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to the
Standing Committee on World Order Under Law
At the Annual Meeting of the
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"THE RIGHT TO FOOD AND INTERNATIONAL LAW"

I certainly am glad to be here and to see old friends, and I would like to thank Father Drinan for inviting me to be among you today.

For the purpose of this discussion I would like to start from the presupposition that a right to food does exist. The aspect of this very rich question that I would like to focus on today is, how reasonable are the prospects of being able to assert that "right"? I might want to climb Mt. Everest, by way of analogy, and I might speak eloquently about it, but unless I have the equipment and personal capability, I simply cannot perform the feat, and my speaking of it, however interesting, lacks substance. The nature of my discussion changes radically, however, if I do have the equipment and can perform the task.

In the past 50 years there has been a mammoth change in the feasibility of ensuring that the right to food can be met. (Let me acknowledge from the beginning, by the way, that in these remarks I will consider the term, "right to food" as a type of code word for overcoming malnutrition and hunger.) I will concentrate on the factors that create these new possibilities in regard to meeting this right.

First I would like to focus on the fact that in the last half of this century, for the first time in history, there are not only vastly greater amounts of surplus foods available to ensure that the right to food can be

met, but also vastly improved means of distributing food to those in need. Just 50 years ago the world did not have the productive capacity to give everyone adequate food. Today it has - as exemplified by food surpluses in the U.S. alone. Fifty million tons of grain annually, costing some $10 billion to purchase and distribute with a modicum of efficiency, would meet the caloric needs and would counter most of the protein deficiencies of the families of the world's poorest billion people. Surplus production capacity in the United States alone could meet this need. Even with production restraints costing billions, we will have grain surpluses of some 200 million metric tons (including 68 MMT of wheat) this year. This bounty is paralleled by surpluses of food in Europe, Australia and Canada. Far greater production capacity exists in developing countries as well if only they had a more equitable price system and if more fertilizer were available.

In regard to distribution, 50 years ago we did not have anything like the international transportation networks and means of distribution within countries that exist today. There has been a revolution in transportation capacities. One could assure adequate distribution of food for an additional amount of less than 2 per cent of what the world spends on arms - and the actual figure is probably much closer to 1 per cent.

The effects of the expanded capacity to provide food afforded by this more-than-adequate quantity available to the world have extended beyond the simple balance of supply and demand, and are now affecting international standards of morality, political and popular will, and laws as well. Less than 50 years ago governments were still not held responsible for famines within their borders, to say nothing of responsibility for disasters beyond their borders - and this applied even where surpluses were available. Thus, in the great Bengal famine of 1943, more than one million people died in the streets of Calcutta without the colonial government lifting a finger despite ample food stocks in the city. People, especially agricultural workers whose crops had suffered a bad year, did not have the purchasing power to avail themselves of the food on hand. I remember during that time watching people die in the streets. You could watch a whole family, perhaps living around a lamppost, as they died one by one over the course of four or five days. Yet there were enourmous bins of stored grain right in their proximity. And there was nothing an individual could do.

If one of us here saw a person dying in the street, as a matter of course we would take care of that person and tend to him. But one person alone couldn't change the effects of the Bengal famine. Likewise, the British rulers of Ireland were not considered bound to provide for those left starving by the potato famine in the 1840s, even though the same moist weather that brought the potato blight led to record Irish corn production for export to the U.K. No governmental accountability was felt toward agricultural workers made destitute when their crops failed and they were left without livelihood, unable to afford the corn grown in their own country but shipped to a more lucrative market. Today we consider it unconscionable not to respond when public attention is drawn to such a situation, that is, when the emergency is "loud."

By contrast, now, since our capability to prevent mass starvation has been realized, when headline-capturing emergencies of famine have erupted - in Kampuchea and Ethiopia for instance - world public opinion has insisted on the right to food for those who have suddenly faced a disasterous retrogression in their circumstances. In the Ethiopian case, once the situation was publicised through the now-famous BBC film clips, we saw - literally within a two week period - major changes in response not only from the U.S., but from the U.S.S.R., from the Ethiopian Government, and from others all over the world. Governments had all been generally aware of the crisis, but their drastic changes in policy toward effective response occured only when public opinion insisted that all governments act more responsibly.

The second factor I would like to focus on, surprising as it may be, is that the principle causes of malnutrition in the world are not related to shortages of food at the family gate. They are due rather to the use made of food within the family. Thus, the most serious causes of malnutrition in children today are:

1) The effects of diseases, especially those involving diarrhoea, which drain away the body's nutritional strength; in a classic viscious cycle these diseases are both made more serious by and exacerbate malnutrition.

2) Fevers which destroy a child's appetite, so he doesn't eat, even though the food may be available right there in the family home.

3) The parents' ignorance as to the best feeding practices. All too often a child going into the weaning period is fed the wrong foods - foods that satisfy his hunger but not his nutritional needs. A life-saving variety of nutritious foods may be readily available, but the parents are not aware that the child requires them. This tragic ignorance extends to many adults as well, with nutritionally lacking diets masked by sufficient caloric intake to ward off hunger, resulting in the insidious onset of malnutrition.

In recent years we have seen mammoth changes that make these three major causes of malnutrition immensely easier to reduce. First of all, directly applicable new, improved, or rediscovered knowledge has emerged. And secondly, this has been coupled with a greatly improved potential for social organization and communication at low cost that can, for the first time on such a large scale, make the new knowledge available to those who need it.

Thus in the realm of new knowledge we have such innovations as oral rehydration therapy (ORT) to combat the dehydration from diarrhoea that takes the lives of 12-14,000 children daily - (that is 4-5 million annually), and the discovery in the mid-1960s of the vaccine against measles, which takes the lives of another 6,000 children daily (2 million annually). This has been followed by the measles vaccine's current refinement in the freeze-dried state - capable of maintaining its potency free from refrigeration for up to a week, and thus greatly easing special demands that formerly encumbered the "cold chain". Likewise, we have rediscovered the merits of mother's milk, and we

have learned the benefits of regular growth monitoring of infants with the use of simple weight scales and charts.

Unfortunately, social organization has lagged badly in making use of the medical knowledge that is available. If we had a cure for cancer that saved the lives of 5-6 million people annually, you can be sure that word would get around very quickly. That of course is because generally those who get cancer tend to be from a far more affluent segment of society. Among the world's poor, the simplest "old" knowledge capable of preventing diseases that claim millions of lives - such as the washing of hands, boiling of water and use of latrines which would prevent most diarrhoea in the first place - is still grossly underutilized. In 1980, less than one per cent of mothers were aware of the new ORT and less than 10 per cent of children in developing countries were fully immunized.

Today we have the vastly increased capacity to communicate with those who need to know - whether it is parents who could save the life of an infant dying of diarrhoeal dehydration by simply knowing to use ORT, or parents who do not understand why they need to bring their children three times to be immunized, often causing fevers to a child who was well. The combination of developmental and technical progress of the past 20 years has resulted in the presence of a radio in a majority of rural homes, of TV in many homes, of a school in every village, and so forth. One can travel to the most remote of countries, the Yeman Arab Republic for example, to a region where helicopter is the only modern access, and there will be a TV there - with a VCR! This newly expanded capacity to communicate with the world's poor is what actually enables us to speak today of the potential for a "Child Survival and Development Revolution", if only all will mobilize to save the health of children through the use of these low cost means. There are 100 million noticeably malnourished children in the world today, and there are these new low-cost means of preventing much of it. A full half of the 40,000 child deaths that occur <u>each day</u> are readily preventable through such simple means. An additional mere $1 billion a year would cover the additional cost of such a revolution in developing countries. What is needed however, is the national will to put children and mothers <u>first</u>; not, as so often is the case, <u>last</u>, among our national concerns.

Fortunately, it is being done. Colombia, for example, has been a pathbreaker in demonstrating the viability of these approaches and their combined effect in support of primary health care. Colombian President Betancur in 1984 began a major initiative to raise the percentage of the country's immunized children from a minority to near universal coverage, and the effort was tremendously successful. The key was leadership from the top, and all sectors of society were persuaded to participate. The President mobilized the media, including the leading opposition newspaper. He encouraged the press, the radio and television stations to co-operate, and he recruited the Church and the Red Cross, the Rotarians, the Lions, the Scouts, schoolteachers, businessmen, and all government ministries.

Together, they set out to do what had never been done before in history: in one 3-month period, through three national immunization days, a nation

mobilized to immunize the great majority of its children against five major diseases then killing and crippling tens of thousands of Colombian children each year. There were more that 10,000 TV spots; virtually every parish priest devoted three sermons to the importance of families immunizing their children, and every school teacher was involved. President Betancur and other leaders personally immunized children.

The Campaign began in June 1984. By the end of that August, more than three-quarters of the under-5s had been fully immunized. Repeated again last fall with particular emphasis on the most vulnerable under-2s, the total rose to over 80 per cent ... which is sufficient in most areas to provide "herd" immunization against the biggest killer - measles. So many children were reached that the "campaign" approach has been able to give way to the on-going Primary Health Care infrastructures which have been vastly bolstered by the intensive efforts of the past two years.

Colombia illustrates the use of communications with a vengeance. The results demonstrated how we can defend children against these brutal mass killers and cripplers, if only we fully mobilze to do so. The great majority of Colombian children now have been immunized and a significant start has been made in teaching millions of mothers how to use oral rehydration therapy, thereby saving the lives of more than 10,000 children a year who would have died only two short years ago. The primary school curriculum has been drastically revised to emphasize health education - and all high school students have to contribute 100 hours of "health scout" service as a pre-condition to receiving their graduation certificates. The Catholic Church has introduced a major training programme for priests; pre-marital counselling now includes health care of children - on immunization, on ORT, etc., as a major component. Ironically, all this was done while simultaneously saving many millions of dollars. Similar techniques are beginning to evolve in country after country, with each nation tailoring the approach to fit the particular structures and cultures of its people.

Turkey is another country where this has been done. Turkey launched its Child Survival Revolution just last September with a national immunization week for 5 million children under 5 years old. The campaign focused on the six diseases which in 1984 took the lives of more than 30,000 Turkish children, and crippled tens of thousands more. With more than 50,000 Moslem imams taking the lead from their mosques (just as Colombian priests had in their churches), and with the active participation of 95,000 village teachers (who returned from summer vacation two weeks early for the purpose), some 85 per cent of all young Turks were fully immunized against these dread diseases. This spring, this social mobilization approach was extended to encompass oral rehydration therapy, means for coping with acute respiratory infections, and family planning.

These success stories are not alone. They are being joined by others - in Burkina Faso, China, the Dominican Republic, Ecuador, Egypt, India, Nigeria, Pakistan, Peru and many others. In Egypt, the toll of more than 100,000 small children annually from diarrhoeal dehydration has been more than halved in

just three years, primarily through a massive use of television, radio, schools and retail outlets as well as the extensive primary health care medical facilities. Even though ORS packets are available free at more than 4,000 government clinics, more than 70 per cent of the packets used are purchased at neighbourhood stores and vendors. In early 1983, less than one per cent of Egyptian mothers were using oral rehydration therapy; by early 1986 this percentage had risen to over 60 per cent.

In many countries massive new efforts are beginning - such as in India, where more than 1 million children died last year as a consequence of not being immunized. (That's 3,000 each day, the same number as all the people killed by the one-day Bhopal chemical disaster.) But a programme is now underway to achieve universal immunization of Indian children by 1990 as a "living memorial" to the late Prime Minister Indira Gandhi.

There is a growing awareness that there is something we can do to avert the tragic practices that result in silent emergencies of mass proportion. The true revolution of the Child Survival and Development Revolution is that we can now respond to the previously overwhelming silent emergencies of malnutrition and hunger.

Thus we see as a first reaching out within the context of these possibilities the current global effort to immunize all of the children in the world by 1990. What was little more than a slogan 18 months ago is being taken very seriously today. During the past year the world has begun to truly commit itself to the goal of Universal Child Immunization by 1990, and the consequences will be to save the lives of several million children annually and reduce malnutrition in many millions more.

This shift in governmental assumption of responsibility for the well-being of the populace is symptomatic of trends leading to the recognition of ever-increasing interdependency in the world. A person's ability to get food is much more dependent today on society than it was even 50 years ago. Consequently, society's responsibility has increased, and when that responsibility is assumed appropriately it is for the good of the whole society. When an industrialized nation obtains materials it needs from a country like, for instance, Mali, that wealthier country benefits.

Let me ask you, don't the wealthier countries of the world have a responsibility to the poorer countries? And don't the billion or so people in this world who are particularly well off have a responsibility to the billion or so in this world who are desperately impoverished?

As we decide in the mid-1980s to truly take a new look at the right to food and how we might realistically accept the responsibility of assuring that right, we must give due emphasis to the fact that we are really talking about the right to avoid becoming seriously malnourished - for which the right to food is the symbolic label. The task we face is to prevent and overcome malnutrition and hunger.

At this juncture we have a capacity to overcome hunger and malnutrition far greater than we had 50 years ago; indeed, our capacity is vastly greater than it was just 10 years ago. The remaining factor that we need to acquire for the success of these goals is, frankly, the political and the popular will to accomplish them.

The driving force behind that will is societal morality, and fortunately, that has, in fact, kept apace of our newly expanded potentials. Whether we want to refer to this as the realm of international law or international morality, it is becoming increasingly unconscionable not to act when so much can be done with so little today.