) modeled after the US Peace Corps, though requiring that staff was already qualified by vocational or professional training.⁴² Though initially health remained largely outside of this framework, the ministry would eventually form the administrative frame for health work in Southern countries. This integration of health work into a development context responded not only to international debates, especially at the UN, but also to long-standing discussions within the German church and development institutions. In the GDR, funds envisaged for medical cooperation with “developing countries” increased by 40 percent between 1955 and 1966.⁴³ Helping “young nation states” build up their health systems was declared a “humanitarian duty” as well as part of intensifying political and economic relations of the GDR with these countries.⁴⁴ At the same time, broadening relations with “developing countries” was considered “an important contribution of the GDR in fighting for safeguarding peace, against imperialism and neocolonialism, particularly against the West German claim for exclusive representation.”⁴⁵ Therefore, “friendship brigades” of the FDJ, the ruling party’s youth organization, worked with volunteers sent, some of them also health workers.⁴⁶ Thus, by the late 1960s, conceptualizations of health activities in Southern countries were on tangibly different trajectories: viewed as “humanitarian assistance” or as a requirement of “development aid” in the West, designed to spur changes in recipient countries according to Western models, while on both sides of the German-German border regarded as a component of a perceived direct East-West confrontation on a global scale.

Conclusions

The early activities of both German states regarding health-related cooperation with Southern countries showed similarities as well as differences: medical staff from both sides worked in countries labelled as “developing

42 Haase 1991, 65–67; Cobbs Hoffman 1998, 101 and 108.

43 MfG, Plan der internationalen Zusammenarbeit auf dem Gebiet des Gesundheitswesens 1966, 26.8.1965, BArch DQ 1/5171.

44 MfG, Entwicklung der internationalen Beziehungen der DDR auf dem Gebiet des Gesundheitswesens, undatiert, BArch DQ 1/3821, 4.

45 Sefrin, “Richtlinien für die Leitung und Koordinierung der Beziehungen zu den Entwicklungsländern auf dem Gebiete der medizinischen Wissenschaft und des Gesundheitswesens,” 25.5.1965, BArch DQ 1/5171, 1.

46 Büschel 2008.

countries” or “young nations,” respectively, in clinical practice and in medical education, both German states provided material equipment (including, sometimes, entire hospitals), invited foreign students and doctors for medical education and further training in Germany and engaged in research cooperation, though in nearly all cases, apart from grants for medical students, the West German contribution was far larger in scale and more diverse in terms of actors and agencies involved, both in Europe and abroad. The treatment of foreign patients in Germany, which became an integral component of East German cooperation agreements, was not considered part of development aid in West Germany, though some cases were arranged by NGOs and ad-hoc initiatives. Initially, both approaches were heavily medical, whereas after 1960, West German aid regularly included public health institutions. The explicit or implicit expectation in both countries was that their actions would assist Southern societies to advance according to their respective socio-economic model.

Otherwise, there were important differences in the scale of activities involved, in the diversity of actors who made independent decisions and in the degree to which these activities could be the object of open and critical reflection. While democratic structures in the FRG offered the possibility for controversial discussions about different policy goals, these options were limited in the GDR. These differences provided the ground for more diverse policies later, particularly in the wake of Alma Ata.

In both countries, the conceptualization of health-related cooperation with Southern countries as “development aid” in the West and as “solidarity” in the East were the result of a gradual development. In the GDR, it resulted from circumstances of medical assistance in military conflict, which provided the blueprint for health-related cooperation in other situations. In the West, it grew from long-standing development experiences and debates in churches and among international experts. Everywhere, medical development/solidarity aid served political interests but was not exclusively motivated by them. To varying degrees, depending on the actors, they mixed with a genuine wish to improve health in far-away countries.

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