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Kekeli Women: The Impact of Being a Community Health Promoter in Ghana, West Africa

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Abstract

The Kekeli Project seeks to improve the day to day health of individuals in Akatsi, Ghana (West Africa) by empowering lay women to serve as health promoters within their own villages and communities. These women volunteer to provide basic health education, blood pressure screening, wound care, and safe delivery assistance. Point Loma Nazarene University has been working with this group through a summer study abroad program since 2015. Previous studies have demonstrated the positive impact of lay health promoters on the health of their communities. However, there are few studies that evaluate the impact of participation as a lay health promoter on the woman, herself. This qualitative study sought to understand the lived experiences of nine Kekeli women. Face to face interviews were conducted after a regularly scheduled Kekeli training event. Analyses of emergent themes indicate several beneficial outcomes as a result of “being” a Kekeli woman: an increase in self-esteem and self-confidence, status elevation within the community and feeling respected by family, peers and community. They also reported personal and family-related health benefits as a result of their own increased knowledge and expertise. Many women also described the significant bond the Kekeli women have to each other and the sense of “family” from this group. The only negative factor noted was a lack of pay. This study adds strength to the value of community health promoters not only to improve the health of the community but to also improve the health and lives of those who conduct the work.

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Background

The term *public health* is a part of the healthcare system that strives for the maximum wellbeing of all members of society and it does so by recognizing the most current health problems and using health promotion strategies to prevent them from occurring in the first place (Kumar & Preetha, 2012). Because public health is not simply focused on one individual and rather it is focused on an entire population, emphasis is placed on the prevention of communicable and non-communicable diseases so that the diagnosis and treatment can ultimately be avoided. Prevention measures occur at three levels and are carried out by trained professionals called “health promoters.” The levels of prevention, treatment, and management include tasks such as providing vaccines and educating, performing early screening tests, and administering medications to prevent worsening severity (Kumar & Preetha, 2012). Together, as the result of dedicated public health professionals, all of these measures contribute to a healthy environment, lifestyle, and decreases morbidity and mortality.

Ghana, a country in West Africa, is not only plagued by many diseases, but also faces many challenges in terms of public health. According to the *World Health Organization [WHO]* (2018) maternal mortality, HIV/AIDS, and malaria are a few of the common illnesses found in developing countries such as Ghana. These health deficiencies are not only due to a lack of resources, but an absence of basic health promotion efforts and/or activities. There are few programs that provide education on healthy living or screening and preventative measures for the relevant diseases. As a result, the majority of people in Ghana suffer from poor health status

which later impacts their development and economic sustainability. With worsening physical states and little hope, people in Ghana simply focus on survival while experiencing a low quality of life (Govender, 2005).

However, one organization currently “impacting the healthcare system in Ghana, through health education and screening,” is the Rural Health Collaborative who created and sustain a group of community health promoters. Established in 2011 by two alumni of Point Loma Nazarene University, Dr. Jason Kroening-Roche, MD, and Olivia Kroening-Roche, RN, this group of women health promoters consist of 47 lay health workers who come from rural villages in Ghana, spanning two districts in the Volta region (Rural Health Collaborative, n.d.). Each health promoter has no prior medical training or schooling; all the basic first aid skills and education techniques they have learned have come from training courses sponsored by the Rural Health Collaborative (RHC). In the hopes of these women preventing disease in their communities and becoming leaders, the RHC has appropriately named this group *Kekeli*, translated from the native language of Ewe meaning “brightness” (RHC, n.d.).

Not only is the Kekeli project improving health conditions in its region, but it is also fighting against gender inequality. Similar to many countries in West Africa and other parts of the world, women in Ghana are not considered equal to men (United Nations, n.d.). Inequalities in educational and economic opportunities are common disadvantages seen among women. These social factors, along with other environmental factors, expect women to solely raise children and be homemakers. This feeling of powerlessness occurs when women do not have access to information, support, or opportunities (Ali Shah, Hulzar, Karmaliani, & Noorani, 2017) and the Kekeli program strives to change this. Empowering the women, while contributing the greatest good for the greatest amount of people, is what makes this project unique and impactful.

According to Govender (2005), the success of health promotion projects, health outcomes, and the influence of health determinants, are indicators of public health policy achievements. Studies done on health promotion projects determine the effectiveness the program has had on the public and its wellbeing. However, there has been little to no evaluation done on the effects these types of programs have on the lay workers themselves. A systematic review from Cochrane Library (Glenton et al., 2014) explored a group of African women volunteers' desire to work and the incentives they were given. It was determined that there is moderate evidence to suggest that the workers gain recognition, improved status, monetary or gift incentives (e.g., bicycles) and a sense of empowerment by participating in health promotion programs. To continue this theory, in the summer of 2018, a program review sought to assess what it truly means to be a Kekeli woman. The purpose was to better understand how participating in public health programs has benefited its leaders, such as the women in the Kekeli project.

Literature Review

Feelings of self-worth and empowerment are two important areas that contribute to one's overall wellbeing. Because of this, the topic under review is the Kekeli Project. Research is needed to explore the personal impact being a part of an all-female group of lay-workers in third world countries has on its volunteers. Many studies have shown the positive impact volunteers and their programs have had on their society's health, but there is little to no research conducted on the volunteers, in particular the women, themselves. It is of interest to see how their status in society, self-esteem, living conditions, job opportunities, and any other personal qualities have changed because of a public health leadership position. The scope of review was limited to published works, works in English, works involving health promotion/promoters, women, and

African countries or similar locations. This literature review will not look at or include previous research sources that contain the following: only first world countries or male volunteer figures. The sources included in this review focused on two main aspects of health promotion: the type of program and the leaders of the programs. When looking at the program details, effectiveness and furthering opportunities were discussed and when looking at the leaders, economics and equality were the key points. Within the African continent, some countries, such as Ghana, suffer from many health disparities as a result of social barriers such as corruption, debt, war, and rape (Govender, 2005). However, primary prevention measures carried out by health promoters could fix this by saving money and increasing the determinants of health because treatment would be less necessary (Govender, 2005). Also, being a part of a non-profit organization, by contracting out of government partnership, may or may not help health promotion programs financially (Odendaal et al., 2018).

Typically, volunteers are unpaid workers. Yet, the role of economics and the question of whether volunteers should be paid for what they do, has been a frequent concern. However, an article by Glenton and colleagues (2010) concluded that volunteers should remain paid and motivated through the use of incentives and applause because this is what ultimately helps increase their moral status. Two of the sources also discussed the ongoing debate of equality. It is still seen that females are treated differently in the workplace and are not seen as leaders because they are less superior when compared to men. However, research shows that women seem to lead with different qualities than men and these qualities may make them more successful leaders. Making decisions based on subjective values and the use of professionalism has proven to be more effective in certain situations (Kobla & Li-Hua, 2018). In addition, to a natural ability to lead, women can also break away and achieve deprived things such as education, respect,

positive self- belief, and job opportunities through empowerment. With this support, women have the opportunity to impact many things. For example, they can change the healthcare system through health promotion and disease prevention all because they are given the leadership to do so (Gulzar, Noorani, Karmaliani, & Shah, 2017).

The availability of sources in the subject area was sparse due to the specific location and population in research. The program review is looking at the women who volunteer in the Kekeli project in Akatsi, Ghana and there are no current sources that comment on this subject area in detail. As a result, sources that encompassed a similar idea of what the Kekeli women do, an area in the same medical, financial, and rural state as Akatsi, and the positive effects of leadership were used. Three specific themes, which include: economics, equality, and primary prevention, occurred frequently throughout the five reviewed references and in more than one article. With such significance, these themes became the focal point of further research.

Economic component

Economics is a broad scope of business and there can be a lot of different ways to approach the subject. For this research, economics was considered in three ways: should volunteers be paid for the work they do, should countries pay to develop their own health promotion programs, and should these types of programs stay under government funding or become non-profit? Two articles, written about health volunteers in Nepal and women in leadership positions, both focused on the arguments regarding volunteers and if they should be financially rewarded for their time and efforts. Like any job, volunteer programs want to keep members, so how do they do that? Research has shown that volunteers are primarily motivated by becoming respected, feeling religiously obligated, and having a desire to learn more through trainings (Glenton et al., 2010). Community health workers are one type of volunteers that have

shown to uphold employment rates and reported that receiving a regular pay adds a negative view to their leadership position (Glenton et al., 2010). On the contrary, some believe volunteers, women especially, should be paid in order to close the leadership pay gap between males and females. Women who receive little to no pay have a huge disadvantage when it comes to providing for their families as well as saving for future needs (Kobla & Li-Hua, 2018). Gender pay is currently the largest aggregate and third world countries who have no laws regarding this subject fear what will happen to those hard-working women trying to fix this gap.

Equality component

Moving from the individual level to the group level: should countries spend funds on health promotion programs? Africa is a continent that has many third world countries within it that suffer from an extreme lack of money due to events such as government corruption and debt as well as diseases such as HIV/AIDS (Govender, 2005). In order to increase economic investment and development, volunteer health programs should be implemented so that less money can be put into cheaper primary prevention measures instead of more expensive secondary and tertiary treatment. Research then further investigated if these programs should contract in or out of government supervision. Potential negative effects of becoming a non-profit are fraud and corruption, but other than that there is not enough evidence to state which way is more beneficial (Odendaal et al., 2018).

Like economics, the fight for equality is a common issue. Fighting for equal representation is seen across all continents. However, a case study specifically looked at Africa, a developing country fighting hard for this right. In general, women are paid less and looked down upon--they aren't even recognized for the hard work they do in the home or for their families. The goal in places where women are treated as secondary to men is to get women

involved in all decision-making processes through an increased representation in political leadership positions (Kobla & Li-Hua, 2018). But in order for this to become a reality, women need the opportunity to receive a higher education as well as receive physical protection through empowerment. Structurally, empowerment is defined as power that is “influenced by the interaction between the environment and the individual (Gulzar et al., 2017). Achieving this feeling requires three things: a positive workplace, belief by others, and appreciation (Gulzar et al., 2017). Especially in the health field and nursing, this bundle of professional power ensures a high quality of care as well as increases the public’s image of the professionals. And with greater satisfaction comes a decreased risk of employee burnout and turnover (Gulzar et al., 2017).

Prevention Component

Lastly, one big issue in the world of public health is prevention. There are three levels of prevention in the healthcare field. Primary prevention includes preventative measures such as immunizations or education, secondary prevention involves catching and treating diseases through screenings, and tertiary prevention involves managing chronic illnesses and preventing further complications. Most people in Africa have a poor health status. Maintaining health is a severe issue, making development and economic viability close to impossible (Govender, 2005). In Africa, secondary and tertiary care consume over 80 percent of the health care budget annually (Govender, 2005). Because of this, primary prevention should be the goal of all health care programs. Patient involvement allows clients to add their own input into the decision-making process and studies have shown that the more engaged a client is, the more likely they are to feel as though they can achieve their healthy outcome and the greater likelihood that they will commit to the plan of care. Health care in many countries, not just Africa, is shifting the

focus to health promotion and disease prevention (Gulzar et al., 2017). This allows for care to be more effective and affordable.

The key findings of this literature review are that women need to be recognized as well as appreciated for their work because often times women are treated as less superior. Women have proven to be just as capable, if not more due to their empathetic nature, as men in being leaders. A common theme of the movement of equality for women was seen in all of the sources reviewed and although it is a slow process, it is happening. Education can not only help individuals, but it also allows for innovation and leadership to impact entire populations. Because of this, programs that allow women to become educated and empowered can greatly impact those around them. The Kekeli project is doing just this--allowing women to become respected and skilled health promoters, focused on primary care. And this in return has benefited the entire villages' health.

Methods

This program review was a mixed methods study, combining quantitative and qualitative data collection methods. The research took place in Akatsi, Ghana located in West Africa and was completed in one day. 47 women, all of which are official health promotion leaders of the Kekeli Project, participated in the study.

Participants

In order to recruit participants, Point Loma Nazarene University nursing students first assessed the Kekeli women's skill of taking blood pressure, and then invited each woman to complete a brief questionnaire. Approximately nine women were chosen to participate in recorded interviews by the Ghanaian Kekeli leader. Each participant, of both the questionnaire and the interviews, participated voluntarily.

Materials

Before going to Ghana, a piece of lined paper for each Kekeli woman was set up for the questionnaire. The paper was titled, “Kekeli Survey”, and on the right-hand side there was a spot for the women to write their names, while the left-hand side was numbered vertically— one through six. The six questions on the questionnaire were pre-written and only the person leading the Research Interview Session had them. In addition, a large poster board explaining the scale for scoring was written and drawn to better help the Kekeli understand how to appropriately rate their responses. As for the interviews, new recorders were brought to capture the answers discussed during the conversations.

Data Collection

At the end of the teaching day, the papers for the questionnaires were individually handed out to the women who chose to participate. Once each woman had a form, the scoring tool and questionnaire process was explained in English and immediately translated by a public health volunteer who spoke Ewe. The six questions were then posed to the women and in response to each of these questions, they selected and wrote down a number that best fit their feeling; with one being strongly disagree and six being strongly agree. Because each woman was not allowed to share or discuss her answers with other members, the research was kept unbiased. Once the questionnaires were completed and collected, the qualitative data was collected. A small, private space was reserved to conduct the interviews so the women participating couldn't share answers or base their views or perspectives on those of their peers. Each woman was called over one after another and the only people present during the interviews were the two researchers, a translator, and the Kekeli woman. The process for each woman was similar in nature. Introductions were exchanged so that the name of the woman speaking was recorded and then the researchers asked

the predetermined questions and the Kekeli woman responded. During this conversation, the translator, another medical volunteer who spoke Ewe, translated each question and each response each time.

Procedure

Analyzing the quantitative data was done by inputting all of the numerical data into an excel spreadsheet and the averages and common scores were identified by a statistical computer program. For the qualitative data, a native Ewe speaker translated the conversations from the recorders to English and then it was transcribed to hard copy by the researcher, also in English. After the data was processed, multiple nursing and business professionals reviewed the two types of data (during three independent sessions of coding) in order to determine common themes and make conclusions.

Data Analysis

Out of all the questions asked during the interviews, three main areas of growth and interest were chosen to be focused on due to their frequent occurrence and similarity in answer in a majority of the women's responses. The topics include: why the women chose to become members, how the work has made them feel, and who considers the women to be a vital part of the community's improving health status (see attached appendices). These specific ideas were questioned and analyzed because they covered each perspective. The women's thoughts and feelings are considered as well as the public's perspectives. Then, within each perspective similar answers and reoccurring themes were noted and analyzed further. The data discussed below will support the idea of why being a Kekeli woman is not only good for the community, but why it is also beneficial for the volunteer herself.

Motivation to join

The Kekeli Project is supported by a non-profit organization so it is run and maintained solely by volunteer status. Being a community health volunteer isn't a "once every so often" job-it takes constant time, commitment, and passion. It is a position that challenges its members, so why did these women choose to be a Kekeli volunteer? From the nine interviewees, four main responses were said in response to this question. First, a lot of them were interested in the healthcare field and one had already been helping a nurse. In addition, a desire to help their own community was common. A couple women noted that they wanted to know about health issues, so they could take care of their fellow villagers as well as themselves. Next, these women had the character of a Kekeli woman, so they were sought out by recruiters. Being easily approachable and able to give advice was just the kind of person the program was looking for. And lastly, a few women honestly told researchers that they were just asked to join so they did. Volunteers were needed, so the organization either found women based off of referrals from others or just recruited women who were open to the idea.

Personal benefits

After hearing why the women joined, the conversation was directed to how they enjoyed being a part the Kekeli Project. Questions were aimed at what it meant to them and how it made them feel. Empowerment was the main response received. The women explained that they have been empowered through knowledge to help others, such as their fellow community members and even their own family. One woman stated, "I am very very glad to be a Kekeli Woman because I feel empowered by what I have learned, especially information regarding blood pressure" (participant two). The women described that one benefit of the learning they receive is that they are able to offer help and give advice to people that are hurt, when the hospital is too far

or too expensive for the client. Using tertiary prevention along with primary prevention measures, the Kekeli women reflect that their people are now more informed about their health.

Authoritative position

Shifting from the personal perspective to the public perspective, allowed the Kekeli women to reflect on their newly-found role as an authority figure in their community. The public now specifically seek these women out and approach them, whereas before they were ignored and expected to just attend to the household chores and children. This newly established respect has allowed the women to increase their status in society. For example, one woman stated that this position distinguishes them from an average citizen and another explained that they are now able to address the chief in order to request more help from the community's highest leaders (participant four) --all of which was never socially recognized or considered acceptable. The sudden trust instilled in these women is due to their newly developed skills in triage, first aid, blood pressure screenings, and condom education. Their ability to give medical advice and treatment has made Kekeli the first line of consultation before other highly respected leaders; some of the public even go as far to go to the women's houses for advice. During this discussion the women used words such as, "good, happy, and glad," to describe how all of this made them feel. In the Ghanaian culture, these words have a stronger meaning and different tone than the words do in the English language context. All of the words express that the women are thankful and blessed to be able to learn a lot and make a positive impact on strangers throughout the village and their own family.

In addition, it was further discovered that the women have become official leaders in their communities and their self-image has drastically increased--all of which have benefited the women mentally and physically. The women again reported a community status elevation

because they are not only invited to come speak at local meetings, but they are even expected to be there. Participant eight explained that, “If people have a problem, they wish to talk to me or have me come to their meetings, so they can ask me for advice because they think that I know the answers to some of their problems.” Being able to go out, speak, and give medical advice, in places which previously the women were not accepted in, makes them feel good about themselves and excites them. Self-esteem has also greatly increased because the women are no longer shy. They are comfortable sharing and teaching their new knowledge to others because they like to advise people when and where to go to the hospital. The women’s communication skills have also improved as a result of the Kekeli program because before, they were not able to speak to elders, but now the elderly come to the women to share their health problems and ask for advice. Being able to have a professional conversation with the elderly population has increased respect towards the women. The women also use their voice to gather people together in order to teach large-group classes to villages and schools about common diseases and health practices.

These women who were once considered average have become special people in their communities because they all exhibit certain qualities and personalities that allow them to connect with people all while committing their heart to helping them. In addition to this, they have also learned and obtained knowledge and skills to allow them to deal with diverse people of all ages. The incredible thing about this volunteer position, is not only are they helping others, but they are also improving their own well-being and their family’s lifestyle. One response reflected, “I come to do special courses, to learn different things and I benefit from all of that. I believe that even if no one in the community benefits from it, it will still benefit me and my own family members” (participant nine). There are currently 47 members of the Kekeli Women and

the hope is to keep adding new members each year because the research shows it is benefiting the community as well as the women.

Implications

The literature review supported that health promotion programs greatly benefit the community and its leaders. This type of female volunteer program allows developing countries to improve the community's overall health all while improving the women's status in society. In order to achieve this, research has shown that the women workers need to be empowered as well as appreciated, and primary prevention measures need to be the area of treatment focus. In Africa, women are placed at a lower standing than men on a scale of hierarchy and, as a result, are seen as less respected and of lesser value. However, the Kekeli Project strives to change this by empowering their women volunteers through education and praise. And in order to decrease the costs of healthcare, the Kekeli Women are focused on educating and screening (healthy foods, blood pressure screenings, etc.) its members of society in order to prevent the development of chronic diseases.

Women have a natural ability to lead because their subjective values and nurturing nature, in addition to their common professional character, has shown to be more effective in most leadership positions (Kobla & Li-Hua, 2018). Empowerment is a key aspect for women wanting to gain leadership abilities and make a difference because it allows them to become educated, respected, and confident. In support of this, during the Kekeli interviews one woman stated, "She is now considered a leader because she is called upon to contribute when health programs are to be discussed and she's also one of the first people to give medical opinions so she can help people to decide if they should go to the hospital or not (participant five). As a

result of this position, the Kekeli Women now have a greater sense of self-worth due to their effective leadership, which increases their overall wellbeing.

There were so many positive aspects noted during the Kekeli research, but unfortunately there was one negative aspect brought to attention by each woman. Each member requested and desired a payment for the work they do: “there is no financial incentive and every once in a while, they almost give up and lose hope because of this” (participant two). Although the women want to be paid for their volunteer time and efforts, this literature review showed women should instead be paid via incentives and applause. Having a desire to make a change and being appreciated and recognized for that effort, results in successful leader (Glenton, Scheel, Pradhan, et al., 2010). And this is what the Kekeli Program is doing. The women have learned to push themselves to do the work in spite of lack of funds, and they are now encouraged to continue to help their community because they are treated better, and people now approach them for help (participant six).

Not only are the Kekeli Women benefiting from the work they do, but so are their communities. The women reported that they use the knowledge and skills learned in trainings to not only clean wounds and refer people to hospitals, but also to prevent common diseases from happening in the first place. Ghana is a country that lacks a lot of money and resources and the Kekeli Project considers this. The program emphasizes primary prevention measures such as educational teachings and blood pressure screenings, so that scarce funding can be utilized in cost containment rather than spent on avoidable and expensive secondary and tertiary treatments (Govender, 2005). Not only that, but the Kekeli women do an excellent job of involving their patients in their own plan of care. Instead of telling them what to do, they have conversations with their clients and determine the best medical action together. This will benefit the

community's overall health because patient involvement has shown that the more engaged a client is, the more likely they are to feel as though they can achieve their healthy outcome and the greater likelihood that they will commit to the plan of care (Gulzar et al., 2017).

Conclusion

Developing countries suffer from many health disparities. Health promoters positively impact their community by improving access to healthcare services and immunizations, as well as reducing child and maternal mortality in rural health settings (Aranda-Jan, Mohutsiwa-Dibe & Loukanova, 2014). The purpose of this study was to determine satisfaction with program participation and explore the lived experience of “being” a Kekeli Woman. The research methods used were a six-item satisfaction survey measured on a Likert-type scale (n=47) for the quantitative data and one on one interviews with pre-selected Kekeli women (n=9). The data was taped-recorded and transcribed/translated and then a content analysis was done (three independent reviews) to reveal convergent themes. Evaluating only one community health promotion program that was located in Akatsi, Ghana didn't cover a large population. Having to translate data on audiotapes from Ewe to English, through a bilingual native, was challenging. And encountering many cultural differences were all limitations faced during this study. In the end, it was determined that overall, there is a positive perception of participation because the women have noticed an increase in the following areas: self-esteem and self-confidence, status elevation within the community, respect by family, peers, and community, and personal and family health benefits as a result of increased knowledge and expertise. The only negative aspect the women noted was a need for greater financial assistance. The Kekeli Project is making a difference in communities all over Akatsi, and similar programs like these should be employed in other developing countries.

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Appedices A

Program Review- Kekeli Women

-Regarding the impact of this program on them, personally

Qualitative (big open-ended questions)

1. What was your role, in the household or community, before you became a part of this program?
 - a. Did that make you happy?
2. Why did you become a “Kekeli Woman?”
3. How does being a “Kekeli Woman” make you feel?
4. How has this opportunity benefited you?
 - a. Your family?
5. Has this program made you a leader?
 - a. If so, how?
6. Do people treat you differently now that you are a “Kekeli Woman?”
 - a. With more respect?
7. How has your personal perception of self, changed?
 - a. More pride? Smarter? Better Purpose?
8. Would you recommend becoming a “Kekeli Woman” to other women?
 - a. If so, why?
9. How does the “Kekeli” group get along?
 - a. Do you all support each other and act as a family?

Quantitative (Likert-scale: strongly disagree, disagree, neither agree nor disagree, agree, strongly agree)

• Personal Experiences:

1. The Kekeli program has been a positive experience for me
2. The Kekeli program has improved my standing/reputation in my community:
3. The Kekeli program has helped me and my family financially
4. The Kekeli program has taught me money management and other financial skills
5. The Kekeli program has given me confidence that I can be a leader
6. The Kekeli program has improved my relationship with community leader