

# The Role of Constituency Development Fund in Rural Development: Experiences from North Mugirango Constituency, Kenya

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**Abstract:** *Fighting poverty at the grassroots level has been one of the key agendas of the Kenyan government. Since independence in 1963, the government has initiated various rural development programmes including Special Rural Development Programme, District Development Planning, Rural Development Fund and the District Focus for Rural Development Strategy with the aim of improving people's wellbeing. However, most of these programmes failed to address the needs of local people due to lack of political will, inadequate government funding, lack of appropriate technology, neglect of institutional development, lack of beneficiary participation and poor coordination from top to the bottom. However, in 2003 the government introduced Constituency Development Fund (CDF), a program that fights poverty at the grassroots. Since its inception, CDF has had tremendous impact among the rural communities in Kenya. This paper argues that the success of CDF as a rural poverty alleviation strategy is not only associated with availability of funds, but also with a myriad of factors, which include, beneficiary participation and involvement and consultative decision making among all parties involved, prioritizing needs by the locals through consultations and effective communication, good leadership and coherent and transparent phase-out plans. The authors conclude that rural development programs are integral in improving the lives of people in the rural settings. Therefore, these programmes should be put at the top of the national agenda by the government. They should be fundamental to all national and rural policies that mitigate underdevelopment. The paper recommends that government should consider allocating more resources particularly to infrastructure such as roads to ensure that rural areas are easily accessible by all stakeholders who want to participate in rural development. In addition, there should be independent structures at the grassroots to track the progress of development projects as well as discourage misappropriation and mismanagement of CDF funds.*

**Keywords:** CDF, Rural Development, North Mugirango, Kenya

## 1. Introduction

Extreme poverty in the world has decreased considerably in the past three decades. However, 1.2 billion people are still living in extreme poverty (Olinto & Uematsu, 2010). This has affected development in most developing countries and core institutions in the society such as health and education have been adversely affected. Poverty is not only an evil in itself, but sustainable development requires meeting the basic needs of all and extending to all the opportunity to fulfill their aspiration for a better life. A world in which poverty is endemic will always be prone to ecological and other catastrophes (WCED, 1987).

Working with poor people to tackle poverty must continue to be the priority in sustainable development, and will require special resource. As noted by Mega, (1996:77), there is nothing more unequal than the equal treatment of unequal...Social justice must be seen as a precondition for sustainable development. This requires recognition that poverty is not just a problem for poor people, and there is no reason why poor people have to be separated out from the rest of the community in tackling poverty and its many implications (Warburton, 1998). This implies that poor people have to be involved in the development of their communities. According to Todaro, (2000), development means the capacity of a national economy, whose initial economic condition has been more or less static for a long

time, to generate and sustain an annual increase in its Gross National Product (GNP) at rates of perhaps 5% to 7% or more. However, most developing countries are not able to achieve development due to their deteriorating economies. Further, studies indicate that in many instances the poor have not been involved or benefited from the national economies, they may have suffered absolute loss during early stages of national development (Irma, 1975).

Development aims at changing social structures, popular attitudes, and national institutions as well as the acceleration of economic growth, reduction of inequality and the eradication of poverty. In improving the socio-economic conditions of people in a country, development has to focus in all sectors/institutions in the society both in urban and rural settings. In response there has been growing interest in new approaches to national development intended to bring the poor more rapidly into full participation in development decisions, implementation and benefits (UNESCO, 1975).

It is worthwhile to note that rural development actions are aimed at developing social and economic development of the rural areas (Chigbu, 2012). It also aims at finding the ways to improve the rural lives with participation of the rural people themselves so as to meet the required needs of the rural areas (Moseley, 2003). Since most of the problems in rural societies are rooted in systemic maladjustments in the social structure and social institutions, the local people

themselves have to participate in their development for sustainability. According to WCED, (1987), humanity has the ability to make development sustainable by ensuring that it meets the needs of the present without compromising the ability of the future generations to meet their own needs.

According to Wade, (1989), participation allows fuller access to benefits of a democratic society. Cook (1975) notes that citizen participation can legitimize a program, its plans, actions, and leadership. Legitimization can often mean the difference between success and failure of community efforts. Unsupported leaders often become discouraged and drop activities that are potentially beneficial to community residents. Voluntary participation can also reduce the cost for personnel needed to carry out many of the duties associated with community action.

Rural development is also enhanced when the resources are decentralized and the local people are empowered to access and utilize those resources. According to Chambers, (1993), decentralization and empowerment enable local people to exploit the diverse complexities of their own conditions, and to adapt to rapid change as they generate their own innovations, and find their own solutions, and determine their own pathways.

Since independence, in order to uplift the living standards of people living in the urban and rural settings, the government of Kenya has attempted to enhance wellbeing of citizens through establishment of various development strategies which include the majimbo (devolution) system (1963), District Development Grant Program (1966), The Special Rural Development Program (1969/70), District Development Planning (1971), Rural Development Fund Kenya, and The District Focus For Rural Development Strategy (1983/84).

Most of these programmes failed to bring development in the rural areas except the CDF. Their inability is attributed to failures of the Rural Development Policies. For instance, government line ministries were perceived as inefficient, technically incompetent, understaffed and philosophically conservative and unable to implement the necessary programmes. In addition, financial arrangements for implementing rural development programmes were also problematic and characterized by excessive delays in the release of funds and lack of counter-part funding from local agencies, both of which severely retarded project implementation.

The government launched one of the most successful programmes called Constituency Development Fund (CDF) in 2003 through the CDF Act in the Kenya Gazette Supplement No. 107 (Act No.11) of 9th January 2004. The fund comprises an annual budgetary allocation equivalent to 2.5% of the government's ordinary revenue. Seventy five percent (75%) of the fund is allocated equally amongst all 210 constituencies. The remaining twenty five percent (25%) is allocated as per Constituency poverty levels. CDF is managed through 4 committees, 2 of which are at the national level and 2 at the grassroots level (KIPPRA, 2007). The current budgetary allocation of these funds is about 110 million US dollars a year and with 210 constituencies in Kenya, each of them gets 524,000 US dollars annually. The

fund aims to control imbalances in regional development brought about by partisan politics. It targets all Constituency level development projects, particularly those aiming to combat poverty at the grassroots and to relieve members of parliament from the heavy demands of fund-raising for projects which ought to be financed through the Consolidated Fund (Chweya, 2006). Since it was introduced, CDF has made a great impact, with numerous CDF projects coming up throughout the country (Gikonyo, 2008). Further, the initiated development projects at grassroots level have led to significant rise in wellbeing of citizens of Kenya (GoK, 2006).

Unlike other development funds that filter from the central government through larger and more layers of administrative organs and bureaucracies, funds under this program go directly to local levels. Thus, provide people at the grassroots the opportunity to make expenditure decisions that maximize their welfare through establishing development projects among the health and educational programs which are perceived as the main challenge facing community development since independence (Kimenyi, 2005). It is within this background, the authors seek to explore the role of Constituency Development Fund on rural development with specific focus on health and education institutions. It also investigates the extent to which these services are available and accessible by rural people at the grassroots.

## 2. Research Methodology

This paper is an outcome of the research that was conducted in North Mugirango Constituency in Nyamira County. The Constituency has thirteen wards. It borders West Mugirango and Kitutu Masaba on the west, Kasupul Kabondo to the north, Nyaribari Masaba to the south and Belgut and Sotik constituencies to the east. The climatic conditions in this area are hot and wet and the major economic activity is farming of crops such as tea, coffee, bananas, corn, and arrowroots.

The study employed quasi-experimental research design to yield qualitative and quantitative data required to answer research hypothesis using questionnaire and interviews. The design was suitable for this study because it involves introduction of a stimulus or intervention to a phenomena and testing resulting changes in the phenomenon. Therefore, literacy and health state in the Constituency before the introduction of CDF in 2003 is a phenomenon, CDF is stimulus or intervention, and the resulting impact is the change measured (a post test). The rationale for choosing the area of study is the fact that the Constituency is one of the underdeveloped areas in Kenya with high rates of poverty.

This paper focuses on the findings of objective three of the study, which sought to establish the role of Constituency Development Fund on social development. The paper critically emphasizes on the extent CDF has impacted on the lives of rural people. It delves on availability and accessibility of health and education institutions before and after the introduction of CDF and the extent of health and education availability and accessibility by the residents. The paper concludes by giving recommendations to the

government and other relevant stakeholders for policy decisions.

### 3. Findings and Discussions

#### 3.1 Availability and Accessibility of Health Institutions before Introduction of CDF

The study sought to find out the health status of the respondents in the constituency before and after introduction of CDF in 2003 by taking into consideration distance to health facility, buildings, drugs, ambulance services, medical equipment and machines, and health workers in hospitals. The respondents were asked to say whether they have a health facility (government hospital/dispensary) in their locality and indicate the distance to that facility. Sixteen percent (16% of the respondents said that there were health facilities whereas 84% asserted that there were no such facilities in their locality. This indicates that most people in the Constituency could not access health services in public hospitals, which were not present before introduction of CDF. During illnesses, the respondents could walk long distances to access treatment. To seek more information on health status of the residents, the respondents were asked to mention the distance to the nearest government dispensary or hospital from their homes before introduction of CDF. The responses were as shown in Table 1 below:

**Table 1:** Distance to Nearest Health Facility before 2003

Distance Covered	Frequency	Percent	Cumulative Percent
0-5 km	31	11.9	11.9
5-10 km	25	9.6	21.5
10-15 km	49	18.8	40.4
15-20km	40	15.4	55.8
Above 20 km	115	44.2	100
Total	260	100	

Analysis in Table 1 above indicates that majority 44.2 % of the respondents walked long distance (above 20 km) to access health centre's for treatment. In addition, 15.4% walked between 15-20 km, those who walked between 10-15km constituted 18.8% followed by 9.6% who walked distance between 5-10km and only (11.9%) of the respondents walked between 0-5km. The above analysis indicates that most residents in the Constituency had to access government health facilities by walking long distances (more than 20km). During key informant interviews, it was noted that the low number of government health facilities and high number of patients led to long queues of patients in the facilities. Thus, most patients took long time before accessing treatment.

The study also established that health facilities were not enough in the Constituency. These facilities also did not provide comprehensive health care because they had insufficient space for wards, consultation, injection, and space to install important medical equipment. Therefore, inadequate buildings posed a great challenge in health sector in the Constituency before initiation of CDF in 2003.

Availability of drugs in health facilities was another measure of health status of the residents of the Constituency.

According to 80% of the respondents, drugs in the facilities were not enough whereas 20% of the respondents said that drugs in health facilities before initiation of CDF in 2003 were adequate. This shows that apart from walking long distances to seek medication, residents did not access adequate treatment in health facilities, which may have led to many health challenges and death of some patients while seeking medication. One of the respondents noted that: "...sometimes we are required to buy drugs from private chemists for treatment in public health facilities (Female, 28 years)."

The study revealed that there were few health practitioners attending to patients. This was reported by 81.5% of the respondents. This implies that most health challenges among the residents in the Constituency were not addressed. Only 19.5% argued that health practitioners were enough to attend to patients. Every public hospital in Kenya needs to have ambulance services in attending to emergency cases of patients. However, during the study majority (91.5%) of the respondents said that ambulance services lacked in hospital facilities whereas 8.5% of respondents said that there existed ambulance services before the introduction of CDF. This means that in case of sickness, residents could look for their own means of transport to take the sick to hospitals. The services did not have first aid equipment in them and this could lead to death of some patients before they get to hospitals.

On medical equipment and machines in the health centre's, 67.7% of the respondents said that there are no medical equipment and machines while 32.3% said that they were available in hospitals. This means that most of the health facilities had inadequate medical equipment and machines. In a nutshell, the health status of residents in the Constituency, were poor before the introduction of CDF. The public health facilities available by that time did not have adequate building/structures, health workers, drugs, and ambulance services to facilitate service delivery to the residents of the Constituency.

#### 3.2 Rating Health Care Services in Health Facilities before 2003

Respondents were required to rate the services provided in government health centre's in the Constituency before CDF was introduced in 2003. Table 2 below gives summarizes their responses.

**Table 2:** Rating health care services in health facilities before 2003

Responses	Frequency	Valid Percent	Cumulative Percent
Very Good	4	1.5	1.5
Good	80	30.8	32.3
Poor	140	53.8	86.2
Very Poor	36	13.8	100
Total	260	100	

According to Table 2 above, 66.4% of the respondents said that before introduction of CDF in 2003, the services provided in health centre's were poor. This is when the respondents who argued that the services were both poor and very poor are summed up. The reasons for such responses, is attributed to insufficient buildings from, which medical

services could be provided, inadequate drugs, health workers, ambulance services, and medical equipment in the hospitals. The other reason was congestion in the health facilities due to coverage of a large catchment area. Further, 30.8% of the respondents said that health services were good and only 1.5% of the respondents said that the services offered in health centre's been very good. However, those respondents who asserted that the services provided were good, that is, 30.2% and 1.5% can be attributed to their proximity of the residents to health facilities. Additionally they are economically well off to afford drugs in pharmacies for injections in the hospitals. They also accessed the health facilities easily since such institutions were not very far from their locality and/or they knew health practitioners who offered them preferential treatment.

#### 4. Health Status of Residents in After the Introduction of CDF in 2003

To establish the role of CDF on health status of people in the Constituency, the study sought to establish whether there are enough health facilities, buildings/structures, health workers, drugs, ambulance services, medical equipment and machines in government health centre's after the introduction of CDF.

The study was interested to establish from the respondents if the health facilities are available and accessible after the introduction of CDF. Majority (77.3%) of the respondents argued that currently, there are public health facilities in their locality. This means that after the introduction of CDF, most people in the Constituency are accessing medical services. This is due to the increase in numbers of public health facilities in the rural areas from 15.5% to 57.3% before and after initiation of CDF respectively. However, 22.7 % said that they do not have a health facility despite government allocation of CDF funds to each Constituency. This suggests that people in the area nowadays have easy access to services in public facilities compared to the period before 2003. Interviews with key informants revealed that most of the projects initiated by CDF were participatory and involved all people in the community hence their success. As noted by Heberlein, (1976), public participation and involvement in community projects results in better decisions. Community decisions that involve citizens are more likely to be acceptable to the local people.

On the distance to the nearest health centre after introduction of CDF in 2003, 77.3% of respondents asserted that such centre's are between 0-5 km away from their village, and that 22.7% of the respondents said that the centre's are 5-10 km away. This implies that since the introduction of the CDF, health facilities have been established at the Constituency level. Even though the ministry of health had established some health facilities, it was evident that most health centre's were initiated with the CDF to complement those established by the national government. Therefore, the distance to health facilities in the area had reduced drastically.

After the introduction of CDF, majority (56.2%) of respondents said that they now have enough buildings in health facilities to accommodate patients whereas 43.8 % said that the buildings are not adequate. This means that after introduction of CDF, some funds from the kitty have

been utilized to build more building structures in public health facilities. If we compare the responses on the unavailability of structures in health facilities before and after 2003 (that is 64.6% and 56.2%) it can be concluded that buildings in health centre's in the Constituency have increased by 8.4% implying that the funds have been used to build new structures. Therefore, wards, offices and consultation rooms are currently available in public health centre's thus, has improving service delivery.

On drugs in health facilities, 53.5% of the respondents said that there are enough drugs in hospitals after 2003 compared to 46.5% who asserted that there are insufficient drugs in health centre's even after funds from the kitty are available in improving the living standards of people in the Constituency. This suggests that initial challenge of drug unavailability in public health facilities has reduced compared to the period before 2003 due to utilization of CDF and government efforts to supply medicines in established public hospitals. Thus, there is decrease drug unavailability responses from 80% (before 2003) to 46.5% (after 2003) implying that health status of people in the Constituency has improved due to availability of drugs in the health centre's.

On health practitioners, 57.3% of the respondents argued that since introduction of CDF, public health facilities have enough health practitioners whereas 42.7% said that still the public health institutions are experiencing shortage of health workers. This makes it difficult for the residents to access health services from the available health facilities. Compared to initial responses on adequacy of health workers in public health facilities in 2003, there is a drastic increase in the number of professionals, that is, from 18.5% to 57.3% after introduction of the CDF. The rise in the number of health workers in public health facilities is attributed to CDF policy of employing health workers at the Constituency level to offer services to people.

During the study, majority (77.7%) of the respondents revealed that there are no ambulance services even after introduction of the fund in 2003 whereas 22.3% of respondents asserted that ambulance services in public health facilities are available after introduction of CDF. The reason for few ambulance services is due to the capacity of health facilities, which are mostly small and do not handle complex health cases or the facilities are in remote areas where there are no roads. Compared to initial response on availability of ambulance services in 2003, it is evident that there is slight positive change in ambulance services in public health facilities, that is, from 8.3% before introduction of CDF to 22.3% after the funds were available to constituencies.

On medical equipment and machines, 56.5% of respondents said that the facilities are currently available in the health facilities whereas 43.5% asserted that still there are no such equipment and machines in public health facilities. This means that since the introduction of CDF, the number of machines and equipment in government health facilities has increased by 13.3% (from 42.3% to 56.5%) and this can also be attributed to the government efforts to improve health services in the country thus, buying such important facilities in all public hospitals. In a nutshell, since 2003, health status

seems to have improved due to increase in number of building/structures, health workers, medical equipment and machines and drugs in health facilities. Although ambulance services still lack in hospitals the services offered is better than the one offered before 2003.

The study was also interested to understand how residents of the Constituency perceive health services provided in government health facilities in the Constituency since the introduction of CDF. The responses are summarized in Table 3 below.

**Table 3:** Rating of health services in the constituency after introduction of CDF

Responses	Frequency	Valid Percent	Cumulative Percent
Very Good	34	13.1	13.1
Good	170	65.4	78.5
Poor	55	21.2	99.6
Very Poor	1	0.4	100
Total	260	100	

As shown in Table 3 above, 65.4% and 13.1% of the respondents were of the view that the services offered in health facilities are good and very good, respectively. However, 21.2% of the respondents maintained that the services were poor and only 0.4% of the respondents argued that the services offered in the facilities are very poor, The data (when 13.1% and 65.4% are combined) indicates that health services offered in government health facilities has improved since the introduction of CDF in 2003. This is due to increase in the number of the health facilities, employment of more health workers in the Constituency based in public hospitals and presence of modern equipment and machines in government health facilities in the Constituency. On the contrary to the argument that CDF has not improved health services in the area of study, it is attributed to insufficient and poor infrastructure (buildings and roads) in the rural areas, lack of ambulance services and insufficient drugs in the health facilities as discussed above.

Respondents were asked to identify other stakeholders in health who have been influential in the development of the health sector in the Constituency. It was revealed that other than the government, there exist other stakeholders in the health sector in the area of study which include tea estates, churches and Non-Governmental Organizations such as World Vision, Care International, and Walter Reeds organizations. Apart from supporting religious medical institutions with medical facilities, drugs, and even payments of salary for the staff, the organizations also settle medical bills for the poor people from the region admitted in national, provincial and district hospitals in the country.

The tea estates in the Constituency include Ng’oina, Keritor, Kepkebe, and Sotik, which have own hospitals that offer medical care to their staff and this extends to the people in the surrounding neighborhoods who pay for the services. More often than not, churches in the region have also established health centre’s to cater for medical needs of community members. The most cited religious institutions with health facilities include Seventh Day Adventist, Catholic, and Lutheran churches. Medical practitioners employed or not employed by the government have set up

their pharmacies, clinics and hospitals to offer medical services to residents although the services are expensive to the residents and also lack adequate facilities to accommodate many patients and provide quality services.

## 5. Education

### 5.1 Education in the Constituency before the Introduction of CDF

One of the ways of determining rural development in the study area was to establish education status before and after introduction of CDF in 2003. Existence of school (s) in the villages, distance to the nearest learning institution as well as the presence of classrooms, teachers and books in those learning institutions before and after introduction of CDF.

### 5.2 Schools in the Constituency before CDF

Respondents were asked whether there was a school(s) in their villages before introduction of CDF. Majority 75.1% of the respondents said that they had no school(s) in their villages whereas 24.9 % said that there were schools in their village. This shows that most people in the Constituency were not able to access learning institutions easily. Further interrogation of the key informants during the study, indicated that the few schools that were available lacked the necessary manpower and facilities such as buildings, desks, libraries and laboratories to offer quality education to students.

In terms of the nearest school, 94.6% of respondents argued that before introduction of CDF, the nearest school was 5-10 km away whereas 5.4% said that the nearest school was between 0-5km away. This indicates that schools were not near people (in villages) therefore, people had to travel long distances to access education. On classes in schools before 2003, 61.5% said that classes in schools were not enough whereas 38.5% argued that existing schools had enough classrooms. This implies that the existence of many schools in the Constituency did not mean provision of quality education to students. Most schools in the Constituency have few classrooms to accommodate all the students. Most classrooms were mud-walled and pupils could sit on stones hence were not conducive for learning.

Availability of teachers in schools was another indicator of education status of the respondents in the study. As such, 72.9% of the respondents said that instructors in such learning institutions were not enough implying that there was a challenge when it came to teaching students due to a wide range of teacher-student ratio (1:70). This led to some schools to collaborate with parents to employ PTA teachers to complement government teachers. On the other hand, 27.1% of the respondents said that teachers in schools were enough. The study established that most schools in the area did not have reading materials hence hindered effective learning. The reasons for lack of reading materials include government’s failure to purchase books in the schools and parent’s inability to buy their children books due to poverty.

### 5.3 Education in the Constituency after Introduction of CDF

The study sought to establish whether education sector in the Constituency has improved since 2003 by focusing on availability of schools in villages, distance to the nearest school, classrooms, number of teachers, books, and availability of bursary for needy students. The study established that majority 98.1% of the respondents were of the view that after the introduction of CDF, new schools were established in the villages.

Accessibility to schools to most of the respondents in the Constituency was possible. It was also evident that students could walk short distances (between 0-5km) to school since more schools were established in the villages. It was also noted that there were enough classes to accommodate students. On teachers in schools, 69.6 % of respondents argued that they received more teachers in their schools, though they were not enough. Some respondents (30.4%) said that schools in the Constituency had not received more teachers thus, continued experiencing shortage. According to 91.9% of respondents, schools in the Constituency had significantly received more reading materials. This was as a result of funding from CDF office to purchase books to supplement those donated by the government. However, it was noted that 8.1% of the schools had not received reading materials. This is because most of these schools have been established recently and are yet to get their share from the CDF. During key informant interviews, majority of the respondents maintained that needy students were able to access bursary through the CDF to further their education. However, the bursary was not enough to accommodate all the needy students.

### 6. Underlying Constraints that needs Mitigation

Despite CDF's huge success in rural development, the study established that CDF has faced some setbacks during design and implementation of projects. For instance, some communities have been excluded from development projects by some members of parliament by favoring those communities that have close kinship ties with them thus, encouraging misappropriation of CDF and involvement in fraudulent activities. This is confirmed by Okungu's, (2006) study which observed that schools, roads, health centers, bursary funds and any form of funding from the government had been diverted to clans more amenable to the sitting Member of Parliament.

The study also noted that poor management of projects was another reason that led to failure of some CDF projects. For instance some Members of Parliament were illiterate to design viable community projects. This was also aggravated by the establishment of incompetent executive committees to oversee CDF projects. Moreover, some projects could take long time before they are implemented or were not implemented at all. Moreover, in some projects the communities were not consulted adequately thus, posing sustainability problems to these projects. According to Warburton, (1994), if we are to achieve sustainability or even a reduction in unsustainability, we have to accept the challenge of seeing and doing differently and learning from

others. There is no single right way, no magic formula, and no quick fix. It is important individuals and communities have a capacity for global awareness, the momentum for personal and local activity and an ability to recognize and deal with their own impact on the world.

### 7. Conclusion and Recommendations

From the foregoing discussions, rural development programs have become fundamental in improving the lives of people in the rural settings. CDF has played a significant role where most people are able to access healthcare services and education is easily within their villages more than before it was introduced. However, there are some challenges that exist and partly hinder the delivery of services to the rural people, which include, misappropriation of funds by MPs and committees managing the funds, lack of community participation and involvement and poor sustainability strategies. The paper recommends that the government should consider initiating more programmes of this caliber and promote greater participation from the local populations. Furthermore, for these programmes to be effective they should be based on rational and transparent procedures that encourage and foster sustainability. In conclusion, sustainable development must be put at the top of the national agenda by the government and should be the fundamental principle, which underpins all national and rural policies that mitigate underdevelopment through equal educational and health investments in enhancing people's well-being. The government needs to have independent structures at the grassroots to monitor the progress of development projects and put in place strong measures to discourage misappropriation of CDF.

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