

Historicising global nutrition: critical reflections on contested pasts and reimagined futures

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ABSTRACT

The COVID-19 pandemic has provoked a range of economic shocks, food systems shocks, public health crises and political upheavals across the globe, prompting a rethink of associated global systems. Prepandemic anticolonial movements that challenged hierarchies of race, space, gender and expert knowledge in global health took on new meaning in the context of the unequal impacts of the SARS-CoV-2 virus as it moved through different kinds of spaces and distinct political contexts. In light of these dynamics, and the desire of many current practitioners in global health to reimagine the future, the need for critical analyses of the recent past have become more urgent. Here we challenge linear understandings of progress in global health—with a focus on the field of nutrition—by returning to consider a previous cycle of dramatic social, political and economic change that prompted serious challenges to the dominance of Western powers and US-based philanthro-capitalists. With a ‘global health and nutrition audience in mind, we put forward considerations on why a better understanding of the continuities and divergences between this past and the present moment are necessary to challenge a status quo that was, and is, highly flawed.

INTRODUCTION

‘The crisis consists precisely in the fact that the old is dying and the new cannot be born; in this interregnum a great variety of morbid symptoms appear.’—Antonio Gramsci (p.32).¹

On 23 September 2021, the United Nations (UN) Food Systems Summit was held in New York. The Summit’s claims of inclusivity and transformational dialogue² has been the subjective of substantial critique, particularly as these claims relate to the obfuscation of the dynamics of power in food systems (and relatedly in global nutrition).³ In the lead up to the event, the issue of power in the fields of ‘global’ nutrition, ‘global’ health and international ‘development’ have become central. Several commenters have pointed out that COVID-19’s effects have both exposed and amplified health and nutrition

Summary box

- ▶ Calls to historicise global health as a starting point for questioning the field’s colonial and imperial origins requires further expanding the boundaries of what kinds of knowledge count in contemporary practice, to be inclusive of humanistic, subjective and interpretative forms of inquiry.
- ▶ The emergence of the SARS-CoV-2 virus and the subsequent COVID-19 pandemic prompted the acceleration of, and increased awareness of, inequities in health and nutrition and the intertwined nature of economic, food and health systems.
- ▶ Taking account of the twentieth century histories of the field of nutrition helps to illustrate the development (and continued challenge) of tensions between expert-led top-down interventions to improve health or mitigate food crises versus those that account for social and political understandings of the potential levers of change.
- ▶ To address current challenges of malnutrition we argue that global nutrition ‘experts’ should practice listening and *crucially* responding to critical perspectives on this field of practice, to avoid further repetition of ‘quick fixes’ responses to food crises.

inequities,^{4 5} while the rhetoric of systems-level crisis as suggested by the summit has helped to mobilise and justify corporate, government, philanthropic and donor-led interventions that focus on technical fixes for what amount to structural and systemic problems, all while vast swathes of civil society have boycotted the event because of its failure to live up to these initial claims of inclusivity.

This article takes a step back from the churn of commentaries, real-time data, news cycles and policy briefings that constitute the remarkable outpouring of new information in these modern pandemic times. Instead, we turn to history for a much-needed vantage point on the complex dynamics of the present. Writing with reference to the early years of the HIV/AIDs ‘crisis’ (such as it was known), historian Charles Rosenberg identified ‘dramaturgical’ patterns in how societies



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respond to epidemics.⁶ He wrote that in taking account of past plagues and pestilences, responses often begin from a fixed starting point ‘...proceed on a stage limited in space and duration, follow a plot line of increasing and revelatory tension, *move to a crisis of individual and collective character*, then drift towards closure’ (p. 2, italics ours).⁶ At the point we began the historiographic review on which this analysis is based (in mid-2020) it seemed that the so-called ‘global’ fields of health and nutrition practice, research intervention and knowledge production were heading towards a crisis of collective character.⁷ The COVID-19 pandemic’s effects laid bare the underlying systems and structures of racism, discrimination and unequal power that have shaped the international health and development institutions (of funding, of learning) that ostensibly exist to serve the ‘global’ public good. The pandemic brought into public debate once more the meanings of, and challenge of achieving, ‘health for all’ and the distances still to travel. It is this crisis—of the character of this ‘global health’ work, but also of the relationships of power that structure how the work is done—that we seek to historicise here.

The field of nutrition offers an illuminating point of entry for three important reasons. First, nutrition research and practice sit at the intersection of food systems and health systems approaches and demands an understanding of environmental, sociocultural, political and commercial determinants. Second, nutrition has struggled in recent years to incorporate historical political economy approaches and intersectional analyses of marginalisation and vulnerability vis-à-vis malnutrition. Third, nutrition as an ‘in-between’ field of international development and public health has received less historical attention than have the institutions of global health, disease-specific subfields of scientific research and practice (malaria, tuberculosis, HIV/AIDS, smallpox, family planning as examples), humanitarian responses to past famines or the so-called ‘Green Revolution’ in agricultural development. For these reasons, contemporary nutrition actors are in a unique position, should they willingly confront the myopia and wilful ignorance of the field’s past, to confront the ‘syndemic’ that COVID-19 has exacerbated.⁸ To understand how this new disease is interacting with existing health and nutrition inequities that have social, economic and political origins, we need to examine how these inequities have been shaped by relationships of changing power *over time*. This historical understanding of nutrition inequities applies not just to the places targeted for current intervention, but also applies to understanding the changing practices of the field itself. To understand the full scope of possibilities for response to these challenges requires consideration of why, in past moments of crisis and rapid change, certain alternatives or divergences from dominant modes of nutrition practice became possible, but also why these alternatives were at the time foreclosed.⁹

In undertaking this review we began with a different objective: this work was commissioned by the Consultative Group on International Agricultural Research (CGIAR) Research Programme on Agriculture for Nutrition and Health in

the wake of the initial stages of the COVID-19 pandemic to surface lessons of history that could inform decision-making in the present. As a starting point, this review focused on what historians of international public health and nutrition had already identified as periods of significant change that shaped the contemporary global nutrition landscape, namely the 1930s–1940s and the 1960s–1970s. On the justification that the last major shift in the geopolitics of international health and nutrition occurred in the 1970s, we focus on the antecedents of the policy and political choices of 1974–1979, which can be found in those two earlier periods of twentieth-century history.

By highlighting the long shadow cast by the events of the interwar period and the emergence of ‘developmentalism’ out of post-World War II, we deliberately challenge the idea that relevant vantage points on the current pandemic can only be found with reference to past pandemics or even discrete periods of international crisis. We also contest the notion that history is only valuable to contemporary global nutrition actors if it can be mined for extractable ‘lessons’ that are applicable to the present. Instead, our aim is to convey to contemporary nutrition actors, and those in the umbrella category of global health, that the colonial and imperial influences on these fields stretch the length of the twentieth century and still ‘yield new damages and renewed disparities’ today (p. 7).¹⁰

The 1974–1979 period was one of a heightened sense of global ‘crisis’: of food, of population growth, of political instabilities and state violence. It was also a time of firsts for the primary mechanism for international cooperation in health, agriculture, development and nutrition: the first UN World Conference on Nutrition, the first World Conference on Population, the declaration of a New International Economic Order (NIEO) and the Alma Ata Declaration of ‘Health for All’ by 2000. These years marked a narrow window of time when the potential emerged for a reconfiguration of global powers, and a reclaiming of the right to sustenance and to health as a matter of state responsibility. For many reasons, including the rise of neo-liberalism in the West, the rising tensions of the Cold War, the consolidation of military dictatorships in wide swathes of Latin America, oil and food price shocks and subsequent economic shocks, and the contested politics of newly independent nation states in Africa and South Asia, this window of possibility quickly closed. We rapidly sketch, therefore, developments in colonial nutrition, the initial postwar orientation of UN institutions, and the build-up to this critical 1974–1979 juncture.^{11–20} In trying to make sense of our current period of heightened disruptions, that is nonetheless marked by historical continuities, we reflect on what has changed, what has not, and what possibilities for change lie on the horizon.

COLONIAL AND NEO-IMPERIAL FORMATIONS OF EARLY INTERNATIONAL NUTRITION

At the point when international nutrition cooperation first began in earnest (the 1930s) some key foundational building blocks of what we now consider ‘global health’

were already in place. First, Western European and US-based actors created mechanisms for international disease control and eradication efforts that would later inform the development of the League of Nations Health Organisation (LNHO) and subsequently the World Health Organization (WHO). These included the Paris-based Office Internationale Hygiene Publique (1907) and the Washington, DC-based International Sanitary Bureau (1902). Shortly thereafter, in 1913, the Rockefeller Foundation entered the scene as a key funder and instigator of new forms of coordinated research and action on ‘tropical’ diseases and agricultural development. The Rockefeller Foundation would go on to become arguably the most powerful actor in international health (including in the field of nutrition) for much of the twentieth century,^{13–17} laying the ground for multiple, powerful, techno-philanthropic actors who would follow. A third important influencing factor in the shaping of these fields was the role played by colonial medical missionaries, who in pursuing conversion to Christianity of indigenous populations expanded health services to mothers and children. This stood in contrast to imperial medicine which focused on those populations contributing directly to the economic growth of empires (eg, men of working age). It also gave a moral sheen to activities that contributed to the ‘civilising’ mission of empires, traces of which are still found in global nutrition today.

More immediately, however, it was the large-scale starvation in post-World War I Europe, alongside the increased recognition of the negative impact of ‘poor diet’ on population health and productivity in colonial settings, that prompted a politically and ideologically diverse range of actors to begin to take seriously the burgeoning science of nutrition.^{11 12 18–20}

The emergence and expansion of international nutrition networks in the interwar period coincided with the rising popularity of the pseudoscientific philosophy of eugenics.²¹ In the USA and Europe, mainstream eugenicists prescribed ‘better breeding’, including selective forced sterilisation, to improve population health.²² A leftist reform eugenicist movement put emphasis instead on the potential to improve population health and ‘genetic stock’ over time through public health campaigns, improved nutrition and sanitation.^{18 23} Needless to say, all schools of eugenicist thought invoked race and racial difference.

In this same period, the ideas of Thomas Malthus gained new adherents within international networks of health, nutrition and development. Through Malthusianism—the idea that unchecked population growth would surpass the capacity of agricultural production—international nutritionists and public health specialists articulated specific concerns regarding certain (again, racialised) women’s reproduction and infant feeding practices.^{24–26} The ‘discovery’ of kwashiorkor, Nott writes, traded on the British imperial portrayal of Africa as a place riddled with poverty and disease.²⁶ Yet, this new science that sought to understand the role of distinct

nutrients in maintaining or disabling physical health ignored the ‘pervasive upturn in undernutrition, food insecurity and famine that accompanied the transition to colonial capitalism’ (p. 4).²⁶

This technical and depoliticised approach to international nutrition was not the only approach going. During these same interwar years, the fields of social medicine and social nutrition gained ground, led by champions of these movements in Eastern Europe, South-East Asia and Latin America, as well as in Western Europe. Both social medicine and social nutrition adherents sought to join up issues of public health, nutrition, sanitation, education and environment. This was, Scott-Smith writes, a ‘golden age in humanitarian nutrition’ led by the League of Nations Health Organisation, and in particular the Mixed Committee (p.77).¹⁸ Remarkably given the rising tensions between communist, fascist, liberal, socialist and radical views on how to respond to hunger and malnutrition, the LNHO’s Final Report of the Mixed Committee in 1936 walked a delicate balance between ascribing the causes of hunger to ‘poverty’ (the progressive view) as well as ‘ignorance’ (the imperial and colonial view) (p. 79).¹⁸

In parallel to the LNHO’s work on social nutrition, the 1937 Bandung ‘Intergovernmental Conference of Far Eastern Countries on Rural Hygiene’ gathered together a diverse range of international health, nutrition, sanitation and education specialists to address for the first time the complex needs of rural populations (p. 24).²⁷ Even so, in calling for technical approaches to mitigate the ‘thoroughly deficient’ diets of poor people living in ‘poor’ countries, participants in the Bandung conference sidestepped the role played by colonial economic powers in shaping malnutrition (p. 85).²⁷ These developments, both at the Bandung conference and within the LNHO, illustrate that some of the core ideas of what would later form the 1978 Declaration of Alma Ata were in circulation a full generation earlier. This ‘golden age’ of nutrition and early consolidation of social medicine gains proved short-lived. In the aftermath of World War II, international nutrition would pivot back to ‘technocratic’ and subsequently less overtly ‘political’ approaches to managing hunger and mitigating ill-health—approaches that both avoided or elided questions of race, racism and inequitable patterns of land ownership, of access to markets, of living conditions and what would later be called food sovereignty.

POST-WORLD WAR II AND THE UN’S ORIENTATION TO NUTRITION

With the reconfiguration of a new world order and the creation of the UN and Bretton Woods Institutions, European adherents of social medicine (and relatedly, social nutrition) maintained substantial influence. At the same time, other positions of leadership were taken up by individuals previously involved in eugenics societies, as well as those adhering strongly to Malthusian ideology

(pp. 115–127).²⁵ Racialised fears of overpopulation were further compounded by the discourse of food and disease outbreak ‘crises’ which became part of the fabric of the UN and subsequent development and humanitarian practice (pp.21–23).¹⁸ This stood in contrast to the multidisciplinary, multisectoral and complex systems approach to tackling ‘want of food’ called for at the UN inaugural conference on Food and Agriculture, also held in 1943 (pp. 52–53).²⁸ In this sense, the formation of the UN did not constitute a total break with the past. Strong tensions between ‘technical’ and ‘social’ approaches to nutrition specifically, and health more broadly, pushed and pulled these new and politically fragile institutions in opposing directions.²⁹

What remained unresolved was how to best achieve the global goal of ‘good nutrition’, whether through agricultural development, targeted antipoverty measures, supplementary food, or through public health education, all of which had implications for where nutrition would ‘sit’ in the UN system. The specialised institutions of the UN were caught between the competing political powers of the Cold War era and struggles for independence in the former European colonies of Africa and Asia. In this context, powerful US government actors and the US-based Rockefeller Foundation, in alignment with Western European governments, framed social medicine and social nutrition as political threats to be contained.^{13–16 24 30} The Rockefeller Foundation in particular favoured ‘vertical’ methods of infectious disease management and famine relief that could be controlled and carried out with militaristic precision and drew, in fact, on military expertise.³¹ Such interventions relied on new methods of measuring success and comparing outcomes across distinct national contexts, which encouraged further dependence on technocratic expertise in both health and nutrition.³¹ These new metrics of hunger, developed with Rockefeller funding, pushed the field of nutrition towards an over-reliance on nutrient-specific interventions and further towards decontextualised and scaleable techniques of hunger ‘management’.^{18 32}

By the start of the ‘Development Decade’ in 1960, the Food and Agricultural Organization of the United Nations (FAO), the Rockefeller Foundation and the USA had joined forces to fight a declared ‘war against hunger’, with the WHO and the United Nations International Children’s Emergency Fund (UNICEF) taking charge of maternal and child health, improved techniques of health planning and rural health promotion, among other initiatives. Rockefeller continued to fund the creation of new fields of expertise in nutrition, documenting cereal supplies and capturing demographic and health indicators in ‘developing’ countries. These new sets of data provided grist for a resurgence of Malthusian fears of overpopulation in the ‘Third World’. Such racialised ‘othering’ of the inhabitants of Latin America, Africa, Asia, South-East Asia and the Middle East through the language, practices and policies of ‘development’ built on not-very-distant (and in some instances, still

actively contested) imperial formations. This way of framing the ‘problem’ of malnutrition and overpopulation in the ‘Third World’ was met with strong resistance by social nutritionists who challenged the idea of scarcity (of food, of land, of resources) peddled by the West (p.9),²³ instead pointing to the underlying and ongoing practices of Western-led exploitation and plunder of less powerful communities.

The launch of the World Food Programme in 1963, a joint UN/FAO initiative, heralded yet further US influence in the agricultural development and food security domain, the programme in effect functioning as a ‘channel’ for the ‘constructive disposal’ of food surpluses (p. 203).³³ This was the landscape in which nutrition scientists retrenched and narrowed focus on protein malnutrition, and one in which social nutritionists lost further ground. In reality, the total amount of resources that were put towards nutrition efforts in the FAO and WHO—whether ‘vertical’ or ‘horizontal’—remained a minuscule proportion of organisational budgets. Even so, the failure of technological innovations in protein supplements delivered through targeted campaigns was disenchanting to the proponents of ‘high modernism’ that ran these campaigns.¹⁸ Similar to critiques of the failed WHO-sponsored Malaria Eradication Campaign (one which was both funded and heavily influenced by the Rockefeller Foundation), the ‘great protein fiasco’ challenged the efficacy of top-down nutrition interventions and the role of nutrition expertise, while at the same time pushing back in the direction of social nutrition and whole systems approaches.^{33 34}

TOWARDS CONVERGENCE: FOOD, HEALTH, ECONOMIC AND IDEOLOGICAL CRISES AS INFLECTION POINTS

On 30 May, 1967, the launch of the Biafran independence movement and subsequent civil war in Nigeria, in which food was weaponised, sparked a famine and humanitarian crisis that captured international attention.^{11 18} On 8 October 1967, the Bolivian military, with the US Central Intelligence Agency (CIA) support, captured and assassinated leftist revolutionary Che Guevara heralding an intensified swing towards dictatorial control in South and Central America, and concomitantly the targeting, assassination and exile of social medicine and social nutrition leaders from the region (pp. 120–131).³⁵ By the middle of 1968, a ‘global rebellion’ took shape as decolonising, anti-imperialism, antimilitary dictatorship and antiwar protests converged (pp 1–9).³⁶ Transnational networks of activists across the ‘Third World’ drew strength from common challenges, circulating new ideas and strategies for resistance to the neo-imperial might of the USA and the lingering (or not so lingering) control of Western European colonial powers.

Within the fields of international health and nutrition, the inflection point came some years later, reflecting biomedical conservatism and the strength of US and Western European influence over key UN institutions.

Through the late 1960s and into the 1970s, 'modernization' doctrine and the ideology of 'rationalism' gave cover to a resurgence in Malthusian tendencies and the racialisation of 'target populations' in both nutrition and public health. In particular, US-based philanthropic foundations (Rockefeller, Ford, Kellogg) together with the US government, pushed increasingly for population control measures in the 'Third World' on the basis of the perceived scarcity of food, fears of communist uprising as a result of these scarcities, and fears of certain (brown, black) women's reproduction.²²⁻²⁵ Within the UN system, overt family planning activities were kept institutionally separate from health and nutrition (with the creation in 1969 of the United Nations Fund for Population Activities). However, the ongoing concern with sufficient 'piles of food' further amplified by increasing awareness of environmental issues and climate shocks, meant that the question of reproduction in the 'developing world' remained tied to nutrition outcomes, and often integrated with nutrition interventions.

Outbreaks of famine in the Sahel region (beginning in 1972 and developing into a multinational 'food crisis' that did not abate until 1975) further underscored the significance of malnutrition as a global health and humanitarian issue.³⁷ The FAO office for the Sahelian Relief Operation became the focal point for the UN efforts, but as a consequence of poor coordination, inter-agency infighting and the limited political power of FAO, the UN response proved inadequate.³⁸ In the FAO's official report on 'Drought in the Sahel' published in 1977, the authors spoke to the limitations of crisis-led response, suggesting that 'the future may well present problems and call for decisions far more difficult to reach than those faced in the emergency' (p. 18).³⁸

In the context of these food systems shocks, together with a rapidly shifting geopolitical landscape, the UN hosted the first World Conference on Population in Bucharest in August 1974, in which US and Western European powers pushed for the formalisation of a Plan of Action that linked population growth to 'development' status, and called for intensive family planning efforts in Latin America, South and South-East Asia, and Africa.³⁹ In opposition, nations of the NIEO (read: countries labelled with 'Third World' status) and their Socialist and Communist allies, argued that the problem to be solved was not overpopulation, but an unfair distribution of global resources.⁴⁰ In November this same year, the FAO hosted the World Food Conference in Rome, where delegates declared that 'every man, woman and child has the inalienable right to be free from hunger and malnutrition'.²⁸ Nonetheless, rights language and multidimensional understandings of nutrition remained secondary to the continued focus on calorie supply and food security.

In part, technical and expert-driven approaches to malnutrition were strengthened by the continuing and expanding food 'crisis' in the Sahel and now Sub-Saharan Africa. In the midst of the abovementioned

events of 1974, the WHO, UNICEF, UN Disaster Relief Coordinator and the Office for Special Relief Operations organised a 'multi donor mission' to the region to address the state of crisis. This mission created a technocratic model for humanitarian nutrition interventions that were to follow in launching a centrally controlled, top-down campaign to deliver 'several tons of drugs and medicines to the six countries by air' in addition to UNICEF's distribution of high protein foodstuffs.³⁸ The FAO for its part sought to claim greater ownership over the agricultural development 'space' in 'developing' countries (limiting its resourcing of nutrition work to a minuscule percentage of the overall budget) with the aim of realising 'quick-action, small scale projects in direct cooperation with interested governments'.³⁸ Later in the 1970s with further outbreak of famine in Bangladesh, FAO leadership expressed concern that their expertise was insufficiently consulted and reflected an inability of the UN family to 'work together'.³⁸

In parallel to what was happening in humanitarian nutrition action and burgeoning family planning interventions, the primary healthcare (PHC) approach to public health gained increasing support within the WHO, spearheaded in part by health systems innovator Kenneth Newell.³¹ Inspired by the Christian Medical Commission, China's 'barefoot doctors' programme and a range of community-health and nutrition pilot initiatives in 'developing' countries, Newell proclaimed PHC the way forward in his 1975 compendium *Health by the People*.⁴¹ In 1975, building on what at this point constituted a half century of experimentation in social health and nutrition programmes in a diverse range of countries, WHO/UNICEF jointly published the influential *Alternative Approaches to Meeting Basic Health Needs in Developing Countries*.⁴²

This complex web of political and socioeconomic factors, combined with the increased connectivity of transnational networks of social medicine and nutrition activists, contributed to the formal articulation of a PHC approach at the 1978 International Conference on Primary Healthcare at Alma-Ata. Here, the 'redistribution' position of the NIEO was reflected clearly in statements that identified 'diseases of poverty' such as malnutrition, respiratory and diarrhoeal diseases as the primary cause of ill-health in 'developing' countries—not overpopulation.⁴³ In this way, the 'social' approach to nutrition and medicine articulated by the LNHO and at the seminal 1937 Bandung Conference was re-articulated by a new generation of actors, this time building on the independence movements of South Asia, the Middle East and Africa, and their reimaginings of the place of public health and food sovereignty in newly formed postcolonial nation states, as well as building on revolutionary movements and socialist reforms in Latin America.

However, in spite of social nutritionists' efforts to secure a place for their field as an 'integral part of agricultural development and primary healthcare' the tide turned quickly back to vertically controlled and

institutionally siloed programmes of work within the UN system.⁴⁴ By 1979, with the publication of White and Warren's famed article calling for 'selective' PHC, the shift back towards the technocratic, expert-driven Rockefeller model of international public health, nutrition and agricultural development was complete.⁴⁵ The tide now strongly turned in the direction of neo-liberal international health and nutrition policy and practice, including the rolling out of structural adjustment programmes in Africa and Latin America that crippled existing public services. Thus, those articulating 'social' approaches that linked public sectors and called into question the political-economic and neo-colonial systems that enabled malnutrition and ill-health faced even more substantial challenges in getting traction within the UN or among the major funders of activities. With further instances of localised famines in sub-Saharan Africa in the 1980s, including the Ethiopian famine in 1984–1985, the critique of top-down technocratic humanitarian nutrition grew stronger, as did the demand for contextually specific, political-economy and anthropologically nuanced nutrition programming.^{46 47} Yet the introduction of new powerful actors in the context of the HIV/AIDS crisis and reconfiguration of 'global health', now heavily influenced by the Bill and Melinda Gates Foundation, meant that the Northern-led technical expertise and interventionist approaches first established by the Rockefeller Foundation would find new adherents and further entrenchments.

HISTORICISING AS A VANTAGE POINT

Why, then, is what happened between 1974 and 1979 so important to the present moment? In our reading, this was a prior moment of crisis when an old world (of empire) was dying and the possibility of the birth of a new postcolonial world order appeared on the horizon. Instead, a confluence of factors that includes the role played by Western technocratic elites in international health and nutrition foreclosed a true break from the 'interregnum' and helped usher in new reconfigurations of old power dynamics. Historicising global nutrition in this instance means to interpret this current field of action as the product of contested historical development, and in doing so, challenge linear or singular narratives of how the field has been shaped over time. This historicised view shows that competing factions, geopolitical agendas and the politics of ownership often prevented the stated goals of ending malnutrition. Yet, a reconfiguration and reimagining of what should constitute international cooperation is still needed. The COVID-19 pandemic serves as a stark reminder that the vulnerabilities of the few can quickly become vulnerabilities for the whole. At the same time, the vantage point of history cautions against a 'leaving no one behind' approach that assumes the project of international development, nutrition or health such as they are currently configured are projects that all should want to join.

If current predictions are correct, and we face an unprecedented food and malnutrition crisis, then what is needed is not 'new' thinking on how to tackle these challenges, but a greater appreciation of historically configured power asymmetries and a level of critical reflection on whose thinking has counted most in this 'global' arena (vs the perspectives that have been silenced). We suggest that if burgeoning malnutrition is to be avoided those most 'expert' should practice listening and, *crucially*, responding to critical perspectives on this field of practice, instead of repeating further cycles of top-down technocratic 'quick fixes'.

Countermovements currently gaining strength include the call to reclaim comprehensive approaches to public health, the alternative understandings of 'healthy societies' being articulated in Latin America, South Asia, East and Southern Africa, and the critiques of the current UN Food Systems Summit made by actors such as La Via Campesina and the Civil Society and Indigenous Peoples' Mechanism for Relations with the UN Committee on World Food Security.^{48–50}

We can only hope that such countermovements indicate the possibility of a way out of an interregnum in global health and nutrition in which a new way forward remains blocked, or as Gramsci would have it, unborn. The crisis of collective character provoked by the COVID-19 pandemic is an opportunity, but also a serious challenge to a powerful status quo. Through critical readings of history and the diverse methodologies of historical practice, we are able to reflect on paths not yet taken and paths foreclosed and, in this way, imagine a new future.

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