March column
Claudio Schuftan

Ho Chi Minh City. En route to Kinshana. Consulting work is catching up with me once again. As I write I am packing to go and spend a week in Kinshasa (Democratic Republic of Congo) as part of an evaluation I am doing of a local NGO, *Etoile du Sud*, that is implementing a three year grassroots human right to health initiative. From what I have read so far, they have done a terrific job at mobilising communities to claim their rights. I am excited, because I will be able to interact with the popular base of the NGO to assess how they have identified and ranked the barriers to health they face. This should allow me know more what they have done to remove or lower them, and especially how they have mobilised the community. The key for me will be to find out what capacities have been strengthened for this work and to assess whether these new skills have contributed to sustainability. I will share more next month.

Cicely Williams. The first public health nutritionist

It's apt then, that I dedicate this month's column to the unforgettable Cicely Williams whom I had the pleasure of meeting in person several times. I even had her home for dinner a couple of times in the late 1970s. For me she is the first public health nutritionist. What I admired most in her in my early career was that although she was deeply involved in clinical care, she never stopped having very clear what the 'big picture' was, that explained scandalous levels of morbidity and mortality. This is the theme of this month's column. But first, a short biography.

Schuftan C. Cicely Williams. The first public health nutritionist, and other stories *[Column]*. *World Nutrition*, March 2012, **3**, 3

Cicely Williams was born in 1893 in Jamaica and attended school there. In 1914, during World War 1, she started to take first aid and nursing classes and thought seriously about studying medicine. In 1916, after her father's death, she decided to go to Oxford. She was one of the women admitted because there were so few male students during the war. After graduation in 1923, she decided to specialise in paediatrics and applied to the British Colonial Office for an overseas posting. She was sent to the Gold Coast (now Ghana) in 1929 and spent seven years there, learning to speak Twi and working to improve health conditions. She established clinics and hospitals and improved record keeping. She also worked with African herbal doctors to learn their treatments for diseases for which European medicine had no cures.

Her most important work in Africa was her diagnosis of the common and often fatal condition kwashiorkor. She learned that 'kwashiorkor' meant 'the sickness the older child gets when the next baby is born'. This seemed to indicate that, when they were no longer breastfed, children were not receiving enough to eat. She published her diagnosis of kwashiorkor as a protein deficiency disease, which attracted the attention of the medical world.

In the late 1930s she was transferred to Malaya (now Malaysia). After suffering from terrible conditions and bad treatment during World War II in Japanese prisoner of war camps, which brought her near to death, she returned to Malaya and was the first woman placed in charge of the maternity and child welfare services. She campaigned vigorously against the promotion by the milk companies of dried and canned milk as a substitute for breastfeeding in the South. From the late 1940s to the mid-1960s she worked first with the World Health Organization, then as a university lecturer in Jamaica, England and Lebanon. She died in England in 1992. She is one of many outstanding Jamaican women who have received recognition for their contributions to the world's peoples.

POVERTY

THE KEY VECTOR OF MALNUTRITION

Now I share with you what will be on my mind as I work with colleagues in Kinshasa. Foreign debt, international and national income maldistribution, the exploitation of agriculture steered towards the production of cash crops, overt or hidden unemployment or underemployment: these are some of the basic causes of malnutrition and so many infectious diseases. Unfortunately, many of us do not even

consider these factors in our work. To put this another way, microbes, parasites and worms are of course immediate causes. But the basic cause is poverty.

Immediate determinants need correction. Of course they do. They are more intimately related to inadequate food intake and preventable diseases. This is the area where most of us who work in the field operate on a daily basis, 'implementing solutions', and where we feel more comfortable.

Thus, many of us get involved in schemes providing incentives for staple and horticultural food production, or in technical assistance to food producers, or in promoting food storage and preservation, in reorganising food marketing chains, in influencing food choices and food preparation, or in health and nutrition education activities. We keep dreaming that everything will get better once we do our technical work more efficiently. But all this decent activity makes little or no difference to the global problem of malnutrition.

Moreover, many development projects worsen the health and nutritional status of mothers and children. Examples are projects that favour cash cropping, introduce water-borne diseases through irrigation projects, or increase industrial pollution.

We need to think hard about this. Are we doing enough – or anything at all – at the underlying and basic levels? Or are we acting mostly or solely at the immediate causal level, and if so, why do we continue in this way? Don't we perceive the limitations of such actions when carried out in the absence of more profound structural changes? Have we chosen accommodation over confrontation, and who does this suit, the people we are meant to help, or ourselves?

What does 'development' do?

We are all for 'development'. But what does this mean in practice? A good chunk of official aid from abroad is doomed to at least partial oblivion from its very conception. Much foreign aid in rural development is actually only patching up the 'holes' of a process of an internal exploitation of the agricultural sector. International organisations often push development aid according to their own preferences. These models are too often adopted by recipient countries, basically because they do not erode the power base of the ruling class, while still giving them a veneer of commitment. In parallel, many non-government organisations do nothing but execute traditional western bilateral agencies projects.

True, there are some that are working towards a more equity-oriented development. The more these are connected with work at the grassroots, the more exceptional they

are. But now a number of organisations have begun springing up and taking their fate and their future into their own hands.

POVERTY

HOW CAN WE BE PART OF THE SOLUTION?

Surely we know by now what is wrong and what is not good enough. Examples of interventions such as nutrition surveillance, long-term food aid, nutrition education, nutrition rehabilitation, community and family gardens, complementary foods and nutrient supplementation, are still high in the agenda of 'packaged development programmes'. Some work. Most have serious shortcomings:

- Nutrition surveillance has served more as an instrument to keep a log, or to 'chronicle' the evolution of nutritional status – often deteriorating. It seldom leads to solutions.
- Non-disaster food aid damages local agriculture systems, and its costs have to be borne by the recipient countries.
- Nutrition education too often ends up teaching people to buy and eat food that they cannot afford.
- Nutrition rehabilitation is probably a necessary stopgap measure. But, even after successful rehabilitation of severe cases, a number of the children die not too long after – a constant reminder of overlooked underlying and basic determinants.
- Family gardens are a sensible alternative; they attempt to tackle the direct underlying cause of food shortages. Unfortunately they are not too often successful in the long run.
- Complementary food programmes have worthwhile elements, provided local foods are available and used for preparing the mixes in the household. Using imported or centrally produced products has had precarious results. (But I do not have to remind you about the ongoing controversy about RUFS – ready to use supplementary foods).
- Nutrient supplementation programmes have a greater potential for impact. (But I do not have to remind you about the ongoing controversy on universal supplementary vitamin A distribution).

Also, even if we become conscious about the need for some structural interventions, it is hard to get to the policy-makers and decision-makers. Even when we do, there is little chance of action. As often as not, the way forward is to help to raise the

consciousness of communities, and to help them articulate their grievances and demand change.

Moreover, the kinds of interventions that are orientated towards greater equity are still far distant from the teaching and practice and mindsets of most public health nutritionists. I am thinking of land reform, small farmer credit, price incentives to food producers, subsidy of labour-intensive agriculture, higher priority for food crops, equitable food distribution schemes, and participatory decision-making. Are we happy about this? I hope not.

So what are we going to do? Should we begin to look for global and local alternatives, with the participation of those who are the victims of the present system? If more work at the grassroots level is what is needed, what should our role be? How can we work to change the minds of our colleagues, and our own minds?

We *can* become change agents. We have science on our side. Let us redouble our efforts at communicating. Let us work more decisively with and for the people in dire need. Let us see and address the fundamental determinants of ill-health and malnutrition.

As public health nutritionists, we have come a long way. We have gone from emphasising basic research to applied research and from there to multidisciplinary research. We now include the social and environmental sciences in our work. Good. But we have not yet reached the point where we really get creative in our search for solutions.

I am looking forward to my assignment in Kinshasa.

cschuftan@phmovement.org
www.phmovement.org
www.humaninfo.org/aviva