FROM PUBLIC TOILETS TO HEALTH CLINICS

BY

Prof. Miriam K. Were
2008 Hideyo Noguchi Africa Prize Laureate;
Medical Services

On the occasion of
Commemorative Lecture
at
Aizu University,
Fukushima, Japan

30th May, 2008.

FROM PUBLIC TOILETS TO HEALTH CLINICS

PREAMBLE

It is a great pleasure and I am deeply honoured to be here in Fukushima, the place in Japan where Dr. Hideyo Noguchi comes from and in whose honour the AFRICA PRIZE given by the Government of Japan is named. I am also greatly honoured to be here with my co-winner, Brian Greenwood and his wife, Alice. We thank Japan very much for this honour to Africa and to us, to our work along with those we have worked with in the health sector over many decades. In 2007, the African Heads of State endorsed the AFRICA HEALTH STRATEGY adopted by Africa's Ministers of Health. By linking the awarding of the first HIDEYO NOGUCHI AFRICA PRIZE to 2008 TICAD, Japan has underscored the importance of the health sector to the development of Africa. The huge burden of disease on Africa reduces productivity and consumes resources and we appreciate these events highlighting the fact that HEALTH IS THE BEACON OF AFRICA'S DEVELOPMENT and needs to be a priority in development efforts. We very much appreciate the special relationship between Japan and Africa through TICAD and the contribution Japan is making to Africa's development. Thank you so much to you in Fukushima for being part of this encouraging development between Japan and Africa. We would like to see this link get stronger and stronger to the benefits of both sides!

I now turn to introducing those who have come with me from Kenya in connection with the HIDEYO NOGUCHI AFRICA PRIZE. My husband Humphreys R. Were and I have been married for over 40 years and we have supported each other in the family and in our professional work. He is an Agriculturist and has contributed a lot to the development of that sector and to growing food in our country. Representing our children and the young people of Africa, so close to our hearts, are our son Daudi, who remained at the TICAD IV which he is covering for UNDP, and our daughter Evaline Diang'a with us here. She works for the World Food Program to which Japan is one of the biggest donors. Also with us is Mrs. Malesi E. Kinaro, the Executive Director of UZIMA Foundation. UZIMA is the word in Kiswahili for ABUNDANT LIFE. Through this name, we communicate hope to discouraged young people hope. Papa Were and I (Mama Miriam) together with friends and relatives sponsored the founding of UZIMA Foundation. The Foundation brings together young people in disadvantaged situations from many parts of Kenya. We bring them together to encourage one another; to learn life skills for improving the quality of their lives; to better look after their reproductive health and control of HIV/AIDS; to learn business skills and also to be involved in the promotion of peace and justice. Papa Were is the Chairman of the Board of Trustees. Finally, am happy too introduce Peter Mutie Head of Communication in Kenya's National AIDS Control Council of which I am the Chairperson. The mandate of the National AIDS Control Council is to coordinate all the work in the work against the spread of HIV in our country. We have had good success in the last four years. Japan is one of our International partners in supporting us in the work on HIV/AIDS in Kenya.

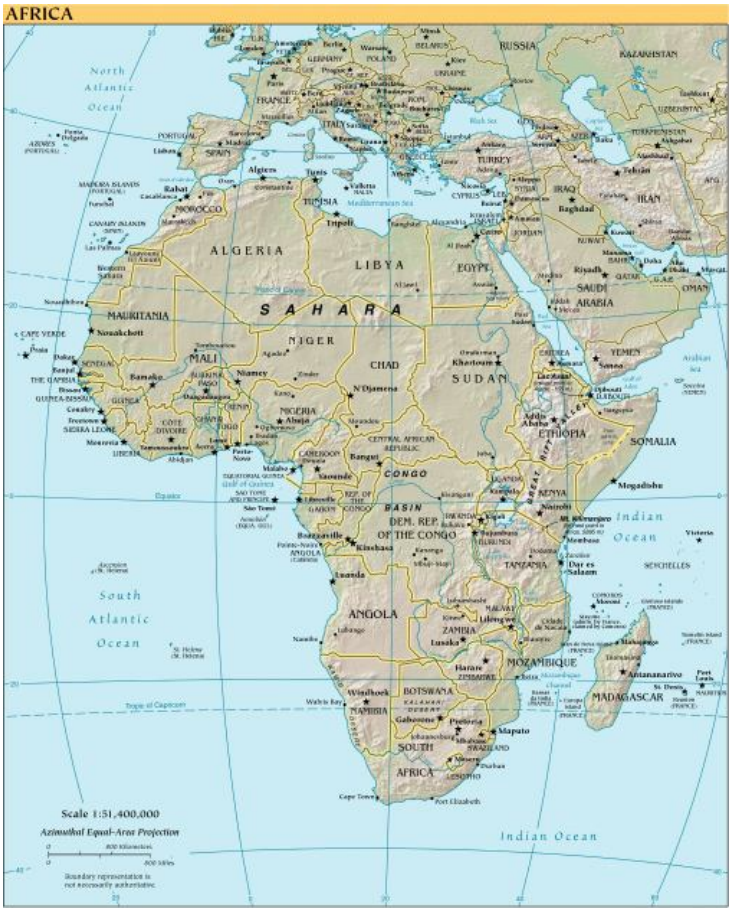
We received a very warm welcome from the leaders of Fukushima while we were still at home. We thank you very much, indeed! We from Africa now want to greet you with song because for us singing is very important and it will encourage me as I talk with you. The song is about the importance of praising each other's efforts.

1. AFRICA

1.1 The Geography of Africa

Africa's geography affects its health The most northerly point in Tunisia is at latitude 37°21' N and the most southerly point in South Africa is 34°51'15" S. Thus the equator passes through Africa. This stretch of Africa from North to South results in Africa having diverse climatic conditions, including the tropics and temperate zones. The North borders the Mediterranean Sea and is close to Europe and shares some of the climatic conditions with Europe. This Northern part is also geographically close to the Middle East. So sometimes the countries in North Africa are grouped within the Middle East region of the world.

MAP OF AFRICA SHOWING PROXIMITY TO EUROPE AND MIDDLE EAST



THE SUB-SAHARA COMPONENT OF AFRICA

There is a "belt" south of the **Northern Africa part.** This is the **Sahara desert**. This desert is very dry and dusty with little to support life but some people live in it. The larger portion of the African continent lies south of this Sahara desert. The part south of the "belt" is **SUB-SAHARA Africa**. This is where we, the majority and black people of Africa, live. This talk is with reference to the health situation in Sub-Sahara Africa.

2. WE AFRICANS ARE A HAPPY PEOPLE!

When you see the TV news or read about Africa, what is presented is mostly BAD NEWS: news about wars and other types of violence; news about POVERTY and how miserable we are; news about sickness and death. Unfortunately, most of these things are true. BUT we also have many GOOD things in Africa that keep us going. But the NEWS never report on these things! Among these are:-

2.1 We Laugh A Lot!

NB: No speaking; just flushing various pictures on the screen.

Health Sciences point out that REAL DEEP LAUGHTER IS GOOD FOR HUMAN BEINGS!

2.2 We Sing and Dance A Lot!

NB: No speaking; just flushing various pictures on the screen.

2.3 We Enjoy Our Food!

NB: No speaking; just flushing various pictures on the screen.

2.4 Africans have a long lasting love affair with God.

NB: No speaking; just flushing various pictures on the screen.

In spite of us being happy people, we are not always happy because we have serious health problems. And that is what I want to focus on now.

3. HIGH DISEASE BURDEN FROM DISEASES OF POVERTY DOMINANT IN AFRICA AND SOME CONSEQUENCES

3.1 High Disease Burden and Diseases of Poverty

In terms of population, Sub-Sahara Africa has about 10% the world's population and yet it carries over 25% of the world's disease burden.

Diseases grouped as **DISEASES OF POVERTY** are responsible for most of the disease burden in Africa. These diseases of poverty include: tuberculosis, malaria and HIV/AIDS; preventable and/or treatable childhood diseases such as polio,

measles and pertussis; diarrhoeal diseases, parasitic diseases and malnutrition. All these are poverty-related diseases and cause high levels of mortality in low income countries. These infectious diseases of poverty are generally placed in 5 categories:

- Infectious and parasitic diseases
- Respiratory infections
- Perinatal and maternal conditions
- Nutritional deficiencies
- Tropical diseases

(Source: Sievens, Philip Diseases of poverty and the 10/90 Gap. International Policy Network; 2004 pg.5)

Maximum damage from diseases of poverty is on children under five years of age and pregnant women. As will be seen later, the consequence is high mortality in these groups. The dominance of Malaria in Africa (cited among the diseases of poverty) can be seen in the following diagram. My colleague has addressed this.

a) Malaria

The Africa Malaria Report of the World Health Organization (WHO) states:
"About 90% of all malarias deaths in the world today occur in Africa South of the Sahara and an estimated one million people in Africa die from malaria each year and most of these are children under 5 years old." [1]
With about 1 million deaths per year attributed to malaria per year malaria is likely the leading cause of death in sun-Saharan Africa.

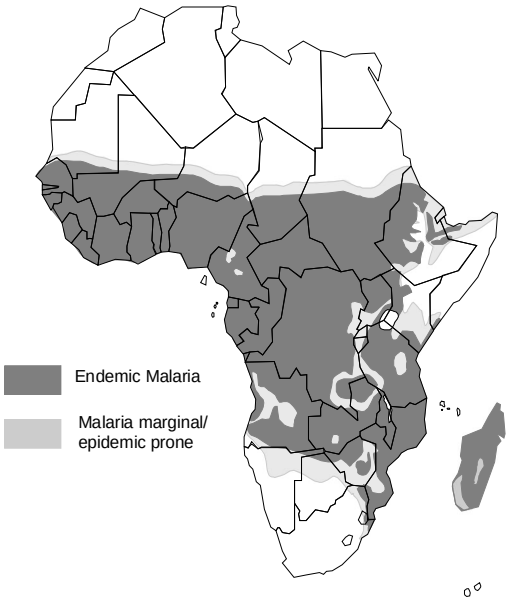
Malaria

The Africa Malaria Report of the World Health Organization (WHO) states:
"About 90% of all malarias deaths in the world today occur in Africa South of the Sahara and an estimated one million people in Africa die from malaria each year and most of these are children under 5 years old." [1]With about 1 million deaths per year attributed to malaria per year malaria is likely the leading cause of death in sun-Saharan Africa.

An African child dies from malaria every 30 seconds

[1] The Africa Malaria report 2003/ World Health Organization and UNICEF; 2003. pg. 17

Distribution of endemic malaria

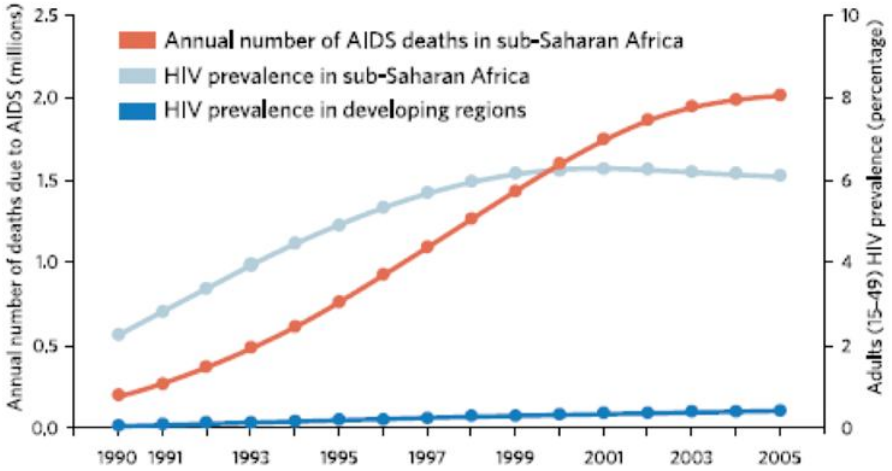


Source: The Africa Malaria Report, WHO UNICEF fig 1.1

[1] The Africa Malaria report 2003/ World Health Organization and UNICEF; 2003. pg. 17

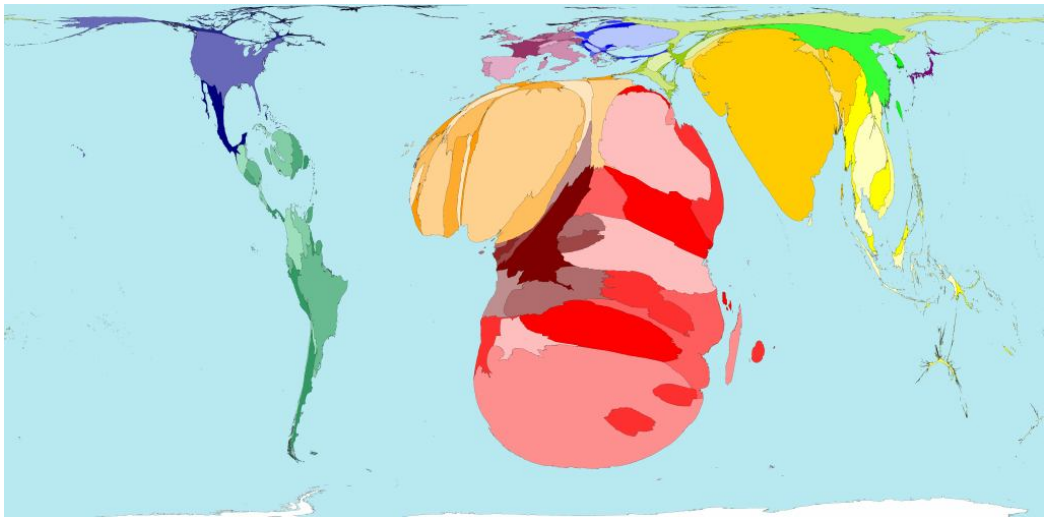
b) Also Dominant Is HIV/AIDS as can be seen in the graph & map below

HIV prevalence in adults aged 15-49 in sub-Saharan Africa and all developing regions (Percentage) and number of AIDS deaths in sub-Saharan Africa (Millions), 1990-2005



WHO, The Millenium Development Goals Report 2006.

Distorted map of Africa in a World map showing territory size according to the proportion of all people aged 15-49 with HIV worldwide, living in each area.



Source: World Mapper http://www.worldmapper.org/display.php?selected=227

The bloated out distortion of the map of Africa is indicative of the huge HIV/AIDS burden that Africa carries.

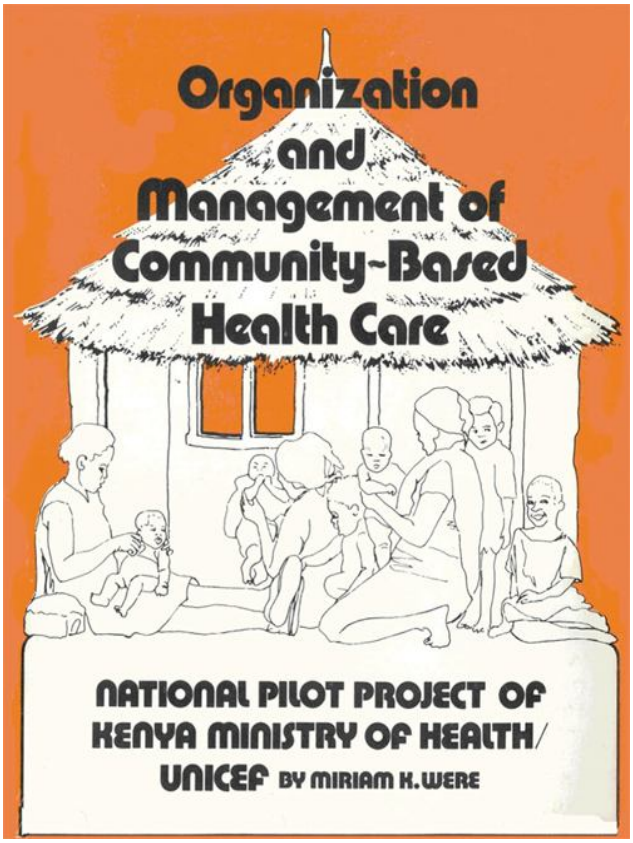
c) Diseases Linked To Lack of Management of Human Waste.

In 1970 during my studies in Medical School, I undertook a study to find out what diseases were responsible for the majority of admissions to the National Referral

Hospital; the Kenyatta National Hospital. To my great surprise, **I found that over 70% of admissions were related to lack of proper disposal of human waste.** Most of these diseases fall in the category of infectious and parasitic diseases among the diseases of poverty.

After qualifying as a Medical Doctor in 1973 and working at the Kenyatta National Hospital in Nairobi, I continued to see the important role of the faeco-oral connection in admissions. I joined the teaching staff of the University of Nairobi Medical School in 1974 (Department of Community Health) and got opportunity to talk about latrines and their important role in health status. Many senior Medical Doctors saw this as a "mundane topic" to bring up in a Medical School. They wanted to focus discussion on "important academic issues". So they sarcastically nicknamed me **Professor of Latrines** long before I got to that professorial status. This was meant to insult me but I was not insulted! My response was and still is that it is a great professional honour to be known by this title in view of the importance that proper management of human waste could play in the health development of our country! Whether this was "academic" or "mundane" is still irrelevant!

From the beginning, it was clear to me that Community Participation could play a major role in health promotion by establishing proper management of human waste and being involved in other health-promotive and diseases preventive activities. But because our people in their communities had been ignored in most development work, it was not clear how to involve them. Therefore, in the period 1976-1982, I carried out research work on **People's Participation in Their Own Health Care** from the perspective of the community. By the end of this research work, there was reduced morbidity due to improved management of human waste. In 1982, UNICEF published my book ORGANISATION AND MANAGEMENT OF COMMUNITY-BASED HEALTH CARE which has been reprinted since.



3.2 Some consequences from high disease burden in Sub-Saharan Africa

a) Mothers of Africa die more than Mothers in other parts of the world

1 in 16 women in Sub-Sahara Africa are at risk of dying from maternal death in comparison to 1 in 2,800 women in the developed regions of the world' The socio-economic circumstances predispose them to this. The table below shows comparison of risk of maternal death among regions of the world.

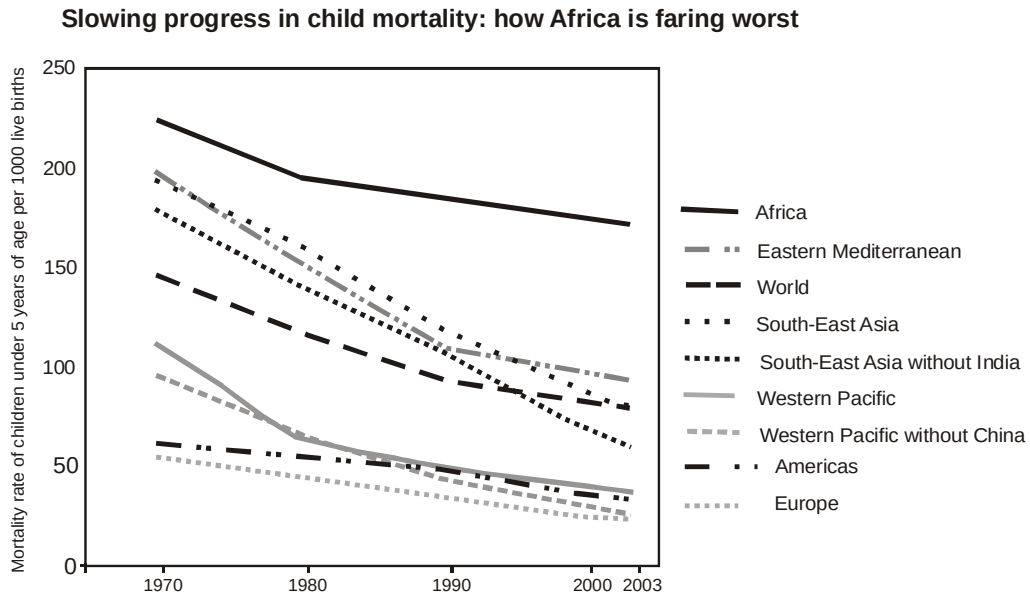
Maternal mortality estimates by United Nations MDG regions, 2000

Region	Maternal mortality ratio (maternal deaths per 100,000 live births)	Number of maternal deaths	Lifetime risk of Maternal death, 1in :
WORLD TOTAL	400	529,000	74
Developed Regions *	20	2,500	2,800
Europe	24	1,700	2,400
Developing Regions	440	527,000	61
Africa	830	251,000	20
Northern Africa **	130	4,600	210
Sub-Saharan Africa	920	247,000	16
Asia	330	253,00	94
Eastern Asia	55	11,000	840
South-central Asia	520	207,000	46
South- eastern Asia	210	25,000	140
Western Asia	190	9,800	120
Latin America and the	190	22,000	160
Caribbean	240	530	83
Oceania			

(Maternal mortality in 2000: estimates developed by WHO, UNICEF and UNFPA, pg. 2)

The death of a mother, especially in Africa, is a huge tragedy to the family and community. Children whose mothers die hardly survive. Even when they do, their performance in school and life tends to be compromised. Husbands also tend to get "derailed" when wives die. Therefore high maternal deaths are obstructing Africa's development efforts.

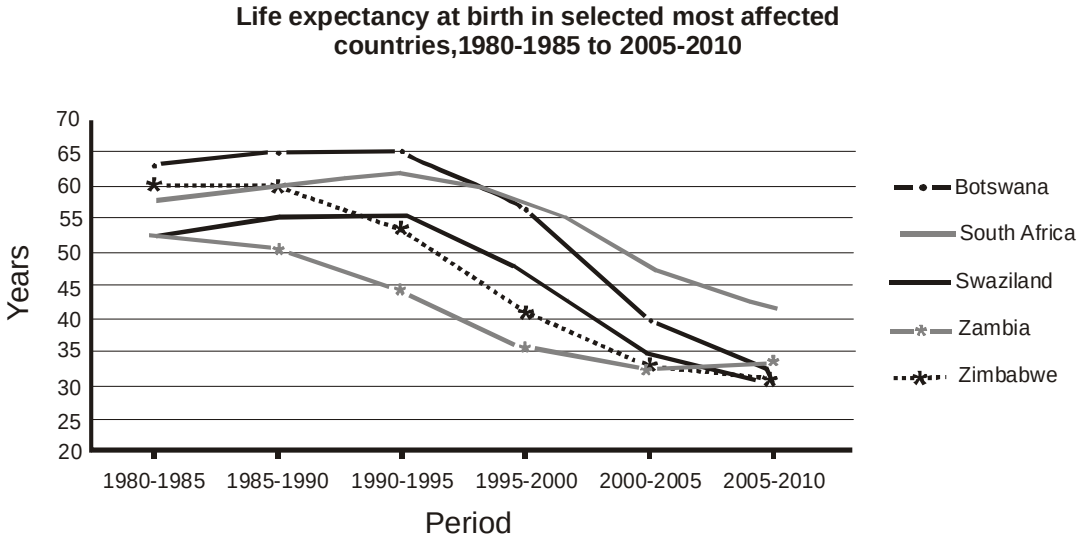
b) Reduction in African Child Death is NOT keeping up with reduction in Child death of other Regions since 1980.



Source: The World Health Report 2005, Make every mother and child count, fig 1.1 pg 9

Sub-Sahara Africa is only about 10% of the world population but provides over 30% of child deaths. High child deaths result in rejection of family planning which further compromises maternal well being.

c) Challenges from HIV/AIDS undermine Life Expectancy in Africa



Source: UN Population Division, World Population Prospect; the 2002 Revision

It is ironic that while life expectancy in developed regions edges upwards towards 80years, in Africa it going downwards towards 30 years.

4. APPROACHES TO SOLUTIONS

4.1 Bringing down Diseases linked to lack of Latrines and Sanitation

In Africa, we do not talk so much about toilets but about latrines. I refer to **latrines** rather than toilets because in most of Africa, what we have are latrines. Toilets need water to flush away human waste and in most of Africa, we do not have piped water to homes and facilities like schools. It's mostly latrines which have holes into which human waste is dropped.

Speaking in Fukushima on the title FROM PUBLIC TOILETS TO CLINICS is a great joy. It establishes a present day link and also a kind of HISTORICAL TELEPATHY between Fukushima and my original research work which highlighted the importance of latrines. I believe that the relationship between Africa and Fukushima in Japan will help us, in Africa, to put behind us the problem of high burden of disease from diseases promoted by lack of human waste management! Diseases that would be drastically reduced include:-

- Diseases from direct contamination of food in which flies play a major part and also from handling food with unwashed hands e.g. food poisoning.

- Diseases arising from parasite ova deposited directly into the soil when faeces are dropped on the ground. The ova contaminate plants that are eaten directly by people or eaten first by animals and then passed on through meat to people (e.g. round worms and tape worms). These worms may cause general malaise and even intestinal obstruction (e.g. round worms). Other types of ova hatch into active forms that penetrate the skin (e.g. hookworm, schistosomias) which then pass up to the digestive track and cause many illnesses including anemia.

- Serious diseases arise from contamination of water and may even lead to epidemics of cholera, dysentery and other diarrhoeal diseases that cause many deaths.

All the above contribute over 25% to disease burden within Africa. In present day Africa without widespread access to piped water, reduction of this disease burden is dependent on construction and use of latrines in the homestead as well as public latrines in places where people gather for long hours.

In the study of 1976-82 the project promoted a package of interventions that promote environmental sanitation and cleanliness. These included:-

- Dish racks - for drying household utensils in the sun after washing
- Latrines - for disposal of human waste
- Grass around the homestead cut short to keep away snakes e.t.c.
- Reduction of potholes that hold stagnant water to reduce insect breeding.
- Clean tap water sources to provide clean water for drinking and household use

Changes in home environment during the project

Homestead Environment and Water-Related Activities

Action Area	*Mean Percentage Positive**		
	October 1977	*April 1979*	*January 1980*
Dishrack presence and use	1	96	88*
Latrine use	1	95	91*
Grass cut within 16m of house	15	90	85+
Home free from potholes and stagnant water	14	84	85+
Cleaned-up water source	12	77	81+

* Due to variability in community sizes findings for each observation were expressed as percentage of households positive (having achieved target) in each community.

A most encouraging finding three years following the initiation of the study was the drop of intestinal worm infestation from 80% to 6% as shown in the table below. Along with this there was great reduction in all diarrhoeal diseases incidence.

Table of reduction of worm infestation

Latrine use and Worm Infestation

	1977	*1978***	*1979*
Percent of households using latrines	1	96	91
Percent positive with* Intestinal worm ova	80	64	6
Sample Size	245	241	250

*Children up to 12 years of age.

It is very sad that today, MANY DECADES since we knew these facts, NOT all homes in Africa have homestead latrines. Furthermore, not all public facilities have well-functioning public latrines. Therefore, ensuring the presence of functioning latrines in every homestead and well kept public latrines is one of the most urgent public health actions to be undertaken.

Latrines for family use are small units build outside the houses where we live. The small unit is built around a hole that is 30 to 40ft deep in the dimensions of 3ft by 4ft. Overlaid across the deep hole are planks of hard wood. Over this hard wood is overlaid wire mesh or similar substance over which either mud or cement with stones are places to make a floor. A small hole is left in the floor into which the human waste is dropped directly. And around this is a unit is built to provide privacy. When human waste is released from the body, it travels a long way to hit the bottom of the deep hole. So the latrine is sometimes called "The long drop".

In a family setting (homestead) there can be 1 0r 2 latrines or one latrine with 2 holes built back to back.

Picture or Sketch of homestead Latrines to show; not to describe

Public Latrines are what are needed in places where people gather for a long time e.g. Schools, places of worship and market places. The safety of these devices is important since each of them can have 4 to 6 holes; which means the larger hole in which these smaller holes are located is much longer and its construction more challenging. Therefore these public latrines must be such that their safety is and cleanliness that is assured to be safe and attractive for use.

Picture or Sketch of Public Latrines: to show; not to describe.

4.2 Beyond Latrines to Health Clinics

a) Diseases of poverty unrelated to latrine use

As can be seen in the classified of **Diseases of poverty** presented in 3 above, some of the diseases of poverty are outside those affected by the presence and use of latrine. Furthermore, there are other diseases of poverty routinely seen in Africa which are not included in the list presented in 3.1 above. In the context of the classification of **Diseases of Poverty being an important consideration in Africa,** a more comprehensive list would include some that are not in the list. Some of these conditions are:-

- Maternal death causes
- Perinatal death causes
- Morbidity and death from childhood diseases preventable by immunization
- Respiratory and other diseases of childhood,
- Malnutrion
- Diseases of the adult population including those afflicting men
- General malaise related to poor sanitation and hygiene
- Mental health & pregnancy related health problems
- Accidents and trauma

- chronic disease e.g. cancers, diabetes, hypertension and other cardio-vascular conditions in children, adult men and women
- Evidence of people living in poor sanitary and hygienic conditions
- Accidents
- Mental illnesses
- Violence-related morbidity and death.
- AND the BIG one: HIV/AIDS.

It would take a long time to go over how each of these diseases affects communities and individuals living in poverty. But I believe that some reflection makes it clear that, indeed, when people live in poverty, these conditions are common. And since over 50% of the people of Africa live in absolute poverty (on less than one US $ per day), these conditions are common on the continent. To help those who are not familiar with what I am saying, let me present to you some pictures of what this means.

Pictures of children and adults with some of the conditions mentioned above.

b) From Latrines and Community Health Services to Health Clinics

Dr. James Nyikal of Kenya's Ministry of Public Health has eloquently stated **"Health is made in the home and community. Damaged health is repaired in health clinics, health centers and hospitals"**. The AFRICA HEALTH STRATEGY adopted by Africa's Ministers of Health and approved by African Heads of State in 2007 recognizes the importance of the Community Level in Health care. It is at the community level that action on latrines is most effective. Community level health work is particularly important for:-

- **Health promotive** activities since this links into lifestyles, culture and traditional practices that are best handled and sensitively treated in a culturally proper context.

- **Disease Preventive** activities e.g. improvement of sanitation and hygiene that includes construction and use of homestead and public latrines and prophylaxis with anti-malarial medicines for young children and pregnant women.

- **First line curative services** such as oral rehydration for children with mild dehydration and treatment of malaria, treatment of simple opportunistic infections of People Living with AIDS (PLWAs).

To achieve good results, the Community Level must have:-

- Well-selected and trained Community Health workers/Agents
- Good back up by health workers from the first referral level who provide supervision and advice on referrals such as Health Extension workers
- Effective referral arrangements to health clinics, health centers and other health facilities like hospitals, Nursing homes etc.

c) The important role of Health Clinics in reduction of the disease burden.

Health clinics constitute the first level facility to which sick people are referred from the Community-Based Health Care services. Most people in Africa get to Health Clinics (sometimes called **dispensaries)** by walking. Therefore for them to make the maximum use of these facilities, they need to be within short distances of no more than 5km. Otherwise, people only go to them when they are desperately ill and usually die because the clinics are not equipped to deal with complications of this nature. Unfortunately, the health coverage of the population is still very poor in Africa which implies that clinics are not within walking distance of most people. This is one of the factors contributing to the high disease burden. When they are available, health clinics should be staffed and equipped to provide basic services that include:-

(A picture to illustrate each point a, b etc)

i. **Handling referrals from Community level services**. For example, a Community Health worker (CHW) may train mothers to manage **mild dehydration** through administration of oral rehydration therapy **(ORT**). Where needed e.g. with a restless or wailing child, the CHW may directly assist mothers with ORT. But when the dehydration become moderate to severe, ORT may no longer be possible as the child may not be able to drink fluids. A child who is **moderately to severely dehydrated** needs intravenous administration of fluids. Therefore such a child must be referred to a health clinic. Also to be referred to the Health Clinic are children who may not be responding to community level management of respiratory tract infection. Supervision by Clinic staff of the Community level health workers within which referrals are streamlined is important.

ii. **Providing immunization** especially to children less than 5 years of age. This is particularly so because immunizations schedules are very precise regarding timing of the first dose and any subsequent doses. Therefore, most countries do not allow this to be done at the Community level because the educational level and the training of Community Health Workers is too basic to be given this responsibility. Health Clinics also all other immunizations except those for international travel. These include immunization of pregnant mothers (to prevent tetanus) and the general public to stop epidemics of meningitis and the like.

iii. **Provision of Family Planning Services:**. Increasingly, many African mothers would like to plan their families. For this, the first dose needs to be given after Medial Examination by a Health Professional at the level of the clinic at which the decision of the Family planning method to be used is made and the first dose provided. Later doses may be given in the context of Community-Based Distribution (CBD). Combination of this clinic service for the first time followed by CBD has proved very successful in increasing access to contraceptive services.

iv. **Antenatal care Assessment of onset of labour**
Health clinics should provide antenatal care to monitor maintenance of good health through out the pregnancy and to screen for high risk pregnancies. At the clinic level, an expectant mother could find out the Expected Delivery Date (EDD) and may even come to be assessed for onset of labour. Some clinics may have staff and equipment to carry out straight forward deliveries.

v. **Providing curative Care Services**

Being close to people, the Health Clinic has a major role in providing curative services for most diseases but especially for acute illness that kill in a short time such as malaria, pneumonia, diarrhoeal diseases and management of opportunistic infection among People Living with HIV/AIDS. These health facilities also play an important role in ensuring compliance for long term treatment regimes such as those required for diabetes, hypertension, tuberculosis and ARVs.

The effectiveness of services at the clinic level depends on:-

i. Adequate numbers of well trained health workers and proper equipment and supplies.
ii. Streamlined referral to the next level facility

The Ministry of Health in Kenya is working on establishing a central facility with satellite facilities that refer cases to it. This would mean that:-

a) To one clinic would be attached about 25 Community Health Workers whom designated staff members at the clinic would supervise. Community health workers would refer what they can't handle to the clinic.
b) A number of clinics would become the satellite to one health centre or sub-district hospital. These clinics would send patients needing further medical attention to these health centers or first level hospitals. In turn these health centers or first level hospitals could refer patients to the 2nd and 3rd level hospitals.

The attractiveness of this approach is that it would be possible to cover an entire administrative unit e.g. (A district of a province) with a network of services beginning with the community level to the health clinic/health centre level up to the hospital levels. The whole country can thus be covered with health services. What would have the greatest impact on the reduction of the disease burden are the levels of the community and health clinic. At the same time, the level of the hospitals would contribute most significantly to quality of care of more complicated cases as well as increasing survival rates from chronic conditions e.g diabetes such cases.

All African countries are preparing plans similar to those of Kenya. The challenge is to get them implemented.

5. OBSTACLES TO IMPLEMENTATIONS THAT NEED BE OVERCOME.

5.1 Coming to terms with a difficult history and facing up to the consequences of that history and present day constraint

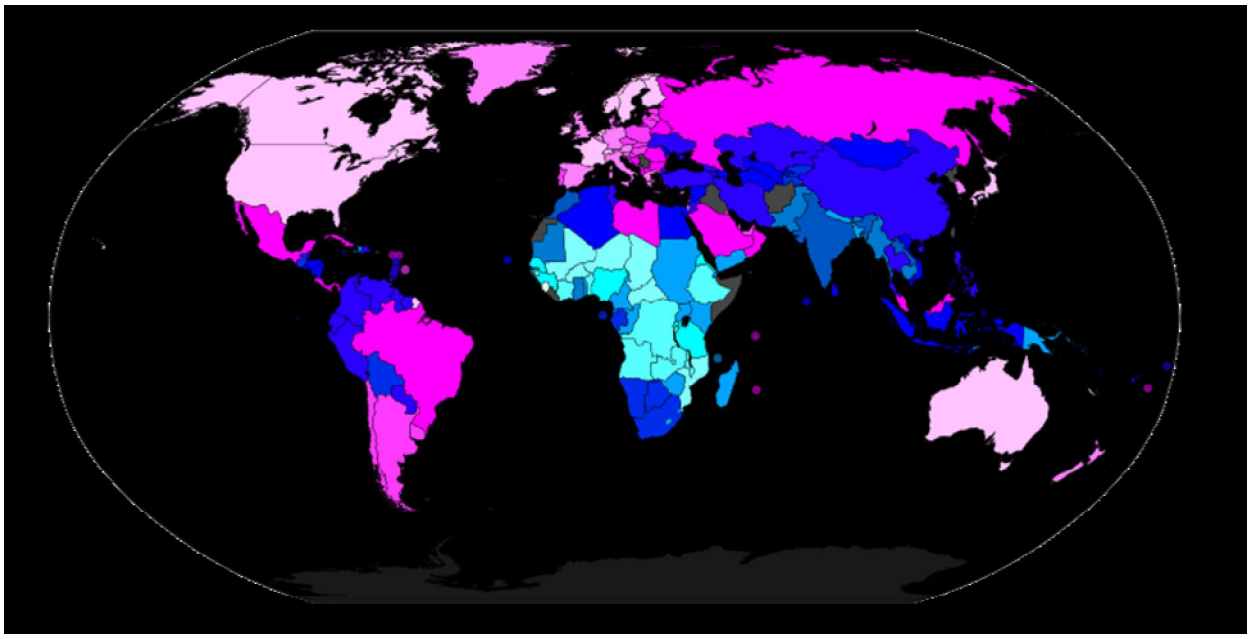
Africa was under a brutal Trans -Atlantic slave trade for over 500 years (early 1400s to late 1800s). This period of 500 years of brutal and massive slave trade was followed by 100 years of colonialism and apartheid (1884 - 1994). Furthermore, African countries begun to attain political independence from the late 1950s during the period of the cold war between socialism/communism and capitalism. As this cold war played out in Africa, each side established dictatorships to keep countries in their camps. This resulted in further entrenched oppression, instability and mis-management of Africa's resources. The resulting **social inheritance of disempowerment** affects Africa to this day. Furthermore, because of the unfortunate consequences of this history, Africa continues to be deprived to the present day.

Therefore, one of the challenges for Africa is that of becoming a partner with other areas of the World. As it works on this, Africa appreciates positive relationships. We note with appreciation that Japan took the lead of establishing consultation between African Heads of State and Japan. It helps us when Africa is looked upon with compassion and positivity. It was so encouraging to see the TICAD IV brochure with the title **VIBRANT CONTINENT** and a lovely African child on it. It was so different from the lead article of a well known international magazine, which a few years ago, declared Africa as "THE HOPELESS CONTINENT". There is no doubt that Africa must get out of social upheavals and instability into which history pushed us. We hope that we can do this with the help of Africa's genuine friends.

5.2 Constraints from wide spread poverty.

Extreme Poverty is Africa's greatest Challenge. This is particularly because with poverty comes oppressive, depressive, lethargic and apathetic out looks on life. This makes it difficult for most people to be pro-active and creative in finding solutions. We believe that with time these destructive consequences will become less as we recognise their existence.

The figure below depicts three levels of the Human Development Index arranged in a colour scheme. The majority of African countries fall in the low income index group indicative of high levels of poverty.



Countries fall into three broad categories based on their HDI: **high**, **medium**, and **low** human development. The 2007/2008 edition of the *Human Development Report* was published on November 27, 2007; in Brasília, Brazil. [1]

High	Medium	Low
0.950 and over	0.750–0.799	0.450–0.499
0.900–0.949	0.700–0.749	0.400–0.449
0.850–0.899	0.650–0.699	0.350–0.399
0.800–0.849	0.600–0.649	under 0.350
	0.550–0.599	not available
	0.500–0.549	

Source: United Nations Development Program's *Human Development Report* 2007/2008, compiled on the basis of 2005 data and published on November 27, 2007.

6. INVITATION TO FUKUSHIMA TO PARTNER WITH US.

I salute Fukushima for being the kind of place from among whom someone of the stature Dr. Noguchi could come from. He was determined and overcame disabilities. He created opportunities where there seemed to be none. And beyond Japan, he also served Asia, North & South America and Africa. He was truly a global citizen. He was a unique person from a unique people. We salute him and we salute you, people of Fukushima and pay tribute to the fact that your beloved son died in Africa. Furthermore, we appreciate that Japan took the lead in establishing consultation between African Heads of State and Japan. Our desire is that these ties get stronger and stronger to the benefit of both sides.

Therefore, in ways that are possible for you, we invite you to visit our continent to work closely with us in promoting the well being of humanity.

On the 29th of May, I spoke at the United Nations University in Tokyo. I made the point that the United Nations is very much needed today for the well being of all the people of the World. It is not by accident that we find the UN University was placed in Japan. It is also not by accident that the important Kyoto Protocol on environment comes from the Japan. We thank the Japan for her many important roles in the world.

However, we also take note **that every individual everywhere in the world has a role to play**. Therefore I end the speech with the opening lines of my favorite prayer.

Lord,
Make me an instrument of peace;

Where there is hatred,
Let me sow love;

Where there injury,
Let me sow pardon;

Where there is doubt,
Let me sow faith;

Where there is despair;
Let me sow hope;

Where there is darkness,
Let me bring Light;

Where there is sadness,
Let me sow Joy!
(Adopted from the prayer of St. Francis)

I THANK YOU people of Fukushima for your interest in and contribution to the people of Africa.

Mama Miriam.