IMPACT STUDY FOR
ROTARY FAMILY HEALTH DAYS (RFHD) NIGERIA 2020

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Contents

List of Acronyms

CDC – Centres for Disease Control and Prevention

DG – Rotary District Governor

EPI – Expanded Programme on Immunisation

HCT – HIV/Aids Counselling and Testing

M & E – Monitoring and Evaluation

NDOH – National Department of Health

PDG – Rotary Past District Governor

PEPFAR –The United States President's Emergency Plan for AIDS Relief

RFHA – Rotarians for Family Health and Aids prevention Inc. – a Rotary Action Group

RFHD – Rotary Family Health Days

RI – Rotary International

USAID – United States Agency for International Development

Introduction

The Rotary Family Health Days, a signature programme of the Rotary Action Group, Rotarians for Family Health & AIDS Prevention (RFHA) is a three-day annual program which provides free comprehensive, preventive health screenings for communities in Nigeria. The program is carried out leveraging on resources from private and public sectors including humanitarian driven resources of Rotarians. Different clubs of the Rotary family Nigeria in collaboration with various stakeholders collaborated to make this programme possible, offering free health services to individuals and families in communities. Through the programme, thousands of people are served in underprivileged communities in Nigeria.

The services provided include immunizations to children, and comprehensive life-saving annual health screenings, counselling, testing and referrals for HIV/AIDS, TB, diabetes mellitus, hypertension, and reproductive health services amongst others.

The programme is led by the four Rotary Districts in the country and partners such as Ministries of Health (MoH) at the national and state levels,, National and States Action Committee on HIV & AIDS (NACA & SACA), the US Mission through the PEPFAR funded agencies of the Centres for Disease Control and Prevention and United States Agency for International Development (USAID).

The 90-day Impact Survey is thereafter conducted to assess lasting impact of RFHDs. This is measured by understanding behavioural or lifestyle changes resulting from the programme, improvements in health conditions, as well as the clients' following up on referrals. The study also is expected to measure the client's satisfaction with services and record recommendations for future RFHDs.

Methodology

The methodology for this study is based on guideline document **"A Monitoring and Evaluation Template for Rotary Family Health Days - Guidelines for African Countries 2014" by Dr Philip J. Silvers (December 1, 2013)**.

Objectives

i. To assess the **lasting impact** of RFHDs.

ii. To assess improvements in **health conditions**

iii. To measure clients' following up on **referrals**.

iv. To measure the **client's satisfaction** with the services,

v. Record clients' **recommendations** for future RFHDs.

Sampling

A sample size of participants in the study was determined by using a single population proportion formula by taking assumption estimates that 50% of the population will participate in the programme.

The minimum sample size required for the study will be estimated using the formula for quantitative data.

$$n = \frac{z^2pq}{d^2}$$

$q = 1 - p$

n - Minimum Sample size

z - standard deviate corresponding to probability of type 1 error (α) at 5%- 1.96

σ- Standard deviation of the outcome variable

d – Absolute error or precision (precision and error of 5%).

$$n = \frac{(1.96)^2 (0.5) (1-0.5)}{(0.05)^2}$$

= 384

assuming a **population size** of **120,000**, a desired **confidence level** of **95%**, and a **margin of error** of **5%**, an appropriate and affordable sample size of **384** ***completed survey questionnaires*** is required.

The 384 was rounded up to 400.

There were 40 sites for the RFHD programme.

Working on a simple rationale of requiring 400 RFHD clients to consent to participating in the impact study, and having RFHD sites of 40; the guidance that was communicated to all districts, was for each RFHD site to collect a *minimum* of 10 signed impact study consent forms.

But, to increase our chances of achieving our sampling plan, a *stretch target "percentage" guideline* was given as follows: small sites (100 to 300 clients anticipated) should systematically approach every 10th client for consent; and larger sites (300+ clients anticipated) should systematically approach every 10th to 20th client for consent. If a beneficiary declined consent, the next person was asked. The phone numbers, age, and sex of the consented members were obtained. A total of 530 beneficiaries were interviewed.

Data Collection

Developed questionnaire were pretested for consistency amongst population type. The data collection tool was a structured interviewer (phone)-administered questionnaire (see Appendices) that contained open and closed-ended questions. The questionnaire elicited information about socio-demographic characteristics of beneficiaries, reasons for attending RFHD, source of information about RFHD, experience at RFHD, health changes after RFHD, desire to attend subsequent RFHDs and recommendations for future programmes. The questionnaire also asked if participants were referred and the outcome of the referral.

Data collection was outsourced by RFHA to ZIMI COMMUNITY GOOD HEALTH INITIATIVE

Telephonic interviews were used to collect data from participants for the impact study. Interviewers were trained to collect the information across the 4 districts.

Combinations of Rotarians, Rotaractors, and other volunteers were used in the different areas.

Training of Interviewers

A one-day training was conducted for Rotaractors who interviewed the consented beneficiaries on phone.

Summary of Training

Title of training: 3-month Post-RFHD 2020 evaluation: How to conduct a telephone interview for beneficiaries.

Date of training: Saturday 13th, March 2021

Venue of training: Awabat Hotel, Makun Sagamu, Ogun State

Total Number of Participants:

Trainers: Dr. E.O Jaiyesimi (ZIMI Consultant)

Dr. J. K. Sodeinde (ZIMI Consultant)

Figure 1: Rotarian addressing the participants

Training Goal & Objectives

Goal

To prepare participants for the 3-month post-Rotary Family Health Day Survey Data Collection using telephone interview

Training Objectives

1. Acquaint participants with the etiquette of a telephone discussion
2. Teach participants about basic principles of research including research ethics
3. Teach participants about data collection using a telephone
4. Ensure participants perform role plays to assess proficiencies learned about a telephone interview
5. Ensure participants (interviewers) conduct telephone interviews for consented beneficiaries of the RFHD under supervision
6. Write a report of training

Training Activities Summary

The training started around 10:00 am with renditions of the National and Rotary anthems. There was a welcome address by Rotarian Ben Okhumale. This was followed by the introduction of all the participants and the facilitators from ZIMI, Drs. Jaiyesimi and Sodeinde. A one-minute silence was observed in remembrance of the former late National Coordinator of RFHD, in the person of Rotarian Olugbemiga Olowu. Ground rules were then established. The objectives of the training were stated and the training started and progressed according to the training agenda (appendix II)

Training Methodology

The training was both participatory and didactic/lecture in nature. An introduction to the training exercise was taken by Dr. E.O Jaiyesimi. She emphasized the etiquette of communication using the telephone. She also gave a lecture on types of data and methods of data collection. Dr. Sodeinde then came up to take a lecture on the introduction to research and principles of research ethics. He gave prominence to the principle of autonomy and why interviewers must ensure interviewees give their consent for the discussion to continue. He then took the participants on

step by step method of administering the questionnaire to the respondents on phone in both English and Yoruba languages. He however, stressed the importance of communicating in the language the respondents were most comfortable with. Participants were allowed to ask questions about the different aspects of the training. Role-plays were then performed by respondents using the questionnaire and verbal evaluation of the training was also done. These showed that participants had improved knowledge about data collection using a telephone interview.

Accomplishment:

- Participants at the end of the training understood the concepts of research, telephone interview, and data collection.
- Participants were able to understand the purpose of the 3-month Post RFHD evaluation
- Participants were able to conduct phone interviews for RFHD beneficiaries.

Figure2: Role play by trainees to further assess the understanding of trainees on communication and data collection

Figure 3: Dr. Sodeinde giving instructions to participants

Figure 4: Cross Section of Participants at the Training

Data Collection Instrument

The survey instrument, also known as 'data collection tool' is designed to obtain data on the objectives of the survey i.e. respondent's motivation to attend RFHDs, actions on any referrals, overall satisfaction with the RFHD event, and any recommendations they may have for future RFHDs.

Dr Philip J. Silvers' questionnaire template (South Africa's version) was used to draft the Nigerian questionnaire for the pilot impact study. The **impact study questionnaire** was reviewed for the purpose of collecting information from participants such that its The questionnaire consist of mixture of open and close ended questions-The intention was that most of the questions are 'open-ended,' whereby the client is asked to respond in his/her own words, without any prompting of categories. The interviewer then records the most relevant 'close-. ended' categories so that the data can be quantified. This technique enables us to obtain precise quotations from the respondent—without putting words in her/his mouth, reduce response bias, and at the same time, can categorize and quantify the responses.

Consent Forms

All four districts were requested to obtain a minimum of 10 **signed consent forms** from every Family Health Day site, using the guidelines described under 'Sampling Plan' above. These signed consent forms were used to contact survey participants for telephonic interviews.

Data Management and Analysis

The questionnaires were cross-checked for errors and cleaned. The data obtained were imputed into IBM Statistical Package for Social Sciences (SPSS) version 23 for statistical calculation and analysis. Data was summarized with mean, proportion/percentages and graphical presentation developed tables, pie charts and bar charts.

Findings Summary

About two-thirds (64.5%) of the beneficiaries were females while the remaining one-third (35.5%) were males (see figure 5). The majority (86.3%) of the respondents were young and middle-aged individuals while only a little above one-tenth (13.7%) were elderly who were 60 years and above. The mean age of beneficiaries was 42.14 ± 14.44 (Figure 6). Most people 86.8% brought three or fewer adults while 91.9% brought one or two children (Table 1).

Table 2 shows that over half (54.9%) of the beneficiaries were at the program for a general check-up while about one-third (35.7%) came for laboratory test. Only few came for vaccination (14.7%), health supplies (13.6%) and health problems (5.3%) (Figure 7). Television and radio (48.1%) are by far the commonest source of information to beneficiaries followed by neighbours (31.5%) and colleagues (11.5%). Only very few got to know about the programme through loud hailer (4.5%), family and friends (2.3%), health facilities (2.1%) and newspaper (0.4%).

The majority (87.2%) of the beneficiaries have regular access to health care. Financial constraint (42.7%), belief that medical care is unnecessary for the healthy (29.4%), time constraint (13.3%) and geographical inaccessibility of health facility (4.4%) were the main reasons why the remaining respondents do not have access to regular health care services. Very few (2.9%) were not having regular health care because they were dependent and utilization of health care was determined by others.(Table 3).

Most (86.6%) of the beneficiaries received treatment while 13.2% of them were referred. About one-tenth of those that were referred refused to go to a referral facility. Out of those who were referred but didn't visit the referral hospital, two thirds (66.7%) couldn’t go because of financial constraints and the remaining one- third didn’t go because of long distance of the referral facility. Among those who were referred and went to the referral centre, the majority (88.3%) had their problems solved while 11.7% said they still needed further help (Table 4).

Virtually everyone (99.2%) who received health care services reported improved health conditions after the programme (Figure 8). More than half (55.5%) of the beneficiaries had excellent while one third (34.0%) had a good experience. The remaining 10.5% said their experience was just okay. The respondent beneficiaries reported excellent or good experiences and that it was well organized, the health care workers with the volunteers were friendly and

caring. Other reasons for the excellent and good scoring of the programme was that it was beneficial to them (12.0%), drugs were available (9.2%) and the programme was free (7.1%). Almost all (99.4%) the respondents said they were treated with respect (Table 5).

Almost all the respondent beneficiaries (97.2%) said they will attend the next RFHD. Their reasons for wanting to attend the next RFHD was to do a medical check-up and/or receive treatment if they are sick (24.5%). Other reasons were because its free (8.3%), it gives them opportunity to run lab test (8.0%),and there is noticeable improvement in their health. Benefits such as free health information and education the respondent got from the last RFHD (14.4%), with the program arrangement which to them were good (5.8%) are additional reasons why they will come again for the next RFHD. Some wanted to come because of their love for the program (4.9%) and because it gave them a rare opportunity to be access free services.. One of the beneficiaries wanted to come next time to serve as a volunteer in executing the programme. Several recommendations were given by the beneficiaries which were categorized into various headings. About one-fifth (17.9%) of those who gave recommendations wanted the organizers to include more rare free services, like kidney function tests while 16.5% wanted the programme to be done more often and 15.4% of respondents wanted the organizers to ensure continuity of the programme. Over one-tenth (11.9%) of the respondents wanted more health workers to be deployed for future programs, 9.1% wanted an improvement in publicity and 4.5% wanted provision of more drugs next time. A few wanted more collaboration with government, NGOs and religious bodies (3.3%), conduct special groups (children and elderly) program (3.3%), increased scope of program to include loan and empowerment opportunities (2.0%) and ensure follow up of beneficiaries (1.8%) (Table 7)

Findings

Total Survey Respondents

A total sample of 400 clients was planned for, but eventually **540 signed consent forms** were received from the various Health Day sites.

We easily achieved our target of 400, by receiving **530 completed questionnaires (surveys)**.

The impact study results can therefore be seen as **statistically reliable**.

RESULTS

Table 1: Survey Demographics

Variable	Frequency	Percentage
Age Group (Years)		
< 20	15	2.8
20-29	89	16.8
30-39	135	25.5
40-49	135	25.5
50-59	83	15.7
≥60	73	13.8
Accompanying Adults to RFHD (n=190)		
1-3	165	86.8
≥4	25	13.2
Accompanying Children to RFHD (n=74)		
≤2	68	91.9

≥3	6	8.1

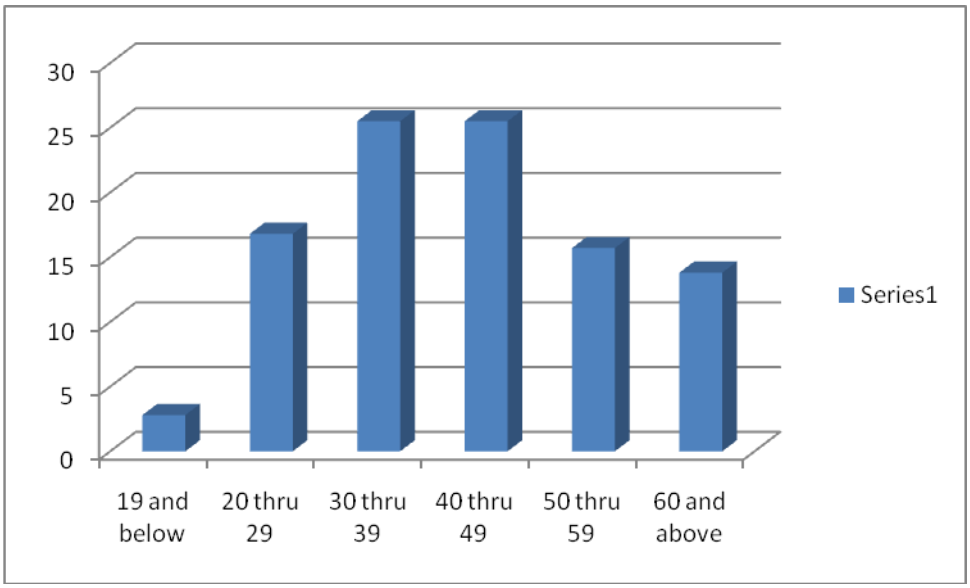

Figure 5: Age distribution of Beneficiary. (Mean = 42.14 ± 14.44)

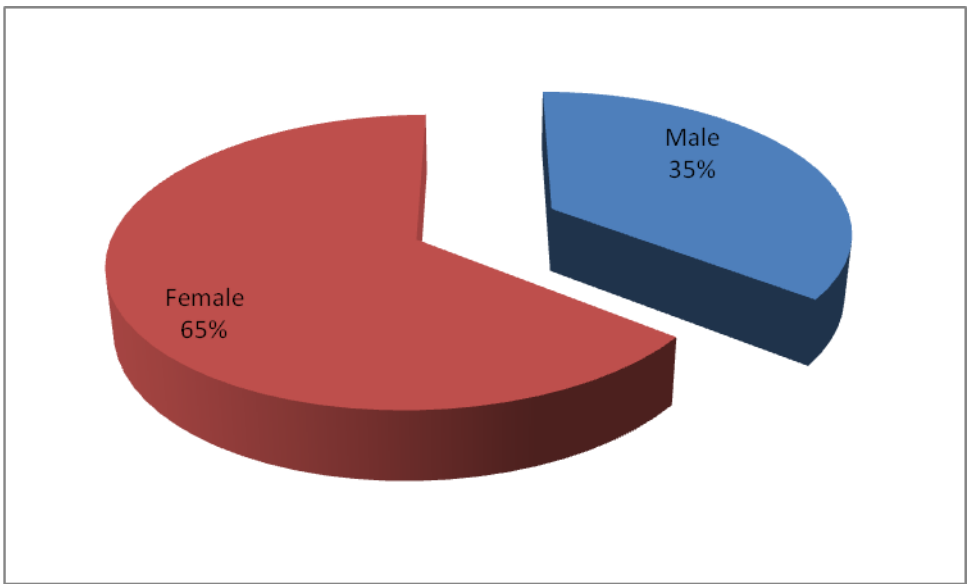

Figure 6: Respondents' Sex Distribution

Table 2: Reasons for Attending RFHD and Source of Information

Variable	Frequency	Percentage
Reasons for Attending		
General Health Check	291	54.9
Laboratory Test	189	35.7
Vaccine	78	14.7
Health Supplies	72	13.6
Health Problem	28	5.3
Others	7	1.3
Reasons for Attending with People (n= 252)		
Laboratory Testing	94	37.2
Treatment	39	15.5
To Benefit from program	39	15.5
Medical Check-up	38	15.1
Program is free	19	7.5
We were in each other's company	15	6.0
They came for vaccination	6	2.4
No particular reason	2	0.8
Reason for Attending Alone (n=279)		
No particular reason	182	65.2
Passing by alone	37	13.3
I was at home alone/I live alone	30	10.7
For check up	10	3.5

To benefit from the programme	8	2.9
Got information late so did not prepare to bring people	6	2.2
Just walked in since programme venue was close by	3	1.1
To receive prompt care for ailment	3	1.1
Source of Information About RFHD		
Radio & TV	255	48.1
Neighbour	167	31.5
Colleague	61	11.5
Family & Friends	12	2.3
Loud hailer	24	4.5
Poster	17	3.2
Clinic	11	2.1
Newspaper	2	0.4
Others	23	4.3

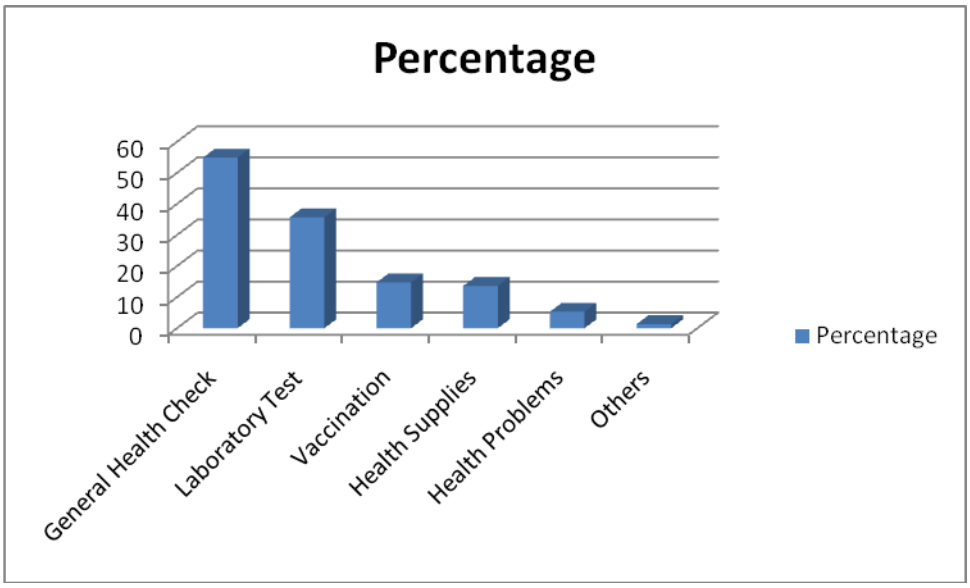

Figure 7: Reasons for attending RFHD (respondent could have more than one reason)

Table 3: Access to Health Care

Variable	Frequency	Percentage (%)
Regular Access to Health (n=530)		
Yes	462	87.2
No	59	11.1
Yes with difficulty	9	1.7
Reason for or difficult access to healthcare (n=68)		
Financial constraint	29	42.7
Medical care unnecessary since am healthy	20	29.4
Time constraint	9	13.3
Geographical Inaccessibility of health facility	3	4.4

Health institution bureaucracy	2	2.9
Dependent Individual	2	2.9
No particular reason	3	4.4

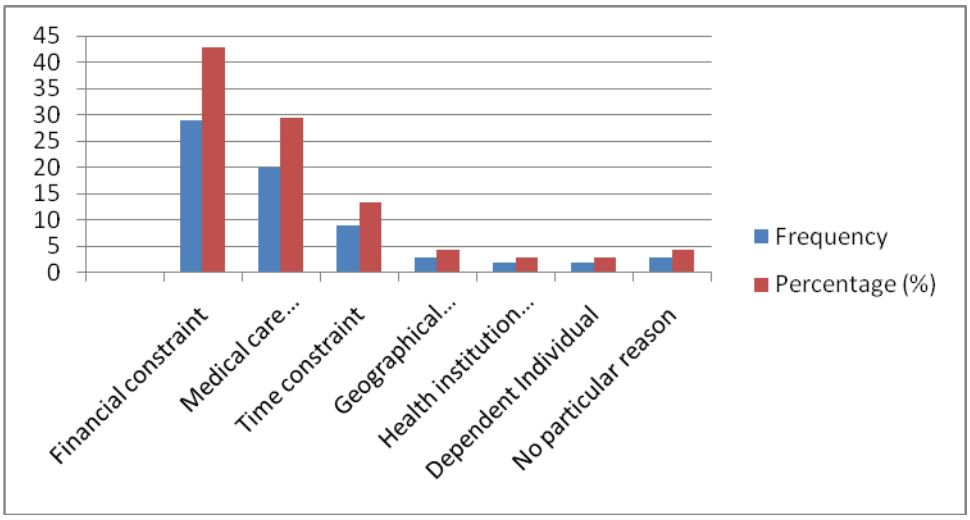

Figure 8: Reasons for difficult Access to Health Care

Reasons for No Access to Medical Care

Table 4: Treatment and Referral Status on RFHD

Variable	**Frequency**	**Percentage**
Received Treatment (n=530)		
Yes	459	86.6
No	71	13.4
Total	530	100
Referral Status (n= 530)		
Referred	70	13.2
Not referred	460	86.8

Total	530	100
Went to Referral Centre (n=70)		
Yes	64	91.4
No	6	8.6
Reason for not going to referral facility (n=6)		
Financial constraint	4	66.7
Long distance of referral centre from home	2	33.3
Got Treatment at Referral centre (n= 64)		
Yes	60	93.8
No	2	3.1
No response	2	3.1
Result of Referral Treatment (n= 60)		
Problem solved	53	88.3
Need further help	7	11.7
Meaning of "Need further help" (n= 7)		
Needs eye care/surgery	3	42.9
Needs Financial support	3	42.9
Still has the chronic disease (diabetes)	1	14.2

Table 5: Experience on RFHD

Variable	**Frequency**	**Percentage**

Change in Health Status (n=530)		
Improved health	526	99.2
Declined health	4	0.8
No health change	0	0.0
Experience at RFHD (n=530)		
Excellent	294	55.5
Good	180	34.0
Okay	56	10.5
Reason for Experience at RFHD (n=430)		
Excellent and Good Experience (n= 425)		
Good staff attitude	143	33.6
Availability of drugs	39	9.2
Services were good and beneficial	51	12.0
Because It's a free programme	30	7.1
Good organization	155	36.5
Timeliness in rendering services	7	1.6
Just Okay Experience (n= 5)		
Programme organization below expectation	2	40.0
Unavailability of drug for particular ailment (eye disease)	1	20.0
Poor timeliness	1	20.0
Poor staff attitude	1	20.0
Total	**430**	**100.0**

Problem Faced at RFHD (n=530)		
None	453	85.5
Poor staff attitude	43	8.1
Unsatisfactory Service including shortage of medications	34	6.4
Treated with respect (n=530)		
Yes	527	99.4
No	3	0.6
Reason for not being treated with respect (n=3)		
Staff Harsh and Rude	1	33.3
No response	2	66.7

Table 6: Willingness to Attend RFHD

Variable	Frequency	Percentage
Will attend next RFHD (n=530)		
Yes	515	97.2
No	15	2.8
Reason to attend next RFHD (n= 515)		
Medical Checkup/treatment	126	24.5
Improvement in health and other benefits from the last RFHD	74	14.4
It is a free programme	43	8.3
To run laboratory test	41	8.0

Well organized programme	30	5.8
Love for the programme	25	4.9
Programme is a rare opportunity to be utilized when available	25	4.9
Good workers attitude	23	4.5
To collect medical supplies like LLIN, condoms	19	3.7
I attend the programme regularly and it is improving	16	3.1
Programme is done in convenient environment	16	3.1
To receive vaccine	9	1.7
To volunteer	1	0.2
No particular reason	1	0.2
No response	66	12.7
Reason not to attend next RFHD (n=15)		
No response	15	100.0

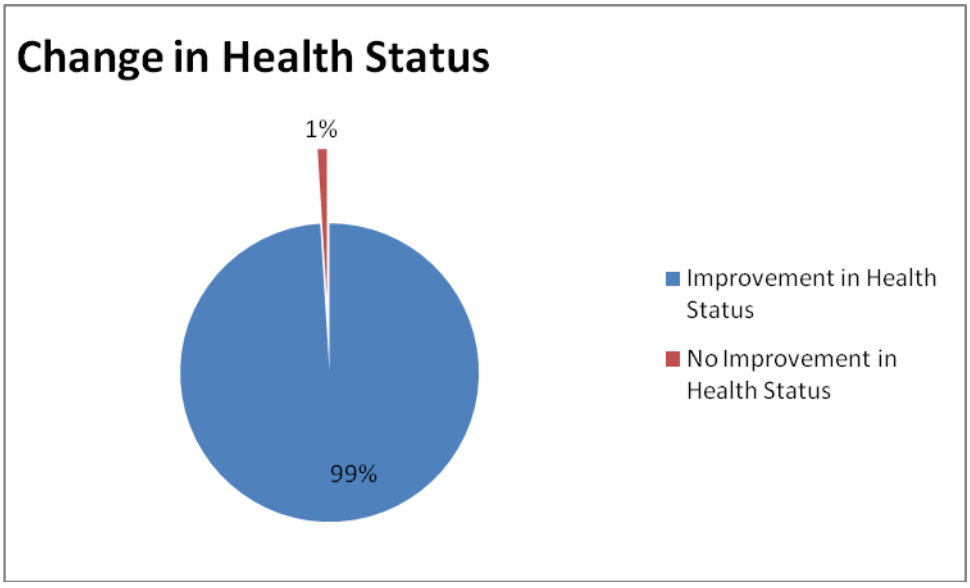

Figure 9: Changes in Health Status

Table 7: Recommendation for RFHD (n= 250)

Recommendation	Frequency	Percentage
Ensure continuity of the annual RFHD	61	15.4
Provide more drugs	18	4.5
Include more services e.g vaccination for more diseases, kidney test	71	17.9
Do Programme more often	65	16.5
Improve on publicity	36	9.1
Conduct programme in more unreached areas e.g. very rural areas	8	2.0
Involve more doctors and other health workers	47	11.9
Improve on programme organization	12	3.0
Ensure equality while rendering services	1	0.2
Extend the number of days for programme	8	2.0
Ensure timeliness	11	2.8
Collaborate with more government and NGOs	13	3.3
Do specific programmes for children and the elderly	13	3.3
Ensure follow up of beneficiaries e.g by phone calls	7	1.8
Increase scope of programme e.g. empowerments through loan or skill acquisition	8	2.0
Fulfill all promises made to beneficiaries	7	1.8
Staff should be more polite	10	2.5

DISCUSSION

In the 1970s, the World Health Organization initiated the health for all by year 2000 agenda which led to the primary health care conference in Alma Ata.[1]The Tokyo declaration of Universal Health Coverage.[2]was a similar commitment but with a different nomenclature. Both agenda focused on availability and accessibility of healthcare services to all individual all over the world irrespective of socio-economic and cultural background

In many developing countries, health care services were made available without any cost before the mid 1980s.[3]Free health services have been shown to improve utilization particularly for those who are in low socio-economic class [4]therefore contributing to the attainment of the health for all and UHC strategies. Majority in the survey who had difficulty accessing health care services are financially constrained. The Rotary Club through the implementation of the Rotary Family Health Day program has been playing a vital role in ensuring that individuals and families have free access to health care and enjoy referral services for more serious ailment therefore ensuring such individuals lead economically healthy and productive lives.

The RFHD has been particularly beneficial to all age groups and their opinions had been documented but, those less than 20 years. Only two (2) respondents in this survey is within the age group of < 20 years. This low representation in the 90 days post program survey are presumed to be probably because they will need accent from parents. Efforts should be made in subsequent RFHD program consent taking to get the adolescents consent/accent as the case may be. Hence document their opinions and use it to inform improvement in the programme implementation. Old age is a susceptible factor for disease and disability. Nevertheless, morbidity encumbrance among the elderly can be effectively reduced by addressing possible risk factors in them.[5] The program offers a great opportunity to further impact the lives of these vulnerable groups. Those whose presence are usually recorded in large numbers in this programme are females. For instance, this 2020 edition of the RFHD recorded about two-third (64.5%) female beneficiaries. Moreover, many of these participants were accompanied by children. Therefore giving attention to high-risk groups like the elderly, women and children will help in achieving a healthier and more productive population. The recommendation by some

beneficiaries that organizers should conduct the programme for special age groups substantiates the above submission. Only a little over one-tenth of the interviewed beneficiaries were elderly above 60 years of age. And some of these participants submitted that being dependent on other actually prevent them from regular access to health care.

A few participants recommended that beneficiaries of the programme should be followed up medically. Medical screening tests are done in asymptomatic individuals to detect health disorders or diseases in the early state. The RFHD programme offers essentially screening tests for early detection/identification and treatment of diseases to prevent complications. Health education are also conducted on various health issues. This is to ensure lifestyle modifications and changes so that diseases can be prevented,. Some Screening tests are not diagnostic. They only detect a group of people who needs further testing for the confirmation of the presence or absence of a disease.[6] Screening tests are usually done once with a final arbitrary result and on a large scale, unlike diagnostic tests which are individualistic and done in combination with other results to make a diagnosis. The screening tests offered by RFHD differ from what obtains in a health facility where diagnostic and curative services are the focus and patients are usually followed up. Therefore, whereas sick people who need treatment are mostly seen in hospitals, the majority of the beneficiaries of the RFHD were healthy people who only attended the program for medical check-ups and screening tests like HIV, blood sugar and cholesterol check. There may be an important need for some level of follow up to be provided particularly for those referred as a result of positive or abnormal test results.

The presence of much more people who came for check- up as compared to those who came for treatment also corroborates the screening nature of the RFHD programme. The healthy nature of the attendees may also explain why only just above a tenth of the beneficiaries were referred and the majority needed no referral. The implication of this is that the RFHD should focus on screening and preventive services more than curative services which will need further follow up and are better done in hospitals. There are already collaboration with health facilities, government parastatals and agencies that can take up referrals from the RFHD and continue the care of such clients as some of the beneficiaries have opined in their recommendation. This however could be improved upon to further create demands for services being rendered by the collaborators.

Health workers attitude has been linked to utilization of health services in Nigeria[7]and other African countries[8,9] It is therefore not surprising that health workers attitude was a significant factor why many of the attendees had excellent and good experiences and why some of attendees wish to come for the next RFHD. It is therefore left for organizers to emphasize relating with others as they prepare for future programs to consolidate this propensity since it was likely that the workers showed good behaviour to the beneficiaries.

The Demographic health survey in Nigeria[10] indicates that more people live in rural areas as compared to urban areas. However, the rural dwellers have less access to health care and other essential facilities. They also have less opportunity for health insurance. Therefore, just as was recommended, the RFHD may give special attention to follow-up programmes that could improve the rural dwellers access to health care. Can the Rotarian for Family Health & AIDS Prevention (RFHA) or other arm of Rotary in future programmes give attention to or focus on wealth generation through economic empowerment programme which could be in form of skill acquisition and financial support to improve economic status of the affected individuals. Financial constraint is a major factor why many cannot access good health care just as many of the beneficiaries in this survey reported.

Conclusively, findings in the report attest to the good work that RFHA are doing through the RFHD programme. It however could be improved upon by injecting new ideas, looking into group targeted programmes, and further expansion to cover fundamentals that could address reasons for non-accessibility to health care especially in the very rural and amongst the very poor. Continuity and better performance of the programme is important to cover more grounds amongst target groups.

5.0. RECOMMENDATIONS:

The following recommendations were hereby made based on the outcome of this exercise

1. There is a need to improve on awareness and publicity of the programme
2. The organizers may include special programmes for some specific groups in subsequent times. This may be done in collaboration with relevant agencies and health workers

3. Some beneficiaries could not visit their referral centres due to one reason or another. The organizers may devise means of tracking those who are referred to support them and ensure they visit the hospitals.

   The organizers may also consider RFHDs with special focus on wealth creation to improve economic status of the beneficiaries and thus empower them to be able to care for themselves and others. This may be more impactful .

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APPENDICES

Training Agenda

TIME	ACTIVITY	PERSON RESPONSIBLE
9:30 - 10:00	Arrival & Registration	Designated Rotaractors
10:00 – 10:05	Welcome Address	Rotarian Ben
10:06 - 10:15	Short Intro of RFHD	Rotarian Ben
10:16 – 10:30	Pretest	Dr. Jaiyesimi
10:31 – 10:45	Objectives of the Training	Dr. Jaiyesimi
10:46 – 11:00	Session I- Research	Dr. Sodeinde
11:01 – 11:15	Session II – Data Collection	Dr. Jaiyesimi
11:16 – 11:30	Session III - Confidentiality	Dr. Sodeinde
11:31 – 12:00	Session IV – Questionnaire Review	Dr. Sodeinde
12:01- 12:30	Role Play & Discussion of Role Play	All
12:31 – 12:41	Conclusion	Dr. Jaiyesimi
12:42 – 13:00	Post Test & Training Close	Rotarian Ben
13:00 – 18:00	Active Data Collection	

Annexure A: Adapted Impact Study Instrument (Questionnaire)

ROTARY FAMILY HEALTH DAYS 2017
SOUTH AFRICA – IMPACT STUDY

Socio-Demographic Details *[COMPLETE BEFORE MAKING PHONE CALL]*

001 Interviewee #: _____ Rotary District: _____ Province: _____

002 Age: _____ Gender: Male ☐ Female ☐

Intro Script *[READ TO CLIENT]*

Hello, my name is _____, I'm with the Rotary Club group that provided the Rotary Family Health Days in your area during **October 2017**. You filled in a consent form at the health site and therefore we have your number. We want to make sure that everything was okay for you with that experience, and I'd like to ask you a few questions. Your responses will be completely confidential. We are not going to use your name for the study so no one will know what you said. That is our promise to you. Okay?

Please also note: *You have the right to choose not to answer any specific questions that you feel uncomfortable answering.*

003 **INTERVIEWER, do you have the OK to continue?** Yes ☐ No ☐

Coming to the Rotary Family Health Days

101 **Why did you decide to come to the Family Health Day?** General Health ☐ Problem ☐ Testing ☐ Health Supplies ☐ Vaccines ☐ Other _____

102 **In addition to yourself, how many people came with you?** Children _____ Adults _____

(Either ask this) ***Why did you come with people?*** _____
(Or ask this) ***Why did you come alone?*** _____

103 **How did you hear about the Family Health Days?** Family/Friends ☐ Newspapers ☐ Colleagues ☐ Radio ☐ Loud Hailer ☐ Neighbours ☐ Posters ☐ Clinic ☐ Other _____

104 **Do you have regular access to healthcare services?** Yes ☐ Yes, but with much difficulty ☐ No ☐

105 **Please explain No or Difficult access to healthcare?** _____

Services Received

201 **Did you, or your children, receive health services at the Health Days?** Yes ☐ No ☐

Referrals Received

301 **Did you receive any Referrals to a medical agency or clinic?** Yes ☐ No ☐
If 'No', skip down to next section.

302 **Did you (or your family) go to the medical agency or clinic?** Yes ☐ No ☐
If 'No', why not? _____

303 **If you/they went to the medical agency or clinic; did you get treated?** Yes ☐ No ☐
If treated ("Yes"), what was the result? Need further help ☐ Problem solved ☐ Do not know ☐ Other _____

Explain 'Need further help' or 'Do not know'? _____

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ROTARY FAMILY HEALTH DAYS 2017
SOUTH AFRICA – IMPACT STUDY

Changes in Your Life

READ TO CLIENT

Please note: *You have the right to choose not to answer any specific questions that you feel uncomfortable answering.*

401 **Are there health changes in your life, because of Family Health Days?** Yes ☐ No ☐
Open probe and then code

402 **If yes, has your health improved or declined?** Health improved ☐ Health declined ☐

The Rotary Family Health Day Experience

501 **In general, how was your experience at the Rotary Family Health Day?** Excellent ☐ Good ☐ Okay ☐ Bad ☐
Why was it so? _____

502 **Were there any problems?** Poor staff attitude ☐ Lack of services ☐ No medicines ☐ Service quality ☐
Waiting times ☐ Other _____

503 **In general, did you feel like you were treated with respect?** Yes ☐ No ☐
If 'No', what do you think was the reason? _____

504 **When we hold Rotary Family Health Days next year, would you like to come again?** Yes ☐ Why? _____
No ☐ Why not? _____

505 **Do you have any recommendations for future Rotary Family Health Days?** _____

Thank you for sharing your thoughts. Your comments will be helpful to us as we plan next year.

ADDITIONAL NOTES:

#	Note

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