April column
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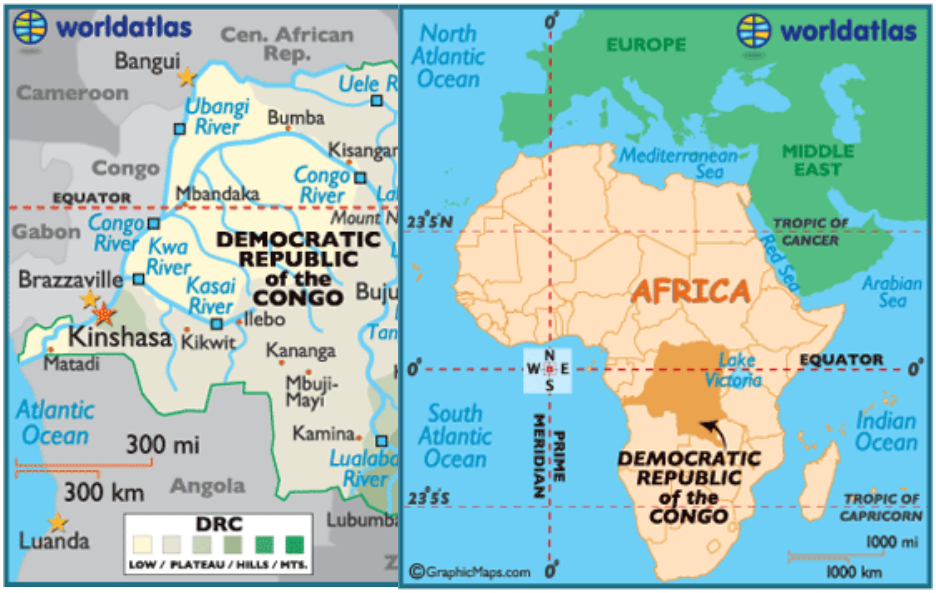

Kinshasa. This is where I have been. You may not know exactly where it is, so see above. It is the capital city of the Democratic Republic of the Congo (which I will now call Congo-Kinshasa). Formerly part of the Belgian Congo, it has been named Zaire. It is the second largest country in Africa, with a population of 71 million. Sometimes I get the feeling that most of us in public health nutrition, at least those regarded as leaders, who advise governments, who publish in high-impact journals, and who may be professors at well-endowed universities, don't see a lot of the world as it actually is. This month I want to expand on this point by telling you a little of my recent experience in one particularly impoverished and exploited sub-Saharan African country, Congo-Kinshasa. As you read, please think: To what extent could what I teach and write apply to countries like this, or, say, Haiti, or Southern Sudan, or Liberia, or Iraq, Palestine, Afghanistan, or north-western Pakistan?

Journeys
I go to Kinshasa

Kinshasa was formerly Leopoldville, after Leopold II the King of the Belgians who – incredible but true – owned the Congo as his very own personal property from 1885 to 1908. He was helped in this astounding personal land-grab by the Welsh explorer

Henry Morton Stanley, of 'Dr Livingstone, I presume' fame. In 1908 Leopold was forced to cede the country to the government of Belgium after revelations of abominable atrocities, an estimated 10 million deaths from murder, starvation, and diseases caused by immiseration, and outrageous looting of rubber and ivory. Between 1880 and 1920 it is said that the population of the Congo halved. *Joseph* Conrad's *Heart of Darkness* is set in the Congo. *The Crime of the Congo* was Sir Arthur Conan Doyle's 1909 account.

Any of Belgium's most palatial edifices and monuments were built with profits from the Congo. Awareness of where much of the most ostentatious wealth in Europe came from seems to be generally rather dim among Europeans. Not so among educated Africans. When we rightly lament the atrocious behaviour of some black African rulers, it's as well to remember that European rule of much of Africa ended within living memory of older people.

According to UN Habitat, Kinshasa had a population of 15,000 in 1900, in 1950 200,000, in 2000 8,900.000, and now close to 10,000,000. Its population has grown faster than any other big city in the world. A pressing reason for country people to crowd into the city remains the very high levels of violence including murder and rape in rural areas. The city's infrastructure is hopelessly overloaded. So it is in trouble. So is the country as a whole.

Joseph Mobutu Sese Seko, dictator from 1965 to 1997, stole billions of dollars. The number of people killed in the civil war of 1998-2003 is estimated at 5 million. Average income is the second lowest in the world. Rates of infant and child death are

The Congo was the personal property of and was looted by Leopold II, King of the Belgians, from 1885 to 1908, helped by Henry Morton Stanley; then by Joseph Mobutu from 1965 to 1997

the second highest in the world. Congo- Kinshasa, which has half the forests in Africa, and river systems that could supply hydroelectric power to much of Africa, also has vast mineral deposits, such as diamonds, copper, cobalt and tin, with untapped resources guesstimated to amount to $US 24 trillion. The recent Congo wars have been in part financed by stolen mineral wealth.

This month's column I devote to my recent experience in evaluating a right to health project by a local network of non-government organisations in Kinshasa. (This is not the Congo where a devastating explosion of an ammunitions depot occurred last month. That is Congo Brazzaville – an ex-French colony – that is across the Congo river from Kinshasa). The so far five-year project is being funded by the Belgian Government by way of a non-government organisation in Brussels.

In reading this column, I invite you to think how you could work in Congo-Kinshasa if called on to do so. My invitation is also to Africans from less devastated countries. I also invite you to consider how much can be done by public health and nutrition professionals, and by lay people with a clear political understanding, in countries with so many problems. You won't find nutrition specifically mentioned very much in this column, which is largely concerned with basic public health and community mobilisation, and therefore with the conditions that must be addressed to enable populations, communities and families to be adequately nourished. Yes, I know I keep on making this point in what I write. But it's the truth!

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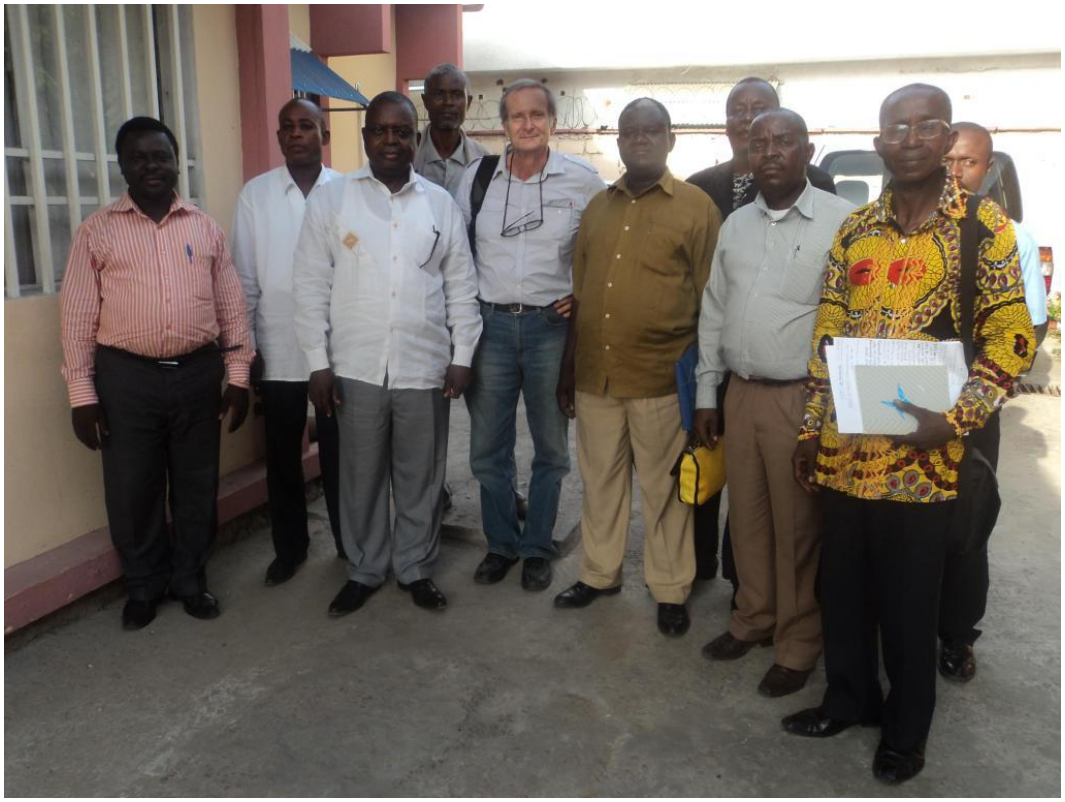

Teaching and learning about the causes of health and disease in the Democratid Republic of the Congo (top) and (below) here I am in a meeting with some of the male leaders of the community

I have to say I come back home to Ho Chi Minh City with mixed feelings. On the one hand I feel optimistic, because I have experienced a budding bottom-centred effort to mobilise populations in the poor *quartiers* of Kinshasa to fight for their right to health. On the other hand I am much less optimistic (indeed, I am pessimistic) about the general situation in Congo-Kinshasa and in the places where I worked for a week.

The country is facing a sort of national disaster. Here are more examples. Almost half of all children do not go to school. Of those who do enter the classroom, half do not complete grade 5. Only one in four girls complete grade 5. The government does not subsidise school fees, nor does it fund health care to anything like an adequate level, with all the financial difficulties this causes families to face. The other side of the coin is the rich *quartiers* of Kinshasa with their lush villas and gardens, a few skyscrapers, boutiques and glittering supermarkets.

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KINSHASA

A TALE OF TWO CITIES: THE DARK SIDE

Kinshasa is chaos in the streets. Air pollution is so bad that you could cut the smog in front of you with scissors. Traffic jams are an everyday occurrence. From the seven full days I spent there I have calculated that I spent a full working day in traffic jams. And this, despite me choosing to stay in a *quartier* close to where I was working, so as to avoid the one hour plus it would have taken me to commute each way had I taken the closest three star hotel.

So I stayed in a half star hotel, which meant no sink in the bathroom, no running water (just two buckets of it), a mirror the size of half an A4 sheet of paper, on-and-off electricity, and a screeching ceiling fan. But my room was clean. However, it was across the street from a bar that blasted dancing music at multi, multi decibels from 7 in the evening the first night to 2.20 in the morning, and the next night to 8.00 in the morning. So I moved out to a quiet hotel, also a half star, this one quite filthy. I will spare you the description of the smell of the bathroom, so I asked for a thorough clean-up and had bearable further five nights there. To read, I had to wait for daybreak at 6 in the morning and put a chair in the patio. The ceiling fan in this hotel was right below the fluorescent tube so that the light flickered, a sure recipe for a headache if I had tried to read at night. So I resorted to the BBC on my short wave battery radio. There were no conventional restaurants in the vicinity, but lunch was cooked for me at the NGO headquarter every day by Mama Oudrade, so I had lovely avocado, sardines, yoghurt and papaya dinners and breakfasts in my room.

How can this city work?

Since I mentioned sardines, I have to tell you about public transportation. The fleet of minibuses, some as old as 20 years, is packed with sardine-people, almost at any time of the day. If you add to that reckless driving, you can begin to understand my adventures in traffic jams. Ah! And there is the taxi fleet: also 20 years plus models on average, all beaten up, so much so that you get the feeling you will have a breakdown by the next corner.

The Chinese government is building the motorway from the airport to downtown. Parts of it are completed and are wide and nice. Other sections are under construction and are a collection of potholes, as well as a bowl of dust when it is dry and a bowl of mud when it rains. Another recipe for traffic jams. The story goes that

the Chinese have deposited the money for the continuation of works in the country's central bank, but the International Monetary Fund and the World Bank have told the government 'if money is now in your coffers, you have to use it to pay your outstanding foreign debt, before it can be released to continue work on the road'. As the BBC would say, this news 'cannot be independently confirmed'.

I could go on, but this is enough for the dark side. I also come with better news.

KINSHASA

A TALE OF TWO CITIES: THE BRIGHT SIDE

The brighter side comes from what I went to evaluate. Since 2008, an effort has been ongoing in the *quartiers* to organise people's health committees. The right to health is at the centre of their objectives and day-to-day work. There are now such committees in 34 *quartiers* in Kinshasa. Their leaders and members are dedicated and strongly motivated. The way they approach the right to health is to organise the population for self-help preventive health actions, and also to get involved in social mobilisation for lobbying. The right to health is primarily based on such mobilisation, to demand responses from duty bearers in state institutions. But in Congo-Kinshasa the government has largely defaulted and does not abide by its responsibilities for health.

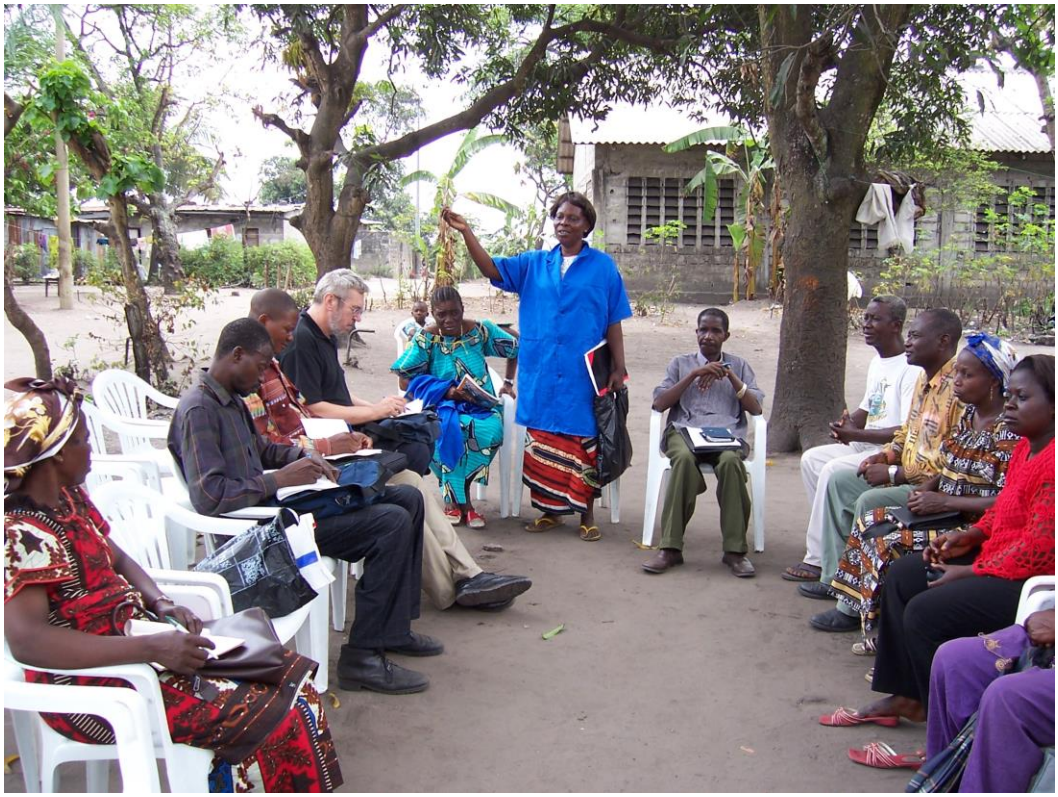
In the foreseeable future, changes will not come from outside. So mobilisation for community and family self-help has become a necessary strategy. I was impressed by the movement building and by the local ownership I saw in these committees. Sure, there are still some deficiencies in their management capacity, especially central management. Their ultimate capacity to mobilise the population for the more action-oriented pursuit of people's rights is also remarkable.

In my evaluation report, I state that the action-oriented activities collectively to demand changes, requires more effort. Self-help actions are only palliative in the long run. Ultimately, a counter power force has to be amassed to solve the problems sustainably. In this country there is a long road to go. But a start always needs to be made, and I think these committees are on the right track.

Here are some ways

Their popular base is expanding. The project attempts both to overcome the passivity of the population, as well as to demonstrate the capabilities and potential of a solid community organisation. The beauty of the model is that it is eminently replicable elsewhere. In a population overwhelmed by problems of all sorts, the empowerment of people to fight for their right to health is at the centre of efforts of the committees.

The number of active members goes from 50 to 300. They meet in assembly every two months. Every committee has established working groups given specific tasks. There is a 'reflection group' that analyses the problems from a local and national perspective, while at the same time keeping in mind the potential of the community to follow a process of empowerment, and to document changes over time. There is an organised group of children. They perform street theatre. There is a sanitary brigade. They collect rubbish from homes and from the streets. There is a group of mothers called 'Bopeto'. They go house to house to make sure home hygiene is kept. There is a group of 'health militants'. They also do house to house work, but for preventive health issues. And more, and more! There is a women's cell; a circle of youth; school health committees run by pupils; a water and electricity committee; a popular library; and a people's electoral committee that handles civic and political issues.



Top: quartiers in the city with very little infrastructure, before cleaning by the people's health committee workers. Above: here is a meeting of a people's health committee, planning local action

Training is offered by my host organisation, using ad-hoc modules. Topics include preventive health issues, right to health issues, and mobilisation and advocacy techniques. Special emphasis is given to raise consciousness of the meaning and implications of the deeper causes of preventable diseases, malnutrition and death. Great emphasis is given to cleaning up the neighbourhoods. I forgot to mention in sketching the dark side of Kinshasa, the depressing sight of filth in the *quartiers*: plastic pollution, rubbish, stagnant water pools, served water dumped in alleyways. I noted that two of the three *quartiers* I visited that have longer-established committees have much cleaner alleys than the others I drove or walked through. Other achievements include a successful child deparasitation campaign, a cholera prevention campaign, and participation in the government's immunisation campaign.

Health is at hand

But most salient is a novel system. This is called 'proximity health'. Health professionals – mostly nurses, but also a few doctors – living in each *quartier* are identified and approached. They are asked to give voluntary time to help provide

primary health care services – mostly preventive, but also curative. Some have accepted to participate and have been instructed by the two staff physicians of the non-government organisation I evaluated.

A system of continuing education is now in place. The professionals who offer a few hours every week see patients and resolve their most common acute problems. When they have a difficult case, they contact one of the two staff physicians by mobile phone for advice, either on the treatment course to follow, or to decide whether the patient should be referred to a secondary level of care. If needed, the staff physician joins the patient in the nearest hospital where colleagues have agreed to receive occasional referrals.

This model of proximity health is very creative, potentially effective, and eminently replicable. I recommended that it should be formally evaluated this year to consider publishing results in an international public health journal. The committees have not tackled the problems of domestic violence and how the same affects women and children, or the problem of access the health of people with disabilities. I recommended that they should.

Finally, here is another interesting initiative. The local school of public health was contacted. Its director was given a proposal, which has worked in South Africa, calling for a partnership between universities and civil society to engage in participatory public health and nutrition research in the *quartiers*. The director of the school is interested and this may become a reality (1).

I'm proud to say that the non-government organisation I visited and have evaluated, which has scores of sister organisations not only in Kinshasa but nationwide, has become the focal point to set up a national People's Health Movement circle, in the wake of the upcoming third People's Health Assembly taking place in Cape Town between 6-11 July this year. The assembly will be devoted to Africa. One purpose of this column has been to ground the concepts I often write about, in a concrete reality. Happily, even in the most impoverished and exploited parts of Africa, there are reasons for hope.

Reference

1 London, L. et al. Filling the gap: A learning network for health and human rights in the Western Cape, South Africa*, Health and Human Rights* 2012*,* 14, 1. http://www.hhrjournal.org/index.php/hhr/issue/view/19

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