HEWRAG

NEWSLETTER FEBRUARY 2022

FEBRUARY 2022

Greetings

Learn more about HEWRAG at the Rotary International Convention in Houston June 4 -8. We invite attendees to an information session in room 381B on Sunday 5th June from 2.30 to 4pm entitled "CerviCAL Action a partnership to Eliminate Cervical Cancer in the Americas" presented by Dr. Walley Temple, Rotary Club of Calgary, Canada, and Karl Diekman , Rotary Club of Woodland CA, USA, followed by our Annual General Meeting.

HEWRAG will again host a booth in the House of Friendship. Please stop by for current information and news about projects, events and opportunities to become involved in HEWRAG's activities. Contact us for details about volunteering in the booth. It's a great way to meet Rotarians with similar interests ready to contribute toward a healthier world.

If you have a project, event, or interest in one of our areas of emphasis, we invite you to look to us as a well-informed and experienced source of support and information. If you would like a HEWRAG program or exhibit for your District Conference, Zone Institute, or another Rotary event, please contact us.

Hoping to see you in Houston

Stay safe and well

Josie Norfolk

Chair

HEWRAG

CONTENTS

World Health Day was observed recently in Rotary District 3080 .
RYLA VISHESH WITH OVER 460 SPECIAL ATHLETES and an equal number of parents and teachers it was a vibrant and energetic event organised and anchored by PP Dr Rita Kalra Director of Hewrag from RC Chadigarh Midtown.

The power of knowledge has the ability to make a difference and together we can make real progress in reducing the impact of cancer. Income, education, location & discrimination based on ethnicity, gender, sexual orientation, age, disability & lifestyle can affect cancer care.

During the day Cervical Cancer screening was done for women employees >35 years to spread awareness about the importance of periodic testing for early detection of cancer. Dr. Rita Kalra confirmed that the HPV& DNA tests are

sponsored by the Origin Life Foundation who will also sponsor Pap smears.

Volunteers Ms. Sharda Ahuja & Mrs. Raj Gupta spoke about the preventive aspect and danger signs to detect cancer at early stage. They have setup counselling to provide emotional & financial support to cancer patients under treatment at Civil Hospital Panchkula.

Dr. Sulbha Arya from the Oncology department together with Dr Rita Kalra (hewrag director) organized the event & distributed protein supplement to patients under treatment and follow-up to boost their morale & immunity.

Dr. Suvir Saxena PMO Civil Hospital Panchkula appreciated the efforts of the NCD team for organizing events of Public interest. He gave away participation certificates for the seminar held to give the latest updates in management & screening of , organized in collaboration with PGI, to all the delegates & speakers.

Attended by 50 staff members & patients the focus of the event was to reduce stigma and listen to people living with cancer. Then only we can build a fairer world and future with healthy lives.

RESTART AFRICA

A STORY OF THE DIFFERENCE ONE PERSON CAN MAKE

Restart Africa is an inspirational orphanage rescuing homeless children from the streets of Kenya and providing them with a home, care and education.

In 2008, Kenya was facing a severe post-election crisis, which resulted in over a thousand deaths and more than 500,000 people being displaced from their homes and villages. Many of them were children, who had been orphaned, abandoned, or driven out of their homes by parents who could no longer support them.

Mary Coulson, a local resident and teacher who had relocated from the UK to Kenya, was horrified by the growing number of street children and felt compelled to do something about the situation, so she founded Restart Africa.

What started with six boys in a modest rental shed is now an orphanage looking after more than 100 children. Working with the authorities, Restart Africa rescues homeless children in Kenya and provides them with a home, education, care and counselling.

Most of the children have suffered severe abuse – often sexual – and deprivation, and all have significant emotional issues. It can take many months before they get over the hand to mouth existence they were leading on the streets and are able to enjoy a more secure life in the Restart Centre.

Restart Africa believes that, given love, care and educational opportunities, all the children will have a wonderful future ahead of them. Looking at their smiling faces, it is often hard to believe the depths of misery they have come from.

Restart Africa does not receive grants or funding from the Kenyan government and is supported purely by donations and sponsorships. The team in Kenya is working

tirelessly to provide for the children on a day-to-day basis and is lucky to have a network of committed volunteers in many corners of the world, who are always on the lookout for more supporters, volunteers and sponsors.

In Australia, the cause is an accredited RAWCS project – a project of the Rotary Club of West Tamar, Tas. The local formation of volunteers is called Restart Africa Australia, and is led by national convenor Peter Maynard, with his wife Pat, who is a Rotarian and a major contributor and leader on the Craft and Community Shop front. They are ably supported by Di, who is the administration and social media volunteer and sponsor of Michael – one of the kids at Restart. They mobilise new supporters, run fundraisers, and engage new volunteers – all in support of Restart Africa, based in Gilgil, Kenya, on its mission to provide a safe and healthy environment for all Restart kids.

However, the main focus of their efforts lies in finding sponsors for all Restart children, because sponsorships are the most important support component of giving each child the bright future they deserve. At the moment, 13 kids are sponsored by Australian supporters, and the regular monthly donations enable Restart to fund each child's welfare and, most importantly, a good quality education.

A full sponsorship costs AU$190 per month, but the team developed a stepped sponsorship program to allow even more people to become part of the cause and support in whatever way they can.

Details of the program can be found at https://directory.rawcs.com.au/121-2017-18. Maybe Christmas is the perfect time to start supporting a child's future – perhaps, even as a unique gift to someone you know?

Volunteering is another major focus for Restart. Onsite volunteers get a chance to pass on certain skills to the children during a period of volunteering at the facility and the kids get some valuable exposure to different social, cultural and

educational experiences. And while you are there, why not combine it with a safari? Touring partner Twiga Tours has a wealth of experience, and Peter and Pat are also happy to advise on a plan as they have gone on one of these adventures in the past. Accommodation is available in a modern villa unit onsite, subject to availability.

But Restart also needs volunteer support in many areas here in Australia. At the moment, they are looking for volunteer convenors in all states of Australia, who can assist with identifying and approaching potential sponsors and donors, communicate with Rotary clubs in their region, arrange occasional fundraisers, and be the local contact for phone and email enquiries.

Restart's profiles on Facebook and Instagram will give you a very vibrant impression of what they do, and the Australian team can be contacted anytime.

CERVICAL CANCER IN SOUTH AFRICA

Cervical cancer could be eliminated by the end of this century, thanks to a preventative vaccine. But ignorance is a major barrier to the rollout of the vaccine in South Africa, where the disease is the deadliest cancer for women.

"When my mom was diagnosed with stage two cervical cancer, she was advised to have her womb removed as they said it was completely damaged and she was bleeding all the time," remembered Shirly Seepe (44), a mother of two adolescent daughters from Limpopo.

But her mother refused the recommended hysterectomy because "she did not want to be buried without all of her body parts", said Seepe.

Chemotherapy treatment was unsuccessful and Seepe's mother lost her life to the illness in 2009.

Five years later, the Department of Health launched a government school-based immunisation programme offering girls in grade four between the ages of nine and 14 a free vaccine, arguably the most important tool that exists to fight cervical cancer.

The vaccine against the human papilloma virus (HPV) – the cause of about 99 percent of cervical cancers – is the only truly effective form of prevention. And it is effective.

Nearly 14 million women will live instead of die over the next 50 years if HPV vaccine coverage reaches 80 percent of those who need it by 2020, according to a February modelling study published in the journal *Lancet Oncology*.

Continued high coverage of the vaccine, usually given as two injections, along with access to screening services could effectively eliminate this form of cancer by 2100.

Seepe said that she wished her mother was born a few decades later.

"If it was available in her time, she might still be alive."

HPV roll-out inconsistent

The Department of Health's bold investment paid off. Coverage data for the first round of vaccinations in 2014 showed that the target of 80 percent coverage had been exceeded.

This percentage is the threshold needed for adequate protection of the population, according to the Department of Health.

But, since then, coverage estimates have inexplicably yo-yoed.

The number of vaccinated learners dropped below 80 percent in 2016 but increased again in 2017 to 83 percent, according to figures provided by Dr Yogan Pillay, Deputy Director General at the Department of Health.

The aim of the HPV vaccination campaign is to reach all of the annually estimated 500 000 eligible girl learners with two doses of the vaccine. Both doses are recommended for sufficient levels of protection.

“About 1.2million grade four girls have received two doses of the HPV vaccine since 2014 [but] more have received at least one dose: 1.9 million,” said Pillay.

But if the campaign had managed to reach all 500 000 learners each year since 2014, the number should be double this.

Cervical cancer fatal to southern Africa

Rates of cervical cancer in sub-Saharan Africa are the highest in the world. Although the region accounts for about 10 percent of the global population of women over the age of 15, over 20 percent of cervical cancer deaths occur here, according to a January study published in the *South African Medical Journal*.

This is mainly because women are often diagnosed late with cervical cancer and need relatively expensive treatment and technologies at that late stage. Women with HIV are also more susceptible to HPV and the infection develops faster in women with HIV, making addressing the hurdles in vaccination access all the more urgent.

Media reports have focussed on parents’ concerns about the safety of the vaccine but experts believe many other factors are fuelling the gaps in our local HPV immunisation programme.

The HPV vaccine works best if given to people before they start having sex because the virus is so common and contagious that the majority of sexually active people will be exposed to it.

A minority of those exposed go on to develop cervical cancer, usually over a prolonged period.

Up to two thirds of South African women between the ages of 15 and 24 are infected with at least one strain of HPV at any given time, according to estimates provided by Dr Tendesayi Kufa from the National Institute of Communicable Diseases.

While the vaccine is only provided by the state to girls in grade nine, young women who have had few or no sexual partners would receive the same benefit.

Seepe’s daughters, aged 20 and 24, are unvaccinated as they fall outside of the government’s target population – yet they are still at an age where the vaccine could protect them against the disease. Seepe told Health-e News that she is anxious about history repeating itself.

“The only option left for my daughters is to go for regular pap smears, but I wish they could get this vaccine for free too. If they did I will know they won’t become victims to cervical cancer, like my mother,” she said.

Where are the gaps?

Researchers have also pointed out that a significant portion of nine-year-old girls are ignored by the programme including those in private schools and those who are a grade ahead. Many countries also vaccinate boys to increase population-level protection and to prevent less common cancers caused by HPV in men.

There are calls for South Africa to broaden the target population to include these groups who often are unable to afford the immunisation in the private sector – at a cost of well over R1000.

But Pillay says expansion is difficult: "We would love to expand but there are no additional funds. [To offer the vaccine to more people] we would need either a single-dose vaccine or significantly lower prices."

But it is difficult to know the true coverage rates and the reasons for why there are higher rates of unvaccinated learners in some areas of the country because of poor quality data, according to a 2018 study published in the journal *Global Health: Science and Practice*

"Countrywide, 369 542 single-dose vials were reported as used [in 2014], whereas only 353 564 learners were reported as vaccinated – a difference of almost 16 000, suggesting high vaccine wastage. More than 4 500 vials were reported as damaged or missing, costing just under R3 million," according to the study.

Access versus anti-vaccine beliefs

Key informants involved in this research, including government officials and health workers, have attributed low coverage rates in some areas to "challenges experienced with informed consent and anti-vaccine activities", but without better quality data, this evidence remains purely anecdotal.

Even so, the researchers suggested that these reports should not be ignored. They noted that anti-vaccine messages, predominantly spread on social media platforms, may have posed an "important threat to the success of the campaign".

But a lack of information and awareness is likely to pose more of an immediate threat to HPV vaccination uptake in the South African context.

Nonzwakazi Faye, an 83-year-old from rural Eastern Cape, refused to sign the consent form for her granddaughter's vaccination earlier this year, because she did not understand what it was about.

"My child was not vaccinated. I don't understand how a child, at the age of nine, is at risk of getting cervical cancer. The child is too young to get such a disease. Back in my day there were no such things," she told Health-e News.

This month, Health Minister Dr Aaron Motsoaledi is set to launch a national immunisation survey, which has not been done since before 1994.

The results will be available by the end of the year and will shed some light on the true state of vaccination coverage, access and gaps locally.

The recent public sector oncology crisis in KwaZulu-Natal is but one example of the pitiful access to cancer treatment in South Africa.

Proper implementation of the HPV vaccine will greatly reduce the need for treatment and save lives and money, according to 28-year-old cancer survivor Nomsa Tshingowe.

Tshingowe, who lives in a rural village in Limpopo with poor access to services, told Health-e that improving access to the vaccine is an “important” step to tackling cancer.

Said Tshingowe: “Cancer treatment is not easily accessible at our public hospitals so any form of prevention becomes a victory. This gives us hope that, in future, we will have a cancer-free generation.” – Health-e News

Cervical Cancer

20 January 2022

Key facts

- Cervical cancer is the fourth most common cancer among women globally, with an estimated 604 000 new cases and 342 000 deaths in 2020. About 90% of the new cases and deaths worldwide in 2020 occurred in low- and middle-income countries (1).
- Two human papillomavirus (HPV) types (16 and 18) are responsible for nearly 50% of high grade cervical pre-cancers.
- HPV is mainly transmitted through sexual contact and most people are infected with HPV shortly after the onset of sexual activity. More than 90% of them clear the infection eventually.
- Women living with HIV are 6 times more likely to develop cervical cancer compared to women without HIV.
- Vaccination against HPV and screening and treatment of pre-cancer lesions is a cost-effective way to prevent cervical cancer.
- Cervical cancer can be cured if diagnosed at an early stage and treated promptly.
- Comprehensive cervical cancer control includes primary prevention (vaccination against HPV), secondary prevention (screening and treatment of pre-cancerous lesions), tertiary prevention (diagnosis and treatment of invasive cervical cancer) and palliative care.

Overview

Worldwide, cervical cancer is the fourth most frequent cancer in women with an estimated 604 000 new cases in 2020. Of the estimated 42 deaths from cervical cancer in 2020, about 90% of these occur in low- and middle-income countries. Women living with HIV are 6 times more likely to develop cervical cancer compared to women without HIV, and an estimated 5% of all cervical cancer cases are attributable to HIV *(2).* Moreover, in all world regions the contribution of HIV to cervical cancer falls disproportionately on younger women.

In high-income countries, programmes are in place which enable girls to be vaccinated against HPV and women to get screened regularly and treated adequately. Screening allows pre-cancerous lesions to be identified at stages when they can easily be treated.

In low-and middle-income countries, there is limited access to these preventative measures and cervical cancer is often not identified until it has further advanced and symptoms develop. In addition, access to treatment of cancerous lesions (for example, cancer surgery, radiotherapy and chemotherapy) may be limited, resulting in a higher rate of death from cervical cancer in these countries.

The high mortality rate from cervical cancer globally (age standardized rate among women: 13.3/100 000 in 2020) could be reduced by effective interventions at different stages of life.

HPV and cervical Cancer

A large majority of cervical cancer (more than 95%) is due to the human papillomavirus (HPV).

HPV is the most common viral infection of the reproductive tract. Most sexually active women and men will be infected at some point in their lives, and some may be repeatedly infected. More than 90% of the infected populations eventually clear the infection.

Cervical cancer is by far the most common HPV-related disease. Nearly all cases of cervical cancer can be attributed to HPV infection.

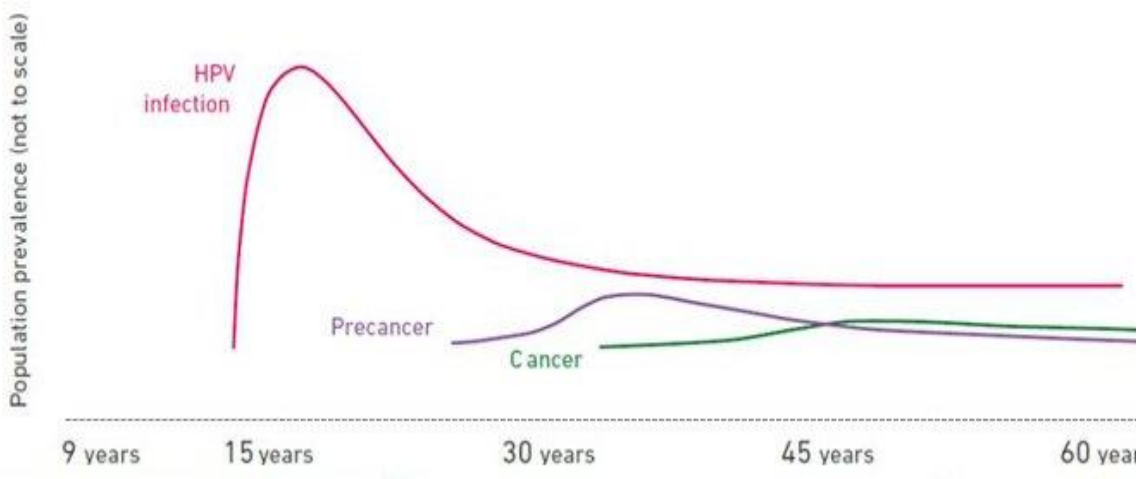
Although most HPV infections clear up on their own and most pre-cancerous lesions resolve spontaneously, there is a risk for all women that HPV infection may become chronic and pre-cancerous lesions progress to invasive cervical cancer.

It takes 15 to 20 years for cervical cancer to develop in women with normal immune systems. It can take only 5 to 10 years in women with weakened immune systems, such as those with untreated HIV infection

Cervical cancer control: A comprehensive approach

The Global strategy towards eliminating cervical cancer as a public health problem, adopted by the World Health Assembly in 2020, recommends a comprehensive approach to cervical cancer prevention and control. The recommended actions include interventions across the life course.

The life-course approach for cervical cancer prevention and control



Primary prevention	Secondary prevention	Tertiary prevention
Girls 9-14 years • HPV vaccination Girls and boys should also be offered, as appropriate • Health	From 30 years of age for women from the general population and 25 years of age for women living with HIV • Screening with a high-performance test	All women as needed Treatment of invasive cancer at any age • Surgery • Radiotherapy

information and warnings about tobacco use
- Sex education tailored to age and culture
- Condom promotion and provision for those engaged in sexual activity
- Male circumcision

equivalent or better than HPV test
- Followed by immediate treatment or as quickly as possible after an HPV molecular positive test.

- Chemotherapy
- Palliative care

Cervical cancer prevention should encompass a multidisciplinary, including components from community education, social mobilization, vaccination, screening, treatment and palliative care.

HPV vaccination

There are currently 4 vaccines that have been prequalified by WHO, all protecting against HPV types 16 and 18, which are known to cause at least 70% of cervical cancers. The 9-valent vaccine protects against 5 additional oncogenic HPV types, which cause a further 20% of cervical cancers. Two of the vaccines also protect against HPV types 6 and 11, which cause anogenital warts.

Clinical trials and post-marketing surveillance have shown that HPV vaccines are safe and effective in preventing infections with HPV infections, high grade precancerous lesions and invasive cancer *(3)*.

HPV vaccines work best if administered prior to exposure to HPV. Therefore, to prevent cervical cancer WHO recommends vaccinating girls aged 9 to 14 years, when most have not started sexual activity.

Some countries have started to vaccinate boys as the vaccination prevents HPV related cancers in males as well as.

HPV vaccination does not replace cervical cancer screening. In countries where HPV vaccine is introduced, screening programmes population-based screening programmes are needed to identify and treat cervical pre-cancer and cancer to reduce cervical cancer incidence and deaths.

Screening and treatment of cervical pre-cancer lesions

Screening

Cervical cancer screening involves testing for HPV infection to detect pre-cancer and cancer, followed by treatment as appropriate. Testing is done among women who have no symptoms and may feel perfectly healthy. When screening detects an HPV infection or pre-cancerous lesions, these can easily be treated and cancer can be avoided. Screening can also detect cancer at an early stage where treatment has a high potential for cure.

With its updated guidelines, WHO now encourages countries to use HPV tests for cervical screening, including HPV DNA and HPV mRNA tests.

- HPV-DNA testing detects high-risk strains of HPV, which cause almost all cervical cancers.
- HPV mRNA detects HPV infections leading to cellular transformation.

Unlike tests that rely on visual inspection, HPV-testing is an objective test. It has been shown to be simpler, prevents more pre-cancers and cancer, and saves more lives. It is also more cost-effective than visual inspection techniques or cytology (commonly known as 'pap smears').

Screening should start from 30 years of age in the general population of women, with regular screening with a validated HPV test every 5 to 10 years, and from 25 years of age for women living with HIV. Women living with HIV also need to be screened more frequently, every 3 to 5 years.

The process for a healthcare provider obtaining a cervical sample is similar with both cytology and HPV testing. However, WHO suggests that self-collected samples can be used when providing HPV DNA testing (this does not apply to HPV mRNA tests). Women need to receive appropriate support to feel confident in managing the process.

Screening must be linked to treatment and management of positive screening tests. HPV positive women may be treated without diagnostic verification in limited resourced settings. A test to triage the HPV positive women (e.g. VIA) is essential for treating HIV positive women.

Treatment of cervical pre-cancer

If treatment of pre-cancer is needed and eligibility criteria are met, ablative treatment with cryotherapy or thermal ablation are recommended. Both treatments are equally effective and safe and can be performed in an outpatient clinic.

In case of non-eligibility for ablative treatment or where there is suspicion of cervical cancer, women need to be referred to the right level of health services, where proper evaluation can be done with a colposcopy and biopsies. Excision treatment (LLETZ) can be offered when appropriate, and in the case of cancer an individual treatment plan is designed depending on the stage of disease, the patient's medical condition and preferences, and availability of health system resources.

Management of invasive cervical cancer

When a woman presents symptoms of suspicion for cervical cancer, she must be referred to an appropriate facility for further evaluation, diagnosis and treatment.

Symptoms of early-stage cervical cancer may include:

- irregular blood spotting or light bleeding between periods in women of reproductive age;
- postmenopausal spotting or bleeding;
- bleeding after sexual intercourse; and
- increased vaginal discharge, sometimes foul smelling.

As cervical cancer advances, more severe symptoms may appear including:

- persistent back, leg or pelvic pain;
- weight loss, fatigue, loss of appetite;
- foul-smell discharge and vaginal discomfort; and
- swelling of a leg or both lower extremities.

Other severe symptoms may arise at advanced stages depending on which organs the cancer has spread to.

Diagnosis of cervical cancer must be made by histopathologic examination. Staging is done based on tumour size and spread of the disease. The treatment plan depends on the stage of the disease and options include surgery, radiotherapy and chemotherapy. Palliative care is also an essential element of cancer management to relieve unnecessary pain and suffering due to the disease.

WHO response

The World Health Assembly adopted the global strategy to accelerate the elimination of cervical cancer as a public health problem. The definition of elimination of cervical cancer has been set up as a country reaching the threshold of less than 4 cases of cervical cancer per 100 000 women per year. To reach this threshold by the end of 21st century, WHO has set up the 90-70-90 targets to be reached by 2030 and to be maintained (WHA 73.2) (4).

- 90% of girls fully vaccinated with HPV vaccine by age 15;
- 70% of women are screened with a high-performance test by 35, and again by 45 years of age.; and
- 90% of women identified with cervical disease receive treatment (90% of women with pre-cancer treated; 90% of women with invasive cancer managed).

WHO has developed guidance and tools on how to prevent and control cervical cancer through vaccination, screening and treatment, management of invasive cancer. WHO works with countries and partners to develop and implement comprehensive programmes in line with the global strategy.

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5. Cervical knowledge repository

Educational and Therapeutic Climbing wall

Autism Connect Learning Centre

The Autism Connect Learning Centre is situated at a wonderful camp area in Strandfontein , Mitchells Plain. The Learning centre was in need of some playground facilities for the Autistic Learners and for an after care initiative for the greater Autistic and Special needs community of Cape Town. After reaching out to the Rotary E Club of Cape Town funds were provided to build a new climbing wall for the kids to start off the upgrade of the playground.

About Us

Our Vision

Unlocking greatness in each learner through an eclectic approach of methods, which are learner specific, with the aim of each child reaching their full potential.

Our Mission

Autism Connect Learning Centre serves to function as a learning and resource centre within our community. We provide a specialised early programme that is Autism specific. We aim to bridge the gap through the preparatory development of learners to a school-readiness state. Our ethos encompasses neurodiversity and advocacy of inclusion focusing on learner intervention.

Our story

As with all things in life, this too began with just a seed placed in the ground, watered by contributors and today this budding flower is in full bloom. So we set out to create a website that would keep you in touch with the latest developments within the Autism fraternity as well as to inspire, aspire and motivate you to enhance the quality of life for your child and your family!

My story

“When my son, Tyler, was diagnosed with Autism spectrum disorder (ASD) we were naturally disappointed but trusted that the good Lord will guide us on this journey.

Our experience was made a bit more challenging when it was discovered that Tyler was on the low functioning Autism spectrum.

This needed private intervention to enable acceptance at established, state run, Autistic schools. Travelling and private tuition costs soon mounted with seemingly little improvement in his development with the condition.

This was draining and disheartening. Having lived in the communities all my life and having been subjected to impoverished conditions and its effects on normal people, my thoughts went with the reality of my situation and its potential effects on the families with similar challenges. Fueled by the desire to actively make a difference in my own child’s life and those in the surrounding community Autism Connect was formed

The Climbing Wall

We lost all of our playground equipment and the climbing wall within the last two years of this pandemic; all of the playground equipment was either damaged badly or stolen.

We asked for assistance to rebuild the activities as this is a vital component to the learning process of our children and their needs. We were donated the funds to build a climbing wall as this serves our learners educational needs , Below are some of the benefits of a climbing wall and a jungle play area.

Benefits of a Climbing Wall for Autistic learners

Sensory Disabilities

- As children climb, they are gaining exposure to movement and sensory input that can help in motor processing.
- Climbing gives children’s bodies proprioceptive input (being aware of body and movement in relation to its joints). The pressure they feel in their muscles and joints can help internal regulation.
- Climbing helps develop the vestibular system.
- Rock climbing is a very tactile activity.
- The climbing wall is visually inviting and may serve as a motivator for children to climb, encouraging increased movement.

Physical Disabilities

- Core strength and muscle tone are positively affected by climbing

- Strength in hands, arms and legs can increase by climbing.
- Children who have physical limitations often participate in sedentary activities. Climbing, at whatever physical level possible, provides body movement that can increase circulation and assist in digestion.
- Range of motion activities can increase flexion and extension, which helps prevent muscle atrophy.
- Climbing helps children gain experience and confidence in bilateral movement and coordination.
- Eye-hand and eye-foot coordination is practiced

Cognitive Disabilities

- Action concepts such as on/off, up/down, right/left, go/stop can all be incorporated into climbing. This helps children learn and understand these words because they are experiencing them verbally as well as kinesthetically.
- Problem solving is naturally incorporated into climbing as children determine hand and foot placement throughout the climb.
- Decision-making is involved as children will be faced with choosing a particular path and following through with their decisions.
- Facing the climbing wall and constantly scanning the wall for the next hold to reach for can help take away auxiliary distractions and increase attention. This also helps children think sequentially.
- Children are better able to focus and attend to cognitive tasks after they have been able to use their whole body in activity.

Communication Disabilities

- Receptive language can be targeted as children listen and process verbal direction by a teacher or another child, for example which color hand hold to reach for.
- Receptive language is further developed as children talk to each other while climbing so they know where they are in relation to others. This is especially important for children who have visual impairments.
- Climbing allows for independent movement. Children who have autism may not like physical contact and this is an activity that caters to that characteristic.
- Cross-curricular activities invite written communication; for example, by finding letters or spelling words on the climbing wall.


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ONE MANS DREAM - MOTALIB WEIJTERS

My dream has always been to fight poverty in my homeland. I was born in Bangladesh. My father was a laborer. We didn't have enough to eat, and I ran away from home. I survived because a street vendor gave me water and food. When I was six, I was adopted by a Dutch family in the Netherlands. I found myself in paradise. In 1994, I returned to Bangladesh. I was shocked to discover my biological family still living in poverty. Determined to improve health and sanitation in Bangladesh, I established an NGO, "SLOPB" Moreover, I created an orphanage because no child should ever be homeless. I had witnessed what a patriarchal country does to women and children. So our activities expanded into maternal and reproductive health, and hygiene. These empowered women and girls by providing them with better access to health services.

In 2001 I established a hospital, which today runs a 30-bed facility for mothers and children. Thanks to its early diagnosis facilities of cervical cancer, over 10,000 women and girls have been treated. Women like Howa Begum from the Kalisuri area. After we ran a cervical cancer awareness program near her home, Howa tested positive with early-stage Cervical cancer. She subsequently received cryotherapy at our hospital and has now fully recovered. With few means, we saved her life. This makes me proud to be working for humanity.

But it is vital that we have modern screening technology such as the vaginal speculum with camera for early diagnosis that transfers pictures from any mobile to any doctor.

Rotary International honored six members as People of Action: Champions of Girls' Empowerment on 11 October, the International Day of the Girl Child. This distinction recognizes the honorees' commitment to improving girls' access to education, health, and sanitation and hygiene resources, as well as their work to create environments where girls can flourish. Empowering girls is one of RI President Shekhar Mehta's key initiatives, and he is encouraging clubs and districts to consider how they can accomplish this through all of their service projects this year.

The honorees will also be recognized at Rotary Day at UNICEF in March

I am one of the Champions of Girls' Empowerment. Short description is given below.

Motalib Weijters

Rotary Club of Uden, The Netherlands

Motalib Weijters, who was adopted by Dutch parents, knew very little about his biological family or about life in their home country of Bangladesh. In 1994, he reconnected with his birth family, and he saw the needs of people in their area. He worked on water and sanitation projects in Bangladesh and later founded a clinic for mothers and children. He also established a cervical and breast cancer treatment center that offers services to women and girls in need. These initiatives have helped more than 21,000 people. The clinics are financially sustained by support from

nongovernmental organizations and Rotary grant projects carried out by clubs in the Netherlands and Bangladesh.

https://my.rotary.org/en/rotary-honors-6-members-people-action-champions-girls-empowerment

Major Activities

A total of 40 children were accommodated in both the Nell and Willem Homes 1 and 2. Among the inmates 20 are boys and 20 are girls. Homes are separate and for boys and girls. Initially children without a mother and father from the age of 3 to 9 years were enrolled in both the homes. However, following the changed approach apart from the orphanage poor but meritorious children aged from 12 years are allowed to get admission .Children are enjoying their livelihoods with satisfaction. Services made available to the inmates are basic and necessary for a healthy life the children are admitted in the neighbouring schools for their formal education. Each of the orphanages has its large poultry and cattle farms and fish ponds for training of the children and livelihood support. Income earned from the farming activities are used to support part of the operational costs. The orphanages/children have it's play grounds with amusement facilities. Plots of agriculture around the orphanage are set up for skill development of the orphans. The children are also provided with training on poultry farming, fish cultivation, computer education, tailoring, embroidery, and Batik printing etc. so that upon leaving the home they are able to sustain themselves.

SLOPB's vision is to improve livelihoods and promote greater health and food security among the poor and marginalized people, including women, orphans, children and the disabled.

The major activities of the project include

- **Support children with food, education, medication, housing, clothing and amusement**
- **Support children with skill development training.**
- **Support children to be socially and economically integrated with the wider world**

Suggestions for Establishing an International Committee at Your Rotary Club

Randeep Singh Arora, Rotary Club of Fairfield-Suisun, District 5160
Ron Reece, Rotary Club of Redding West (RWR), District 5160

Why establish an international committee and support international projects at your Rotary club?

Rotary International is an international service organization that brings together business and professional leaders to provide humanitarian services and to advance goodwill and peace around the world. What better way to participate in the worldwide vision of Rotary than for your club to have an international project?

Who should be your international committee chairperson?

Your chairperson should have a passion for international service. Generally, the chairperson has experience travelling abroad and has worked on international projects with other organizations in your community.

How many people should be on your committee?

Your core group should compose 5-6 people. They should be willing to commit to serving 3 years on the international committee to lend continuity to past, present, and future projects. In addition, your club's past president, president, and president-elect can be on the committee and/or should be included in email correspondence.

Should your international committee have a budget?

Yes. For example, RWR's budget has been $10,000 per year. This should be established at the beginning of your presidential calendar year and approved each year by your Rotary club's Board. This would allow funding for 4-5 projects ranging from $2000 to $2500 each.

RWR does not carry over unused funds but starts with a fresh budget each year. Budgets may vary according to your fund-raising efforts and your club's yearly budget. Your club's international budget should not be considered an add-on expense but integral to your club's activities. Your budget may be enhanced by applying for a district Rotary grant, a Global Grant, or teaming up with another Rotary club on an international project.

Should you work with an established Rotary club that can oversee the project in the project country?

Yes, working with a Rotary club in the project country is a good idea. They will be able to help oversee the project and assure the finances are distributed appropriately. It also builds international Rotarian camaraderie.

However, there may be an international project connected to other organizations and individuals. Having your own international committee allows flexibility in project selectivity.

How do you start an international project for your club?

It is desirable to have international projects where at least one of your club members is directly involved on the project. An international program presented at your club may have an international project you could embrace. Encourage your international committee members to embrace an international project.

What paperwork is involved?

Keep it simple. RWR uses three forms: (1) Grant Request Form, describing the project and financing needed, (2) Grantee and Grantor Agreement Form, and (3) Project Final Report Form.

Should the project be sustainable? Should you set a time limit for contributions to an international project?

Your international project may be a onetime event, such as providing supplies for a classroom, or it may involve a longer commitment.

It is wise to set the time frame for your project to be initiated and completed within the presidential year. For Rotary clubs, that is from July 1st to June 30th the following year so that the president-elect has input to continuing the project in the future.

Commit to projects your Rotary club can focus on and complete. Project updates and project programs can be a part of your Rotary meetings bringing your entire club onboard.

Should you write checks to individuals involved in the project, or should one pay only 3rd party vendors or the local Rotary club?

Other than exceptions (decided by your club board), checks are generally written to the Rotary clubs/districts. Once a project is approved by your international committee, it should be reviewed by your Rotary club board.

Having the past president, president, and president-elect on the committee or included in email communications assures the project has ongoing approval before submitting to your Rotary club board.

Any check written should go through your club's check approval system, usually requiring two signatures.

Should we pay for any of our club members to visit the site?

Generally, travel and trip expenses are donated by the Rotarians. However, there may be exceptions recommended by your international committee and your Rotary club board. For example, some may have the time and motivation to work on an international project but cannot finance themselves. Some may have technical know-how on the project. Some may only give financial contributions.

Districts can use District Designated Funds (DDF) to support travel to and participation in Rotary project fairs to help districts identify project partners. District 5160 has included Project Fair Attendance Grants in its portfolio of funding available to clubs.

What should be your policy in giving money to an organization such as Shelter Box, Doctors without Borders, or other organizations to address a specific issue in another country?

In general, it's advisable for your club to focus on projects where a member is directly involved. However, during natural calamities, your club may want to support these other organizations.

How should we keep track of what is happening with our international project? Zoom calls, visits, other methods?

Zoom calls, Rotary programs, remote CCTV installation, member visits, social media, publications, newspapers clippings, quotes from beneficiaries, receipts/invoices can all help your club understand and follow the project. The grant forms should help you organize and following each project.

With questions or comments, please contact the authors at disc@rotary5160.org.

Rotary Club of Hout Bay Vision Project

2 October 2021

SERVE TO CHANGE LIVES

Vision Project – Need Identified

- RFHD – high demand for eye testing services, including children
- March 2019 pilot test in one school identified almost 15% of Grade 1 & Grade 7 students needing glasses
- Five primary schools in Hout Bay, with about 5,000 students
- Nurse only visits once a year for 1 day, sometimes bringing an eye testing person
- Service erratic and incomplete – no broad based testing
- “Problem” students identified by teachers but no means to deal with their vision needs
- School Principals fully supportive of a Rotary-led initiative in schools
- **Children who cannot see cannot learn**

Rotary Club of Hout Bay

SERVE TO CHANGE LIVES

Project Implementation – 2020 & 2021

- Partnered with Jonga Trust, a specialist eye-testing NGO
- Focus on Grades 1 & 7, about 1100 students across five primary schools
- **2020: Screened 952 children, 101 (11.0%) received glasses**
- **2021: Screened 954 children, 109 (11.4%) received glasses**
- Conjunctivitis/allergies identified in **12 children - eye drops provided**
- **3 children required medical attention** - access to medical care arranged
- Training for teachers/assistants to help them identify and deal in the classroom with eyesight problems
- All provided at no cost to parents or school

Jonga Team - Zoli, Chris, Donald

Rotary Club of Hout Bay

SERVE TO CHANGE LIVES

Screening & Testing

- Two screeners + optometrist Chris Eksteen
- 1-2 days per school – in empty hall or classroom
- Two Rotarians assist with queuing learners & recording stats

Rotary Club of Hout Bay

SERVE TO CHANGE LIVES

Selection & Fitting of Prescription Eyeglasses

- Refraction done at the school with portable equipment
- Wide range of fashionable frames – child chooses

Rotary Club of Hout Bay

SERVE TO CHANGE LIVES

“Wow! I can see!”

Rotary Club of Hout Bay

SERVE TO CHANGE LIVES

Project Expansion

Grade 10 - High School Pilot Test - 2021

- Silikamva HS in Imizamo Yethu township (10-11 May)
- Screened 231 learners, 64 received glasses (28%)
- Cost R50k funded by Midtown Memphis RC, USA
- Two High Schools – Silikamva (IY) & Hout Bay HS (Hangberg)
- Need to raise R100k to test Gr. 10 in the two schools in 2022

Grade 5 - 2022

- Expand to Gr. 5 in two schools with highest need
- Cost R29k funded by Wallingford RC + District 7870, USA

Rotary Club of Hout Bay

SERVE TO CHANGE LIVES

Project Costs

- Annual cost of running the program in five primary schools is **R150,000**
  - Screeners daily rate + transport
  - Frames + lenses – at discounted rate

- Funded for three years (2020-2022) from:
  - RCHB Funds + District Grant
  - Private donations – Friends of RC of Hout Bay
  - Overseas Rotary Clubs – Germany (2), USA (3), Canada (1)

- Ongoing funding needed – every year new children arrive in school with sight problems
  - Look for corporate CSI investment
  - RCHB members make connections with overseas Rotary Clubs
  - Rotarians come to Hout Bay on holiday – opportunity to help the community

Rotary Club of Hout Bay

SERVE TO CHANGE LIVES

Extending to Other Communities

- **Optometrist – Identify a Local Partner**
  - Ideally one who is willing to travel to schools rather than transporting learners to a clinic
- **Screeners**
  - Trained screeners are available from Khaylietsha – pay for transport
  - Jonga Trust could train new screeners in your community
- **Conduct a Pilot Test**
  - Confirm interest & expected need at one school – test one grade
  - RCHB members available to assist with set-up / organization
  - Est R15k cost to screen 100 learners with 15% needing glasses
  - Use test results to gain support from other schools in your community and estimate funding required to rollout

Rotary Club of Hout Bay

SERVE TO CHANGE LIVES

In Summary:

We are investing in improving the quality of life and education for the children of our community.

Children who cannot see cannot learn.

Rotary Club of Hout Bay

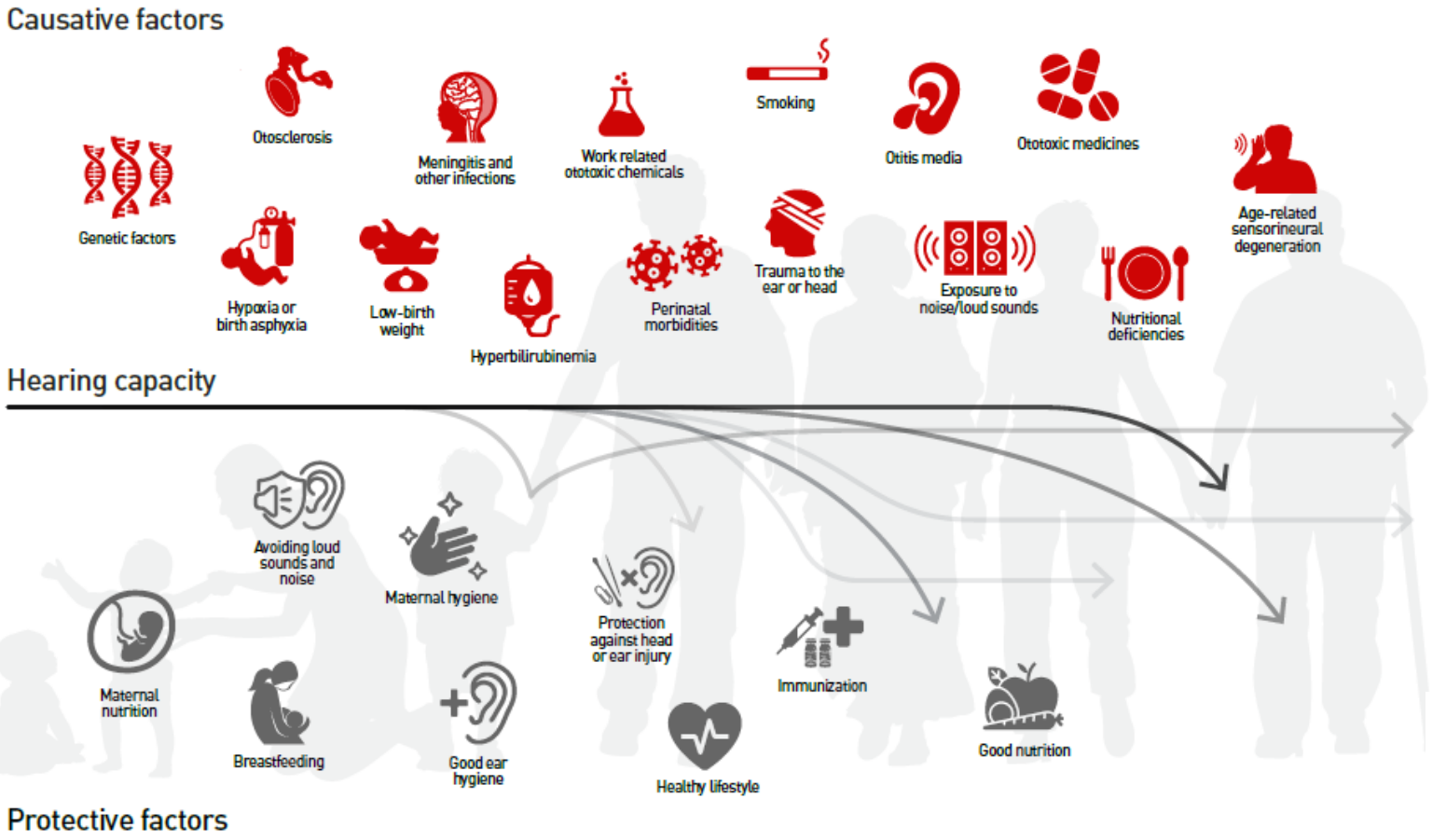
SERVE TO CHANGE LIVES

HEARING LOSS IN CHILDHOOD
THE IMPACT OF EARLY INTERVENTION

Nadia Abdulhaq, PhD, AuD

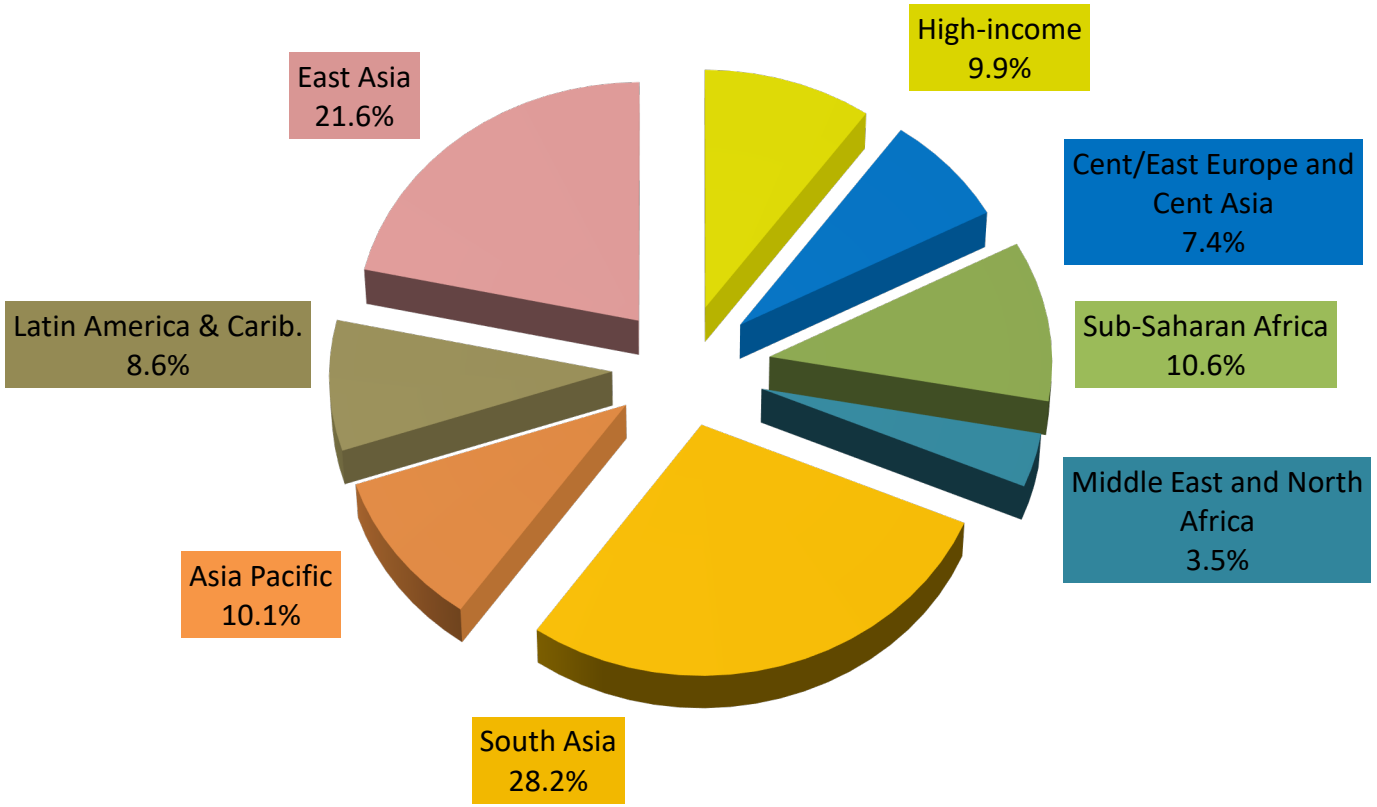
WORLD REPORT ON HEARING

Figure 1.1 Hearing across the life course



World Health Organization

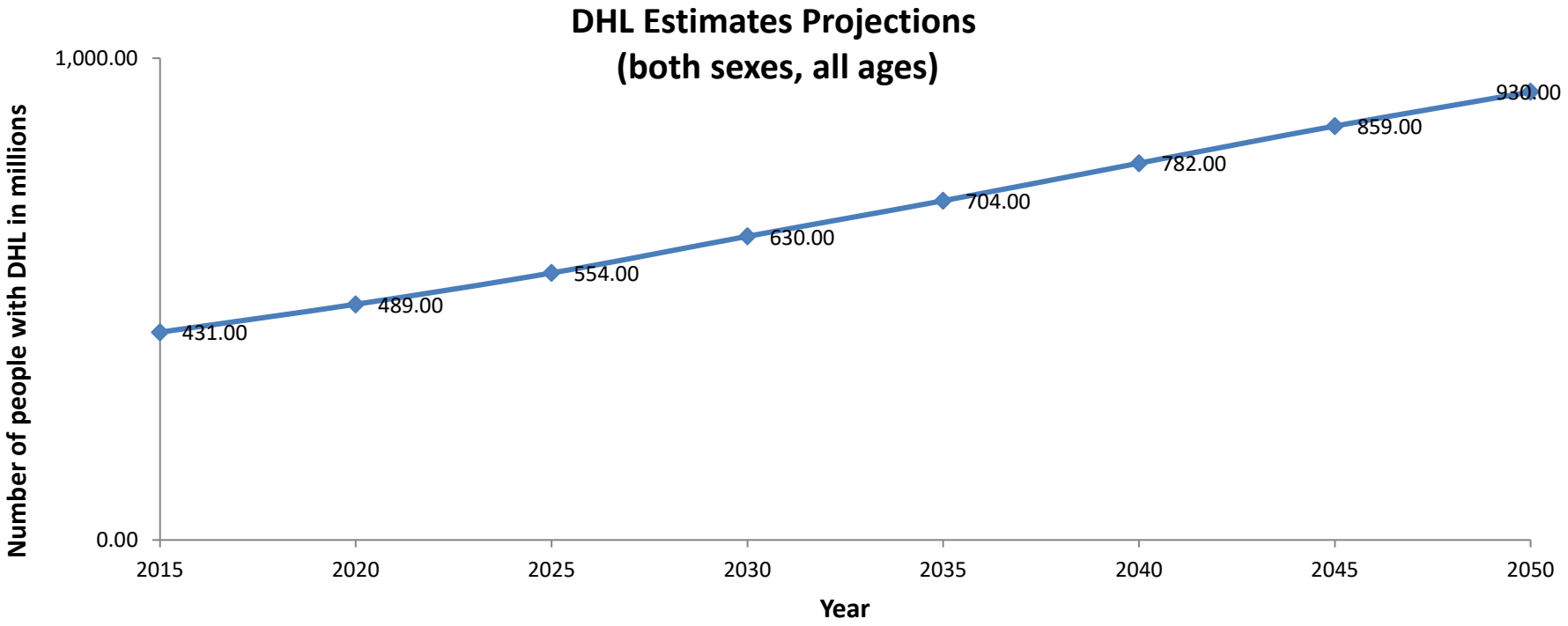
DISABLING HEARING LOSS IS UNEQUALLY DISTRIBUTED ACROSS THE WORLD



The pie-chart shows the distribution of disabling hearing loss across different regions of the world.

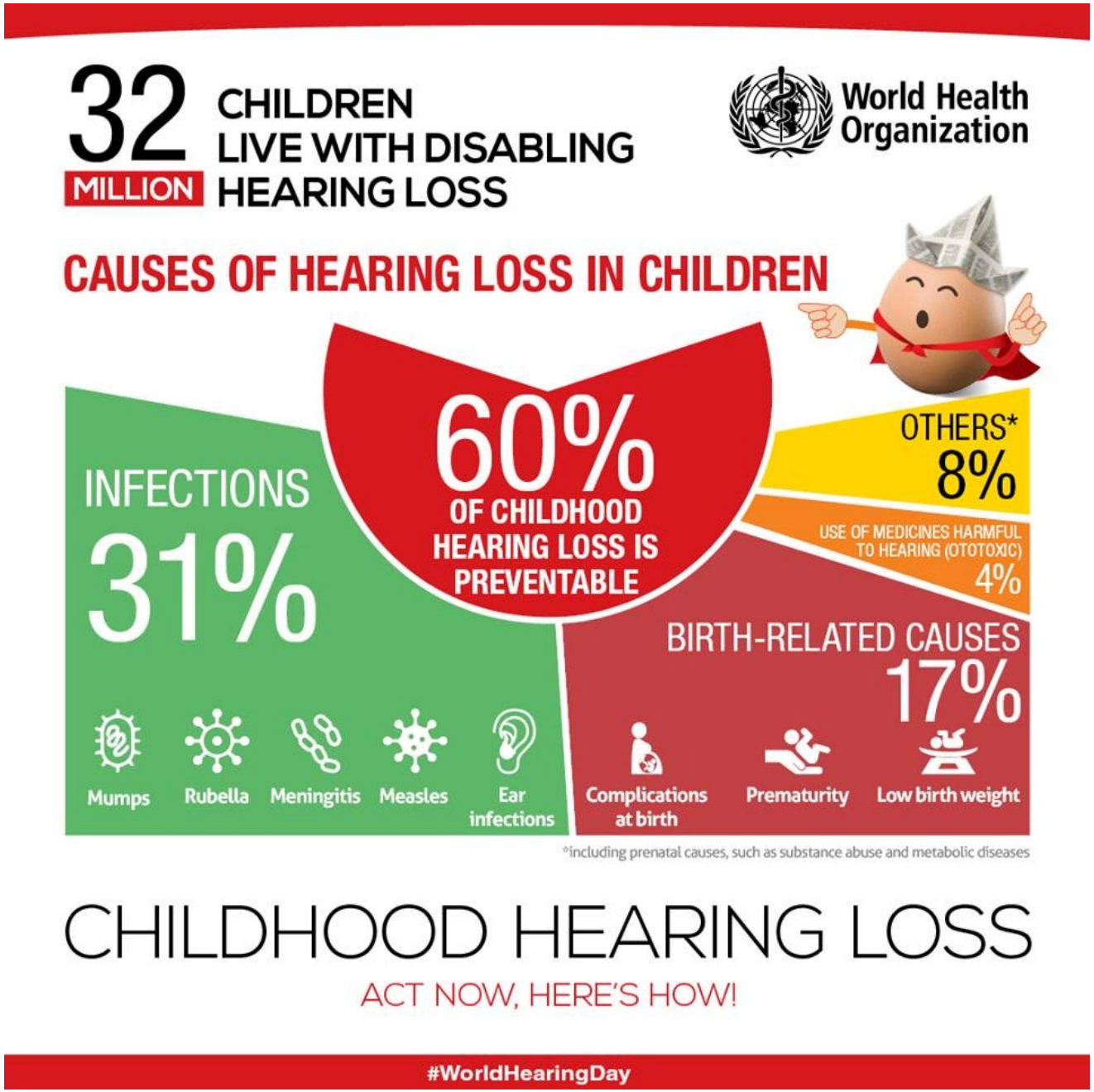
World Health Organization

TRENDS IN HEARING LOSS OVER THE NEXT 35 YEARS



This graph shows (in millions) WHO's projections regarding the number of people likely to have DHL is growing in coming years.
It could rise from 466 million in 2018, to 933 million in 2050.

World Health Organization



World Health Organization

World Health Organization

May 2017: Resolution on Prevention of Deafness and Hearing Loss

The World Health Assembly resolution calls on every country:

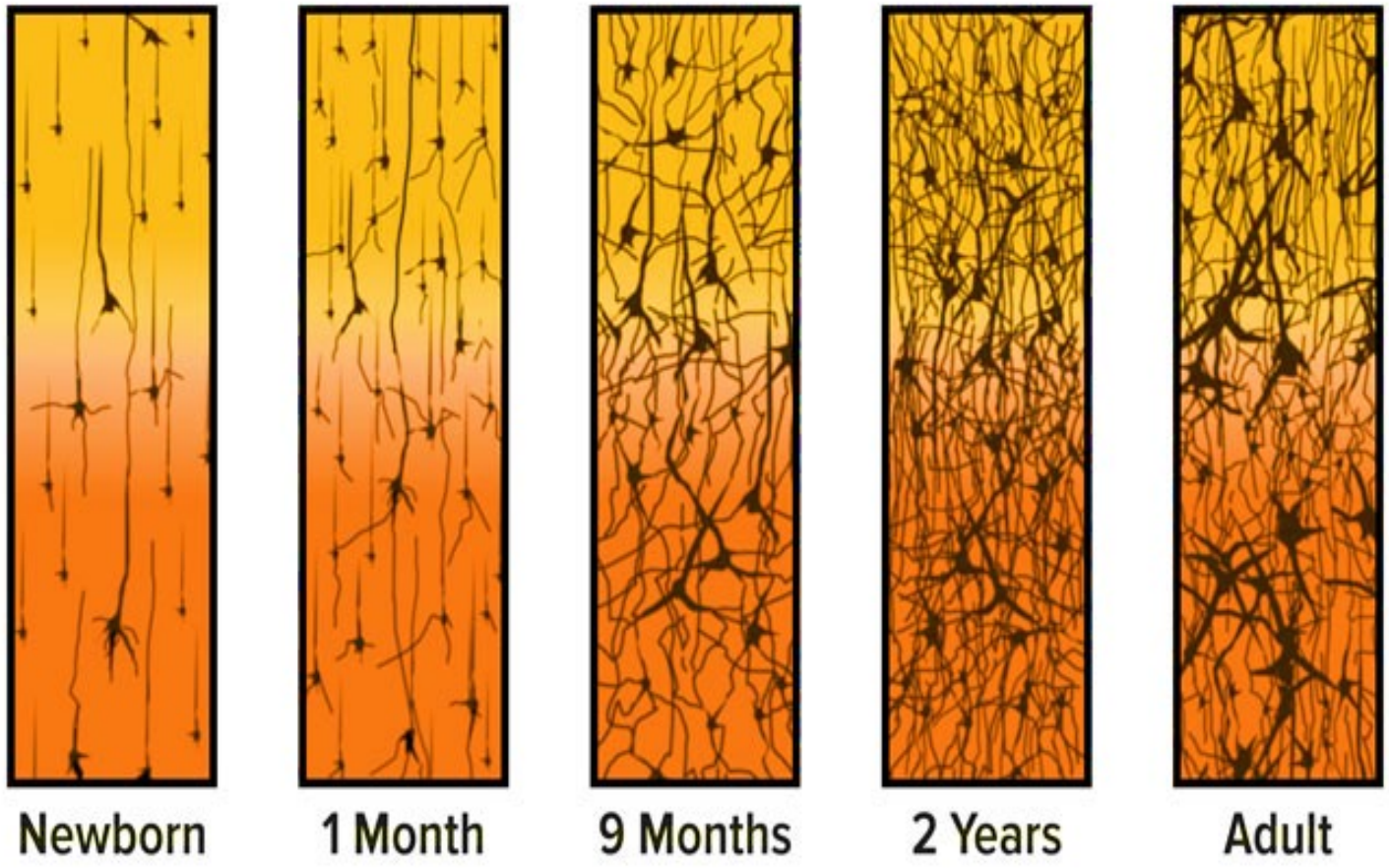
“Improve access to affordable, high-quality assistive hearing technologies and products, including hearing aids, cochlear implants and other assistive devices, as part of universal health coverage”

EARLY DETECTION

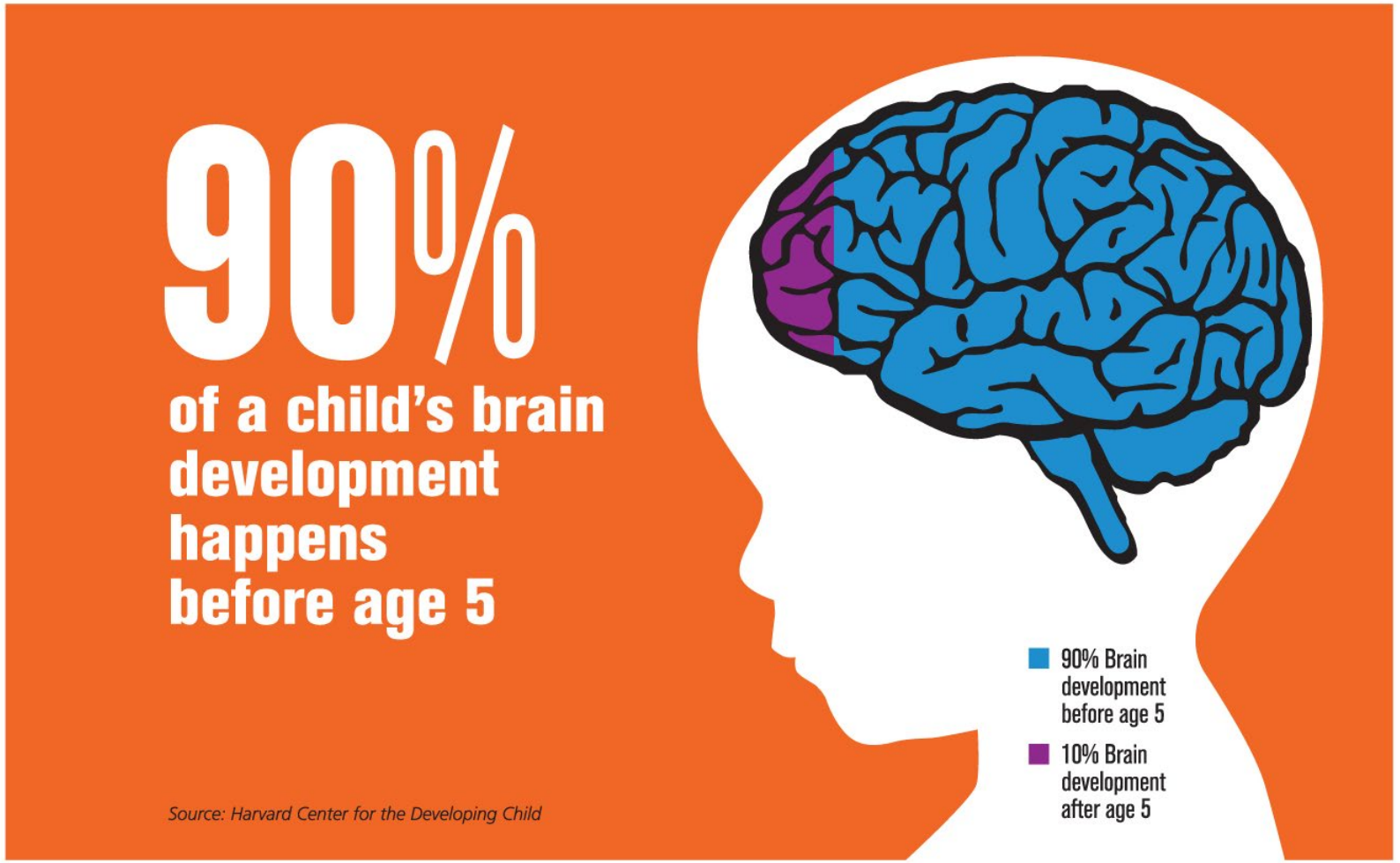
What is meant by early?

- at birth
- as soon as possible
- before the age of one
- before the age of 6 months

WHY EARLY INTERVENTION IS IMPORTANT

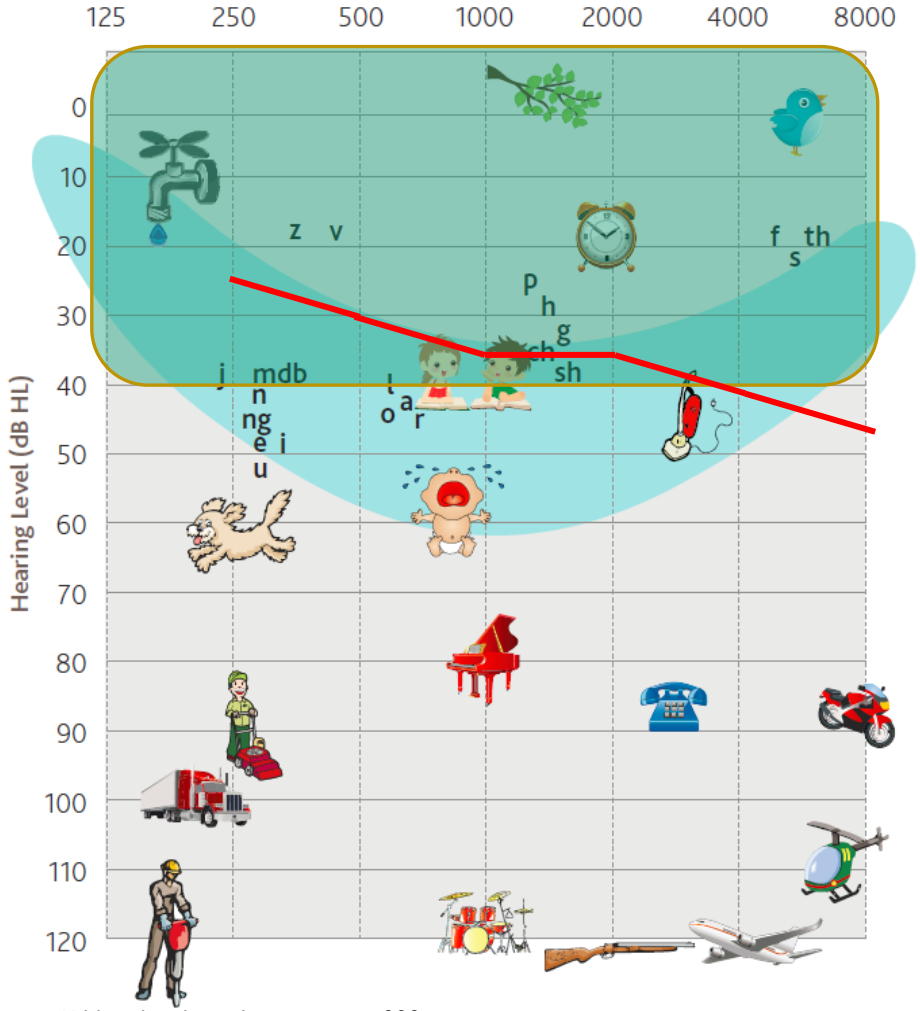


WHY EARLY INTERVENTION IS IMPORTANT



IMPACT OF HEARING LOSS IN CHILDREN

Reduced speech recognition ability in adverse listening conditions	Multiple Talkers
	Noisy environment
	Distant listening
Academic difficulties	Most are missed
	May fail a grade
	Listening fatigue
Social Difficulty	Low Self-esteem
	High stress
	Need social support



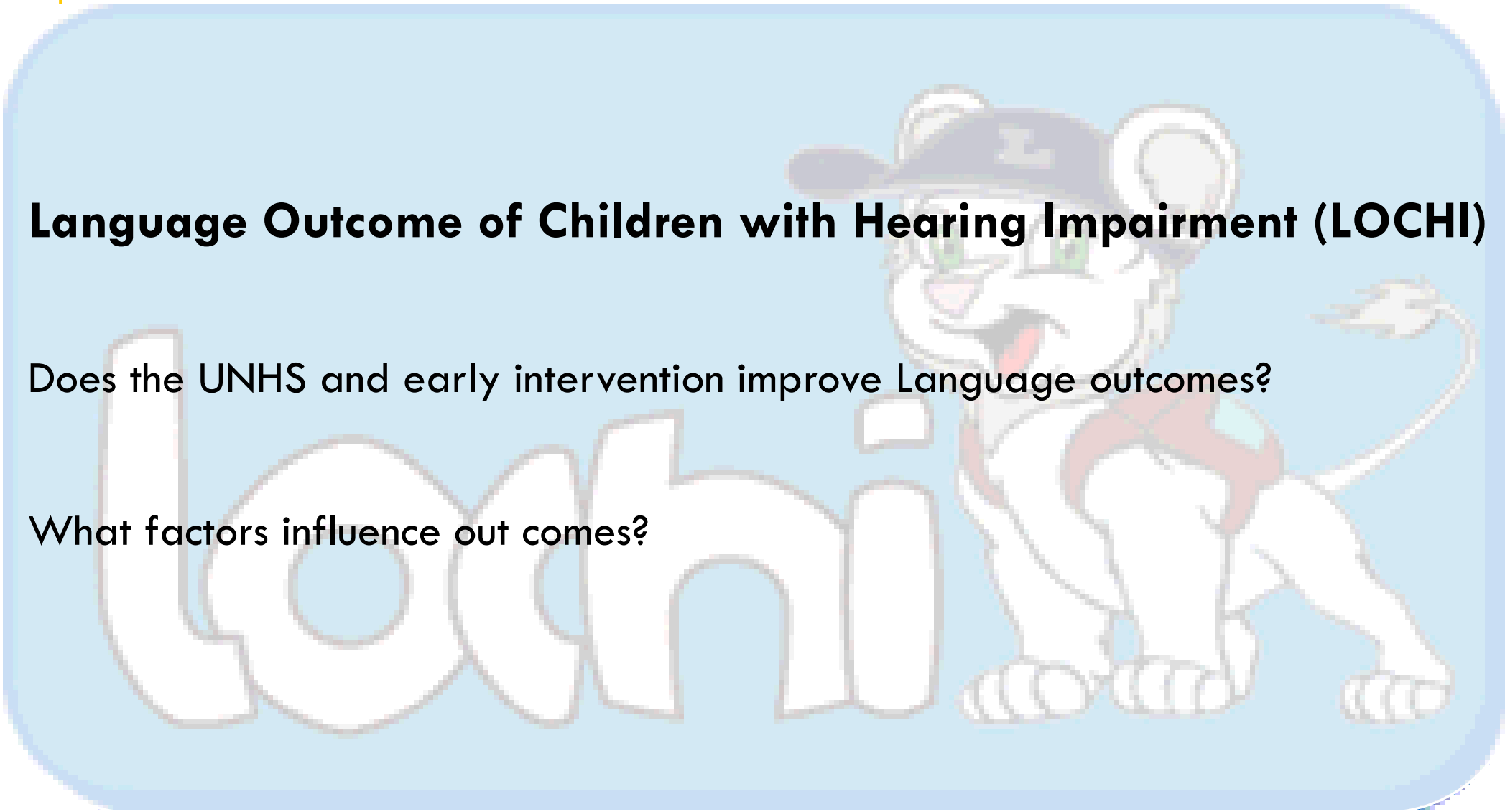
1 Academic, Social, and Behavioral Outcomes in Children with Minimal Hearing Loss Anne Marie Tharpe, PhD. Workshop Proceedings: National Workshop on Mild and Unilateral Hearing Loss 2005
2 Outcomes in Children with Mild and Unilateral Hearing Loss Christie Yoshinaga-Itano, PhD, CCC-A, CED. Workshop Proceedings: National Workshop on Mild and Unilateral Hearing Loss 2005
3 Clinical Implications of Children with Minimal Hearing Loss Arlene Stredler-Brown, MA, CCC-SLP, CED. Workshop Proceedings: National Workshop on Mild and Unilateral Hearing Loss 2005

LOCHI STUDY AIMS

Language Outcome of Children with Hearing Impairment (LOCHI)

Does the UNHS and early intervention improve Language outcomes?

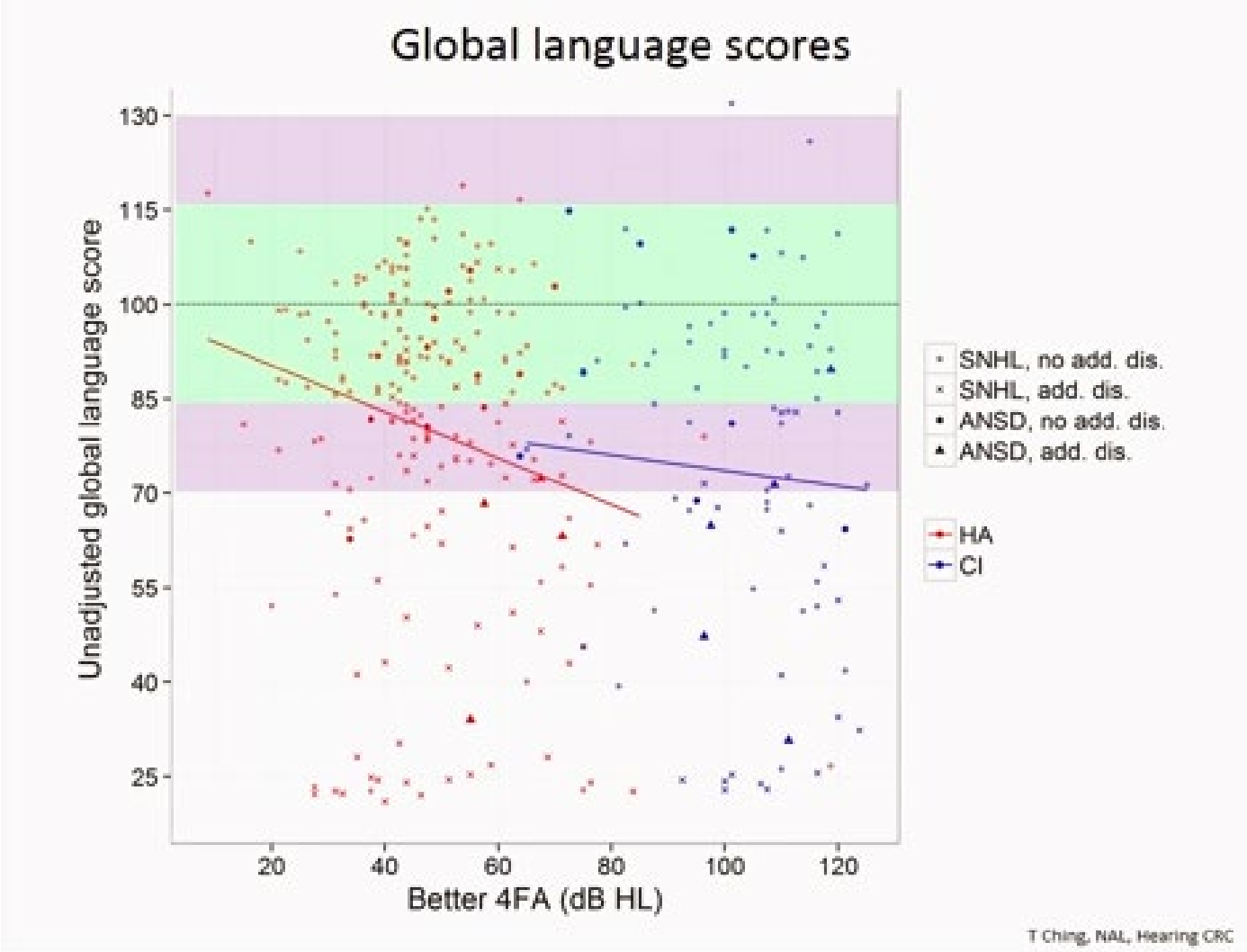
What factors influence out comes?



 CHING, T. Y., DILLON, H., LEIGH, G., & CUPPLES, L. (2018). LEARNING FROM THE LONGITUDINAL OUTCOMES OF CHILDREN WITH HEARING IMPAIRMENT (LOCHI) STUDY: SUMMARY OF 5-YEAR FINDINGS AND IMPLICATIONS. INTERNATIONAL JOURNAL OF AUDIOLOGY, 57(SUP2), S105-S111.

OUTCOMES AT 5 YEAR OF AGE

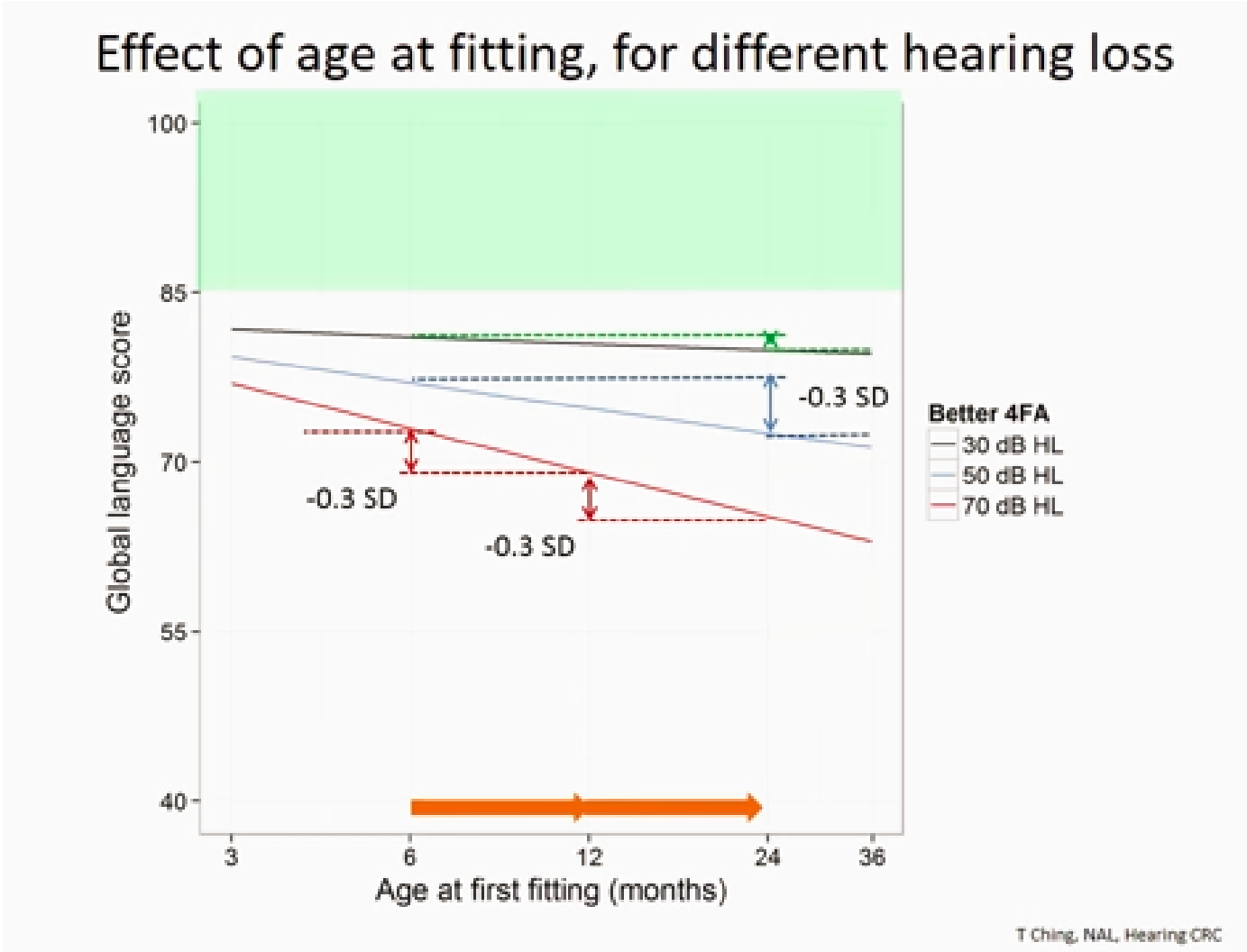
Relation of hearing loss level with Global Language score using HA or CI



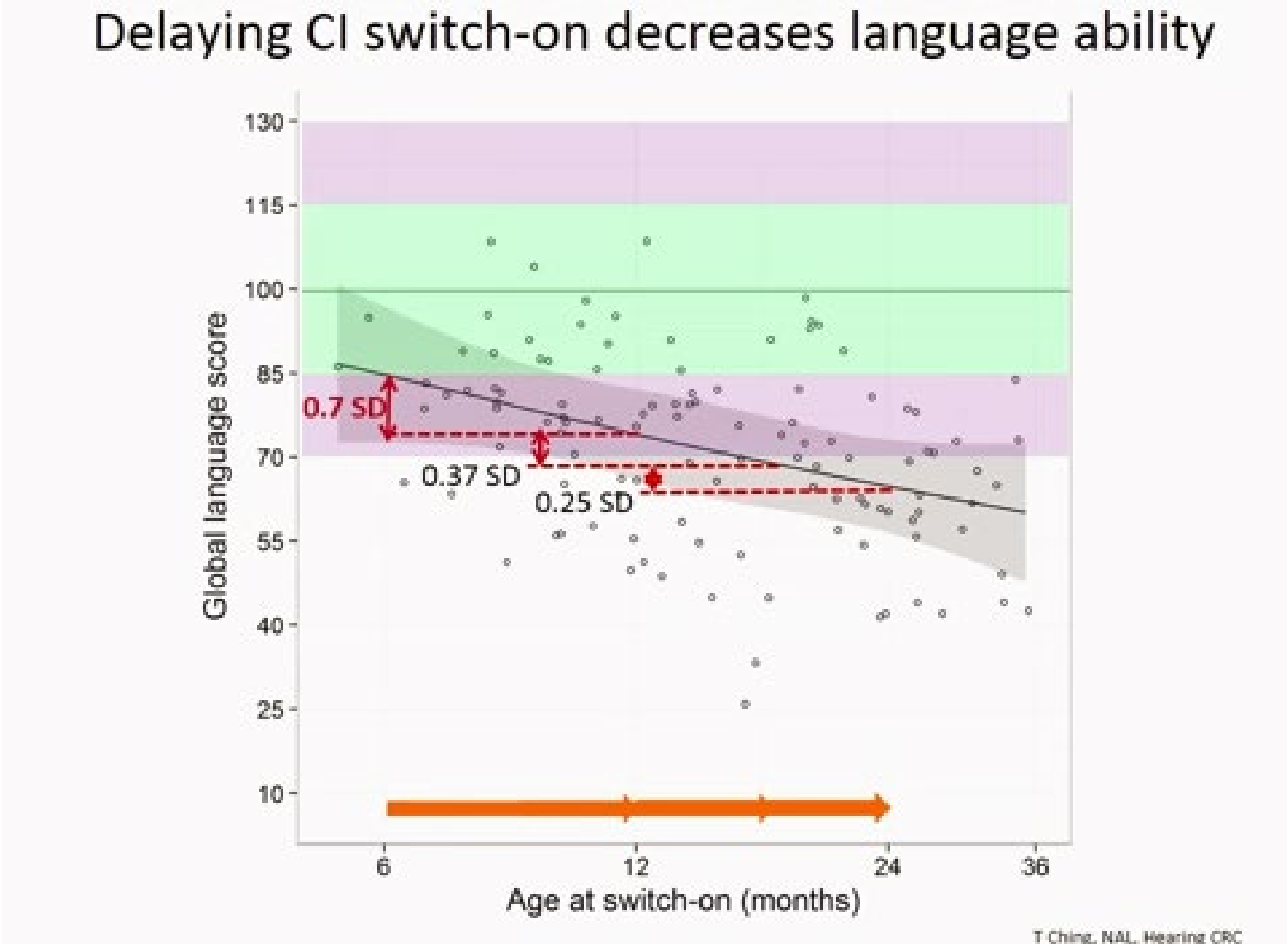
OUTCOMES AT 5 YEAR OF AGE - HEARING AID

The effect of delay in fitting age based on Hearing Level in relation to Global Language Score

Mild Hearing Loss fitted with Hearing Aids



OUTCOMES AT 5 YEAR OF AGE – COCHLEAR IMPLANT



PREDICTORS OF OUTCOMES FOR HA AND CI USERS

Significant predictors for n = 243 Impact of category change. For continuous variables, variation as per specification.

Predictor	Significance (p)	p – value
Age first fit (log)	0.003	0.11
4FA hearing loss	<0.001	0.002
Log Age first fit x 4FA	0.07	0.06
Cognitive ability/WNV	<0.001	<0.001
Gender	0.16	0.19
Birthweight	0.73	0.08
Other disability	0.04	0.13
Maternal education (uni re school)	<0.001	0.01
Socio-economic status (dec)	0.39	0.44
Communication mode (other re oral)	0.007	0.009
ANSD	0.59	
HA prescription	0.64	
Early PLS	<0.001	
Early PEACH		0.03

$R^2 = 0.74$

$R^2 = 0.69$

Significant Predictors for 114 children with CI

Impact of category change. For continuous variables, variation as per specification.

Predictor	Significance p – value)	Impact
Age first switch on (log)	0.001	
4FA hearing loss	0.60	-0.06 (-0.30,0.17)
Cognitive ability/WNV	<0.001	0.53 (0.37,0.69)
Gender (Female re male)	0.15	4.84 (-1.73, 11.42)
Birthweight	0.79	0.51 (-3.27,4.3)
Other disability	<0.001	-19.1 (-28.39,-9.83)
Maternal education (Dip re school) (university re school)	0.20	4.64 (-4.33,13.61) 8.28 (0.76,17.32)
Socio-economic status (dec)	0.40	2.3 (-3.05, 7.65)
Communication mode in Edn. (other re oral) (changed or nil re oral)	0.04	-12.38 (-24.5,-0.31) 2.56 (-7.42,12.55)

$R^2 = 0.70$

$R^2 = 0.58$

T Ching, NAL, Hearing CR

DAUB ET AL (2017) THE LANGUAGE OUTCOMES OF CHILDREN WHO ARE DHH BASED ON THE LANGUAGE ABILITIES BEFORE HA INTERVENTION. JSLHR 60: 3310-3320

UNIVERSAL SCREENING

Box 2.5 Universal screening is the goal

A population study on the long-term outcomes of children identified with permanent hearing loss contrasted three screening programmes: a universal programme; an "at-risk" programme; and an opportunistic programme.

Results demonstrated the clear benefits of a universal programme, in terms of age of diagnosis; receptive and expressive language; and receptive vocabulary (in children without intellectual disability), when compared with the other two screening types *(113)*. Nonetheless, in environments with no screening programmes, and where resources are lacking, opportunistic screening could form a first step towards implementation of other more effective programmes.

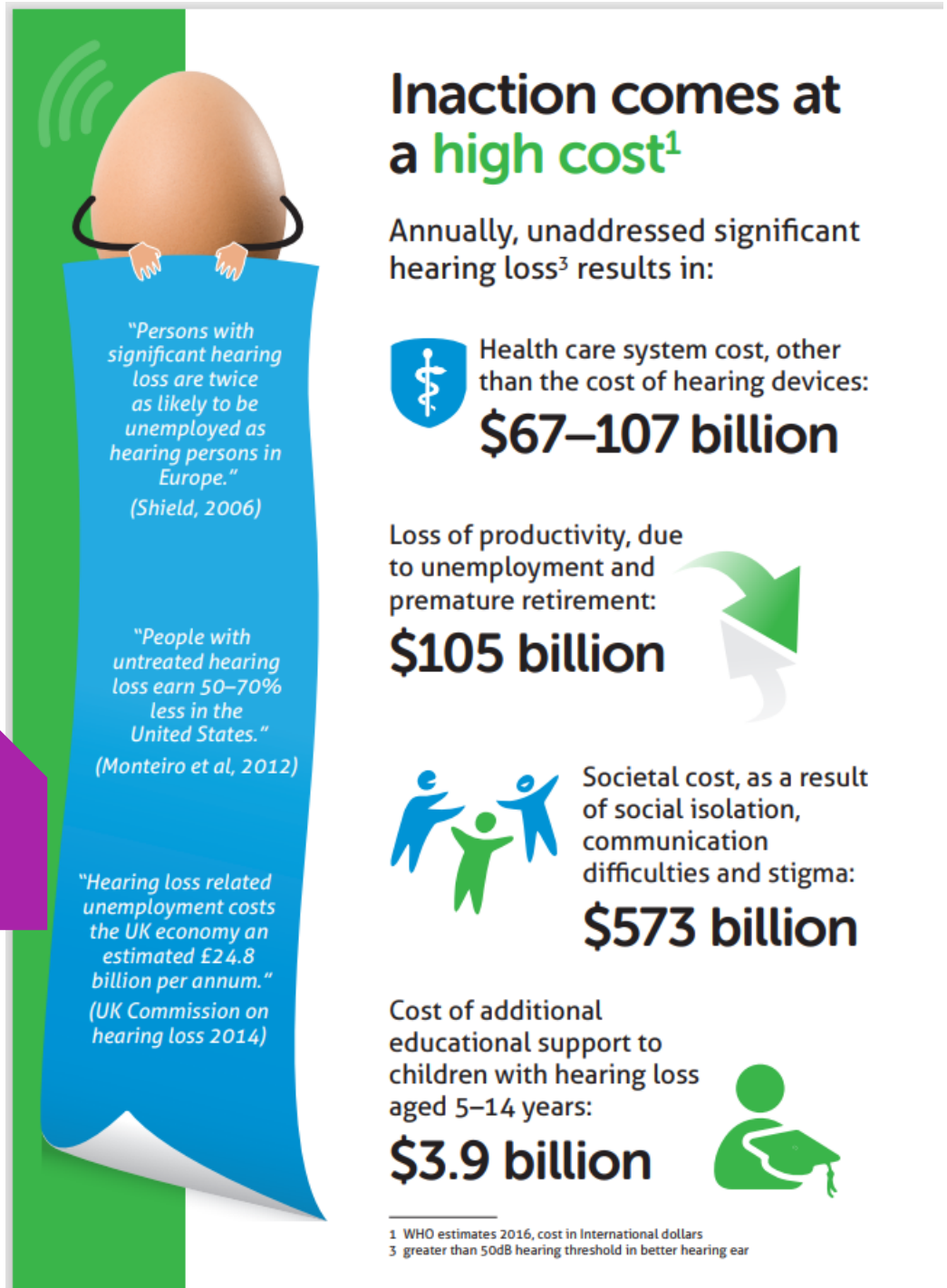
COST EFFECTIVENESS

A study undertaken in the USA *(110)* projected that the reduced costs of special education services could plausibly offset the cost of universal newborn hearing screening (UNHS) within a space of 10 years *(131)*.

In 2006, it was estimated that UNHS saves an estimated 4500 euros in Germany per hearing impaired child, per year

In Philippines, a UNHS being implemented since 2009 has resulted in considerable long -term savings

Results, based on actual costs, estimated that in a lower-middle-income setting (taken as an example) there would be a possible return of 1.67 International dollars for every 1 dollar invested in newborn hearing screening. With a highincome country, this return was estimated to be 6.53 International dollars for every 1 dollar invested.



COST EFFECTIVENESS

Action is cost-effective

Evidence shows that it is cost effective to:

Prevent hearing loss by:
- Protecting against loud sounds
- Identifying and treating otitis media (ear infections)

Identify hearing loss early through screening of:
- newborns
- school children
- adults above 50 years

Provide rehabilitation together with support for continuous use of hearing aids

Improve access to cochlear implants

Action benefits society and countries

Interventions to address hearing loss result in:

- Financial savings and significant return on investment
- Increased access to education
- Greater employability and earnings which benefits the economy
- Lower costs related to depression and cognitive decline
- An integrated society

'In 2009 the Government of Philippines passed a legislation that has made universal newborn hearing screening mandatory across the country. This has resulted in a saving of 1.4 million pesos for each hearing impaired child receiving early intervention.'

Charlotte Chiong, Philippines

"Cochlear implantation not only improves quality of life but also translates into significant economic benefits for patients and the Canadian economy."
(Monteiro et al, 2012)

"Cochlear implants significantly increase the quality of life of hearing impaired children in India."
(Drennan et al 2015)

"In the United States, for each dollar invested to treat a hearing impaired child with cochlear implants, there is a return on the investment of US$ 2.07."
(Penaranda et al 2012)

Rotary Distretto 2032

A.R. 2019-2020

IL ROTARY CONNETTE IL MONDO

DISTRICT 2452

Armenia • Bahrain • Cyprus • Georgia • Jordan • Lebanon • Palestine • Sudan • UAE

GG2122131

DAVID GIBSON MOORE PREVENTION AND CARE OF CHILDHOOD DEAFNESS IN PALESTINE

Rotary Club
Ramallah, Palestine
Club No. 83183 District 2452

على هذه الأرض
ما يستحق الحياة

THE PROJECT BACKGROUND

- In Palestine the number of newborn children with hearing loss is estimated to be more than 800 cases per year.
- The impact of hearing loss affects children's lives most. It results in language delay that can prevent children from developing spoken language to go to school and complete their education and thereby grow to be an independent productive member of society.
- According to WHO 60% of childhood hearing loss is preventable.
- According to WHO only 17% of those who need hearing aids globally have access to them.

GOALS OF THE PROJECT

1. Prevention and diagnosis of childhood/neonatal deafness also informing and educating communities.
2. Training of specialized local clinical and health workers. Training includes teachers of the deaf, speech therapist and audiologist to ensure adequate intervention. ENT doctors and Health care staff at the hospital will be trained to perform newborn hearing screening and treatments including surgical treatments.
3. Hearing treatment, care and rehabilitation. Including hearing aids and cochlear implants, as well as medical and surgical therapy of deafness.

THE PROJECT

Target beneficiaries:

- Collaborate with existing New-born haring screening lead by John Paul II foundation to identify hearing loss at birth. And expanding it to additional maternity hospitals.
- Fitting hearing aids for babies identified with hearing loss from the screening
- Raising awareness of families about hearing loss, treatment, and impact
- Train professionals in identifying and rehabilitation of hearing loss (mainly at Ephpheta School)
- Train healthcare professionals in treatment of hearing loss: Nurses, audiologists, and ENT surgeons.

PROJECT COLLABORATION

Rotary
Club di Genova

GRANT FUND

Genova-Sud-Ovest
Genova-Nord
Bra
Bethlehem
Rapallo-Tigullio
Genova Golfo Paradiso
Chicago
Tortona
Casale Monferrato
Ramallah
Novi Ligure
Amman
Evanston Lighthouse
District 2032

Endowed/Directed gift T10681	2452	15000.00
District Designated Fund (DDF)	2452	1000.00
District Designated Fund (DDF)	2060	1000.00
District Designated Fund (DDF)	1730	1500.00
District Designated Fund (DDF)	6440	2500.00
District Designated Fund (DDF)	5500	3000.00
District Designated Fund (DDF)	2031	5000.00
District Designated Fund (DDF)	2032	13000.00

Total Funding
94,600.00

Up to
21,600.00
World Funds

LAUNCH GG2122131

Stay tuned

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- Josie Norfolk, Chair, District 9350 (South Africa)
- Jeffery C. Bamford, Past District Governor, District 9212 (Kenya)
- Karl Diekman, Past District Governor, District 5160 (California, USA)
- Kathryn Ann Hester, Treasurer, District 9630 (Australia)
- Sheila Hurst, International Service Chair, District 5160 (California, USA)
- Liz Kane, District 5000 (Hawaii, USA)
- Karen Kankkunen, Secretary, District 9570 (Australia)
- Jane Little, Past District Governor, District 5010 (Alaska, USA)
- Miguel A. Martinez Pereyra, Past District Governor, District 4890 (Argentina)
- Rajendra K. Saboo, Rotary International President, 1991-92, District 3080 (India)
- Laura Young, Past District Governor, District 5160 (California, USA)
- Dr. Rita Kalra, Rotary Club of Midtown Chandigarh, District 3080 (India)
- Dr Rami Sarkis Rotary Club of Beirut, Lebanon District 2452

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- Richard D. King, Rotary International President, 2001-2002, District 5170 (California, USA)
- Barry Rassin, Rotary International President, 2018-2019, District 7020 (New Providence, Bahamas)
- Phil Silvers, Past Rotary International Director, District 5500 (Arizona, USA)
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- Morrison Heth, Past District Governor, District 5450 (Colorado, USA
- Dr. Emman Ude AKPEH, Past District Governor, District 9142 (Nigeria)
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- Bruce Mills, Rotary Club of Logan, District 9630 (Australia)
- Dr. Sanjay Kalra, Rotary Club of Midtown Chandigarh, District 3080 (India)
- Chinelo Ude Akpeh, Rotary Club of Onitsha East, District 9142 (Nigeria)
- Dr. Richard Godfrey, Rotary Club of Niles, District 5170 (California, USA)
- Richard Clarke, Past District Governor, District 5020 (Canada

The goal of the Health Education and Wellness Rotary Action Group is to promote good health and wellness through healthy lifestyle choices and disease prevention. The emphasis is on building awareness, promoting education, and providing information to help achieve and maintain good health and to utilize effective prevention in an integrated way. Rotary members are encouraged to promote the action group in their districts and especially in their clubs.

The Health Education and Wellness Rotary Action Group operates in accordance with Rotary International policy but is not an agency of or controlled by Rotary International