Street-Level Bureaucrats in Homa Bay County, Kenya

A bottom-up implementation analysis of the policies on malaria and gender inequalities

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Abstract

The fight against malaria in Kenya is tightly connected to gender inequalities. The traditional gender roles in some households create exposure patterns that affect the most vulnerable groups: pregnant women and children. Current political strategies to prevent malaria in pregnancy rely on community health volunteers (CHVs), who fulfil a crucial role as implementers of malaria policies on community level.

This bottom-up study identifies barriers for CHVs to implement the policies that focus on gender aspects of malaria in pregnancy. A participant observation of CHVs was done for one month in Homa Bay County, one of the most malaria burdened regions of Kenya, followed up by qualitative interviews with five CHVs. Empirical data is categorised based on the findings of barriers in previous research and analysed by using two policy implementation theories regarding a bottom-up approach to policy analysis and street-level bureaucrats.

The study concludes that CHVs face a lack of accurate training and supervision and are restricted by heavy workload due to time limit and insufficient financial support provided by public authorities and NGOs. This increases the relevance of discretion that CHVs exercise in their role as street-level bureaucrats. Consequently, CHVs' discretion is important in determining the policy outcome.

Keywords: Community health volunteers, Street-level bureaucrats, Kenya, Policy implementation, Gender, Malaria in Pregnancy
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Abbreviations

CHV	Community Health Volunteer
KNMSP	Kenyan National Malaria Strategy Plan
MiP	Malaria in Pregnancy
NGO	Non-Governmental Organisation
WHO	World Health Organisation

Table of Contents

1 Introduction

In 2009, the Kenyan government released a new set of policies that articulates efforts required to reduce malaria, which is a major cause of mortality in the country. Some of the new policies specifically regard malaria in pregnancy (MiP), since children and women are most vulnerable to malaria infection (Kenya. Ministry of Public Health and Sanitation. [KMPHS], 2009 p. iii, xvi; Kenya National Bureau of Statistics, 2016). A central concern of this objective is to confront malaria as a *gender issue*, as gendered disparities in social behaviour and socioeconomic privileges within households affect women's risk of exposure to malaria (KMPHS, 2009 p. 19, 21). In the policies, the gender dimension is addressed as to be a part of the implementation work of health care workers on all levels (ibid).

A major player in the implementation of the MiP policies are the community health volunteers (CHVs), who execute the policies on a community level and constitute the object of study in this essay (Division of Community Health Services [DCHS] 2013, p. iii). To obtain a deeper understanding about the CHVs' role in health sector and the connection between gendered issues and malaria, two malaria researchers were interviewed. One of them was Bernhard Ogutu, a malaria researcher at Kenya's Ministry of Health (Interview 1, 2018). Ogutu means that in order to see the critical role of CHVs in the implementation process, malaria in Kenya has to be understood as an issue that needs to be fought on a community level. Rather than being a centralized, hospital-based problem, malaria is a problem where the most vulnerable people tend to have restricted access to hospitals because of the distance or economic reasons. In the case of MiP, CHVs therefore have an important role as civil servants who have the opportunity to interact, and thereby inform families about the link between health and gender differences (Interview 1, 2018).

The purpose of this explorative study is to identify and describe barriers for CHVs to work with the implementation of gender related MiP policies, by interviewing CHVs with several years of experience in MiP health care. It follows the structure of a health policy analysis with a bottom-up approach (Buse, Mays and Walt 2012, p. 133). As a basis for the bottom-up approach, the CHVs are observed as *street-level bureaucrats*, a theoretical term coined by Lipsky (1980) to describe front-line staff delivering public services. Applying Lipsky's theory gives a relevant perspective on CHVs as it states that such actors have the power to form the policy outcome at their own discretion (Lipsky, 2010 p. 13). Given that CHVs might be able to determine how the policy unfolds, the study will also discuss whether possible restrictions in their work lead to different perceptions among the CHVs of how the policy should be implemented. Consequently, the study also aims to contribute with empirical groundwork to the study of health policy implementers on a community level in Kenya.

The main research question that this thesis aims to answer is: *What are the perceived barriers that prevent community health volunteers in Kenya from implementing gender focused policies on malaria in pregnancy?*

A critical limitation of this study is that all CHVs who are interviewed work in Homa Bay County. The limitation is motivated by the fact that the county is located in one of the regions with the highest risk of malaria in Kenya, with a total rural population of 92%, according to the County Government of Homa Bay (2013, p. 77). The geographical limitation of the gathered data means that the findings of the study are to be seen as examples from where the MiP policies are highly relevant due to the current burden of malaria, rather than representative for the whole country.

A crucial pre-study was made to acquire a certain comprehension of the central topics of the study. In September 2018, I assisted a medical research group on malaria, inter alia consisting of CHVs from different communities in Homa Bay County and Kenyan public health and malaria researchers. We travelled around in Homa Bay County for a month, investigating the conditions of malaria in numerous communities. During the trip, meetings were held with local

community members, village elders, the Minister of Health in Homa Bay County and several other stakeholders working close to the CHVs.

2 Background

To introduce the topic of this study, this chapter gives a factual explanation of malaria in pregnancy and how it is connected to certain gender issues. Thereafter, it offers a brief overview of the policy documents and the political organisation that composes the hierarchical context in which CHVs work.

2.1 Malaria in Pregnancy

Pregnant women are particularly vulnerable to malaria, as pregnancy reduces a woman's immunity to the disease and increases the risk of illness, severe anaemia and death (WHO 2003). Malaria in pregnancy is mostly caused by the parasite *Plasmodium Falciparum* and occurs predominantly in Africa (World Health Organisation [WHO], 2017). The infection can lead to miscarriage, congenital infection and perinatal death. Having malaria during pregnancy increases the risk of spontaneous abortion, still birth, premature delivery and low birth weight which constitutes a leading cause of child mortality in Africa. (WHO, 2003; Centers for disease control and prevention, 2018). In 2016, the most vulnerable groups to malaria infection were children under five and pregnant women (KMIS, 2015). The three main strategies recommended by WHO to prevent women from getting MiP are sleeping under insecticide-treated nets, getting intermittent preventive treatment during pregnancy and prompt treatment in cases of fever and malarial illness (WHO, 2003).

2.2 Malaria in Pregnancy and Gender

Gender related dynamics of treatment seeking, decision making and financial authority within households are factors that impact the difference between women and men's risk of exposure to malaria. Hence, increased attention to gender aspects of social behaviour has become a way to improve the effectiveness and coverage of malaria policies (WHO, 2007). As an example, a report by WHO from 2007 gendered division of labour and decision-making regarding the usage of mosquito nets within families may play a significant part in determining the exposure to mosquitoes (ibid). Some studies from the report also show that some women have to ask for their husband's permission to access treatment for themselves or for their children. (ibid)

The report by WHO gives another example of women in Cameroon, where the burden of illness due to malaria disproportionally rested on economically disadvantaged women (WHO, 2007). Given that men in some cases are the breadwinners, women's financial dependency on their husbands may prevent them from purchasing insecticide-treated nets for themselves or their children, unless the husbands prioritise the usage of nets (ibid).

In the case of Kenya, gender issues are connected to MiP in similar ways to those mentioned by WHO. As patriarchal norms dominate cultural practices around pregnancy in different communities, especially in some geographically remote areas, factors like decision-making and intra-household arrangement of budgets affect the way pregnant women feel, behave and what they can or cannot do (Interview 1, 2018). The second malaria researcher that was interviewed in this study states that in such a context, the risk for a pregnant woman to get malaria could increase as she, for instance, might not be able to get support from her husband in getting access to health facilities, mosquito nets or an accurate treatment (Interview 2, 2018).

2.3 Organisation of the Health Sector

For the purpose of this study, the CHVs' formal linkages to the health system should be understood in relation to the organisation of political actors in the health sector, which will now be explained.

2.3.1 Community Health Volunteers

CHVs in Kenya are employed as part-time volunteers, mostly based in the community where they live. They are expected to do monthly household visits in their community (Rose et al. 2018, p. 2). Formally, CHVs are employed as community health workers who implement the health programmes governed by the Ministry of Health (Interview 6, 2018). Their central role in the implementation process is due to their potential reach and proximity to populations in need of health services (Rose et al. 2018, p. 2). As opposed to educated health workers in general such as nurses, CHVs are "community members with an in-depth understanding of community values, local culture, and language (…) who (…) provide a defined package of health promotion and services at the community level as part of the health workforce (…)" (ibid). They are selected by their community through a participatory process and get certified by a standardised training (ibid). National guidelines are offered to instruct CHVs in their work (Interview 6, 2018).

Delivering public services within the primary health sector, CHVs are tasked with improving the well-being of the communities and linking individuals to health facilities (ibid; DCHS, 2013 p. 13). The activities of CHVs are constantly being reported to units managed by the county governments (DCHS, 2013 p. 13, 17). Their working tasks strive to build trust with people in communities and provide health related advice (DCHS, 2013 p. 16-17). Among the responsibilities of CHVs, some key tasks consist of organising, mobilising and leading village health activities. These also include involving households in a dialogue with the community to monitor working strategies (ibid).

Regarding gender issues and MiP, their work includes educating families to understand what pregnancy means for the woman and how gender dynamics within the families could be disruptive or supportive to the pregnant woman's status. This means that CHVs facilitate the interventions that are adopted as a part of the MiP policy implementation (Interview 1, 2018).

2.3.2 National Government and County Government

Although the working guidelines of CHVs come from the Ministry of Health, the guidelines are adapted and defined specifically on a regional level by county governments and NGOs as the national MiP policies are supposed to be executed by the county governments (DCHS, 2013 p. 3; Interview 1, 2018). As both CHV guidelines and national MiP policies are originally made by the national government, the way malaria issues are addressed on a local level is affected by how receptive the county governments are, and how they distribute financial and human resources to implement the guidelines and the policy framework (Interview 1, 2018). The fact that CHVs have to interpret the given guidelines and policies implies that different perceptions of how to implement them could emerge (ibid). Consequently, one interesting aspect that will be explored in this study is whether there is a lack of coherency among the CHVs in policy perception and if it changes their conditions of implementing the policies.

2.3.3 Decentralisation of the political power

As previously stated, the working environment of the CHVs is indirectly affected by the political organisation of counties and the national government. Therefore, a relevant aspect of the study is whether the recent national devolution could help us to identify certain challenges for CHVs to work as implementers of the policies.

The devolution was initiated by the new constitution in 2010, in order to decentralise the political power. A new governance framework was introduced

consisting of a national government and 47 county governments. (Barker et al., 2014). For the CHVs as a part of the county health system, the intended gains of the Kenyan devolution were to allow county governments to adopt national health policies and distribute resources from the national government so that it would match their specific needs (Interview 1, 2018). It would thereby change the working context of the CHVs, as to support them with more adequate interventions in regard to the counties' micro environments, especially since the burden of malaria differs between the geographical areas of the counties (ibid).

2.4 Policy context

The national policies of MiP and gender constitute a fundamental groundwork for the goals that direct the CHVs in their role as implementers. In order to give a better picture of the political context in which the CHVs work, the current policy on MiP and gender are explained in the following section.

The main source of Kenyan national policies on malaria is the Kenyan National Malaria Strategy Plan (KNMSP), an operational framework for malaria control interventions (Interview 1, 2018). The KNMSP that was supposed to cover the period 2009 – 2017 (KMPHS, 2009) was revised following a mid-term review in 2013-2014. The revision took into account the issues that had arisen concerning the newly introduced devolution. As an outcome, a new strategy reaching until 2018 was established (Kenya. Ministry of Health [KMH], 2014 p. 1). In 2015, the ministry of health released a review of the KNMSP focusing on the of gender aspects of malaria (Malaria Control Unit 2015).

2.4.1 The Kenyan National Malaria Strategy Plan

In the KNMSP, gender is declared as a factor that, along with socio-cultural and economic factors, determines the access to and utilisation of health services. The report states that gender is taken into consideration by strengthening malaria control prevention in pregnancy. It also mentions that health promotion activities

should focus on women's role in intra-household decision making, in order to reduce barriers to access to services (KMPHS 2009, p. 21). Furthermore, the report aims to increase men's understanding of the risks for pregnant women and the foetus, as well as the importance of health services (ibid).

The revised version of the Kenyan National Malaria Strategy Plan includes a more descriptive objective towards gender (KMH, 2014 p. 5). It states that a gender perspective must be incorporated in issues of "malaria exposure, prevention, treatment-seeking behaviour, access to care, decision-making and resource allocation (…)". The report does not mention gender specifically in relation to pregnancy, although it states that gender-specific data "will be used to inform decisions, interventions and policies (…)" (ibid). In neither of the reports, CHVs are explicitly mentioned in connection to the gender integration of the MiP prevention.

3 Theory

The following chapter is divided into three different sections. First, it defines street-level bureaucrats and how it is used to observe CHVs. Second, a theoretical background is given to the bottom-up approach of the study. At last, a recent research study on CHVs in Kenya offers three categories of barriers that restrict the capacity of CHVs to work with the gender aspects of MiP. These three categories are then examined among the CHVs in the analysis.

3.1 Street-Level Bureaucrats

Lipsky's definition of street-level bureaucrats refers to public service workers who interact directly with citizens in their jobs (such as health workers) and who have substantial discretion in the execution of their work (Lipsky, 2010 p. 3). Considering CHVs as street-level bureaucrats is partly motivated by the fact that they formally serve the national government by providing public services, even though their work is voluntary. CHVs could also be regarded as holding a certain discretion, when comparing their working tasks to the definition by Lipsky.
In Lipsky's definition, discretion is exercised by street-level bureaucrats in decisions about citizens with whom they interact. It determines "(...) the nature, amount, and quality of benefits and sanctions provided by their agencies." (Lipsky, 2010 p. 13). Lipsky argues that discretion among street-level bureaucrats is difficult to severely reduce because of the characteristics of their jobs. For example, "(...) street-level bureaucrats often work in situations too complicated to reduce to programmatic formats." (Lipsky, 2010 p. 15). This means that the specific needs among the recipients of a service might not be able to cover in the instructions that control the street-level bureaucrats. Also, street-level bureaucrats often have to respond to the human dimensions of situations they meet in their

work. The discretion comes into play when the definition of their working tasks calls for sensitive observations and judgement of the service recipient (ibid).

The critical role of street-level bureaucrats in policy implementation comes out of several reasons. Since citizens normally encounter government services through the public service workers, each action of these workers can be seen as an example of policy delivery. Taking together the decisions made by public service workers, they become, or add up to agency policies (Lipsky, 2010 p. 3). The relevance of street-level bureaucrats also depends on the fact that they have a certain impact on citizens' relationship to the state. According to Lipsky, street-level bureaucrats "(...) socialize citizens to expectations of government services and a place in the political community. They determine the eligibility of citizens for government benefits and sanctions." (Lipsky, 2010 p. 4). Thus, considering CHVs as street-level bureaucrats highlights the importance of studying possible barriers in their work.

For implementation analyses, discretion is an important factor since it could possibly influence street-level bureaucrats' compliance with agency objectives. Street-level bureaucrats with broad discretion might have the capacity to resist organisational pressure in their work as policy deliverers (Lipsky, 2010 p. 25). For instance, when the objectives of the policies are not commonly shared, the relationship and compliance with their managers might be at risk. In such a case, Lipsky emphasises the importance of starting with "(...) an understanding of the working conditions and priorities of those who deliver policy (…)" when analysing policy implementation (ibid). This means questioning the assumption that influence always flows with authority of high level to lower levels (ibid). Hence, Lipsky's theoretical framework suggests that a *bottom-up approach* provides a relevant perspective of implementation analysis.

3.2 Bottom-up approach

The bottom-up approach to understanding the implementation process is rooted in the awareness of implementers playing an important function in policy

implementation (Buse, Mays and Walt 2012, p. 133). In the book "Making Health Policy" by Buse, Mays and Walt (2012, p. 133), the bottom-up approach is described as relevant because subordinate implementers often change the way a policy is implemented and informs those higher up in the political system in a way that influence policy making (ibid).

According to Buse, Mays and Walt, Lipsky's theory about street-level bureaucrats has helped re-conceptualizing the implementation process particularly in the delivery of health services (Buse, Mays and Walt 2012, p. 133). Consequently, several researchers of implementation processes have switched from top-down studies to focusing on the ideas, goals and strategies of implementers. The studies have made clear that the power of health workers as street-level bureaucrats in forming the outcome of policy implementation makes a bottom-up approach to health policy analysis relevant even in low income countries (ibid). Hence, such evidence has guided the choice approach in this study.

Buse, Mays and Walt (2012, p. 134) state that policy implementation depends on the culture, learning styles and networks of local actors. Moreover, they argue that "insufficient attention has been given to (…) their everyday organizational reality and, in particular, to developing the tools for building networks, persuasion, information and changing cultures." (ibid). Hence, this inspires the bottom-up approach of this study, that examines the impact of workers on a local level, rather than the ability of central actors to control lower levels of the system. However, the preparatory work of this study included mapping out different stakeholders of the MiP policies and considered the function of a potential top-down approach. This is further discussed in the discussion chapter.

To sum up, the bottom-up approach in this study should be seen as a tool to explain how the Kenyan malaria policies are implemented. The theoretical framework brought by this approach raises the research question which this study intends to discuss. If any sort of evaluation criteria is to be expressed, it is to discover the extent to which the implementation process is designed to "take into account local participants' views and influences on how policy unfolds" (Buse, Mays and Walt 2012, p. 135). Having explained the relevance and power of low-

level public health workers in implementation processes, the following part adds a narrowed scope to the existing theory, based on earlier research released this year.

3.3 Three categories of barriers

As earlier stated, integrating gender into the implementation of MiP policies executed by CHVs requires a sensitive attention to certain gendered behaviours that expose the pregnant women to malaria. Therefore, the following study by Rose et al. (2018) gives an assumption of barriers that could possibly hinder CHVs when working specifically with MiP. It should be taken into consideration that other potential barriers could be examined that are not included in the findings by Rose et al. However, these barriers constitute examples based on recent research and gives an interesting approach to the purpose.

The study by Rose et al. (2018), states that while the implementation work of CHVs has been seen as a vehicle for health promotion and behavioural change, less research has explored the capacity of them to execute the strategies of such goals (Rose et al. 2018, p. 2). Hence, the study observes the daily work of CHVs in the Kenyan city Kisumu, to explore factors that restrict their performance in implementing health programs. The working environment of CHVs is described as a complex set of contextual factors such as different culture norms, social hierarchies and gender expectations (Rose et al. 2018, p. 2, 6).

In summary, the study points out that the role of CHVs is held in a web of work-related and personal barriers, including those that affect the CHVs' capability and opportunity to carry out services that strive towards health-related behaviour change (Rose et al. 2018, p. 6, 10). For the analysis of this study, three categorises of such barriers are used to analyse the results achieved by the interviews. These are (1) CHV training, (2) supervision and support and (3) financial compensation, time and workload (Rose et al. 2018, p. 6).

While this study offers examples of work-related barriers among CHVs, Lipsky's theoretical perspective of street-level bureaucrats could help to explain how the barriers affect CHVs' possibility to work with policy implementation in terms of discretion. In this regard, the choice of studying CHVs raises some interesting questions, as their position differs from more formally educated health workers such as nurses. The fact that the crucial function of CHVs is based on their experience of local communities, rather than working as specialised health professionals, suggests different factors to study in a bottom up approach. How do the three categories possibly become barriers that restrict their working capacity, given that they have to integrate the aspects of gender behaviour in the MiP health work? And does Rose et al. (2018) miss out such an explanation in terms of discretion?

The categories by Rose et al. will now be further explained in how they are to be understood in the context of this study. They are discussed in order to open up for an interpretation that includes the role of discretion, and to approach the CHVs from a bottom-up perspective.

3.3.1 CHV training

The study by Rose et al. (2018 p. 6) reports that CHVs receive trainings of different lengths covering different thematic areas. Training is primarily done on an ad hoc basis by NGOs partners, while other training sessions are held by Ministry of Health workers. Critique regarding the training was mainly expressed towards the limited time of trainings and the fact that not all CHVs was trained (Rose et al. 2018, p. 6).

The contents of the training sessions usually focus on medical work. However, there seems to be a knowledge gap among CHVs regarding techniques and strategies to manage complex cases related to changing behaviours of community members. The study also finds that there is a lack of education on how to mobilise communities (Rose et al. 2018, p. 6).

In the context of this study

Regarding CHVs in the field of MiP, this category raises the question whether they have enough knowledge to perform their working tasks. In accordance with the MiP policies, CHVs need to know not just about MiP itself, but about relevant gender aspects, how they affect pregnant women and the needs for change of gendered behaviour. Consequently, they also need knowledge about how to work with these issues to create improvement (KMPHS, 2009 p. 21).

This category is used to understand what CHVs need to be trained on, and if there is a lack of accessible education on these topics. It should also be taken into consideration that CHVs might have knowledge that the authorities who conduct the training do not possess, in terms of specific behaviours that are beyond the CHVs' capacity to change. This could potentially add another aspect to the barriers identified by Rose et al. (2018). Observing CHVs as street-level bureaucrats, it also becomes relevant to explore what lack of training means for their perception of the MiP-policies and for the exercise of discretion in their work.

3.3.2 Supervision and support

Another factor that forms the working environment of the CHVs is the support and supervision they get during their work. The CHVs in the study by Rose et al. report that they get a robust on-going support from supervisory leaders of the Ministry of Health (2018, p. 6). This supervision helps the CHVs to identify and work around health related behavioural change in the community, however it is offered to a limited extent which is insufficient according to some CHVs. In addition, occasional support also comes from NGO partners, although also regarded as deficient by some CHVs. The lack of support during key activities is according to CHVs an issue that has a demotivating effect (Rose et al. 2018, p. 6).

In the context of this study

Accordingly, this category aims to examine whether the amount or quality of supervision has an effect on CHVs during their work with gender aspects of MiP.

This consequently leads to the question whether CHVs feel unmotivated in their work as a consequence of deficient supervision. An interesting aspect would also be to explore whether support provided by NGOs exist and if it is perceived as insufficient. At last, supervision, like training, is linked to the knowledge of CHVs. If CHVs perceive the MiP policies and their job descriptions as ambiguous, in combination with the barrier of little supervision, does that influence the role of their discretion?

3.3.3 Time, workload and financial compensation

The last category concerns the time limit and lack of financial support that could possibly constrain the CHVs' capacity to work with MiP. Rose et al. (2018 p. 6-7) find that the time spent on each household and the catchment area for each CHV to cover is beyond what they can handle. In addition, as CHVs do not get any salary from the Ministry of Health which they serve, an important way of earning an income is from local NGOs (ibid).

In the context of this study

This category basically raises the question if the economic situation and time related workload of the CHVs' job position create barriers in their work. As CHVs sometimes could receive an income from for example NGOs, it also becomes relevant to discover whether such compensation occurs in the context of gender related MiP interventions and if it has any effect on the CHVs' working capacity.

4 Methods

In this chapter, the choices of methods are explained, including the analysis of the policies and the process of the conducted interviews. A table of the interviewees is to be found in the appendix.

4.1 Choice of methods

Talking to key stakeholders may sometimes be the only way to gather valid information for policy analysis, especially in eliciting information of a more sensitive nature (Buse, Mays and Walt 2012, p. 204). The preparatory work of this study was made through a participant observation, as to get a flexible way of observing the field of study (Teorell and Svensson 2007, p. 88). Assisting the research group in Homa Bay County brought some insight in the broad variation of factors that influence CHVs' in their working life. The fact that it does not exist much written evaluation data of the MiP policy implementation that cover the diversity of these factors, motivated the initial idea of making an interview study.

Furthermore, the method of this study is explorative, inspired by Steinar Kvale's description of such an approach as to seek "new information about and new angles on the topic" (Kvale & Brinkmann 2009, p. 106). While CHVs work with many different issues, this study investigates the context of MiP specifically, in contrast to the study by Rose et al. (2018, p. 2). Therefore, the study explores whether the barriers by Rose et al. exist in this context, and if other challenges are more relevant. For instance, the work on gender aspects of MiP possibly require other forms of training and workload, in regard to the more sensible issues of women and men's relation to each other.

In line with the purpose of this study, the intention of interviewing CHVs is to get a nuanced perception of their view on the environment in which they work. Hence, qualitative interviews became a natural choice of method, as it seeks to bring qualitative knowledge rather than a quantification of a certain phenomenon. Kvale and Brinkmann describe the qualitative interview as aiming at "nuanced accounts of different aspects of the interviewee's life world (…)" (2009, p. 26, 30).

This study can be regarded as a case study in the sense that it investigates the execution of a specific contemporary policy implementation process (Yin 2014, p. 15-16). The method of analysing the case is used to interpret and understand the case in a deductive way, in order to describe it rather than explain it (Teorell & Svensson 2007, p. 98-99). A common concern about case study research is the inability to generalise from the findings. However, this study aims towards a rather analytical generalisation, a definition of "generalising" that goes beyond statistically quantitative generalisation. Case studies, like experimental studies, are namely generalizable to theoretical propositions and not to populations (Yin 2014, p. 21). This study presents an empirical base, that is observed through the scope of the theoretical framework. This also allows us to discuss if any result calls for further theoretical explanation.

4.2 Policy documents

This study is formed as a retrospective policy analysis of the policy documents mentioned in the background. These are therefore the policies to which the purpose refers. To cover relevant policies with a certain limitation, all national malaria policies were initially studied followed by thoroughly analysing all objectives that contain any issue of MiP and/or gender. The policy documents that are observed have been verified with several malaria and public health researchers and policy makers to ensure that they are the main source of national MiP policies.

4.3 Interviews

The interviews were semi-structured with open questions that were formulated in a way to approach the form of an everyday conversation. However, the interviews were conducted by prepared questions and a clear purpose (Kvale & Brinkmann 2009, p. 27; Buse, Mays and Walt 2012, p. 204). Asking open questions allowed interviewees to follow up with spontaneous questions and ideas that were not expected on beforehand (Teorell & Svensson 2007, p. 89). By such using such a flexible structure, space was created to encouraging the interviewees to describe as precisely as possible their experiences and feelings of the topic, which is a fundamental aim of a qualitative study (Kvale & Brinkmann 2009, p. 30). Another benefit of such a structure was that it gave the opportunity to follow up the answers by verifying the interpretations, which strengthens the validity of the answers (Kvale 1997, p. 214).

A central limitation of using data from interviews, is the fact that there might be a certain discrepancy between what people say and how they say it, as opposed to what they actually do or think. To come around this, the responses were triangulated with the responses from other informants (Buse, Mays and Walt 2012, p. 205).

Interviewees for this study were successfully found by using snowball sampling. An appreciation of potentially useful interview subjects was made on beforehand by talking to several CHVs, researchers and staff at numerous health facilities in different communities of Homa Bay County. After finding CHVs who were willing to contribute to the study, they were handed an invitation document with a description of the study to invite additional interviewees. The restricted access to interviews with CHVs was undoubtedly a limiting factor. However, the selection of respondents was strategically based on the principle of maximal variation explained by Esaiasson et al. (2007, p. 297). This was done by finding CHVs with different working locations, job tasks and length of employment, although within the working area of MiP policy implementation. A more diverse gender representation among the interviewees might have given additional empirical

perspectives, however the results still constitutes interesting aspects concerning both women and men.

The CHVs that were interviewed in this study are treated as respondents, as their thoughts constitute the central object of study. It is primarily the subjective arguments and reflections by the CHVs that are compared to each other to identify convergences and differences regarding the research question. Therefore, they were mostly asked the same questions (Esaiasson et al. 2012, p. 227-228).

The two interviewees that are not CHVs were included partly as elite informants to provide background material, and partly as respondents to triangulate the responses by the CHVs (Kvale 1997, pp. 94-95). The selection of these informants was done according to the stakeholder analysis guide described in "Making Health Policy" (Buse, Mays and Walt 2012, p. 193). To ensure legitimacy of the informants' answers, they were selected due to their profession as doctors who possessed expert knowledge on health policy implementation (Buse, Mays and Walt 2012, p. 195). They also had top positions in national MiP research and substantial experience of gender and MiP policy making.

The interviews were arranged in accordance with the quality criteria and the guide for semi-structured interviews by Kvale, based on a fairly structured set of questions so to facilitate the analysis (Kvale & Brinkmann 2009, pp. 130-132, 164). Each interview was prepared with research on the interviewees and the specific issues that were expected to come up during the conversation. This improved the accuracy of the questions and helped getting a better understanding of the answers. Also, by actively listening to the language of the respondent, this helped formulating the questions more adequately to the conversation (Kvale & Brinkmann 2009, p. 144).

All interviewees were asked for permission of recording and were briefed on the study purpose, without revealing any possible hypothesis. The interviews were rehearsed on beforehand to keep the questions as short as possible but still obtaining long answers. Throughout the interview, answers were interpreted and clarified.

All interviews were conducted and recorded by phone, followed by transliteration. Also, one interview was answered by texting the response. The interviews were scheduled mainly during early mornings and evenings in regard to the shifting network connection. However, some calls were interrupted by frequent loss of connection, but not to the extent that it severely disturbed the process. The interviews were intentionally scheduled outside working time which contributed to the fact that none of the interviewees seemed stressed during the conversations. Before quoting the interviewees, they were all asked for permission and got informed about the ethical rules conducting the study. All transcripts are available upon request.

The content of the interviews was coded through categorisation based on the theoretical categories by Rose et al. (2018), which provided an overview of the transcripts and facilitated comparisons of statements (Kvale & Brinkmann 2009, p. 203). The analysis chapter is therefore structured based on the theoretical categories. Results that appeared ad hoc during the interviews are integrated in each analysis category, but also raised in the discussion chapter as some interesting aspects does not fit in to the structure based on the theoretical framework.

5 Results and Analysis

In the following analysis, empirical data from the interviews are structured in relation to the theoretical framework about the three categories of barriers by Rose et al. (2018). Hence, data from different interviews are integrated under each category. Results that are related to the context but not included in any category are lifted in the discussion chapter.

5.1 CHV training

In accordance with the findings by Rose et al., a significant challenge that was frequently lifted by the majority of the interviewees comes with the lack of *training and education* that the CHVs get in order to face the gender issues in their MiP work.

According to the CHV in interview 3, who has been working as a CHV for 10 years, he and his colleagues have barely been called together for any training since his CHV activities started. Even though he says that his working experience has made him aware of how to carry out his work, the county provides insufficient training on how to use their knowledge in order to bring change in the field of gendered behaviour related to MiP (Interview 3, 2018).

More specifically, CHV training should address MiP related to gender more as a question of how to involve men in their wives' health situation (Interview 3, 2018). For instance, by encouraging men to join their wives during health clinic meetings to learn about MiP. This would furthermore promote equal knowledge in

the families about the woman's exposure risks, which could give incentives to a more equalised gender behaviour.

Likewise, the CHV in interview 6 (2018) emphasises the knowledge gap that appears as some CHVs are not taught enough about exactly what to do with the policies on gender aspects of MiP, even though they do understand the policy issues. This creates a situation where CHVs cannot deliver much of the intended service to the community members (ibid). This becomes especially critical in those areas where there is no reachable health facility for community members to seek help – for example on rural islands. Here, in line with Rose et al., training focusing on *mobilisation* seems to be extra important as CHVs have to inform the communities about what they miss out from not attending health facility information (ibid).

However, even in cases where women in MiP *can* access health facilities, CHVs need further knowledge about the kind of information that could be given to men on how to support their wives (Interview 6, 2018). This could include staying home with children during health care visits, and in a case where the man is more educated than his wife, support her with information about MiP that she might lack. Also, as men often are the only breadwinners in the family, they should be encouraged to offer economic support for their wives to afford registration at the health facility (ibid; Interview 4, 2018).

The CHV in interview 7 (2018) gives another example of a barrier related to the content of the trainings. During her work, she normally experiences households where either men or women could bear the general role of decision making. Although, a pregnant woman's usage of insecticide-treated nets is sometimes threatened by her husband's decision to not use it. In these cases, she states that CHVs usually try to educate men on the risk of MiP that appears due to such behaviour. However, she urges that she needs more education on additional knowledge that she might not be aware of, but which could be useful in the "health talks" with these men (ibid).

The main points that came out of interviews with the CHVs are echoed by Ogutu (2018). He states that empowering the CHVs with training and education on gender and MiP is a key factor, as malaria is a public health problem that has to be tackled at the "first level of the health system which is the home and the family" (Interview 1, 2018). He emphasises the fact that the burden of malaria in Kenya is mainly borne by the population with the lowest economic status, which is also the population currently located in rural settings. Except for offering health systems that are less functioning than in urban areas, rural settings tend to be areas with more conservative norms and cultural strains regarding gender roles. In areas with such traditional norms and values "women tend to be less at the centre of decision making" (ibid). Thus, looking at malaria as a problem of the less economically privileged also requires an understanding of how women's status is entrenched by gender norms (ibid).

Moreover, regarding the role of NGOs as training organisers discussed by Rose et al., the CHV in interview 6 (2018) mentions that his CHV team collaborate with NGOs in constructing CHV guidelines for MiP work. Placing this in a broader context, Ogutu says that several NGOs have certain impact on the CHVs' working environment as they partake in implementing some of the activities around MiP policies. A major stakeholder among such NGOs is the "MiP Consortium", a network that has successfully driven MiP interventions based on an agenda focusing on empowering women (Interview 1, 2018).

In the interview with the second malaria researcher, who has experience of working with the MiP Consortium in Kenya, it is emphasised that MiP is affected by gender inequalities in terms of women's reduced access to treatment due to socioeconomic restrictions within households (Interview 2, 2018). For example, as disproportional distribution within households could prevent a pregnant women from affording registration at health facilities, where antenatal care and preventive material is delivered (Interview 2, 2018). She also emphasises the challenge to promote reluctant men to join their wives at the clinic (ibid). These aspects are mentioned because they help to triangulate the key points mentioned by the CHV respondents, as in what has to be included in the training of CHVs to empower women's gender role to reduce MiP exposure.

In summary, the interviews give a detailed picture of where some knowledge gaps exist among CHVs in *how to face* the gender issues related to MiP. However, CHVs do possess an in-depth knowledge about the issues that exist, which naturally gives importance to the role of discretion in their work. As a general conclusion, the CHVs stresses that additional training is needed to acquire useful tools when working for improvement on the issues that they experience.

5.2 Supervision and support

Now, looking at the *support and supervision* that CHVs get during their working activities as stated by Rose et al., this category seems to be of high relevance in several aspects. However, the reason why this category becomes important in determining CHVs performance capacity seems to differ among the interviewed CHVs, as they experience different types of gender issues depending on the specific community they work in.

In interview 6 (2018), it is stated that supervision of CHVs during work seems to be a fundamental tool as some CHVs move around in different communities with various cultural set ups and gender norms, which might as well differ from the community context of where they originate. Hence, their work might include cases where gender issues are of different character and relevance in relation to MiP (ibid). For instance, the CHVs in interview 5 and 6 (2018) say that some previous gender issues are nowadays less problematic in some communities. Such issues concern, for example, male dominance in decision-making about whether women are allowed to leave their home to participate in MiP education at health facilities (ibid).

The differing types of gender issues that CHVs meet in the communities obviously call for a sensitised response when delivering the services. Even though the current national gender and MiP policies are clear on some general issues, The CHV in interview 6 expresses a lack of clear job descriptions for the CHVs,

which seem to increase the importance of supervision as described by Rose et al. He gives an example on how such a challenge could be managed more specifically, which is by increasing meetings between CHVs, their supervisors and village elders in the communities. In this way, integrating local people's involvement in the development of CHVs' strategies would facilitate their work and make their services more customized based on local gendered behaviours that influence exposure to MiP (ibid).

Regarding the main providers of supervision in the study by Rose et al. (2018), the CHV in interview 7 (2018) urges the need for support from personnel at district hospitals. She says that the supervision from county supervisors is not always there when needed, which sometimes puts her in a situation where she either has to act using her own judgement or postpone the appointment (ibid). Thus, the discretion that normally help CHVs in managing complex situation is problematized in cases where supervisors are not there to give feedback on critical decisions. The same CHV also says that NGOs do provide certain support, although they seem to "come and go" in a rather fluctuant way. The importance of frequent meetings with NGOs is also emphasised as they need to be informed of the current challenges that CHVs face, to be able to provide accurate support (ibid).

Supervision has so far been considered as on-going support by county workers that follow up the work of CHVs. However, when some CHVs in this study are asked about supervision, they often mention the written guidelines for CHVs that the counties are supposed to write based on the national MiP policies (Interview 3, 6, 2018). The CHV in interview 3 (2018) points out that a challenge for him as comes with the fact that while CHV training offers an important platform of knowledge to stand on, there is not enough specific gender policies about MiP that provide updated supervision to his work. Therefore, as supervision is defined by Rose et al. (2018) as an important feedback from county supervisors on CHVs, the role of supervision in the context of this study may also imply the importance of *policies* that support CHVs in a local context.

Lastly, the CHV in interview 5 (2018) emphasises that lack of support has a demotivating effect among CHVs who work with MiP, as highlighted by Rose et al. (2018). He says that more qualitative and frequent support would according to give motivation to the CHVs in during their work, as available sources of updated information to rely on gives a feeling of being well equipped when facing certain working tasks (ibid).

5.3 Time, workload and financial compensation

Not surprisingly, it seems that working as a CHV in rural settings, with the responsibility to cover different communities that are distanced from each other, means hard pressure in terms of workload and time prioritisation. In interview 6 (2018), the CHV reminds me of the time I followed him in his work in September 2018. Villages including those on small islands in Lake Victoria required hours of transport by boat or car on severely obstructed roads. In summary, the results of this section mostly go in line with the study of Rose et al., as the pressure from a heavy workload seems to create a challenge for some CHVs to fulfil their work on MiP.

The time limit and workload however seem to be differently challenging depending on what tasks the CHVs face. For instance, some tasks only include referring a woman with MiP to a health facility (as in the case of severe symptoms), while other cases require procedures of medical tests to diagnose a patient, or teaching people about health and how to empower women with MiP (Interview 5, 6, 2018).

Given that CHVs are supposed to include gender aspects in their provision of health services, the CHV in interview 6 (2018) gives an example of how this could be efficiently integrated in their work when time and workload becomes challenging. He points out that a more established communication between CHVs

and village representatives is key when, for instance, village members need to be either just referred to a health facility or diagnosed by a CHV (ibid):

> (…) as a CHV I have a big area to cover. So I think if possible I could also be having linkage people (village representatives) that appoint people. So at least they can make good referrals to me in time or if there is need for me to be there at a particular time, I get the information as early as possible so that I do attend, and if it is a referral to a health facility that needs to be made, I do it as early as possible. And also I try to encourage men to accompany the women to these health facilities (ibid).

The burden of heavy workload seems to go hand in hand with the pressure that comes with the small amount of money that CHVs gain for their work. Being a volunteer means getting either a very small amount or basically no income at all. Even though some NGOs provide occasional sums to CHVs, the CHV in interview 6 (2018) states that it is mostly to motivate them in certain tasks rather than as a regular salary. Besides, he says that he has not yet experienced any financial support from NGOs in the interventions on MiP. The lack of a salary creates a barrier for CHVs to find time for their working duties, as they have to make it work together with the life outside the voluntary work (Interview 3, 7, 2018).

The findings of the CHV interviews regarding time, workload and financial compensation are clearly similar to the findings by Rose et al. Although the results do not seem to be solely linked to MiP issues, it highlights a challenge that should be seen in a broader context of the implementation of MiP policies, which is given in the interviews with the two malaria researchers (Interview 1; Interview 2, 2018). Ogutu says that even though guidelines might be clear on how to support CHVs on gender issues related to MiP, their conditions to perform are heavily dependent on how counties prioritise their economic resources on such topics (Interview 1, 2018). The researcher in Interview 2 (2018) points out that there is a lack of public financial support to prevent both the medical issues and gender-related issues that CHVs work with. Not only is antenatal health care insufficiently prioritised, but so are the resources that should be invested in the operational implementation of gender policies related to MiP. As a consequence,

while CHVs are responsible for delivering related services on community level, the small amount of economic support creates a lack of incentives to prioritise their time spent on working on these issues (Interview 1, 2018).

6 Discussion

Devolution and the bottom-up approach

Recalling the theoretical framework of a bottom-up approach, an underlying aim of this study is to explore whether the design of the implementation process allows local implementers to shape the policy outcome, and what potential barriers they might face in their work, observed as street-level bureaucrats. In the interview with Ogutu (Interview 1, 2018), the aftermath of the devolution gives a broader context to the analysis of the CHVs' responses. This could potentially explain how the changed political organisation, in which the MiP policies are implemented, has contributed to the identified barriers among the CHVs.

According to Ogutu, the process of realignment and negotiations between the national and the county governments as a part of the devolution has been too hasty to successfully achieve the intended political structure (interview 1, 2018). The failure of establishing a decentralised political system within the health sector brings an unfortunate loss for counties with a high burden of malaria. Because for these counties, it could have been beneficial in terms of being able to distribute resources and adapting national health programmes in relation to their specific needs (ibid). Regarding MiP, Ogutu states that as the health sector is heavily dependent on human work force, limited human resource coupled by rapid devolution of responsibilities has brought the implementation of the malaria policies into stagnation (ibid).

For the case of this study, it gives a hint of how the restructured political organisation of the health sector might have contributed to the barriers that were identified among the CHVs working with the MiP policies. Education, supervision, economic support and heavy workload are namely referred to by the CHVs as challenges that are all dependent on the prioritisation by the county governments. For further research, this suggests that a rather top-down approach

could investigate the counties' strategies to efficiently use CHVs in the implementation of MiP policies since the devolution.

Discretion and policy perception

Now looking back, Lipsky's theory about street-level bureaucrats raises another question: what do the identified barriers in this study mean for the CHVs potential impact on shaping the policy outcome? This question again highlights the role of CHVs as policy makers and the power of their discretion. As stated in the theory chapter about Lipsky, an implementation analysis that focuses on street-level bureaucrats should pay attention to possible discrepancies in the perception of certain policy objectives among street-level bureaucrats, as their discretion could be used to shape policies. The findings of the analysis lead to the conclusion that the discretion of CHVs is somewhat exercised in order to compensate for the challenges to translate gender and MiP policies into their working context. For instance, insufficient and differently organised training and supervision on how to concretely understand the policies seem to create situations where CHVs have to make decisions based on their own perception of gender issues connected to MiP. Not only does this study reveal that different perceptions of such gender issues exist among the interviewees, but some CHVs also confirm that the perceptions of and opinions on how to implement the gender and MiP policies differ among their CHV colleagues.

Apparently, a certain discretion seems to be needed for CHVs in order to be flexible when working in different communities. But the findings of this study also point out that the CHVs' discretion allows them to determine which and to what extent gender issues are to be covered in their implementation work. In summary, the identified barriers potentially partake in forming each CHV's policy perception, which in turn could play an important role when using their discretion to implement the policies and thereby forming the policy outcome.

Linkages between the three categories

The analysis of this study mainly treat the identified barriers as separate answers to the research question of this study. However, in retrospect the results suggest a rather "zoomed-out" perspective in order to see how the barriers are also linked to

each other. A quote from Interview 3 (2018) is given as an example that summarises the three categories in connection to each other:

> There is a lack in that they (CHVs) need to be trained. They need to be trained so much so that they can get the knowledge to enter the villages. They then need to be given support. Because they are also not being paid anything by them (the community). They are just doing voluntary work. They create the time because some of them have families. Most CHVs have families and their family must go on with their life. They are getting little time to serve the community.

This quote gives the impression that the three categories form the relevance of each other and might even enhance each other in the CHVs' perception of work related barriers. Taken together, they characterise the overall working position of CHVs in the field of gender and MiP, which in a broader context entails a wider discussion on how to formally strengthen their position to avoid these barriers. Ogutu builds upon this by stating that a fundamental improvement would come by giving CHVs a more formalised position as a well-organised part of the health system to make sure that the policies are not implemented on voluntary conditions (Interview 1, 2018). He also says that as gender is a cross-cutting issue, it calls for a rather inter-sectoral contribution by the education and health sector in developing the capacities of CHVs. By including them in such a formal program, awareness would increase of what it means to empower women in the context of improving malaria control (ibid). Due to the limitation of this study it will not be discussed further; however the reflection by Ogutu proposes an additional field of research which would preferably study political debates about the future position of CHVs as a more formal part of an inter-sectoral implementation process.

Topics related to the context, but not included in the three categories

During the study, two topics appeared that were related to the theoretical framework and the policy context, but not directly included in the three categories by Rose et al. Hence, it might be seen as an empiric contribution to the study of implementation analysis of MiP policies.

Regarding the issue of encouraging male counterparts to accompany their pregnant wives when visiting health facilities, the CHV in interview 3 (2018) says:

> I think there needs to be enough knowledge on women, and male involvement. They must both be involved because (…) when female mothers go to the officials, they're being taught alone. The male is not there. When she comes back she's just being quiet with her knowledge; the man does not know anything. So there is a need for male involvement to be taught about malaria.

Although it seems that increased training of CHVs could facilitate such working tasks, a possible restriction of the CHVs capacity to bring change comes with the organisation of the health system. In this case, CHVs might be limited in what they can improve to meet the MiP policy goals, due to the fact that the service is offered by the health facility, where men have to be included.

The second topic is about the connection between gender based violence expressed by in interview 4 (2018). Gender based violence within households sometimes leads to that women seek refuge in the bush or at their neighbour's place, where they cannot access insecticide treated nets and hence expose themselves to malaria (ibid). This is mentioned, because it is not addressed in the MiP policies, but adds a problem of more controversial and sensitive nature to the picture of the CHVs work to implement the policies. It highlights the question of how CHVs are supposed to interpret the gender related policies, and in terms of discretion, to what extent they should be or are even capable of managing the gender issues that perceive as risks for MiP.

Research design

Lastly, the research design of this study should not be left uncriticised. For instance, a rather extensive setup could have been approached by involving additional CHVs in a quantitative analysis to compare the amounts of people arguing for the different types of barriers. In that case, further possible categories could have been taken into consideration in the analysis, instead of focusing

deeply on the current aspects. However, the choice of design appeared to bring some interesting empirical results that covered the purpose. Also, it opened up for a discussion that touch more complex connections such as between discretion and barriers in the specific work on gender and MiP.

Conclusion

Kenya's CHVs that work with the implementation of MiP policies have an important role in delivering services to change gendered behaviour that increase women's risk of MiP. Some of the barriers that restrict them in this work include lack of accurate training, supervision and working conditions that give them time and financial support to execute their tasks. The complex work environment of the CHVs is influenced by actors like NGOs and the county governments, who seem to be directly involved in forming the future appearance of these barriers.
As a consequence of these barriers, CHVs might use their discretion to decide how the policy should be carried out in the communities.

This study gives an empiric contribution to the bottom-up study of CHVs, regarded as street-level bureaucrats in Kenya. It suggests further research to address the factors that limit the capacity of CHVs and what consequences it gives to the outcome of the policies. Such studies could either examine a wider spectrum of potential barriers, or go deeper into the effect of the CHVs' discretion as well as studying CHVs' position in relation to the development of the devolution.

7 Appendix

7.1 Appendix A: List of Interviewees

Elites.

Interview, Name and/or Position	**Date and Length of Interview**
1. Ogutu, Bernhard Chief Research Officer, the Kenya Medical Research Institute (KEMRI) Member of the Regulatory Authority of the Kenyan Ministry of Health Senior Clinical Trialist with the Malaria Clinical Trials Alliance, INDEPTH-Network Founding President of the East African Chapter of the Association of the Clinical Research Professionals Masters in Medicine (Paediatrics) with extensive experience in malaria research.	2018-12-03 35 min
2. "The second malaria researcher" Researcher on malaria in Kenya. Has experience of working with the MiP Consortium.	2018-11-10 36 min

Community Health Volunteers.

Interview	Position and length of service	Date and length of interview
3.	CHV, Homa Bay County (10 years)	2018-12-02 32min
4.	CHV, Homa Bay County (7 years)	2018-12-03 (in writing)
5.	CHV, Homa Bay County (7 years)	2018-29-11 25 min
6.	CHV, Homa Bay County (4 years)	2018-12-01 35min
7.	CHV, Homa Bay County (9 years)	2018-12-31 30min

8 References

Barker, C., Mulaki, A., and Mwai, D., and Dutta, A. (2014). Devolution of healthcare in Kenya. [Online]. Health policy group, Futures Group. Available at: https://www.healthpolicyproject.com/pubs/479_KenyaPETSCountyReadinessFINAL.pdf [Accessed 2018-11-26]

Buse, Kent, Mays, Nicholas & Walt, Gillian (2012). Making health policy. 2nd ed. Maidenhead: Open University Press

Centers for disease control and prevention. CDC. (2013). Treatment of Malaria (Guidelines For Clinicians). [No. 3]. [Online]. U.S. Department of Health & Human Services: Centers for disease control and prevention. Available at: https://www.cdc.gov/malaria/resources/pdf/clinicalguidance.pdf [Accessed 2018-11-27]

County Government of Homa Bay, Kenya. (2013). Homa Bay County Integrated Development Plan, 2013 – 2017. [Online]. Available at: http://www.homabay.go.ke/wp-content/uploads/2016/01/CIDP-DOCUMENT-HOMA-BAY-COUNTY-GOVERNMENT.OCT_.2013.pdf [Accessed 2018-12-01].

Division of Community Health Services, Ministry of Health. (2013). Community health volunteers (CHVs) basic modules handbook. [Online].

Available at: http://guidelines.health.go.ke:8000/media/CHV_handbook_PDF-F.pdf [Accessed 2018-11-25]

Esaiasson, Peter (2007). Metodpraktikan: konsten att studera samhälle, individ och marknad. 3rd ed. Stockholm: Norstedts juridik

Esaiasson, Peter, Gilljam, Mikael, Oscarsson, Henrik & Wängnerud, Lena (2012). Metodpraktikan: konsten att studera samhälle, individ och marknad. 4th ed. Stockholm: Norstedts juridik

Kenya National Bureau of Statistics. KNBS. (2016). Kenya Malaria Indicator Survey 2015. [Online]. Available at: https://www.knbs.or.ke/kenya-malaria-indicator-survey-2015/ [Accessed 2018-11-27]

Kenya. Ministry of Health. National Malaria Control Programme. (2014). The Kenya Malaria Strategy 2009 – 2018 (Revised 2014)

Kenya. Ministry of Public Health and Sanitation. Division of Malaria control. (2009). National Malaria Strategy 2009-2017

Kvale, Steinar (1997). Den kvalitativa forskningsintervjun. Studentlitteratur: Lund.

Kvale, Steinar & Brinkmann, Svend (2009). InterViews: learning the craft of qualitative research interviewing. 2. ed. Los Angeles: Sage Publications

Lipsky, Michael (2010). Street-level bureaucracy: dilemmas of the individual in public services. 30th anniversary expanded ed. New York: Russell Sage Foundation

Malaria Control Unit. (2015). Gender and Malaria in Kenya. [Online]. Available at: https://www.measureevaluation.org/pima/malaria/gender-and-malaria-in-kenya [Accessed 2018-09-15].

Rose Evalyne Aseyo et al. (2018). Realities and experiences of community health volunteers as agents for behaviour change: evidence from an informal urban settlement in Kisumu, Kenya. *Human Resources for Health*, vol. 16, Iss. 1, Pp 1-12. [Online]. Available at: https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-018-0318-4 [Accessed 2018-08-20]

Teorell, Jan & Svensson, Torsten (2007). Att fråga och att svara: samhällsvetenskaplig metod. 1st ed. Stockholm: Liber

World Health Organization, WHO. Department of Gender, Women and Health. (2007). Gender, Health and Malaria. [Online]. Available at: https://www.who.int/gender-equity-rights/knowledge/gender_malaria_leaflet/en/ [Accessed 2018-09-04]

World Health Organization, WHO. (2003). Live at risk: Malaria in pregnancy. [Online] Available at: https://www.who.int/features/2003/04b/en/ [Accessed 2018-11-25]

World Health Organization, WHO. (2017). Malaria in Pregnant women. [Online]. Available at: https://www.who.int/malaria/areas/high_risk_groups/pregnancy/en/ [Accessed 2018-11-25]

University of Washington. Malaria in Pregnancy Consortium – Pharmacovigilance Activities. [Online]. Available at: http://globalmedicines.org/projects/malaria-

in-pregnancy-consortium-pharmacovigilance-activities/ [Accessed 2018-11-26]

Yin, Robert K. (2014). Case study research: design and methods. 5. ed. London: SAGE