THE ROLE OF THE CONSTITUENCY DEVELOPMENT FUND ON HEALTH CARE SERVICE DELIVERY IN KENYA: A CASE OF RANGWE CONSTITUENCY

BY

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PROJECT REPORT SUBMITTED IN PARTIAL FULFILLMENT FOR THE REQUIREMENTS OF THE AWARD OF THE DEGREE OF MASTER OF ARTS (M.A) IN PROJECT PLANNING AND MANAGEMENT OF THE UNIVERSITY OF NAIROBI

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DECLARATION

This project report is my original work and has not been presented for a degree or any other award in any other university.

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DEDICATION

This work is dedicated to my parents, my husband and my children Edger and Patience. May God bless you abundantly.

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I wish to acknowledge the support of all people who in one way or the other made this research project successful. Firstly, I thank God for enabling me to come this far with this study and secondly I sincerely thank my Supervisor Prof. G.P. Pokhariyal whose honest criticism and guidance has enabled me to refine this document. My deep appreciation also goes to my husband Mr. Oyugi for his enduring support which has enabled me to complete this project report in good time. I am greatly indebted to my brother Erick and my dear children Edger and Patience whose prayers and support has immensely contributed to the completion of this research project. I recognize the effort of Dorothy Mulonzi for her continuous reading and constructive criticisms of the work. Her contributions has gone a long way in coming up with this report. I also recognize my peers and friends for their ideas, constructive criticism and assistance in various ways. Further gratitude goes to the respondents particularly the Constituency Development Fund beneficiaries of Rangwe Constituency and the Committee. For those who assisted in one way or another and who are numerous to be mentioned by names, May God bless you!

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ABBREVIATIONS AND ACRONYMS

GoK	-	Government of Kenya
MoH	-	Ministry of Health
CDF	-	Constituency Development Fund
KHPF	-	Kenya Health Policy Framework
NGOs	-	Non Governmental Organizations
NHSSP	-	National Health Sector Strategic Plan
MDGs	-	Millennium Development Goals
M & E	-	Monitoring and Evaluation

ABSTRACT

Various studies have been done on the impact of the Constituency Development Fund (CDF) and other devolved funds in Kenya. However, a few focuses on the role of such funds on health care service delivery despite health being an important factor in the development of any community. Therefore this study was geared towards bridging this knowledge gap and was undertaken in Rangwe constituency in Kenya. The objectives of this study were; to assess the influence of the annual constituency development fund allocations on health care service delivery, to assess the level of community participation in decision making and to examine the communication channels used by the CDF committee as well as to examine the influence of the monitoring and evaluation approaches used by the CDF committee on health care service delivery. The study employed a descriptive research designs with the questionnaires as the main instruments of data collection. The data analysis was performed using Statistical Package for Social Sciences (SPSS-16) while the presentation of the information was done in form of frequency tables, correlation and multivariate regression models. The study findings demonstrate that CDF has played a significant role in health care service delivery in the constituency as corroborated by increased number of wards, consultation rooms, laboratories and even recruitment of additional medical personnel. Towards this end, 68.4 percent reported that the number of wards in the constituency has increased in the ranges of 1 to 3 in health centres while 34.8 percent of the respondents affirmed increase in consultations rooms in the dispensaries. The study established different levels of correlation between the levels of participation in the CDF funded health care projects and age of the beneficiaries, level of education and the awareness to the fund. In this regard, awareness has a positive but not significant influence on participation with correlation value (r) being 0.385 while age of the beneficiaries has a positive but not significant influence on the participation with a correlation value (r) being 0.042. This implies that the more the awareness increases, the more the likelihood of an individual to participate in the CDF health care funded projects. On the other hand, the level of education of beneficiaries had a negative and not significant influence on the level of individual's participation in the projects with correlation value (r) being 0.001. This implies that the lower the level of education of a beneficiary, the more one is likely to participate in the project. This is granted that the greatest mode of participation in the project is through labour provision, of which the highly educated and meaningfully economically engaged are not likely to be involved in. However, the level of community involvement, monitoring and evaluation are negatively but not significantly influencing the improvement in health care service delivery at correlation values (r) -0.207 and -0.024 respectively. This implies that the lower the level of community involvement, the less the improvement in health care service delivery. The study also demonstrates that there was some consultation between the CDFC and the community with the community feeling sidelined in monitoring and evaluation aspect of the fund's administration. The study therefore recommends that the facility administrators be actively involved in the entire process of the projects and that the amount of CDF allocations be increased to ensure completion and quality of the work done.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

In the recent past, there have been widespread attempts to redefine the role of the public sector in the developing countries for the improvement of its performance. An increasing important component of these reforms has been the introduction of policies to decentralise the functions of governments. As a policy, decentralisation seeks to improve service delivery and enhancing accountability. This is granted in that citizens within the centralised regime normally have to voice their demand for better services to central authorities who in turn direct local level bureaucrats to respond. However, if well conceived and implemented, decentralisation makes it easy for citizens to voice their demands on governments as well as better monitor the performance in service delivery (Smoke, 2001).

Like other developing countries, Kenya has been troubled by the issue of equity in resource redistribution. Since independence in 1963, the Kenyan government has formulated an array of decentralization programs, among them the District Development Grant Program (1966), the Special Rural Development Program (1969/1970), District Development Planning (1971), the District Focus for Rural Development (1983/84) and the Rural Trade and Production Centre (1988/89). Through out, these programs suffered the same fate notably; lack of funding and excessive bureaucratic capture by the central government (Obuya, 2008).

It is from this background that in 2003 the Constituency Development Fund (CDF) was created through an act of parliament with the aim of ironing out regional imbalances by providing funds to the constituencies. This fund was mainly to be used to fight poverty through the implementation of development projects at the local level and particularly those that provide

basic needs such as healthcare, education, water, agricultural services, security and electricity. The enactment of the Constituency Development Fund (CDF) in 2003 through the CDF Act in The Kenya Gazette Supplement No. 107 (Act No. 11) of 9th January 2004 saw the introduction of a fiscal decentralisation process. This process entails undertaking community prioritised projects through community participation and accountability. The fund is designed to actively engage the local citizens on their priority needs therefore, the fund holds strong opportunities in poverty reduction and national development if well managed. The fund comprises an annual budgetary allocation equivalent to 2.5 percent of the government's ordinary revenue and an equivalent of 75 percent of the fund is allocated equally amongst all 210 constituencies while the remaining 25 percent is allocated based on the constituency's poverty levels. A maximum of 15 percent of each constituency's annual allocation may be used for an education bursary scheme. The CDF is managed through 4 committees 2 of which are at the national level and 2 at the grassroots level.

According to the CDF Act (2007), expenses for running the constituency project offices should not exceed 3 percent of the annual constituency's allocations while each constituency is required to keep aside 5 percent as an emergency reserve. However, the fund is not to be used to support political bodies/activities or personal projects. A sitting MP is not a signatory to the CDF bank account but convenes the CDF Committee in her/his constituency. The penalty for misappropriation of the Funds is a prison term of up to 5 years or a fine of Kshs. 200,000 or both. The CDF project proposals are submitted to MPs who in turn forward them to the Clerk of the National Assembly. The approved project list is reviewed by the National CDF committee, which presents final recommendation to the Finance Minister. These imperatives are important in the exploration of the implications of fiscal decentralization policies under the CDF utilisation

in tackling rural development through education, water and healthcare projects among others at the local level.

The Constituency Development Fund is no exception to Kenya. In fact it's a policy which has been adopted by several countries like Uganda, South Africa, India and Ethiopia amongst others. The Ugandan CDF was introduced in 2005/2006. Its inception is similar to that of Kenya in that it arose out of meetings between the Presidency and Members of the 7th Parliament (MPs) and the subsequent Presidential pledge to MPs that was intended to relieve them of the pressures of their constituents in regard to the promised and other development projects. Parliament then recommended that a CDF sum of 2.95 billion shillings be earmarked for MPs and released expeditiously.

In Kenya, the CDF is governed by the Constituencies Development Fund Act, 2003 and the revised act of 2007. This is the same case in India where, the Constituency Development Fund has an elaborate legal framework, premised on a policy that individual MPs have no direct access to the CDF funds. The MPs only participate with their constituents to identify the projects to be funded by an amount set for the CDF during a particular Financial Year. Both the MPs and constituents participate in monitoring the implementation of the projects under the CDF unlike the case of Uganda, where there is no comprehensive law governing the management of CDF. The literature available on the CDF in Uganda has the following highlights: one of them is that every MP has to establish a Committee of 5 people composed of him/ herself as the chairperson, a secretary, a treasurer and two other members for the purpose of handling this money and that the money would be released to the individual MP and the responsibility of accountability to the accounting officer (Clerk to Parliament) would lie with the MP. Another is that the funds should only be used on activities that directly increase household incomes and productivity; on interventions that can trigger rapid rural transformation and economic development; and on agro-

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processing and marketing of produce in the respective constituencies. In addition, the money should not be used on development of infrastructure projects already under the Local Government initiatives or Central Government programmes or projects, and on political and/or religious activities.

According to the Uganda Debt Network (UDN, 2007), the Ugandan CDF seems to have been ill-constituted, thus falling short of public interest and susceptible to abuse, contrary to the 1995 Constitution of Uganda and the Public Finance and Accountability Act, 2003. It is against this background, that they conducted a study on the CDF during November and December, 2006. The study involved a) Desk reviews b) Field visits to 19 districts of Kamuli, Kaliro, Namutumba, Kanungu, Bushenyi, Bugiri, Iganga, Bukedea, Amuria, Katakwi, Apac, Kumi, Kalangala, Mpigi, Rakai, Kasese, Mbarara, Kabale and Arua and involved over 3067 local officials, religious and opinion leaders, the youth, elders, teachers, health workers, community groups and ordinary citizens c) A sample of over 167 MPs, some of whom served in the 7th Parliament and others that made it to the current 8th Parliament, were interviewed. This was done through both random and judgemental sampling backed up by focused group discussions and in-depth interviews.

The Key findings of the UDN study on the CDF revealed that the guidelines on the CDF were inadequate and, worse still, were not followed by the Members of Parliament. From the field visits to the different districts, the study revealed that most (over 87%) of the respondents did not have knowledge of the CDF. They, therefore, neither participated in the selection of projects nor in the utilization of the fund. Out of the interviews with the Members of Parliament, the majority of the respondents (73%) could not pinpoint the exact projects where the money had been spent and that the CDF money had been banked on the MPs' personal bank accounts. Many of the MPs were further not aware of the guidelines to be followed in disbursing the money.

Like in Kenya, the UDN eventually made their recommendations that the beneficiaries of the CDF in the constituencies should be involved in the selection and planning of the projects, so that they can participate in project implementation, monitoring and evaluation and that the chosen projects should be submitted and explained by the MPs to the Local Governments' planning committees. This is to ensure there is no duplication of the projects funded by the government which resonates with the Kenyan scenario. Secondly, whenever CDF money is disbursed, it should be publicized to create citizens' awareness and participation in the utilization and accountability of the fund. The CDF money should not be banked on the MPs' personal accounts or mixed with their other emoluments, but be banked on a separate account of Local Governments where the Chief Administrative Officers should be part of the CDF management. Thirdly is that the clerk to parliament should work closely with the Chief Administrative Officers to ascertain the existence of a credible Constituency Committee to oversee the management of the Constituency Development Fund. Fourthly is that the CDF accountability and auditing procedures should be a function of the Clerk to Parliament and the Auditor General, respectively and finally that the CDF should not simply be paid towards the end of any Presidential/ Parliamentary term and or impending elections to avoid a risk of exploiting the fund for personal political gain. The case is not any different in Kenya and several efforts have been made to stem out such anomalies. For instance stringent measures have been enacted in the new constitution which bars the mps from direct involvement in the management of the fund and also the type of projects which should be implemented by CDF are specified in the act. These projects have a great influence in the quality of life of people and they include education, water and health amongst others.

In Kenya, health services were made 'free' at independence in order to meet health needs of all Kenyans while at the same time making the government popular among the masses. However,

this was unsustainable hence the introduction of cost-sharing in 1989 to supplement the governments resources. Since then, a number of strategies and reforms have been implemented in the health sector with the aim of improving and enhancing the decentralization of health care service delivery. For instance the Kenya Health Policy Framework of 1994 called for an enabling environment to strengthen the NGO, Local Authority, Private and Mission sector providers in health. The National Health Sector Strategic Plan I (NHSSP I) also recognised the need to improve partnerships. This was followed by seconding of staff to non state actors and later, provision of health commodities to these facilities. This was later reinforced by the NHSSP II (2005-10).

Furthermore, efforts to achieve efficiency and effectiveness in the health care service delivery in Kenya are also currently guided by the Millennium Development Goal which is an international development strategy. The MDG's were defined in 2000, to guide prioritization of countries as they move towards improvement of their development. The health MDGs relate to the reduction of the burden of HIV/AIDS, tuberculosis, malaria, child mortality rate and maternal mortality rate. In addition, the country has specifically defined its long term Vision, the Vision 2030 which is the current Government's blue print for transforming the country into "an industrialized, middle income country with a high quality of life by 2030". It also recognises the participation of the private sector and other stakeholders as key to meeting national development objectives.

This objective has been supported by various donor-financing modalities, through a sector-wide approach with a fundamental goal of improving access to health care services among the poor and more vulnerable sectors of the population, especially in the areas of maternal and child health care.

Despite all these efforts, the health sector has continued to face several challenges and constraints in terms of equity, accessibility, affordability, efficiency and effectiveness. Notably the poor individuals living in rural areas and the vulnerable population groups such as the poor urban households have continued to have lesser access to health care services and preventive care as corroborated by long distances they have to cover to access the health care services, lack of medicines, and high costs This set of access and affordability constraints causes poor users to utilize health care services less than non-poor users (Owino, 1997).

As a result many Constituency Development Fund committees have utilised the fund for the development and improvement of health care services which is considered as a dominant factor towards enhancement of quality of life. However, the exercise needs deeper understanding in terms of the role which CDF has played in the health sector. It is with this background that this study seeks to assess the progress which has been realized in health care service delivery in Rangwe Constituency where the fund has actively been used in the development of health care service delivery.

1.2 Statement of the Problem

Kenya has implemented various health sector reforms since independence such as the historical free health care services and cost-sharing. In addition, other development strategies have also been implemented like the Kenyan's Health Policy Framework and the National Health Sector Strategic Plans which have all had positive impacts on the Kenyan health care service delivery. Indeed health indicators show gradual but steady improvements in access to basic services such as clean water and sanitation facilities alongside other related performance indicators such as life expectancy, infant/child mortality, immunization rates and child nutrition among others.

However, challenges such as financial constraints, inaccessibility, inefficiency, inequality and poor management are sill a reality in the provision of health care services (Owino, 1997).

In response to these challenges, the MoH is encouraging partnership with Non Governmental Organizations alongside other interventions like increasing the financial allocations for the MoH. For instance, Rangwe constituency of Homa -Bay County has a number of NGOs such as Plan international, Care Kenya, APHIA I I, and Medicine sanfrontiers amongst many others which are supporting health care service delivery in the constituency. The constituency has also benefited a lot from the Economic Stimulus Package. Further more, health care service delivery in Rangwe constituency is also supported by the constituency development fund. CDF was conceived to tackle efficiency, inequality and accountability challenges in infrastructure service delivery, financial management (including budgeting), participatory planning and local governance, revenue mobilization, monitoring and evaluation, institutional reform, fiscal and overall decentralization (GoK, 2005).

However, a question arises whether the improvement of health care service delivery in Rangwe constituency has been overtaken by the many NGOs in the constituency or whether CDF is also playing its part. This study therefore sought to investigate the role that has been played by the CDF in health care service delivery in Rangwe constituency of Homa-Bay County.

1.3 The purpose of the Study

The purpose of this study was to assess the role of the Constituency Development Fund on health care service delivery in Rangwe Constituency of Homa-Bay County.The study assessed the influence of annual CDF allocations on health care service delivery over a period of 5 years, the level of community participation in decision making to improve health care service delivery, the

communication channels and the monitoring and evaluation approaches employed by the CDFC for the health care improvements in Rangwe constituency.

1.4 Objectives of the Study

The study was guided by the following objectives:-

Main Objective

The main objective of this study was to assess the role of the Constituency Development Fund on the health care service delivery in Rangwe constituency.

Specific Objectives

Accordingly, the specific objectives of the study were to:-

i. Assess the influence of the annual CDF allocations on the health care service delivery in Rangwe constituency
ii. Assess the level of community participation in decision making to improve health care service delivery in Rangwe constituency
iii. Examine the communication channels used by the CDF team on the health care service delivery in Rangwe constituency
iv. Examine the monitoring and evaluation approaches used by the CDF team on health care service delivery in Rangwe constituency

1.5 Research Questions

The research questions in this study were:-

i. What has been the influence of the annual CDF allocations on health care service delivery in Rangwe constituency?

ii. To what extent is the community involved in decision making to improve health care service delivery in Rangwe constituency?

iii. What are the communication channels used by the CDF team on health care service delivery in Rangwe constituency?

iv. What are the monitoring and evaluation approaches used by the CDF team on the health care service delivery in Rangwe constituency?

1.6 The Study Assumptions

The study was conducted with the assumption that:-

i. The devolved funds shall continue to supplement the other government interventions in the health sector development in the constituency

ii. The public health care facilities shall continue to bear the burden of catering for the health needs of the population relative to private health care facilities

iii. The CDF allocations and other devolved funds have contributed to an improvement in the health care service delivery in Rangwe constituency

1.7 Significance of the Study

The findings of this study shall inform the public policy on the governance and management challenges that are inherent in CDF in its effort in improving health care services as well as highlight some reforms that would be necessary for the achievement of the adequacy in the health care provision for the community.

The findings of this study would also inform the ministry of planning and national development in the key areas where much more funding is required with the understanding that their contribution to the achievement of the other development goals could be significant. (WHO, 2001) argued that just as important as economic well-being, good population health is a critical

input for poverty reduction. Health is shown to have its most important economic effects on human and enterprise capital. Three main channels, through which disease impedes economic development, have been identified. The first channel is the reduction of number of years of healthy life expectancy, resulting in considerable economic loss. This is particularly severe in low-income countries. Second, disease reduces the overall parental investment in children. Due to high mortality rates, couples produce large numbers of children to compensate. The resulting numbers put a strain on family resources affecting the health and education of each child. Third, ill-health has depressing effect on business and infrastructure investment, not only by decreasing the productivity of individual workers but also the purchasing power of the Whole society (WHO, 2001).

The selection of Rangwe Constituency is based on several reasons, key among them is the fact that the constituency has a large outlay of rural and urban population almost on an equal proportion and thus acts well in gauging the extent of the health care service delivery perception on the rural and urban population granted that the two population groups have different levels of awareness, income and participation in community projects. Further, poverty is quite prevalent in the constituency with a large proportion of its residents living below the poverty line and experiencing increased disease burden such as infant mortality levels as well as high HIV/AIDS prevalence levels. Finally, the findings of this study would contribute to the existing literature in terms of the management and performance of CDF funded projects. In addition other researchers may also make reference on it and build upon it.

1.8 The Scope of the Study

The study.was conducted in Rangwe constituency and it assessed the role of the CDF on health care service delivery. The parameters that were studied under the contribution of the fund

includes the influence of the CDF annual allocations on health care service delivery, the level of community participation , the communication channels used by the CDF team and the of Monitoring and Evaluation approaches used by the CDF team on health care service delivery in Rangwe constituency

1.9 Limitations of the Study

The study encountered the following limitations: -

i. The sensitivity of the financial data forced some of the health care facility administrators not to undertake full disclosures of such data. In fact three out of the ten health facilities sampled did not disclose the amount of CDF allocations they have received in the last five years.

ii. The study was also limited by a small sample size due to time and financial constraints involved in the study.

iii. The means of transport was also such a problem since about 80% of the health facilities sampled could only be accessed by motorbikes.

iv. In one health facility called Ndiru, the administrator was overwhelmed with the number of patients and had very little time to respond to the questionnaire even after several visits to the health facility.

1.10 Definition of Key Terms Used in the Study

Health - means not only the absence of disease but also generally mental, physical and social well-being of an individual. In this definition, the environment in which people live including access to nutritious food, safe water, sanitation, education and social cohesion also

determines health.

Community- community refers to a group of users of a service who live in the same area and have access to, and use, the same service. It may also refer to the people who live-in the same area or town and share common values, believes and the culture and have a common interest.

Community Participation- is the act of taking part in an activity or event that directly affects one. It comprises the varying degrees of involvement of the local community that may range from the contribution of cash and labour to consultation, changes in behavior, involvement in administration, management and decision-making. In the context of this study the constituents of Rangwe constituency are taken as the community.

Development - Economic and structural transformations in the society from what is perceived as bad to what is perceived as satisfactory.

Decentralization– Is the process of dispersing decision-making, governance and financial management closer to the people and/or citizens.

Fiscal Federalism - Fiscal federalism constitutes a set of guiding principles, a guiding concept, that helps in designing financial relations between the national and sub national levels of the government, fiscal decentralization on the other hand is a process of applying such principles (Sharma,2005: 178)

Fiscal Illusion - Fiscal illusions refer to the inability of local decision makers to grasp the collective financial costs of their independent expenditure decisions on the overall financial standing of the central government (Brennan and Buchanan, 1980).

1.11 Organization of the Study

This study is organized into five chapters, chapter one introduces the study concept by detailing the background of the study, the statement of the problem, the objectives of the study, the assumptions of the study, the significance of the study, the scope and the definitions of the key terms used in the study.

Chapter two details the theoretical and the empirical literature which gives the various scholarly arguments on community participation, communication and monitoring and evaluation. Chapter three is the research methodology which presents the study design, the target population, the sampling procedure, data collection methods and instruments, validity and reliability and finally the presentation of the findings of the study.

Chapter four presents the analysis and interpretation of the data and finally chapter five gives the summary, the conclusion and the recommendations of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

In this section, literature related to this study has been reviewed. In the first place is theoretical literature which focuses on the theory of fiscal federalism and decentralization. Secondly, studies based on community participation in development projects, monitoring and evaluation of CDF projects and the communication channels are examined with a view of identifying the gaps to justify this study. Thereafter, the study culminates into a conceptual frame work.

2.2 Theoretical Literature

This study relies on the fiscal federalism and decentralization literature to understand how CDF equitably redistributes resources to all the 210 constituencies and how CDF healthcare expenditures accomplish the locative efficiency goal. Fiscal federalism constitutes a set of guiding principles, a guiding concept that helps in designing financial relations between the national and sub national levels of the government, fiscal decentralization on the other hand is a process of applying such principles (Sharma, 2005: 178). The theory of fiscal federalism conceives the organization of the public sector in a more or less federal way so that different levels of government provide public services and have some scope for *de facto* decision-making authority irrespective of the formal constitution within a nation state (Oates, 1999). It identifies three roles for the public sector: macroeconomic stabilization, income redistribution and resource allocation in the presence of market failure (Oates 1999; Burkhead and Miner 1971). The macroeconomic stabilization and income redistribution functions are assigned to the central government while resource allocation function is assigned to sub-national governments (World Bank Report 1999/2000).

The main benefit associated with a federal fiscal structure is economic efficiency, which rests on

two assumptions. First, it assumes that a group of individuals who reside in a community or region possess tastes and preference patterns that are homogenous and that these tastes and preferences differ from those of individuals who live in other communities or regions. Secondly, it assumes that individuals within a region have a better knowledge of the costs and benefits of public services of their region (Burkhead and Miner 1971). Thus, resources devoted for public purposes should be left to the local people to enhance their preferences for public expenditure that optimizes costs (Boadway and Wildasin, 1984).

A federal fiscal structure, however, is not without problems. Once created, it produces a new category of interest groups that are geographically located and lobby for greater transfers to enable them to provide more vote generating expenditures to their constituents at no additional direct tax cost (Grossman 1989). Additionally, a federal fiscal structure financed by transfers from the central government, encourages local jurisdictions to ignore the tax collection burdens of financing their expenditures while at the same time increasing public expenditure obligations (Joulfaian and Marlow, 1990). The use and adequacy of transfers however, hinges on the goals that the national government seeks to advance. If the national goal is to improve the populations' welfare, then whether transfers export tax burdens to the national government is less important. If, however, the goal of the transfers is to free local jurisdictions from the centre's dictates and make them sustainable, then transfers that lack a benefit-taxation principle might be detrimental. A possible remedy for the above problems seems to be the need for clarity in defining a jurisdiction's fiscal responsibilities and the fiscal instruments needed to support the delivery of the needed public services (Oates, 1999).

2.2.1 The Concept of Decentralization

The literature on decentralization on the other hand, points out that decentralization involves the establishment of an arena of decision making that lies outside the influence of the central

government in which the central government delegates some of its power to local or regional administrators which carry out certain functions on their own (Kalaycioglu, 2000). In his view, Smith (1985) sees decentralization as the delegation of power to lower levels in a territorial hierarchy whether the hierarchy is one of governments within a state or offices within a large-scale organization. Further, Smith notes that decentralization can occur in all geographical areas such as neighbourhoods, field personnel in the area of central departments or within a large organization. From a fiscal perspective, decentralization refers to a set of policies designed to increase the revenues or fiscal autonomy of sub-national governments (Falleti, 2005). According to Tanzi (2000), fiscal decentralization exists when sub-national governments have powers given to them by the constitution or by legislative laws, to raise some taxes and/or carry out spending activities within clearly established legal criteria.

According to Rondinelli and Nellis (1986), decentralization can take three forms namely de-concentration, delegation, and devolution. Under decentralization the central government shifts some tasks to the local administrative units without allowing local discretion. Under delegation, local jurisdictions have a certain degree of discretion in the provision of public services, but they still follow the central government's directions and requests. Under devolution, local jurisdictions are independent decision makers that respond to their residents' preferences and needs in the provision of public services (Kwon, 2003). Though none of these three designs works better than the other in terms of satisfying people's needs, scholars agree that different decentralization designs produce different outcomes depending on the existing political and economic institutions in a country (Kumar, 2006). Thus, the "success" of any fiscal decentralization design can be argued to be context dependent and an acceptable criteria for judging success of any fiscal decentralization design, is on how well it serves the presumed national policy objectives.

In most developing countries, fiscal decentralization is promoted as a panacea for the ills of centralized structures and its potential benefits. Firstly, fiscal decentralization is associated with improvement in performance of the public sector through locative efficiency. It also brings public services closer to the people unlike centrally planned services located in capital cities. Close proximity, it is argued, enhances accountability, autonomy and participation (Oates, 1999; Ebel and Yilmaz, 2002).Secondly, decentralization is associated with improved performance on measures of basic needs such as health and education in developing countries and thirdly, fiscal decentralization is associated with equity. When resources are allocated based on an agreed upon formula, all local jurisdictions are guaranteed a minimum level of per capita expenditures for essential services (World Bank Report, 1999/2000).

Fiscal decentralization however, poses a number of problems. First, especially in developing countries, it can be captured by local elites to advance their selfish interests. Second, it is difficult to assign taxes/transfers to match local spending needs due to administrative considerations and access to and sharing of information (Tanzi, 2001). Third, decentralization distorts macroeconomic stabilization policies especially when local jurisdictions engage in expansionary policies while the national government pursues concretionary policies (World Bank Report, 1999/2000; Ebel and Yilmaz, 2002). Fourthly, fiscal decentralization may result in higher government expenditures due to loss of economies of scale for some services, increased public employment due to demands for more public services, and thus additional administrative costs for coordination, and auditing (Tanzi, 2001; Turner and Hume, 1997; Oates, 1999). Fifthly, from a budgetary perspective, fiscal decentralization may be relatively expensive.

Lastly, due to the fact that devolved spending powers encourage local people to fund projects that fit their tastes and preferences, decentralization literature suggests that citizens often suffer

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from fiscal "illusions" when they engage in public policy decisions which blind them from seeing the collective financial costs of their expenditure decisions on the central government's general fund. Fiscal illusions refer to the inability of local decision makers to grasp the collective financial costs of their independent expenditure decisions on the overall financial standing of the central government (Brennan and Buchanan, 1980).

Fiscal illusion is an adaptation of the concept of the *"Tragedy of the Commons"* as first postulated by Hardin (1968). In his original piece, Hardin imagined a pasture open to all herdsmen, who, motivated by self interest, try to keep as many cattle as possible. To maximize individual utility on the shared commons, a rational herdsman will seek to add another animal to his herd. Since the resources of the commons are limited, adding together the component of partial utilities of all rational herdsmen, leads to tragedy for all. To evade such a tragedy, Hardin recommended the adoption of either coercive laws to limit exploitation of the shared commons or the creation of tax devices that communicate the cost of maintaining the shared commons. These recommendations have been adopted in the fiscal decentralization literature to connote the benefit-taxation principle (Bahl, 1999).

In the Kenyan perspective, the tragedy of the commons may be evident given the CDF's current operational structure which blurs the total cost of development projects as a result of the independent local decisions that put pressure on the centre's general fund. The problem of the commons arises when some government programs that concentrate benefits to certain areas are financed from the general fund mainly through transfers (Stein, 1998) and whose collective outcome is fiscal deficits. Apart from its policy problems, fiscal decentralization also poses some technical problems. First, fiscal decentralization is rarely designed to improve the fiscal discipline or reduce the size of government in fact a poorly designed decentralization structures based on transfers from the central government and where expenditure responsibilities are

inadequately defined weaken the centre's budgetary constraints due to coordination problems (Stein, 1998).Therefore in designing a decentralized fiscal structure, policymakers try to answer the question: "Who pays for what and how?" (Kalaycioglu, 2000: 7). For decentralization to work adequately, those who initiate local capital projects must be accountable to those who pay for local projects and those who benefit from those projects. Scholars suggest that different fiscal decentralization designs affect the size of government with mixed results. For instance, Oates' (1999) notes that from a budgetary perspective fiscal decentralization does increase the central government's overall expenditures

Fiscal decentralization in Kenya through CDF is conceived as a delegated form of decentralization because constituencies enjoy some form of discretion in expenditure decision making although they have to follow central government's directions and requests. For instance, constituencies use CDF funds to build clinics but expect the central government to bring such clinic into operation by employing new nurses, supplying drugs and incurring regular maintenance costs. The costs of running two or three clinics in one constituency may not appear to be much but collectively such costs across the entire country may be monstrous for the Ministry of Health (MoH). Thus, a failure to grasp the 'true' cost of running such projects creates fiscal illusions on recipients of such services to view public services as 'free.' Fiscal illusions as a result of independent constituency level decisions which are likely to exhaust the common pool resources and thus, aggravate the problem of the commons. These issues call for attention to address the budgetary implications of fiscal decentralization.

2.3 Empirical Literature

At this point literature on community participation in development projects, monitoring and evaluation of CDF projects and communication channels are examined as postulated by various

chalars who have worked in these fields in reference to community resource mobilisation and accountability.

2.3.1 Community Participation in Decision Making

According to Paul (1987), community participation refers to an active process by which beneficiary client groups influence the direction and execution of a development project with a view to enhancing their well being in terms of income, personal growth, self reliance or other values they cherish. This definition implies that the beneficiaries of any project in a community need to have a say in the decisions concerning the project especially in the identification, implementation and in the maintenance of the projects. For this study, the CDF committee should actively involve the constituents in the health projects, and live up to the provisions of the Act which gives the community full responsibility in the management of the CDF projects.

Community participation may result into the acceptance or rejection of the project or service. This was echoed by Mwaba (2002) who argued that project beneficiaries determine the success or failure of any project. By involving project beneficiaries development workers stand a better chance of identifying the needs of communities and the possible solutions to the needs and factors that could hinder the success of the interventions. Failure to involve project beneficiaries may result in many projects failing. He further mentions that there are countless stories about health centres that have no participants seeking services and schools without students, among others. Those are as a result of poor project identification and lack of beneficiary involvement.

Paul (1987) suggests that community participation may improve project efficiency; project planning and implementation could become more efficient because of timely beneficiary inputs. It could also be used to promote agreement, co-operation and interaction among beneficiaries and between them and the implementing agency of the projects so that delayed are reduced,

smoothen flow of project services is achieved and overall costs are minimized. A study by Bamberger (1986), on the role of community participation in the development planning and project management, showed the potential benefits and costs of community participation. The benefits were improvement of design, project social acceptability, equitable distribution, resource mobilization and essential conditions for sustainability. He also identified social factors affecting project identification and planning as socio-cultural and demographic characteristics of intended beneficiaries, social organizations of productive activities, cultural acceptability of the projects, methods of electing participation (commitment) and gender factors affecting the design and implementation. He further came up with a model relating to the role of participation to reduce project costs, risks and equitable distribution of benefits. This study has relevance on the present study as it looks into community participation methods. However, it does not show how community participation in CDF operations influences health care service delivery in Rangwe constituency.

In another study, Learning Needs in Rural Areas:- a case study of Vihiga and Hamisi Divisions, Oluoch *et al.,* (1980) evaluated how rural development programmes accelerated strategies of development and how communities participated in identifying their needs during the special rural development program(SRDP). He found out that community participation was very weak and recommended the need to strengthen community participation in needs assessment. The role of decentralized funds such as LATF and the CDF have also shown that the concept of participation is in the heart of the policy and is the single greatest feature of community development for it addresses the need of citizens, their associations and that helps them to achieve greater confidence and self determination and influence at the levels of government closer to the people. However, the apparent gap between the promise of enhanced participation through democratic decentralization on the one hand and the everyday realities of participatory

politics on the other, suggests the need to understand more fully the barriers and dynamics to participation in the local governance as well as the enabling factors and methods that can be used to overcome them These two studies have a bearing to this study in that they assess the methods that can be used to overcome the gap between the theoretical and practical aspect of community participation in decision making. However, they differ slightly from current study because this study looks into the role of CDF in the health care service delivery. They both give a general view of community participation in decision making in the projects funded by the devolved funds like CDF yet this study narrows down to how community participation in decision making influences health care service delivery of the CDF funded health care projects.

Other scholars are of the opinion that the community characteristics may also limit their participation in the local governance of the projects. For instance, Social-economic characteristics of a constituency have a bearing on community participation. A key factor is those factors that impact on social capital. The average level of education in a constituency is expected to influence the involvement of the community and also the extent to which they are able to monitor the utilization of funds. We expect that CDF projects will be more in line with priorities in areas where the average level of education is higher. Likewise, religion may also influence the choice of projects and cohesiveness of the community (Kimenyi, 2005). These challenges should be mitigated through enhanced community awareness programs so that the people become competent enough to make informed decisions on the management of CDF fund and other development projects within the constituency (Kimenyi, 2005). Further still he elaborates that there is no doubt that CDF is a novel concept and one that is expected to have major positive impact on development at the grassroots. In addition to advancing the welfare of the people through community projects, CDF has a statutory effect on participation which is itself pivotal to empowerment of communities. This is the main reason why this paper is intends

to evaluate the extent to which the constituency development fund has lived up to the provisions of the act on community participation specifically in the improvement of health care service delivery in Rangwe constituency.

2.3.2 Communication

Communication is the means by which social inputs are feed into the social systems. It is the means by which behaviour is modified, change is effected, information is made productive and goals are achieved. Whether we are considered as a church, a family, a school or a business enterprise, the transfer of information form one individual to another is absolutely essential. (Koontz and Weinrich, 1988)

According to Mbithi (1974), communication is a method used to let another person know what is taking place and when such a thing is taking place. He goes further and says that communication is a life long blood of any organization and asserts that without it, it is impossible to run any activities of any organizations and as such a medical system as well as the operations of the CDFC as far as health is concerned would collapse without communication. Furthermore, Ayot and Patel (1992) explain that communication is an attempt to establish commonness with somebody. They go further to state that communication is a process by which information or messages are passed from one person to another and as such they conclude that every communication is necessary for informing, persuading and evoking the people. Informing the people means explaining, instructing, defining demonstrating and teaching while persuading the people includes influencing, convincing, motivating, selling, preaching and stimulating action. Evoking the people on the other hand means entertaining, inspiring, helping, relieving, celebrating and Commemorating.

Effective communication should be carried out through a particular procedure which consists of five elements. First is the source of the message which may include the sender, the writer, and the encoder who transmits a message through a selected charnel to the receiver. Secondly is the format of the message which may be in the form of a letter, a memo, a report, a speech or a chart. Next they felt that there should be the time factor which gives the duration the message may take to reach the destination and then the receiver of the message. Finally there is the feedback which will give an acknowledgement from the receiver to indicate that there has been communication.

Communication can be differentiated in many ways such as interpersonal and organizational communication. Interpersonal communication is that exchange of information between sender and receiver while organizational communication refers to communication which takes place among groups of people (Gordon, 1987). However, Okumbe (1996) observed that organizational communication is improved by the organizational rules and practice. He identified three main patterns of communication namely downward, upward, and horizontal communication. Downward communication refers to the transfer of messages from those in the highest position to those below and he suggests that a combination of oral and written media be used in disseminating information so as to achieve effective downward communication. Upward communication on the other hand is that which emanates from those in lower position directed to those in higher hierarchy. Upward communication is very crucial in the implementation of the CDF projects because it provides the CDF committee with information from the beneficiaries especially on the relevance, quality, and accessibility and even on their level of satisfaction with the projects already implemented. Downward communication is also very crucial. The CDF committee should endeavour to furnish the community with information about everything that they are pursuing especially on the amount of capital allocated for a particular project, how they

have been used and generally on the whole circle of the project until the project is commissioned for utilization.

Whether interpersonal or organizational, the communication process assumes varied forms. First is oral communication which is the use of the spoken words in a face to face expression. This form of communication is faster and allows the use of gestures however its serious limitation is that it is less permanent and more prone to distortions. Second is written communication which is more permanent, tangible, verifiable, more logical, and clear and thought than oral communication (Robbins, 1996). However, Campbell (1971) notes that a serious drawback of written communication is that it is time consuming, has no inbuilt feedback and also unlike the oral communication, the receiver cannot gauge the non verbal cues.

Communication can also be categorised as verbal and non verbal communication. Verbal communication is essentially oral while non verbal communication is the non-word human responses such as gestures, facial expressions and the perceived characteristics of the environment through which the human verbal communication and verbal messages are transmitted. This kind of communication is enhanced by actions such as dress of the sender, time or reason, space and physical appearance of the persons involved. In another classification, Bell (1981) talks of visual communication which includes posters, diagrams flowcharts and photographs. A final category was added by Mbithi (1974) and this is communication by use of electronic devices such as telephone, radio, television and computers.

Communication can also be categorised as formal communication which occurs through an established organizational hierarchy of authority and informal communication which occurs through the structures without following the chain in the organization. In this regard, Okumbe (1998) notes that the "grapevine" is an informal communication system in an organization and

further concludes that rumours and gossips which are all aspects of grapevine can be minimized if the administrators eliminate ambiguity in the organizational communication. This is a view shared by Robbins (1996) who postulates that up to 75 percent of information passed through grapevine is accurate and that the rumours are aroused by uncertainty in the organization. He further observed that the main advantage of grapevine is that it translates to formal communication to the groups' own jargon and that the message forms part of what employees consider important and their own. This is a view which is consistent with the experience of CDF in a way that a large percent of the information possessed by the community members about CDF is rumours especially on the amount of finances, their usage and even the projects implemented. This level of uncertainty should be avoided by the CDFC and as such they should ensure that there is accurate and effective communication trickling down from the committee to the community members and upwards from the community members to the committee members as well as horizontally amongst the members of the CDFC. In addition, the correct channel should be used to convey the information to the people. This can be achieved by examining for instance the level of education of the people, the cost of the communication, the size of the population to be served with the information and the time to be taken to convey the information amongst others. In the case of health care service delivery in Rangwe constituency, the CDFC should endeavour to furnish the constituents with the information about the projects and services already available to them so that they may utilize those services without which the constituents will continue to guess about their operations and in the long run it will give CDFC a bad publicity.

2.3.3 Monitoring and Evaluation

According to Nunguti (2010) monitoring and evaluation are important tools that are essential for effective implementation and quality outcome of projects. They should be recognized as integral

parts of the phases of the project cycle and as fundamental management functions for determining the course of the project. She further notes that without valid and competent monitoring and evaluation process, success is curtailed, as the project process is not understood without investigations and learning from what happened in the project. Monitoring and evaluation of CDF projects is important to ensure that the intended results and impacts are realized and sustained. This is recognized by the CDF acts which allow the CDF committee to lead the monitoring and evaluation exercise. The CDF Act (2007) stipulates that the CDF committee at the constituency level identity projects, implement them, monitor and evaluated or appoint technical experts to evaluate them. However there is a strong case that CDF should come up with a particularly monitoring and evaluation component in its management.

The monitoring, evaluation and reporting of CDF should be strengthened and applied to all CDF projects. The fact that the CDF committee can monitor and evaluate projects sends wrong signals since most of the times they do not possess the technical know how for carrying out the exercise. This may result into biased and fabricated feedback therefore there is need for an independent and competent body to carry out professional monitoring and evaluation. This is a view shared by Mulwa (2007) who argues extremely that any judgment from any evaluation will to a larger extent; depend on the value system from which the evaluating party originates. Conversely, evaluating party is usually part of the evaluation mission contracted and dispatched by the project sponsor or donor.

According to Allen (2001), the need and importance of monitoring and evaluation is about vision 2030, about community development fund (CDF) and Millennium Goals (MDGs). He notes that realizing all these enormous dreams is only by conducting successful projects and thus availing successful projects depend on what we do in the projects and how much we want them to be successful. Projects are the various things we do to change our world for the better. The things

we do in our lives to get what we want and move a step a head. How do we do them? Are we sure that what we are doing is what we really need? If yes, are we doing it in the right way? Is it taking us to the direction of self improvement? Are our efforts sufficient to do what we are doing? Are the scarce resources we have been used as outcome of what we did changed our lives? What we have put in place can we hold onto it? Are we learning from what we are doing so that we correct the mistakes that we previously made and not repeat them tomorrow? Are we proud of what we have done and happy that we have done very well? Further still, it is said that 'if you do not know where you are going then any road will get you there'. People who get things done are usually clear about what they want to do, how they will do them and most importantly, how they will know if they have been successful. As we try to understand these issues and as we also try to understand these issues and as we also try to answer the questions, we are conducting M&E. For a successful monitoring and evaluation to be undertaken indicators are to be put in place that is which outcome of the project can be understood and measured, gauged or standardized against which change.

Feverstein (1986) came up with nine types of indicators. The first one is the indicator of availability which shows whether something exists and if it's available. This can be of much help to the CDF in checking the projects they have funded. Then there are indicators of relevance and indicator of accessibility which show how relevant or appropriate something is and whether what exists is really within the reach of those who need it respectively. These are serious indicators which need to be applied by the CDF always since the beneficiaries are always interested in what is of relevance to them For instance the health centres and dispensaries funded by the CDF in Rangwe constituency should be accessible to the beneficiaries and serve the purpose of improving the health situation of the constituents. The other indicators which Feuerstein came up with are indicators of utilization, coverage, quality, effort, efficiency and indicator of impact.

These indicators are concerned with the population that is served by the project, the quality of the projects, the cost and time being installed to achieve the project and whether the projects have the likelihood of bringing any difference.

The use of indicators in monitoring and evaluation of CDF projects can yield great results. For instance if employed in health care service delivery, indicators of quality, reference and availability will evaluate the rating of the services provided, the type of projects already funded by the CDF and the patients level of satisfaction with the services provided. The indicator of coverage will assess the doctor patient ration while the indicator of accessibility will examine the distance to be covered to the nearest health facility.

Monitoring and evaluation of projects may also be guided by the different reasons why we conduct evaluations. This diversity of reasons will give rise to the different approaches to evaluation. About five approaches have been highlighted by Nunguti (2010). The first approach is the objectives oriented approach. This approach tracks the performance of the project focused on the project goal or objectives and measures how best the project is performing to reach them. The second approach is the management oriented approach. The purpose of this evaluation is to identify and provide information needed by project managers, which can help them to consider the best decisions for the project. Assessing a range of options related to the project, this approach looks at the inputs, processes, services and products establishing some sort of decision making concerns. This can track the effectiveness of management performance or the workability of the management strategy.

The third approach is the beneficiary oriented approach which is meant to assess the consequences of the project on the beneficiaries of a project. Prominently, this approach assesses the relevance aimed at determining if the project is the right project for the right

beneficiaries. It also provides information for the use of the project by the beneficiaries and seeks answers to questions on what the results of the project will be and the value of the project to the beneficiaries.

The fourth approach is expertise oriented approach in which projects uses highly complex and sophisticated technology using the experts. In this approach the judgment of the experts is the main source of information for evaluation. Projects that use this approach must have used experts at the planning and implementation of the projects thus the need for the expertise to conduct the evaluation. Lastly is the participants' oriented approach in which the participants are taken as the stakeholders included in the project and they include; the project team, sponsors, beneficiaries, government and local agencies and regulatory body. Participatory methods increases ownership, autonomy and self organization by providing institunalisation of participation empowerment, better information, joint learning; improves performance and outcomes, increases accountability and transparency and strengthens commitment to implement collective measures.

Varied monitoring and evaluation approaches can be advanced to the evaluation of CDF projects since the projects are of varied nature. Some are technical like the sinking of boreholes and construction of health facilities while others are simple necessitating the CDF evaluation teams to adopt an all inclusive approach. In addition, there should be adequate resources for carrying out the exercise within a clear framework noting that the CDF Act (2003) emphasizes M&E yet it does not specify the mode of carrying out the same. The Act gives the technical departments, the district development officers and the CDF committee's authority for M&E but this money is only spent after the CDF Committee's recommendation through minutes (CDF Act, 2007). There is a strong case that CDF should change this. The fact that there is money for M&E but the framework is lacking makes the exercise deficient as it is the CDF Committee that

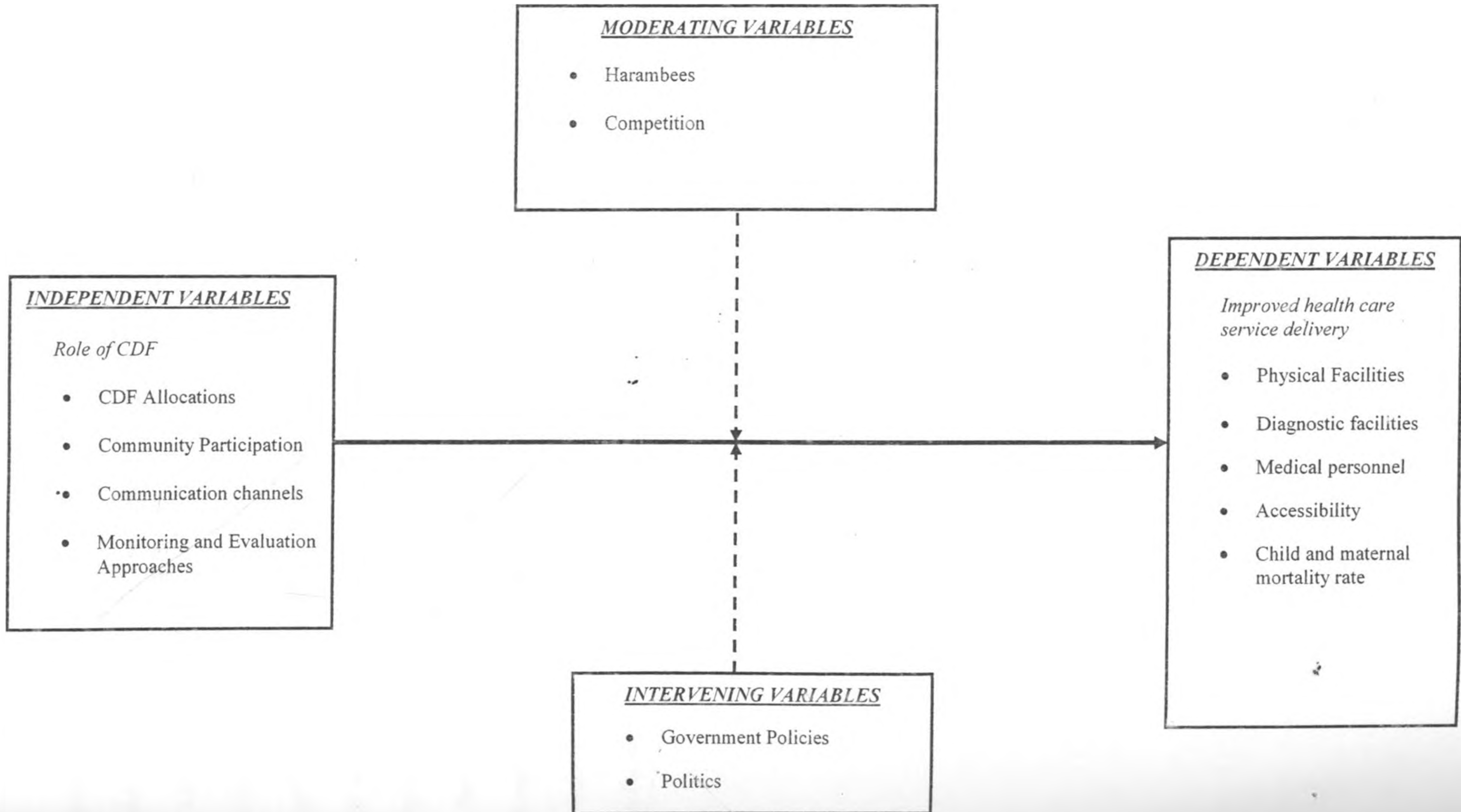
decides which project to monitor and evaluate, how much funds to allocate and who carries out the exercise. However, CDF can be very instrumental in bringing development close to the people especially if community participation is efficiently enhanced and political interference reduced through implementation of the above stated corrective measures.

According to the GoK (2005) the aim of decentralization as occasioned by the CDF is to improve local governance of the facilities identified by the community; management processes and delivery of the envisioned services hence contribute to the national poverty reduction and improvement of quality of human life. The constituency development fund is also conceived to tackle efficiency and accountability challenges inn infrastructure services delivery, financial management, participatory planning and local governance, revenue mobilization, monitoring and evaluation institutional reforms, fiscal management and decentralization. Adherence to these values will ensure quality services, equity in the location of the facilities, accessibility, ownership and sustainability of the health care projects and the health of the community.

2.4 Conceptual Framework

This Conceptual model helps to identify the concepts of the study and the relationships between the independent variable namely CDF annual allocations, level of community participation, communication channels, M&E approaches and the dependent variables on the improved health care services namely number of improved physical facilities, number of improved diagnostic facilities, number of additional medical officers and reduced child and maternal mortality rates. The dependent variables are controlled by intervening variables in that there are issues beyond the reach of CDF management namely government policies and politics. Some moderating variables are also at play namely community motivation and communal fund raisings.

Figure 2.1 Conceptual Framework



Source: (Researcher, 2011)

2.5 Summary

This chapter reviewed relevant literature as regards to the impact of CDF on development projects. Literature acknowledges the great role played by the CDF in the improvement of service delivery in education, water and health. Despite this, various problems have been cited that hamper the efficiency and effectiveness in the use of this fund. For instance, there have been complaints of inadequate fund allocations to the said projects, little involvement of the community in decision making and in accountability in the use of the fund. With this knowledge, there has been no research carried out in Rangwe constituency to assess the role of the CDF in the health sector. It is this gap that the research aims at filling. The researcher also seeks to generate information and recommendations that can contribute to solving the identified challenges facing the management of the CDF fund.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This section is aimed at examining the procedures which were used in guiding the study. It therefore details out the techniques and tools that were employed in data collection, the sources of the data, sampling design, methods of data analysis as well as the presentation of the study findings. This study was geared towards the assessment of the extent to which the CDF allocations have improved health care service delivery in Rangwe Constituency of Homa-Bay County. This was achieved through the analysis of the level of community participation and communication channels. Other assessments involved the analysis of the influence of the fund on enhancement of physical and diagnostic facilities as well as the analysis of the monitoring and evaluation approaches employed by the fund's management in this constituency.

3.2 The Study Design

Research design refers to the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in the procedure (Babbie, 2002). This study adopted a descriptive design. A descriptive study design is concerned with explaining the who, what, when and how of a phenomenon and therefore is probably the best method available to social scientists who are interested in collecting original data for purposes of describing a population that is too large to be observed directly. (Cooper *et al*, 2003).This design enabled the researcher to describe and explain conditions of the present health service delivery in ten selected health facilities in Rangwe constituency. This study also used both quantitative and qualitative methods of data analysis as well as various sampling methods to appropriately come up with the sample size of which findings thereof have been generalized and deemed to apply to the universe population.

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3.3 Target Population

Target population in statistics is the specific population about which information is desired. This study targeted all the 20 public health facilities in ranging from the health centres to the dispensaries since they are the ones who are the beneficiaries of the CDF, the 20 facility administrators, the 13 CDF committee members and the beneficiaries of the implemented health care services. However, the only district hospital in the constituency was not considered since it receives a wide range of funds from NGOs and other sources hence the effect of CDF on it can be very negligible thus misleading to the study.

3.4 Sampling size and Procedures

The sample size for this study were 97 respondents who were arrived at through the following sampling procedures: Stratified random sampling procedure was adapted to select 10 public health facilities of which 3 are health centres and 7 dispensaries. The health centres sampled were distributed among the divisions as Asego Division 1, Rangwe Division 2 while the dispensaries were distributed among the divisions as Asego 3, Rangwe 4

Table 3.1: Total and sampled health centres and dispensaries

Division	Total Health Centres	No. Sampled	Total Dispensaries	No. Sampled
Asego	1	1	6	3
Rangwe	3	2	9	4
Totals	4	3	15	7

Source: (Researcher, 2011)

Judgemental sampling was employed to select 10 facility administrators 1 from each of the ten health facilities sampled. In addition, a total of 7 CDF Committee members were selected through judgemental sampling technique. This was influenced by the weight of the position that a member holds in the committee and therefore a member's ability to influence the decision. However, the selected committee members did not come from the same location.

Eight community members were randomly selected from each of the 10 health facilities selected for the study. Therefore, a total of 80 community members were selected. The basis of this selection is that the community members selected originated from the area of influence of the health facility and therefore the members selected for the study must have benefited from the facility.

Table 3.2: Summaries of the Respondents

Level	No. Interviewed
Health facility administrators	10
CDF committee members	7
Beneficiaries/ community members	80
Total	97

Source: (Researcher, 2011)

3.5 Data Collection Methods and Instruments

The study adopted the survey method of data collection. In this case primary data was collected by the researcher/research assistants through administering questionnaires containing open and closed questions and conducting field observations on the health care infrastructure implemented within the constituency using the CDF funds. Observations are important in giving additional and more accurate information on behaviour and expressions of the beneficiaries as they explain their relationship with the projects and services. The method was used in comparing information collected through questionnaires especially on sensitive issues of the study.

3.6 Validity and Reliability

According to Mugenda and Mugenda (2003), Validity is the degree to which results obtained from the analysis of the data actually represents the phenomenon under study. In this study, validity was enhanced by a pre- testing done to the instruments used so as to identify and change

any ambiguous, awkward or the offensive questions. Also to help improve the validity of information collected from the beneficiaries, the respondents to the questionnaires were limited to person of over 25 years of age and who have lived in the constituency for over two years. Objective questions were included in the questionnaires and also the indicators of the variables of the study were clearly defined and scrutinized.

Reliability on the other hand refers to a measure of the degree to which research instruments yield consistent results (Mugenda and Mugenda, 2003). In this study, reliability was enhanced by ensuring equal level of understanding of the questionnaire used in data collection. This was achieved through offering training to the research assistants on the data collection instruments so as to ensure better explanation of concepts captured in the instruments.

3.7 Data Analysis and Presentation of the Findings

The completed questionnaires were edited and then coded to facilitate statistical analysis. The aim here was to eliminate unusable data and interpret ambiguous answers. The data was then feed into a computer, and tabulated to facilitate analysis. Statistical Package for the Social Sciences (SPSS) was used to guide this process.. The findings of this study have been presented in forms of descriptive statistics which includes the frequency tables, percentages, measures of central tendencies (mean, mode and median) as well as the quantitative statistics such as the analysis of correlation and multivariate regression analysis alongside the written statements as explanations to the findings.

Table 3.3: Operationalisation of Variables

	Objectives	Variables	Indicators	Level of Measurements	Data Collection Methods and Tools	Data Analysis
1.	To asses the influence of the annual CDF allocation on the health care service delivery	**Independent** Annual CDF Allocations	• The amount of money allocated to for health improvements	• Nominal	• Questionnaires • Document analysis	• Measures of central tendency
		Dependent health care service delivery	• No. of new and improved physical facilities • No. of new and improved diagnostic facilities • No. of additional medical personnel	• Ordinal • Ordinal • Ordinal	• Observation	• Measures of central tendency
2.	To assess the level of community participation in decision making to improve health care service delivery	**Independent** Level of community participation **Dependent** health care service delivery	• No.of barasas called by the committee • Provision of labour, finance etc • Proportion of community members attending the barasas	• Nominal • Nominal • Ratio • Nominal	• Report analysis • Questionnaires • Report analysis • questionnaires	• Descriptive Statistics • Correlation and regression

			• Utilization levels of the health care services			
3.	To examine the communication channels used by the CDF team on the health care service delivery	**Independent** Communication channels used by the CDF team **Dependent** health care service delivery	• No. of barasas convened by the team • No. of memos drawn by the team • No. of notices and signage	• Ordinal • Ordinal • Ordinal	• Questionnaires • Report analysis • Report analysis	• Descriptive statistics
4	To examine the monitoring and evaluation approaches used by the CDF committee on health care service delivery	**Independent** Monitoring and evaluation approaches **Dependent** health care service delivery	• No. of visits to the facilities • No. of monitoring and evaluation reports • Quality and relevance of the facilities	• Ordinal • Ordinal	• Report analysis • Questionnaire	• Descriptive statistics • Correlation and regression

Source: (Researcher, 2011)

3.8 Summary

This chapter detailed the various research methods that were used to generate data and information to address the study objective. Among the sections discussed included: study design, the procedure of sampling and sample size, data collection instruments, data collection and data analysis. Reliability and validity testing and operationalization of the variables were also highlighted.

CHAPTER FOUR

DATA PRESENTATION AND INTERPRETATION

4.0 Introduction

This chapter presents the study findings as analyzed in different sections in line with the study objectives. The first sections present findings on the respondents' profile. The second section gives results on influence of the annual CDF allocation on the health care service delivery in the Constituency while the third section relates to communication channels used by the CDF team on the health care services delivery in the constituency and the last section presents observations on monitoring and evaluation approaches used by the CDF committee on health care service delivery

4.1 The Socio-Economic Profiles of the Respondents

Various socio-economic factors were considered in the survey for both CDFC members and beneficiaries in general and Table 4.1 gives a detailed description of the respondents' profiles

Table 4.1: Social -Economic Profiles of Beneficiaries and CDFC Members

	Beneficiaries		CDFC members		Pooled	
Respondents' Profiles	Freq	%	Freq	%	Freq	%
Age						
18-24	12	15		-	12	13.8
25-50	52	65	4	57.0	56	64.4
Above 50	16	20	3	43.0	19	21.8
Highest Level of Education						
Primary	28	35		-	28	32.2
Secondary	32	40	5	71.0	37	42.5
College	15	18.8	1	14.0	16	18.4
University	5	6.2	1	4.0	6	6.9

Source: (Field Survey, 2011)

The respondents' ages varied from 18 up to over 50 with the majority (64.4 percent) being between the ages of 25 to 50. The respondents were by and large literate as 42.5 percent of them

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have attained secondary education as indicated by the results. Approximately 65 percent of the beneficiaries and 57 percent of the CDFC members are in the age bracket of 25 to 50, followed by the over 50 age cohort who constitutes 20 percent among the beneficiaries and 43percent among the CDFC members respectively. However, only 15 percent of the beneficiaries are in the 18 to 24 age cohort. This reveals that age is associated with experience coupled with the fact that the CDF Act requires that the committee member must be retirees and with the retirement age having been 55 years, the majority of the CDFC members are above 55 years of age with majority of them having attained at least secondary education. This is again granted for by the CDF Act that the membership of the committee must be a holder of minimal secondary education.

4.2 Influence of the Annual CDF Allocation on the Health Care Service Delivery

The influence of the CDF on the health care service delivery depends to a greater extent on the amount of money allocated to the sector. In this study, the CDF Manager was asked to state the amount of the annual CDF allocated to the health sector in the constituency on general principles while the Health Facility Administrators were also asked to state the amount of money that the sampled facilities have received in the last five years. This analysis is presented in Table 4.2. According to the in CDF manager, the annual average amount of money received by the health facilities in the constituency from CDF for the last five years amounted to Ksh 3,110,305. This information was corroborated by other CDFC Members as the true state of the disbursements. However, it was noted that a relatively large amount of funds were allocated to the health sector in 2010. This could be attributed to the fact that many health related projects were proposed to be undertaken in the financial year 2009/2010 which necessitated the extra allocation to the sector as well as for the completion of the old projects.

Table 4.2: Money Allocated to Health Care Service Delivery According to CDF Manager

Year	Total Amount (Ksh.)
2007	2,200,000
2008	2,700,000
2009	2,450,000
2010	5,135,214
2011	3,066,309
Average	**3,110,305**

Source: (Field Survey, 2011)

As appertaining to the impact of the developed and improved health care facilities, the study undertook to inquire the accessibility aspects of the developed health care facilities and consequently their impact on the reduction on the walking distance by the patients in the constituency. This was done in lieu of the fact that long distance is one of the challenges to quality health care services delivery in most rural areas of the developing countries. Towards this end, Table 4.3 gives the summary of the findings on the accessibility in terms of the walking distance to the health care facilities.

Table 4.3: Walking Distance to Health Facilities per Division

	Rangwe		**Asego**		**Overall**	
Distance (Km)	H/Centres	Dispensary	H/Centres	Dispensary	H/Centres	Dispensary
less than 1	26.3	29.6	33.3	31.1	28.6	30.8
1.0 to 2.9	47.4	45.1	37.3	44.3	39.3	46.2
3.0 to 3.9	10.5	11.3	9.8	8.2	10.7	9.6
4.0 and above	15.8	14.1	19.6	16.4	21.4	13.5
Total	*100*	*100*	*100*	*100*	*100*	*100*
Average distance	**1.73**	**1.71**	**1.94**	**1.48**	**1.8**	**1.61**

Source: (Survey Results, 2011)

From this analysis, it is clear that there is insignificant difference in the walking distance between the health centres and the dispensaries both in Rangwe and Asego Divisions. However, the health centres and dispensaries are closer to beneficiaries in Asego Division than Rangwe Division. Overally, 39.3percent of the respondents said that their walking distance to the health

centres ranges between 1.0 to 2.9 kilometres while 46.2 percent noted that they covered similar distance to the dispensaries with the rest being 10.7 percent and 9.6 percent for those between 3.0 to 3.9 while 2.1percent and 13.5 percent for those who covered 4 kilometres and above respectively. The average walking distance to health centres is 1.835 kilometres while the average walking distance to the dispensaries is 1.595 kilometres with the average walking distance to the health facilities being 1.715 kilometres. This compares favourably to the World Health Organization's recommendation of 2.5 kilometres to a health facility in the rural areas. This reveals that CDF has improved accessibility to health care facilities in Rangwe Constituency.

Furthermore in assessing the influence of the annual CDF allocation on the health care service delivery, respondents, particularly beneficiaries and facility administrators' were asked to indicate the number of new wards, laboratories, additional medical personnel hired and consultation rooms that have been undertaken by the CDF. Tables 4.4 and 4.5 give the breakdown of the results according to beneficiaries and Health Facility administrators' respectively.

Table 4.4: The Beneficiaries' Response on the Physical Improvement of the Health Facilities brought about By CDF.

	Health centre		**Dispensary**	
No of facility	Wards	Laboratory	Consultation Rooms	Laboratory
1 to 3	68.4	75.0	34.8	41.2
3 to 5	5.3	-	13.0	-
above 5	21.1	-	13.0	-
Not aware	5.3	25.0	39.1	58.8

Source: (Field Survey, 2011)

From Table 4.4, it is clear that there has been a significant improvement on physical facilities in health centres compared to dispensaries. A large fraction of beneficiaries (68.4 percent) reported

the number of wards increased in the range of 1 to 3 in health centres compared to only 34.8 percent for consultations rooms in dispensaries. It was also noted that a significant fraction of beneficiaries were not aware of the number of additional laboratories in both health centres and dispensaries. This is attributed to the fact that they are not the implementers of the project and therefore the Health Officers who are involved in the running of the projects were in a better position to know this as corroborated in Table 4.5.

Table 4.5: Health Facility Administrators' Response on Types of Improvement Implemented by CDF Allocation in the Health Facilities.

	Health centre			Dispensary		
No of facility	Wards	Labs	Additional Personnel	Consultation Rooms	Labs	Additional personnel
1 to 3	50	75	50	66.7	50	50
3 to5	5.3	-	25	33.3	50	25
Above 5	21.1	-	-	-	-	25
Not aware	23.6	25	25.0	-	-	-

Source: (Field Survey, 2011)

According to health facility administrators, CDF has been used to add more wards as well as consultation rooms for health centres and dispensaries respectively. Unlike beneficiaries the health facilities administrators were able to tell the number of laboratories in the health care centres as a result of CDF. Further, the influence of CDF allocation on health care was assessed by asking both beneficiaries and Health Facility Administrators to rate the level of infant and maternal mortality in the last five years and Table 4.6 gives a summary of the findings.

Table 4.6: Response on the Rate of Infant and Maternal Mortality Rate in the Last Five Years

	Beneficiaries		Health Facility Administrators		Pooled	
Rates of mortality	Infant (%)	Maternal (%)	Infant (%)	Maternal (%)	Infant (%)	Maternal (%)
Low	45.5	53.8	62.5	75.0	54.0	64.4
Moderate	45.5	41.2	37.5	25.0	41.5	33.1
High	9.1	5.0	-	-	4.5	2.5

Source: (Field Survey, 2011)

In response to three levels given regarding the rate of infant and maternal mortality, 54.0 percent postulated that the infant mortality had gone down except for 4.5 percent of them who indicated that it had gone up. There was also a remarkable reduction on maternal mortality as reported by 64.4 percent which is attributed to the improved health care service delivery. However, 45.5 percent of the beneficiaries and 62.5 percent of Health Facility Administrators admitted that the rate of infant mortality have gone down while 45.5 percent and 37.5 percent of the same respondents respectively were of the opinion that the rate was moderate as 9.1 percent of the beneficiaries believed that infant mortality was high. Likewise, there was a marked difference in terms of maternal mortality where a larger proportion of both beneficiaries (53.8 percent) and Health Facility Administrators (75.0 percent) acknowledged that rates had also gone down compared to 41.2 percent of the beneficiaries and 25.0 percent of the Health Facility Administrators of those who said it was moderate. Again, only 5.0 percent of the beneficiaries revealed that the rate is high.

There were mixed responses on the general view of all the respondents regarding the nature of improvements. However on average the majority of the respondents (67.0 percent) were of the consensus that the qualities of the developed and improved physical infrastructure were standard while 94.8 percent agreed that there was a reasonable improvement in the health care service delivery in the constituency as detailed out in Table 4.7. It was worth noting that a relatively larger fraction of Health Facility Administrators, 57.1 percent noted that the qualities of physical infrastructure developed through the CDF were substandard. This is attributed to the fact that this category of respondents are highly skilled and thus competent enough to gauge appropriate quality unlike the general beneficiaries who are not necessarily aware of the specifications for the infrastructure needed for the health facilities such as the room size, design and ventilations

among others. As such they view any additional infrastructure as adequate and a move in the right direction.

Table 4.7: Quality and Extent of Improvement

Variable	Beneficiaries (%)	Health Facility Administrators (%)	CDFC Members (%)	Overall (%)
Quality of improvement				
Standard	72.5	42.9	85.7	67.0
Sub-standard	27.5	57.1	14.3	33.0
Extent of improvement				
To a great extent	47.5	14.3	57.1	39.6
Reasonable extent	51.2	85.7	28.6	55.2
Not at all	1.2	-	14.3	5.2

Source: (Field Survey, 2011)

4.3 The Level of Community Participation in Decision Making for the Improvement of Health Care Service Delivery

Community participation which is defined as a strategy for involving society in matters that concerns them is very vital in decision-making. Table 4.8 gives the findings on the level of community participation in the health care facilities management and prioritization, particularly those which have been funded through the CDF in the constituency. As illustrated by Table 4.8, the majority (68.0 percent) are generally aware of how decisions were arrived at in funding the health care facilities using the CDF. Results from the table further confirm that the community and other stakeholders form the bulk of groups of people in terms of participation. A further 63.9 percent revealed that indeed meetings were held and as such, more than three meetings were held and attended by between 11 to 39 people. This is fairly a good indication of community involvement in the CDF projects.

Table 4.8: Distribution on Response on Community Participation

Response	Beneficiaries(n=80)		Health Facility Administrators(n=10)		CDFC Members(N=7)		Pooled Results	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
If aware of how decision were arrived at								
Yes	52	65.0	7	70.0	7	100	66	68.0
No	28	35.0	3	30.0	-	-	31	32.0
Decision making								
Community	24	30.0	2	20.0	-	-	26	26.8
MOH	3	3.8	-	-	-	-	3	3.1
MP	3	3.8	1	10.0	2	8.6	6	6.2
All Stakeholders	23	28.8	4	40.0	3	42.9	30	30.9
CDF committee	6	7.5	2	20.0	-	-	8	8.2
Community Leaders	7	8.9	1	10.0	1	14.3	9	9.3
If meetings were held								
Yes	49	61.2	6	60.0	7	100	62	63.9
No	17	21.2	4	40.0	-	-	21	21.6
m.s	14	17.5	-	-	-	-	14	14.4
No. of meetings								
Once	4	5.0	-	-	-	-	4	4.1
Two	10	12.5	1	10.0	-	-	11	11.3
Three	8	10.0	-	-	2	28.6	10	10.3
Above 3	25	31.2	5	50.0	5	71.4	35	36.1
Not aware	33	41.2	4	40.0	-	-	37	38.2
No. of people attending meetings								
1 to 10	8	10.0	2	20.0	-	-	10	10.3
11 to 39	31	38.8	1	10.0	1	14.3	33	34.0
40 to 79	3	3.8	1	10.0	1	14.3	5	5.2
80 to 150	5	6.2	1	10.0	1	14.3	7	7.2
More than 150	5	6.2	1	10.0	4	57.1	10	10.3
Not aware	28	35.0	4	40.0	-	-	32	32.9

Source: (Field Survey, 2011)

The distribution on the major ways of community participation is illustrated by Table 4.9. The majority (27.8 percent) participated in terms of labour while very few individuals (2.2 percent) contributed capital. The study has also revealed that there was no significant difference between those who contributed land which is 3.3 percent and those who offered security which also constituted 3.3 percent. Participation is a product of individuals' capability coupled with affordability in lieu of poverty levels in the constituency, the greater form of participation is labour provision which is affordable by all the able bodies.

Table 4.9: Distribution of Responses on Forms of Participation

	Beneficiaries(n=80)		Health Facility Administrators(n=10)		Pooled Results	
Participation	Freq.	%	Freq.	%	Freq.	%
Yes	32	40	4	40	32	35.6
No	48	60	6	60	58	64.4
Ways of participation						
Labour	24	30	1	10	25	27.8
Capital	2	2.5	-	-	2	2.2
Land	3	3.8	-	-	3	3.3
Security	3	3.8	-	-	3	3.3
Others	-	-	2	20	2	2.2

Source: (Field Survey, 2011)

It is further evident that the commonly used mode of consultation is the Chief's *barazas* or through verbal/oral communication as indicated by 24.7 percent and 30.9 percent respectively. This could be attributed to their low cost and high reliability. Again the study having been conducted in rural setup, it is not surprising that this is the most preferred methods. Table 4.10 below gives a breakdown of the results. Several factors were considered in the identification of the improvements in the health care service delivery. According to the results, distance was considered the most important variable in the identification as indicated by an overall result of 62.2 percent followed by the extent /pressure of vulnerable groups requiring the urgent support at 32.2 percent as illustrated by Table 4.11.

Table 4.10: Distribution of Response on Modes of Consultations

Whether Community Members are Consulted	Beneficiaries(n=80)		Health Facility Administrators(N=10)		CDFC Members(N=7)		Pooled Results	
	Freq	%	Freq.	%	Freq	%	Freq	%
Yes	57	71.0	7	70.0	7	100.0	71	73.2
No	23	29.0	3	30.0		-	26	26.8
Mode of consultations								
Stakeholders meetings	5	6.3		-	7	100.0	12	12.4
Chief's *Barazas*	19	24.0	5	50.0	-	-	24	24.7
Verbal/oral communication	27	34.0	3	30.0	-	-	30	30.9
Media/Radio	2	2.5		-	-	-	2	2.1
Not aware	19	24.0	2	20.0	-	-	21	21.6

Source: (Field Survey, 2011)

These results imply that the major problem in this constituency has been in physical inaccessibility to health care service delivery which is pronounced in terms of physical distances people used to travel to seek for medical services.

Table 4.11: Factors Considered In the Identification of Improvements in the Health Care Services Delivery

Criteria	Beneficiaries (n=80)		Health Facility Administrators(n=10)		Pooled Results	
	Freq	%	Freq	%	Freq	%
Distance	51	63.8	5	50.0	56	62.2
Ability to implement projects within budgets, time and specification	2	2.5	1	10.0	3	3.3
Ability of the community to sustain the improvement/projects	4	5.0	-	-	4	4.4
Pressure of vulnerable groups that require urgent support	25	31.3	4	40.0	29	32.2
Others	11	13.8	-	-	11	12.2

Source: (Field Survey, 2011)

4.4 Communication channels Used to Support Health Care Services Delivery

In assessing the level of awareness of respondents, both beneficiaries and health facility Administrators were asked whether they had heard about CDF. The Findings of this is presented in Table 4.12.

Table 4.12: Awareness on CDF and Its Impacts on Health Care Service Delivery

Variables	Beneficiaries		Health Facility Administrators		Pooled Results	
	Freq.	%	Freq.	%	Freq	%
Heard of CDF?						
Yes	79	98.8	10	100	89	98.9
No	1	1.2	-	-	1	1.1
Sources of Information						
Radio	64	80	8	80	72	80.0
Newspapers	25	31.2	7	70	32	35.6
Television	9	11.2	6	60	15	16.7
Internet	6	7.5	5	50	11	12.2
MOH	11	13.8	6	60	17	18.9
Others	38	47.5	1	10	39	43.3
Whether the Health Facility has benefited from CDF in the last five years						
Yes	64	88.9	10	100	74	82.2
No	8	11.1	-	-	8	8.9

Source: (Field Survey, 2011)

It was noted that 98.8 percent of beneficiaries who filled questionnaires indicated they had heard about CDF while an insignificant 1.2 percent of them revealed that they had not heard about it. This is contrary to the Health Facility Administrators who all indicated that they have heard about CDF. This could be linked to their education levels which go hand in hand with the level of awareness coupled with the fact that CDF disbursement is their engagement. The majority of respondents attribute their source of knowledge to the media, which is a very powerful tool for community development and thus has been used by the government to enlighten the public for its ability to reach multitudes of people within a very short time. A little effort though is still needed to educate all the stakeholders with regards to CDF which could also help in its proper management. The study further reveals that about 88.9 percent of the beneficiaries are grateful for the CDF as opposed to only 11.1 percent of them who still believe they have not benefited from the kitty. Again, the entire ten Health Facility Administrators acknowledged that they have benefited from CDF.

Generally, chief's *barazas* seems to be the most preferred way of conveying information to the community as indicated by 64.9 percent of all respondent. In addition, *dhuluo* was found to be

the language commonly used by many during these meetings and quite a large number of the respondents were happy with it since 79.4 percent indicated that there was no language problem. Overally, 53.6 percent of respondents indicated that they are satisfied with the communication channels used. This does not mean that other avenues of communication should not be explored. Table 4.13 presents results on the major communication channels used in the constituency.

Table 4.13: Communication channels Used and Level of Satisfaction

	Beneficiaries		Health Facility Administrators(n=10)		CDFC Members		Pooled	
Response	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Awareness of communication channels								
Yes	50	62.5	7	70	7	100	64	66.0
No	30	37.5	3	30	-	-	33	34.0
Channels Used to Convey Information to the Community								
Memos	11	13.8	-	-	-	-	11	11.3
Barazas	53	66.3	3	30	7	100	63	64.9
Notices	10	12.5	2	20		-	12	12.4
Others	6	7.5	-	-	-	-	6	6.2
Common language used								
Dholuo	40	50	4	40	1	16.7	45	46.4
Kiswahili	7	8.8	-	-	1	16.7	8	8.2
English	12	15	1	10		-	13	13.4
All the three	21	26.3	-	-	4	66.7	25	25.8
Language problem								
Yes	12	15	-	-	2	33.3	14	14.4
No	68	85	5	50	4	66.7	77	79.4
Best language								
Dholuo	12	15	-	-	1	16.7	13	13.4
Kiswahili	-	-	-	-	-	-		
English	-	-	-	-	1	16.7	1	1.0
N/A	68	85	-	-	4	66.7	72	74.2
Level of Satisfaction with Channels								
Not Satisfied	10	12.5	2	20	-	-	12	12.4
Moderately satisfied	27	33.8	3	30	2	33.3	32	33.0
Satisfied	43	53.8	5	50	4	66.7	52	53.6

Source: (Field Survey, 2011)

4.5 Monitoring and Evaluation Approaches Used by the CDFC on Health Care Service Delivery

Monitoring and evaluation is a vital tool used for determining effective implementation of projects and the quality of project outcome. This research assessed whether respondents were aware of the role of monitoring and evaluation and if they have previously participated in the same. Table 4.14 gives details of the findings.

Table 4.14: The Role of Monitoring and Evaluation

	Beneficiaries		Health Facility Administrators		Committee Members		Pooled	
Responses	Freq	%	Freq	%	Freq	%	Freq	%
Whether aware of the role ofMonitoring and Evaluation								
Yes	59	73.8	8	80	7	100	74	76.3
No	21	26.2	2	20		-	23	23.7
Total	**80**	**100**	**10**	**100**	**7**	**100**	**97**	**100.0**

Source: (Field Survey, 2011)

From Table 4.14, all CDFC Members are aware of the role of monitoring and evaluation in the CDF Funded health care projects as compared to only 73.8 percent of beneficiaries who are aware of the same. Overally, 76.3 percent of all respondents know the role of monitoring and evaluation relative to only 23.7 percent who reported that they were not aware. This study further evaluated the extent of community participation in monitoring and evaluation of CDF funded health care projects and Table 4.15 presents the summary of the findings.

Table 4.15: **Level of Community participation in Monitoring and Evaluation of CDF Funded Health Care projects**

Responses	Beneficiaries		Health Facility Administrators		CDFC members		Pooled	
	Freq	%	Freq	%	Freq	%	Freq	%
Participated in Monitoring and Evaluation								
Yes	24	26.2	2	20.0	5	71.4	31	32.0
No	56	73.8	8	80.0	2	28.6	66	68.0
Total	**80**	**100**	**10**	**100.o**	7	**100.0**	**97**	**100.0**

Source: (Field Survey, 2011)

From Table 4.15, it is clear that majority of the CDFC members engage in the monitoring and evaluation process However, the study also reveals that a large proportion (80 percent) of the Health facility administrators have not participated in the evaluation process and this raises an issue on the level of competence needed in monitoring and evaluation process. Ordinary, one would expect more of Health Facility Administrators to be involved since this is a health concern but this is not the case. This has often raised the cases of projects being developed for health provision purposes through the CDF yet they do not meet the standards for the purpose. Further still, it is also clear that most of the beneficiaries have also not participated in the monitoring and evaluation of the CDF funded health care projects. This implies that community members who are the beneficiaries have been sidelined in the evaluation process as confirmed by results in Table 4.16 which outlines the major ways of community involvement in the monitoring and evaluation process.

Table 4.16: **Ways of Community Involvement in the Monitoring and Evaluation Process**

Ways of involvement in monitoring and evaluation	Frequency	Percent
Being part of the monitoring &evaluation team	6	25
Consultation/community participation in decision making	10	41.7
Inspection of projects	4	16.7
Examination of monitoring and evaluation reports/feedback	2	8.3
Others	2	8.3
Total	**28**	**100.0**

Source: (Field Survey, 2011)

Out of the 24 respondents who indicated that they have participated in the monitoring and evaluation, only 25 percent of the beneficiaries revealed that they were part of the team that undertook the monitoring and evaluation of the projects while 41.7 percent said they were consulted. In addition, only 16.7 percent of the beneficiaries revealed that community members were sometimes called upon to inspect the projects while 8.3 percent appreciated that there were at least some feed back/reports from the monitoring and evaluation process. This gives a clear indication that the people are sidelined in this process while the CDFC is quite committed to the process as further illustrated by table 4.17 which gives the findings on the other parties involved in the monitoring and evaluation process other than the community members.

Table 4.17: Stakeholders Involvement in Monitoring and Evaluation of CDF Funded Health Care projects

Stakeholder	Beneficiaries (%)	Health Facility Administrators (%)	CDFC Members (%)	Pooled
MP	26.1	20	14.3	20.1
CDFC Members	35.6	70	-	35.2
Government Officers	26.2	10	28.6	21.6
PNC	-	-	-	-
Not aware	12.1	-	57.1	23.1
Total	**100**	**100**	**100**	**100.0**

Source: (Field Survey, 2011)

From the findings, it is clear that CDFC Members forms the major part of the monitoring and evaluation team which is partly attributed to the fact that they are the main sponsors of these projects and are granted by the CDF Act to be the imperative supervising agency for the projects. Government officials such as local area chiefs and sub-chiefs are also instrumental agents of the project Monitoring and Evaluation while the area member of parliament also occasionally engage in this process as indicated by 20.1 percent of all the respondents. in this study, the respondents' were also asked to state their perception on the role of CDF on health care service delivery. These views are illustrated by Table 4.18 which gives the summary of the results.

Table 4.18: Respondents' Perception on the Role of CDF on Health Care Service Delivery

	Beneficiaries		**Health Facility Administrators**		**CDFC Members**		**Overall**	
Comment	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Very Good/excellent	6	7.5	-	-	2	28.6	8	8.2
Fair/good	64	80.0	7	70	2	28.6	73	75.3
poor	5	6.2	1	10			6	6.2
Others	5	6.2	2	20	3	42.9	10	10.3

Source: (Field Survey, 2011)

According to Table 4.18, 75.3 percent of the respondents are of the view that CDF has done fair/good work in health care service delivery as compared to only 8.2 percent who were of the view that it has been excellent. In the contrary, 6.2 percent said it has done poorly while 10.3 percent were non-committal on the effects of the fund on the same. This therefore means that people concerned with the management of the CDF still have a lot to do so that all parties can be happy. Finally the analysis of regression results are presented in Table 4.19 which shows the linear regression model for the level of education, age of the beneficiaries and the level of awareness to the fund with the likelihood ratio or level of significance (β) being 0.005.

Table 4.19: Regression Results on Participation in CDF Funded Health Care Projects

Variables	Coefficient	Standard Error	t-value
Constant(K)	0.656	0.359	1.829
Age(r_1)	0.042	0.088	0.478
Level of education(r_2)	-0.001	0.059	-0.023
Awareness/have you heard of CDF(r_3)	0.385	0.105	0.657*

Source: (Field Survey 2011).

* *Significant at 0.05% level, Adjusted R=-0.121 R^2=0.005 Likelihood ratio = 0.005*

$$Y = \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon$$

Where:-

Y	=	Level of participation in the CDF Funded health care projects
X_1	=	Age of the beneficiaries,
X_2	=	Level of education
X_3	=	Awareness to the CDF.
ε	=	Error term

The unifying equation: -

$$Y = \mathbf{0.042\, X_1 - 0.001 X_2 + 0.385 X_3 + 0.611}$$

The above equation correlates level of participation to age of the beneficiaries, level of education and the awareness to the fund. From the analysis, it is clear that awareness (x_3) has positively and significantly influenced participation while age (x_1) has a positive but not a significant influence. This implies that the more the awareness increases, the more the participation in the project such that there is likelihood in participation in the CDF funded health care projects with an increase in age and level of awareness. On the other hand, the level of education (x_2) of beneficiaries had a negative and not a significant influence on participation implying that the lower the level of education the more one was likely to participate in the project. This is granted that the greatest mode of participation in the project is through free labour provision, of which the highly educated and meaningfully economically engaged are not likely to be involved in. Furthermore, community involvement also exerts a positive though insignificant influence on satisfaction to the quality of the projects undertaken. This implies that the more community were involved in

the CDF funded health care projects in the constituency, the more the level of satisfaction as illustrated by Table 4.20.

Table 4.20: Regression Results on the Role of CDF in CDF on Health Care Service Delivery

Variables	Coefficient	Standard Error	t-value
Constant(K)	2.297	0.573	4.008
Level of Community Involvement	-0.207	0.237	-0.874
Communication channels	0.202	0.102	1.977*
Monitoring And Evaluation	-0.024	0.086	-0.277

Source: (Field Survey, 2011)
* *Significant at 0.1 level Adjusted $R=-0.026$ $R^2=0.105$ Likelihood ratio = 0.105*

$$Y = \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon$$

Where:-

Y = Role of CDF or the satisfaction with the role of the fund on health
X_1 = Level of community involvement
X_2 = Communication channels
X_3 = Monitoring and evaluation
ε = Error term

The unifying equation: -

$$Y = \mathbf{-0.207X_1 + 0.202X_2 - 0.024X_3 + 2.297}$$

The regression analysis in Table 4.20 indicate that communication channels exerted a positive but weak influence on health care service delivery implying that the better the communication channels. the more the improvement of health care service delivery. However. the level of community involvement and monitoring and evaluation negatively and not significantly influenced improvement in health care service delivery. Implying that the lower the level of community involvement and monitoring and evaluation, the less the improvement in health care service delivery

4.6 Summary

This chapter details the data analysis, the interpretation of the findings and presented the findings in frequency tables. The purpose of this chapter is to represent the result of the procedures described in the methods and present evidence in form of tables, text and figures. The data analysis was done on the basis of the study objectives. Moreover, the analysis was done by handling each question in the data collection tool. Descriptive statistics were widely used in the analysis of the data.

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of the major study findings and discussions of the same as well as further detailing the conclusions and suggesting recommendations in line with the study objectives.

5.2 Summary of the Findings

5.2.1 Influence of the Annual CDF Allocation on the Health Care Service Delivery

The study findings show undoubtedly a picture of considerable gains in as far as the role of CDF on health care service delivery is concerned. Health care centres and dispensaries are now closer to the people than before as revealed in Table 4.3. The study also reveals that CDF has played a significant role in the improvement of physical structures as well as increased number of medical personnel as illustrated by Tables 4.4 and 4.5. The increase in the facilities is corroborated by increased wards (50.0 percent), Laboratories (55.2 percent) and the additional personnel (50.0 percent) in the health centres. The dispensaries, have also recorded an increase in the number of the consultation rooms with (66.7 percent) representing an increase of 1 to 3 consultation rooms while 50.0 percent in the laboratories and an equal proportion of additional medical personnel. With regard to infant mortality rate, 54 Percent of the respondents revealed that infant mortality rate had gone down except for 4.5 percent who indicated that infant mortality rate had gone up. There was also a remarkable reduction on the maternal mortality rate as reported by 64.4 percent of the respondents.

5.2.2 The Level of Community Participation in Decision Making to Improve Health Care Service Delivery

The findings of the study revealed that at least a large proportion of respondents are aware of how decisions to fund health care provision projects using CDF are arrived at. This is indicated by 65.0 percent of the beneficiaries and 70.0 percent of the Health Facility Administrators. Nevertheless, a few beneficiaries and health facility administrators said they did not know how the decisions over the same were arrived at. On the other hand, 30.0 percent of the beneficiaries and 20.0 percent of the Health Facility Administrators revealed that they were involved in decision making through the consultative meetings convened at the location level which attracted good attendance from the community members.

5.2.3 Communication channels Used by the CDFC for the Health Care Services Delivery.

This study revealed that chiefs' *barazas* is the major mode of information/communication channel used by the CDFC members as indicated by 24.0 percent of the beneficiaries and 20 percent of the Health Facility Administrators.

5.2.4 Monitoring and Evaluation approaches used by the CDFC on Health Care Service delivery

The study observed that CDFC members did not adequately involve the community in monitoring and evaluation. When asked whether community was involved in monitoring and evaluation, a larger proportion of both beneficiaries and Health Facility Administrator revealed that they were not involved with a significant percentage of CDFC Members noting that they were involved. Notably, this is because the CDF Act grants that it is them who are imperative in undertaking monitoring and evaluation with not involving other stakeholders being an omission offence which often results in poor quality of work and lack of accountability.

5.3 Discussions of the Findings

Health care systems in most constituencies especially the rural areas have been a great challenge as the rural areas are characterized by poor service delivery which is partly linked to lack of resources, both in terms of personnel and capital. In addition, there is usually lack of specialised services. Also people in rural communities often have poorer health status and greater needs for primary health care, yet they are not as well served and have more difficulty accessing health care services than people in urban centres (Romanow, 2002: 197). It is also noted that more often than not, rural areas are faced with the challenge and inability to sustain health care services at accessible locations (Humphreys *et al.,* 1996). Considering this background, it is not surprising that respondents were quick to note the improvements ranging from increased number of wards, laboratories, medical personnel and reduced walking distance to the health care facilities.

The study findings also revealed a marked reduction of infant and maternal mortality. Previous studies particularly on maternal mortality indicate that three main birth-related complications which cause the majority of maternal deaths are haemorrhage, eclampsia and septicaemia (Oyediran; 1987). Similarly, the WHO (1986) indicated that direct obstetric deaths constitute between 50 to 98 percent of all maternal deaths. Towards this end, haemorrhage, infection, toxaemia and obstructed labour are cited as the leading causes of maternal deaths. However, it has been said that between 63 to 80 percent of all maternal deaths could probably have been avoided with proper handling. This makes the provision or the improvements in health care facilities paramount in reducing maternal mortality particularly in the rural setups such as Rangwe constituency. In this regard, the CDF Kitty in the constituency has made a tremendous effort in reducing the ravages of the aforementioned challenges by improving the overall health care facilities.

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The gains so far noted in the study can be attributed to the government policy and partly to its agenda of improving standards of living and the general health of its populace. The constituency development fund was established in 2003 through the CDF act in the Kenya gazette supplement no. 107 (Act no. 11) of 9th January 2004 as a means towards controlling inequality / imbalances in regional development brought about by partisan politics among other things.. Since its inception in 2003, the CDF has benefited many communities, some of which had not felt the government's presence on developmental issues like health care for decades.

Community participation is generally seen as a very vital ingredient of any project and according to Mwabu (2002), beneficiaries may determines the success or failure of any project. He postulates that by involving the community, the development workers stand high chances of identifying the vital needs of the community as well as the solutions to the challenges that could act as stumbling block to the success of their intervention. It is also worth noting from the results that a larger fraction of respondents have heard about CDF courtesy of vibrant media which has done a tremendously good job. More workshops and training have also been carried out which has significantly increased the level of awareness which is very significant in monitoring, evaluation and management of the fund.

From the study, it is notable that knowledge gap still exist as expected of most rural settings therefore, there is still need to enlighten all people concerned. Nonetheless, it was observed that at least some community members (26.8 percent) were involved in decision making. In addition quite a number of respondents revealed that decision were not just made by the community members alone but by 30.7 percent of all the stakeholders. This is linked to the fact that one of the key responsibility of community members is attending meetings convened at the location level, for instance chief's *barazas*, which are usually aimed at identifying and prioritizing community needs/projects to be implemented under CDF. Further more, community

participation in project identification and prioritization is a prerequisite under the CDF Act. This is aimed at ensuring citizen participation through decision-making in project identification, implementation, monitoring and evaluation

The level of participation was also assessed by looking at the number of meetings and the number of people who attended such meetings. A larger proportion of respondents acknowledged that in deed meetings were held, a fact which is further corroborated by the CDF Members. However, there is low level of participation in project implementation by a segment of stakeholders as more than half of the beneficiaries and Health Facility Administrators revealing that they never participated in the implementation of CDF funded health care facilities. This is partially attributed to the socio-economic factors in regards to poverty levels in the constituency as it was observed that for those involved, very few contributed capital, security and even land. A relatively small proportion of respondents however were able to contribute their labour, which is affordable. Kimenyi (2005) attests that social-economic characteristics of a constituency have a bearing on the overall community participation. If for-instance land and capital are needed, very few are likely to contribute on the other hand; many are likely to contribute labour.

This study reveals that the community members were fairly consulted mainly through chiefs' *barazas*, where verbal/oral communication were used and to some extent the media has also been used. These channels are more reliable particularly in the rural set-up. Again unlike memos and notices, it does not require the need to know how to read and therefore able to reach a higher proportion of population. The use of *barazas* has also been favoured for it involves the use of vernacular which is a common mode of communication by a larger fraction of the community. However, the study observes that the use of the three languages (Kiswahili, *Dholuo* and English)

was common in the meetings attended by CDFC Members. Again this could be attributed to their educational levels.

The study further observed that the CDFC members incidentally do not involve the community in monitoring and evaluation. This is attributed to the fact that monitoring and evaluation requires specific technical knowledge which may be missing among most of the beneficiaries and some Health Facility Administrators. The same sentiments have also been shared by Mulwa (2007) who is of the opinion that monitoring and evaluation should be carried out by independent and competent body in a bid to ensure a professional monitoring and evaluation process. In terms of approaches used in monitoring and evaluation, the study revealed that community views are generally accommodated. This is generally the basic principle of beneficiaries' oriented approach to monitoring and evaluation identified by Nunguti (2010). The approach is meant to assess the consequences of the project on the beneficiaries such as whether the project is the right one for the beneficiaries or not

5.4 Conclusion

The study was done to establish the role of the constituency development fund on health care service delivery in Rangwe Constituency. The study has empirically established that the CDF has enabled the constituency to enhance health care service delivery as corroborated by the improved accessibility, increased number of physical facilities like wards or consultation rooms, increased medical personnel as well as the reduced infant and maternal mortality levels. This has been achieved through a combination of the increased amount of allocation and fair management. It therefore follows that the community can witness a major improvement in the health care service delivery with increased funds allocation, absence of misappropriation of funds and proper management of the same. It can also be concluded that sustainability of CDF as tools of decentralized and effective development significantly depends on the level of acceptability by

takeholders. The management of CDF in Rangwe Constituency has really tried to mmodate community participation especially in decision making. However, it is a fact that bers of the community are not welcomed in the technical aspects of monitoring and ation processes. The team has particularly adopted beneficiary approach strategy of toring while it is also apparent that most evaluation has taken the form of internal as sed to external evaluation.

Recommendations

From the findings and conclusions, it is evident that the overall outputs of the CDF funded project depend in a great extent to the amount of funds allocation. There is therefore the need to increase the amount of funds allocation to adequately improve the health care service delivery.

The CDF Advisory Committee should also consider other criteria for allocation of CDF using level of poverty indices, Development needs of constituency, Geographical/Spatial coverage, and Population distribution as this has a direct impact on the costs of services delivery and on the impact of CDF. For instance Rangwe constituency is haunted with high poverty levels and very high disease prevalence rates like HIV and AIDS.

There is also a need to redefine capital development projects that the CDF should support to avoid fragmentation and duplication of projects and ensure coordination and involvement of other development partners such as the NGOs in the constituency. For instance in Rangwe constituency, there are about six dispensaries which have been constructed using CDF but they are in operational since they have to wait for the government to recruit medical personnel to these health facilities

iv. Community participation should also be encouraged particularly in monitoring and evaluation. This would bring a sense of belongings as well as cohesiveness

v. There is need for an establishment of multi-sectoral project committees with broader membership and representation in the constituency for monitoring and evaluation of projects as well as for the accountability in the use of funds. For example the MoH should be fully involved at every level in the implementation of the CDF health care projects and that goes for the other sectors as well.

vi. There is a need to enhance information and communication strategy for purposes of awareness raising and advocacy to garner the constituency and political support for the CDF.

vii. In the systems of monitoring and evaluation, there is a need to simplify monitoring and evaluation guidelines with emphasis on local and self monitoring. This will require empowerment of local community as well as improvement on methods and tools for monitoring by specifying who is to do the monitoring, how it is to be done and the available resources for the task.

5.6 Suggestion for Further Research

The study limited itself to the role of CDF in health care service delivery yet there are other development partners who also support health care service delivery in Rangwe constituency. Therefore, a study should be done to investigate the role which has been played by the other development partners like the NGOs and the churches on health care service delivery in the same constituency. Other studies could also focus on the role that has been played by CDF in the other sectors like in the development of schools, water and youth empowerment in the same constituency.

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APPENDICES

APPENDIX I: QUESTIONNAIRE FOR THE BENEFICIARIES

I am a post graduate student from the University of Nairobi and I am currently carrying out a research on the Role of The Constituency Development Fund on Health Care Services Delivery in Rangwe Constituency, Homa Bay County. I hereby submit my questionnaire/interview guide meant for the purpose of this research study. I kindly request you to answer the questions honestly and objectively. Your responses will be handled with utmost confidentiality and shall solely be used for the purposes of this research. Your cooperation is highly appreciated.

Questionnaire Number..............

PART A: General information

1. Sex a) Male ☐ b) Female ☐
2. Age: a) 18 – 25 years ☐ b) 25 – 50 years ☐ c) Above 50 years ☐
3. Highest Level of education achieved

   Primary ☐ Secondary ☐ College ☐ University ☐
4. Name the health facility closer to you ____________________
5. How far is this health facility from your home? ____________________
6. What type of health facility is it? (Please tick appropriately)

   a) Health centre ☐ b) Dispensary ☐
7. State the administrative division where this health facility is found ____________

PART B: CDF Allocations and Improved Health Care

8. Have you ever heard of CDF?

   a) Yes ☐ b) No ☐
9. If yes how did you come to know about it?

   a) Radio ☐ b) Newspaper ☐ c) Television ☐ d) Internet ☐ e) MOH ☐

   Other specify ____________________
10. Do you know if the health facility closer to you has benefited from CDF in the last five years?

    a) Yes ☐ b) No ☐
11. If yes, what are the types of improvements implemented using the CDF allocations in this health facility

Type of improvement *Number*

i) Wards a) 1 – 3 ☐ b) 3-5 ☐ c) above 5 ☐

ii) Labs a) 1 – 3 ☐ b) 3-5 ☐ c) above 5 ☐

iii) Additional medical personnel a) 1 – 3 b) 3-5 c) above 5

Others specify ______________________________

12. How would you rate the level of infant mortality in the last five years?

a) Low ☐ b) Moderate ☐ c) High ☐

b) What about the maternal mortality rate?

a) Low ☐ b) Moderate ☐ c) High ☐

PART C: Community Participation

13. Do you know how the decisions to improve the health facility using CDF allocation was arrived at?

a) Yes ☐ b) No ☐

14. If yes, who made the decisions?

a) Community ☐ b) MOH ☐ c) MP ☐

d) All Stakeholders ☐ e) CDF Committee ☐ f) Community Leaders ☐

15. Were there meetings held over CDF and its role in this health facility

a) Yes ☐ b) No ☐

16. If yes, how many meetings were they?

a) 1 ☐ b) 2 ☐ c) 3 ☐ d) Above 3 ☐

17. Approximately, how many people attended the meetings?

a) 1 – 10 ☐ b) 11 – 39 ☐ c) 40 – 79 ☐

d) 80 – 150 ☐ e) More than 150 ☐

18. Have you ever participated in the implementation of the improvements in health care service delivery funded by the CDF in this health facility?

a) Yes ☐ b) No ☐

19. If yes, in what ways have you participated?

a) Labour ☐ b) Capital ☐ c) Land ☐ d) Security ☐

Others (specify) ______________________________

20. Was the community consulted about their problems in health care before the implementations were arrived at?

a) Yes ☐ b) No ☐

21. If yes, what was the mode of consultation? ______________________________

22. What factors were considered in the identification of these improvements in the health facility by the CDF?

a) Benefits of the wider community ☐
b) Ability to implement projects within budget, time and specification ☐
c) Ability of the community to sustain the improvements/projects ☐

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d) Pressure of vulnerable groups that require urgent support ☐

PART D: Communication Strategies

23. Do you know how the CDF committee communicates the details of the improvement in the health facility that they have implemented by the CDF to the community?
a) Yes ☐ b) No ☐

24. If yes, what mode do they use to convey this information to the community?
a) Memos ☐ b) Baraza ☐ c) Notices ☐

25. What language is commonly used by the CDF Committee during the communications?
a) Dholuo ☐ b) Kiswahili ☐ c) English ☐ d) All the three ☐

26. Is the language commonly used a problem to the community?
a) Yes ☐ b) No ☐

27. If yes, what is the best language to be used?
a) Dholuo ☐ b) Kiswahili ☐ c) English ☐ d) N/A ☐

28. Are you satisfied with the communication strategies used?
a) Not Satisfied ☐ b) Moderately satisfied ☐ c)Satisfied ☐

PART E: Monitoring and Evaluation

29. Do you know the role of monitoring and evaluation?
a) Yes ☐ b) No ☐

30. If yes, have you ever participated in the Monitoring and Evaluation of the improvement implemented by the CDF in this health facility?
a) Yes ☐ b) No ☐

31. In your opinion, is the CDF committee involving the community in the M&E of the health care service delivery improvement projects?
a) Yes ☐ b) No ☐

32. If yes, how do they involve the community? ______________________________

33. Can you tell whether the M & E team in CDF management has been giving a report after the exercise?
a) Yes ☐ b) No ☐

34. If yes, how many reports have been given that you know of?
a) 1 ☐ b) 2 ☐ c) 3 ☐ d) above 3 ☐

35. Identify the teams that participate in M & E a part from the community.
a) MP ☐ b) CDFC ☐ c) Government officers ☐ d) PNC ☐

36. What has been the frequency of the M & E visits to the health facilities?

a) 1 – 3 ☐ b) 3 – 4 ☐ c) 5 – 10 ☐ d) Above 10 ☐

37. How would you rate the impact of M & E approaches of the CDF team on the improvements done on the health facility?

a) Satisfactory ☐ b) Moderately satisfactory ☐ c)Not satisfactory ☐

38. In your opinion what is the quality of the improvements done by the CDF in the health facility

a) Standard ☐ b) Sub-standard ☐

39. To what extent has the availability of CDF assisted in the improvement of health care service delivery in the last five years?

a) To a great extent ☐ b) Reasonable extent ☐ c) Not at all ☐

40. What is your general view of the CDF on development of health care service delivery?

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Thank you for your valuable time and cooperation!!!

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APPENDIX II: QUESTIONNAIRE FOR THE HEALTH FACILITY ADMINISTRATORS

I am a post graduate student from the University of Nairobi and I am currently carrying out a research on the Role of The Constituency Development Fund on Health Care Services Delivery in Rangwe Constituency, Homa Bay County. I hereby submit my questionnaire/interview guide meant for the purpose of this research study. I kindly request you to answer the questions honestly and objectively. Your responses will be handled with utmost confidentiality and shall solely be used for the purposes of this research. Your cooperation is highly appreciated.

Questionnaire Number..............

PART A: General information

1. Name of the health facility ______________________________
2. What type of health facility is it? (Please tick appropriately)

   b) Health centre ☐ b) Dispensary ☐
3. State the administrative division where this health facility is found

   ____
4. What is your designation in this health facility? a) Doctor, b)Nurse c)Financial comptroller d) Administrator

PART B: CDF Allocations and Improved Health Care

5. Have you ever heard of CDF? a)Yes ☐ b) No ☐
6. If yes how did you come to know about it?

   b) Radio ☐ b) Newspaper ☐ c) Television ☐ d) Internet ☐ e) MOH ☐

   Others specify ______________________________
7. Do you know if this health facility has benefited from CDF in the last five years?

   a) Yes ☐ b) No ☐
8. If yes, state the amount of money received by this health facility from CDF in the last five years

YEAR	AMOUNT (Kshs)
2007	
2008	
2009	
2010	
2011	
TOTAL	

9. State the amount of money received from other sources for the health facility development apart from the CDF the last five years

YEAR	SOURCE(S)	AMOUNT (Kshs)
2007		
2008		

2009		
2010		
2011		
TOTAL		

10. Do you know how this money has been spent? a)Yes ☐ b) No ☐
11. If yes, what are the types of improvements implemented using the CDF allocations in this health facility

Type of Improvement *Number*

iv) Wards a) 1 – 3 ☐ b) 3-5 ☐ c) above 5 ☐

v) Labs a) 1 – 3 ☐ b) 3-5 ☐ c) above 5 ☐

vi) Additional medical personnel a) 1 – 3 ☐ b) 3-5 ☐ c) above 5 ☐

Others *(specify)* ______________________________

12. How would you rate the level of infant mortality in the last five years?

c) Low ☐ b) Moderate ☐ c) High ☐

13. What about the maternal mortality rate? a) Low ☐ b) Moderate ☐ c) High ☐
14. Approximately how many patients do you serve in this health facility in a month?____________

PART C: Community Participation

15. Do you know how the decisions to improve the health facility using CDF allocation were arrived at?

b) Yes ☐ b) No ☐

16. If yes, who made the decisions?

b) Community ☐ b) MOH ☐ c) MP ☐

d) All Stakeholders ☐ e) CDF Committee ☐ f) Community Leaders ☐

17. Were there meetings held over CDF and its role in this health facility a)Yes ☐ b) No ☐
18. If yes, how many meetings were they? a) 1 ☐ b) 2 ☐ c) 3 ☐ d) Above 3 ☐
19. Approximately, how many people attended the meetings?

b) 1 – 10 ☐ b) 11 – 39 ☐ c) 40 – 79 ☐ d)80 – 150 ☐ e) More than 150 ☐

20. Have you ever participated in the implementation of the improvements in health care service delivery funded by the CDF in this health facility? a) Yes b) No
21. If yes, in what ways have you participated? a)Labour b) Capital c) Land

d)Security e) Others (*specify*)

22. Were you consulted about the healthcare problems of the community who are the beneficiaries of this health facility? a) Yes b) No

23. If yes, what was the mode of consultation?______________________________

24. What factors were considered in the identification of these improvements in this health facility by the CDFC?
    e) Benefits of the wider community
    f) Ability to implement projects within budget, time and specification
    g) Ability of the community to sustain the improvements/projects
    h) Pressure of vulnerable groups that require urgent support

PART D: Communication Strategies

25. Do you know how the CDF committee communicates the details of the improvements in this health facility to the community? a)Yes b) No

26. If yes, what mode do they use to convey this information to the community?

    a) Memos b) Barazas c) Notices

27. What language is commonly used by the CDF Committee during the communications?

    b) Dholuo b) Kiswahili c) English d) All the three

28. Is the language commonly used a problem to the community? a)Yes b) No

29. If yes, what is the best language to be used? a)Dholuo b) Kiswahili c) English d) N/A

30. Are you satisfied with the communication strategies used? a) Not Satisfied b)Moderately satisfied c)Satisfied

PART E: Monitoring and Evaluation

31. Do you know the role of monitoring and evaluation in health care service delivery? a)Yes

    b) No

32. If yes, have you ever participated in the Monitoring and Evaluation of the improvements implemented by the CDF in this health facility? a)Yes b) No

33. If yes, briefly explain how you have participated? ______________________________

    ____

34. In your opinion, is the CDF committee involving the community in the M&E of the health care service delivery improvement projects? Yes b) No

35. If yes, how do they involve the community?

    ____

36. Can you tell whether the M & E team in CDF management has been giving a report after the exercise? a)Ye b) No

37. If yes, how many reports have been given that you know of?

    b) 1 b) 2 c) 3 d) above 3

38. Identify the teams that participate in M & E a part from the community.

    a) MP b) CDFC c) Government officers d) PNC

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39. What has been the frequency of the M & E visits to the health facilities?

b) 1 – 3 ☐ b) 3 – 4 ☐ c) 5 – 10 ☐ d) Above 10 ☐

40. How would you rate the impact of M & E approaches of the CDF team on the improvements done on the health facility? Satisfactory b) Moderately satisfactory c)Not satisfactory

41. In your opinion what is the quality of the improvements done by the CDF in the health facility a) Standard b) Sub-standard

42. To what extent has the availability of CDF assisted in the improvement of health care service delivery in this health facility in the last five years?

b) To a great extent ☐ b) Reasonable extent ☐ c) Not at all ☐

43. What is your general view of the CDF on development of health care service delivery?

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Thank you for your valuable time and cooperation!!!

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APPENDIX III: QUESTIONNAIRE FOR THE CDF COMMITTEE MEMBERS

I am a post graduate student from the University of Nairobi and I am currently carrying out a research on the Role of The Constituency Development Fund on Health Care Services Delivery in Rangwe Constituency, Homa Bay County. I hereby submit my questionnaire/interview guide meant for the purpose of this research study. I kindly request you to answer the questions honestly and objectively. Your responses will be handled with utmost confidentiality and shall solely be used for the purposes of this research. Your cooperation is highly appreciated.

Questionnaire Number...............

PART A: General information

41. Sex a) Male ☐ b) Female ☐
42. Age a)18 – 25 years ☐ b) 25 – 50 years ☐ c) Above 50 years ☐
43. Highest Level of education achieved a) Primary ☐ b) Secondary ☐ c) College ☐ d) University ☐
44. What is your designation in the CDF Committee?______________________________

PART B: CDF Allocations and Improved Health Care

45. What is you level of understanding of the purposes of the CDF? a) Good b) Fair c) Poor
46. Please give reasons for your answer____

---

47. Do you know the type of projects CDF is supposed to fund? a)Yes ☐ b) No ☐
48. If yes, which ones are they?____
49. State the criteria used by the CDFC to allocate funds to a project?____________________
    - a) Lack of facility ☐
    - b) Political Influence/decision by the area MP ☐
    - c) The community priority needs ☐
    - d) Pressure from vulnerable groups that require urgent support ☐
50. Do you know if CDF has been allocated to health care service delivery in this constituency?
    a)Yes ☐ b) No ☐
51. If yes, state the amount of money allocated to health care service delivery in this constituency by the CDFC in the last five years

YEAR	AMOUNT (Kshs)
2007	
2008	
2009	

2010	
2011	
TOTAL	

52. Do you know how this money has been spent? Yes ☐ b) No ☐

53. If yes, name some of the health facilities in the constituency which have benefited from the CDF allocations and the improvements implemented using the same

NAME OF THE FACILITY	TYPE OF IMPROVEMENT	NUMBER

PART C: Community Participation

54. Do you know how the decisions to improve the health care facilities using CDF allocation were arrived at? Yes ☐ b) No ☐

55. If yes, who made the decisions?
    c) Community ☐ b) MOH ☐ c) MP ☐
    d) All Stakeholders ☐ e) CDF Committee ☐ f) Community Leaders ☐

56. Were there meetings held over CDF and its role in these health care facilities?
    a) Yes ☐ b) No ☐

57. If yes, how many meetings were they?
    b) 1 ☐ b) 2 ☐ c) 3 ☐ d) Above 3 ☐

58. Approximately, how many people attended the meetings?
    c) 1 – 10 ☐ b) 11 – 39 ☐ c) 40 – 79 ☐ d) 80 – 150 ☐ e) More than 150 ☐

59. As the CDFC, do you normally consult the community members during the decision making process to improve on the health care service delivery? a) Yes ☐ b) No ☐

60. If yes, what is the mode of consultation? ______________________________

PART D: Communication Strategies

61. Do you know how the CDFC communicates the details of the improvements in the health care facilities to the community? Yes ☐ b) No ☐

62. If yes, what mode is normally used to convey this information to the community?
    a) Memos ☐ b) Barazas ☐ c) Notices ☐

63. What language is commonly used by the CDF Committee during the communications?
    c) Dholuo ☐ b) Kiswahili ☐ c) English ☐ d) All the three ☐

64. Is the language commonly used a problem to the community? a)Yes ☐ b) No ☐

65. If yes, what is the best language to be used? A) Dholuo b) Kiswahili c)English ☐
    N/A

66. Are you satisfied with the communication strategies used? a)Not Satisfied
b)Moderately satisfied c)Satisfied

PART E: Monitoring and Evaluation

67. Do you know the role of monitoring and evaluation in the CDF funded projects
a) Yes ☐ b) No ☐

68. If yes, have you ever participated in the Monitoring and Evaluation of the improvements implemented by the CDF in the health care facilities in the constituency? a)Yes
b) No

69. If yes, briefly explain how you normally conduct the M&E process? ______________

70. In your opinion, is the CDF committee involving the community in the M&E of the health care service delivery improvement projects? a) Yes ☐ b) No ☐

71. If yes, how do they involve the community?

____

____

72. Can you tell whether the M & E team in CDF management has been giving a report after the exercise? a) Yes b) No

73. If yes, how many reports have been given by the CDF committee that you know of?
c) 1 ☐ b) 2 ☐ c) 3 ☐ d) above 3 ☐

74. Identify the teams that participate in M & E a part from the CDFC?
a) MP ☐ b) Community ☐ c) Government officers ☐ d) PNC ☐

75. What has been the frequency of the M & E visits to the health facilities?
c) 1 – 3 ☐ b) 3 – 4 ☐ c) 5 – 10 ☐ d) Above 10 ☐

76. How would you rate the impact of M & E approaches of the CDFC on the improvements done on the health facilities?
b) Satisfactory ☐ b) Moderately satisfactory ☐ c)Not satisfactory ☐

77. In your opinion what is the quality of the improvements done by the CDFC in the health facilities in the last 5 years? a)Standard b) Sub-standard

78. To what extent has the availability of CDF assisted in the improvement of health care service delivery in this health facility in the last five years?
c) To a great extent ☐ b) Reasonable extent ☐ c) Not at all ☐

79. What is your general view of the CDF on development of health care service delivery in the consituency?

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Thank you for your valuable time and cooperation!!!

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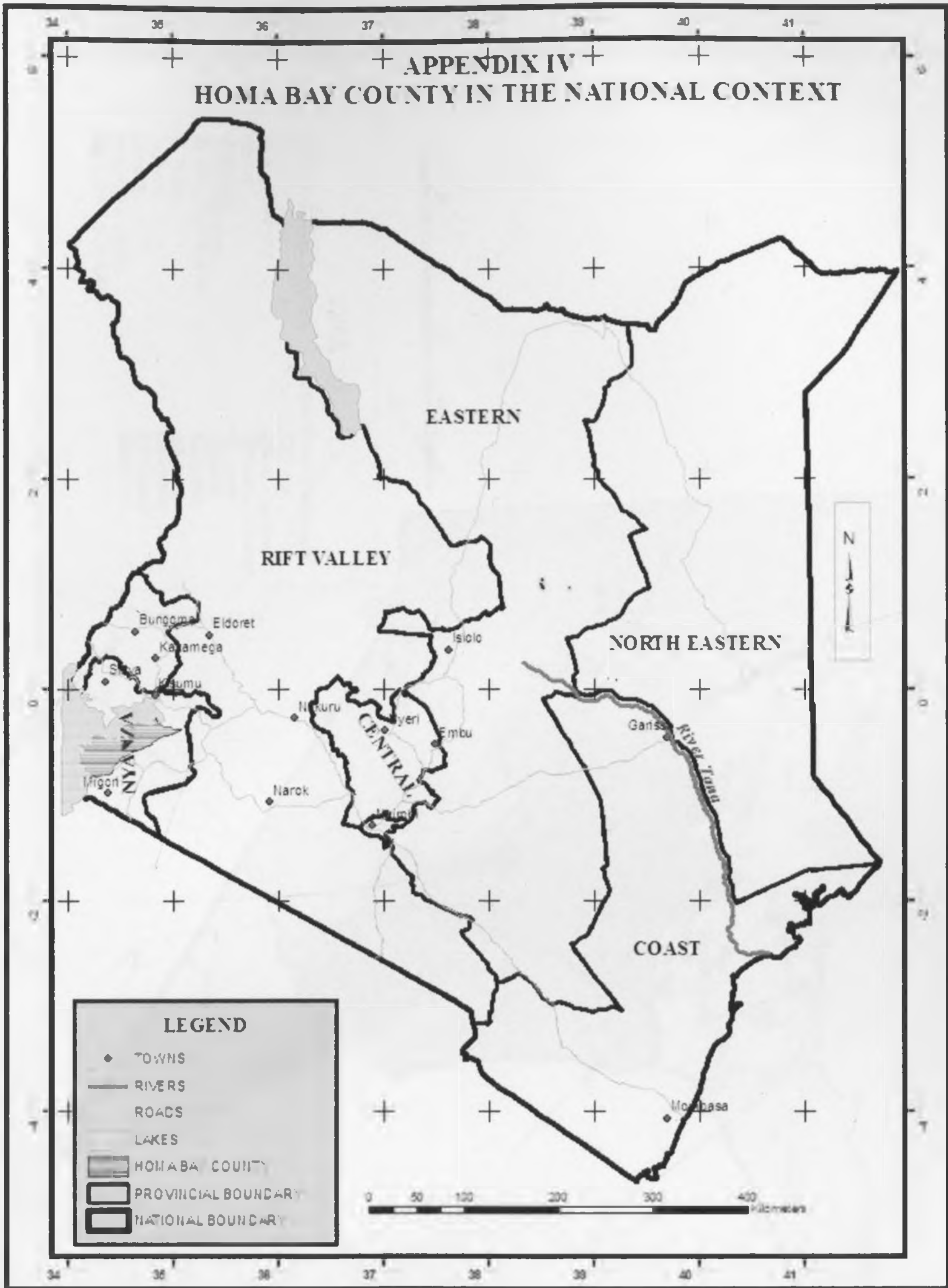
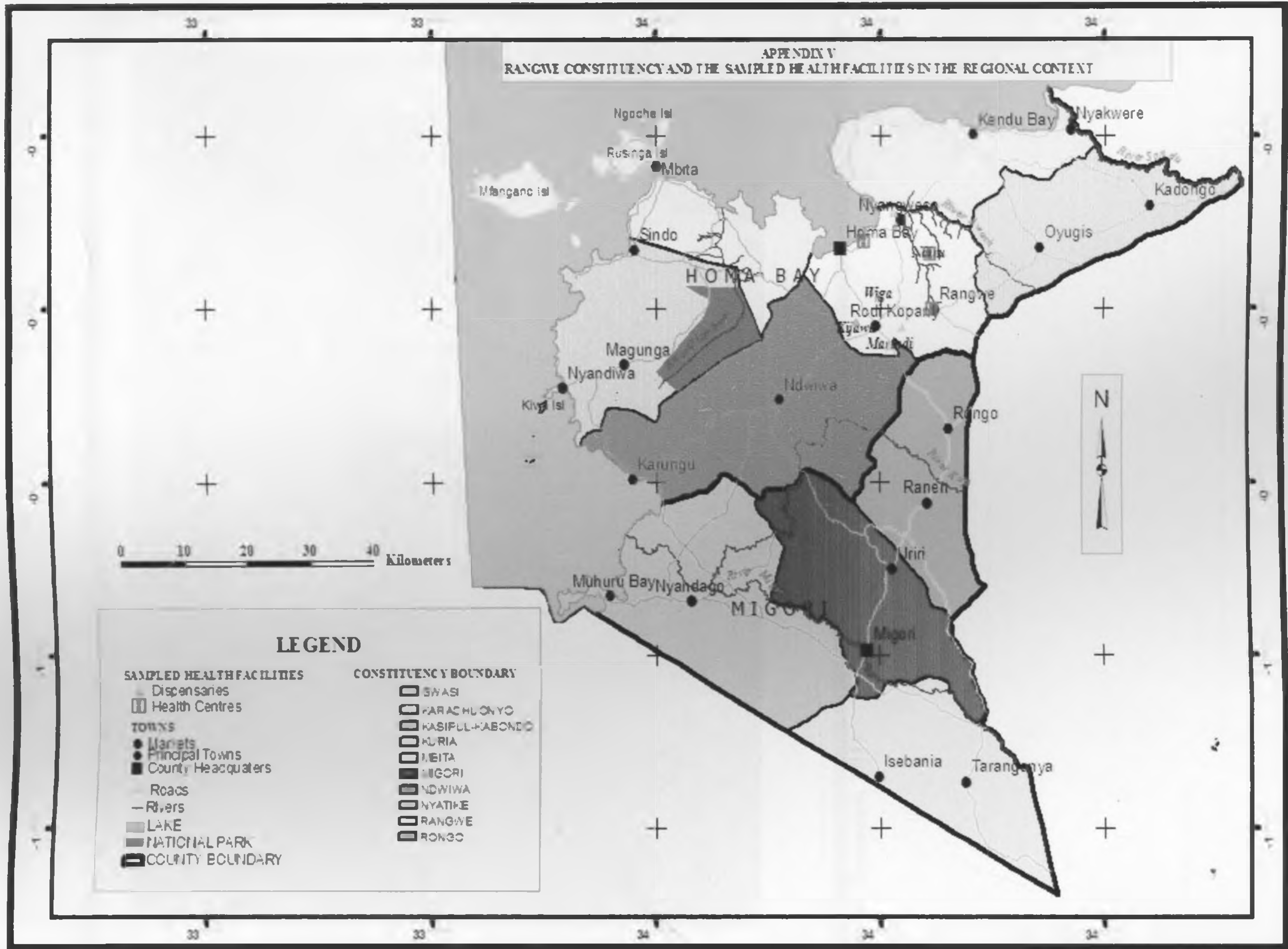
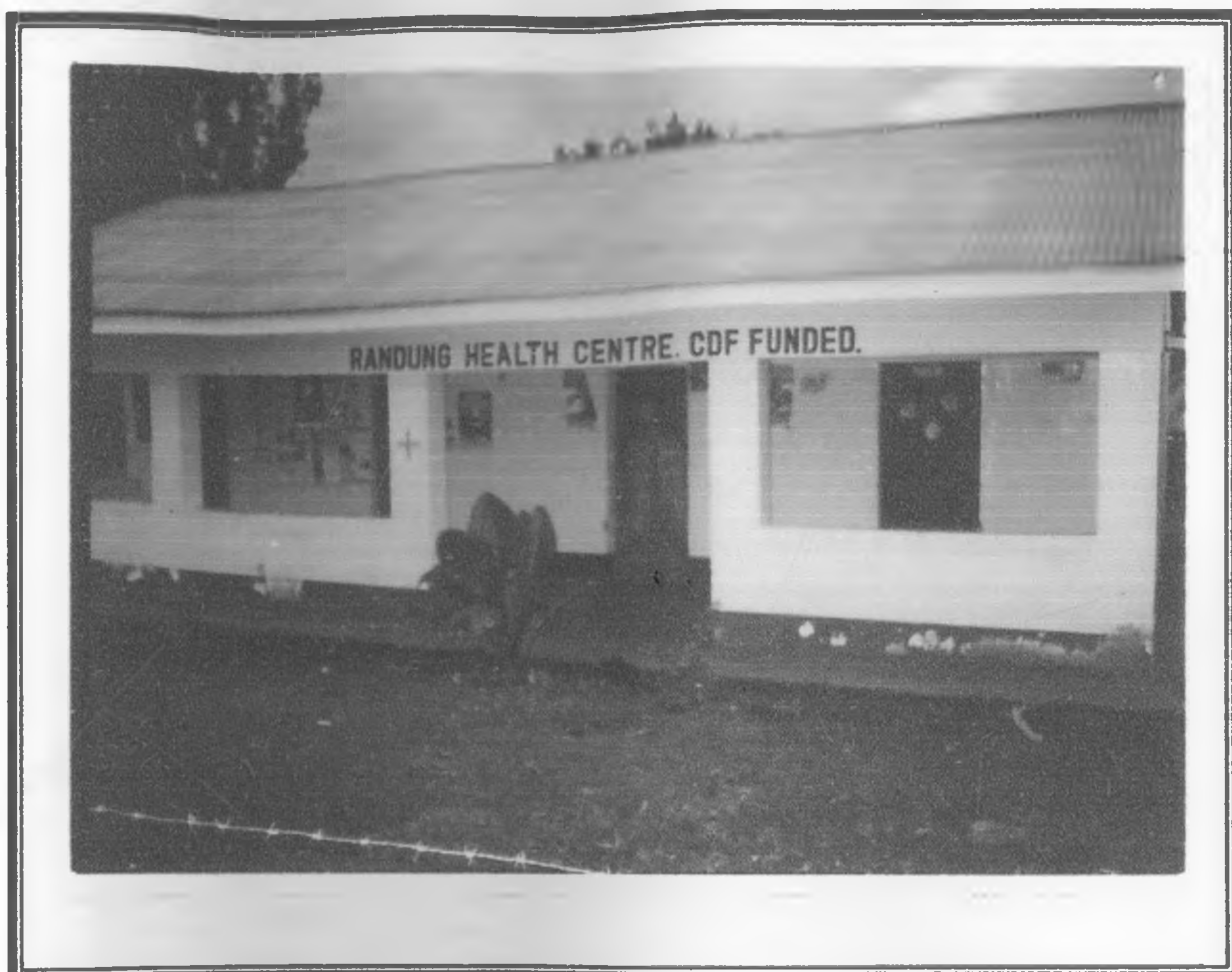

APPENDIX IV
HOMA BAY COUNTY IN THE NATIONAL CONTEXT
EASTERN
RIFT VALLEY
NORTH EASTERN
CENTRAL
NYANZA
COAST
Eldoret
Isiolo
Narok
Embu
Garissa
River Tana
LEGEND
TOWNS
RIVERS
ROADS
LAKES
PROVINCIAL BOUNDARY
NATIONAL BOUNDARY


APPENDIX V
RANGWE CONSTITUENCY AND THE SAMPLED HEALTH FACILITIES IN THE REGIONAL CONTEXT
Ngoche Isl
Rusinga Isl
Mbita
Mfangano Isl
Kendu Bay
Nyakwere
Kadongo
Oyugis
Sindo
Homa Bay
HOMA BAY
Rangwe
Rodi Kopany
Magunga
Nyandiwa
Ndiwa
Rongo
Karungu
Ranen
Uriri
Muhuru Bay
Nyandago
MIGORI
Migori
Isebania
Tarangenya
N
0 10 20 30 40 Kilometers
LEGEND
SAMPLED HEALTH FACILITIES
Dispensaries
Health Centres
TOWNS
Markets
Principal Towns
County Headquaters
Roads
Rivers
LAKE
NATIONAL PARK
COUNTY BOUNDARY
CONSTITUENCY BOUNDARY
NDIWA
NYATIKE
RANGWE
RONGO
MIGORI

APPENDIX VI:

RANDUNG HEALTH CENTRE AS AN EXAMPLE OF CDF FUNDED PROJECT



Source: (Researcher, 2011)

APPENDIX VII: PUBLIC HEALTH FACILITIES IN THE CONSTITUENCY

	Health Facility	Category of the Facility	Division
1.	Homa-Bay	District Hospital	Asego
2.	Marindi	Health Centre	
3.	Wiga	Dispensary	
4.	Lavemp	Dispensary	
5.	Miniambo	Dispensary	
6.	Obunga	Dispensary	
7.	Nyalkinyi	Dispensary	
8.	Kisawa	Dispensary	
9.	Randung'	Dispensary	Rangwe
10.	Obwanda	Dispensary	
11.	Nyamasi	Dispensary	
12.	Rangwe	Health Centre	
13.	Oneno	Dispensary	
14.	Kager	Dispensary	
15.	Gongo	Dispensary	
16.	Nyagoro	Health Centre	
17.	Ngegu	Dispensary	
18.	Ndiru	Health centre	
19.	Manyatta	Dispensary	
20.	Rariw	Dispensary	

Source: (Researcher, 2011)

Sampled Health Facilities for the Study

	Health Facility	Category of the Facility	Division
1.	Marindi	Health Centre	Asego
2.	Wiga	Dispensary	
3.	Nyalkinyi	Dispensary	
4.	Kisawa	Dispensary	
5.	Rangwe	Health Centre	Rangwe
6.	Obwanda	Dispensary	
7.	Randung'	Dispensary	
8.	Ndiru	Health Centre	
9.	Kager	Dispensary	
10.	Ngegu	Dispensary	

Source: (Researcher, 2011)