

Constituency Development Fund Investments in Primary Health Care: Stakeholder Perspectives from Lufwanyama District, Zambia

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Cite this article as: Mukuka, J.M., Kooma, E.H. Constituency Development Fund Investments in Primary Health Care: Stakeholder Perspectives from Lufwanyama District, Zambia. *Texila Int J Acad Res.* 2026;13(4).
<https://doi.org/10.21522/TIJAR.2014.13.04.Art003>

Received: 30.08.2026

Accepted: 25.09.2026

Published: 30.10.2026

Article Type: Original Research

Abstract Zambia's Constituency Development Fund (CDF) provides a decentralised mechanism for financing local priorities, including projects that affect health service delivery. This qualitative single-case study explored stakeholder perspectives on the contribution of CDF investments to primary health care (PHC) in Lufwanyama District, Zambia. It examined stakeholders' understanding of CDF, their participation in implementation processes, and perceived factors that enable or constrain the contribution of Constituency Development Fund investments to Primary Health Care service delivery. In July 2026, 40 purposively selected participants from the local authority, District Health Office, health facilities and community structures took part in semi-structured key-informant and in-depth interviews. Relevant documents were also reviewed, and the data were analysed thematically using deductive and inductive procedures. Participants viewed CDF investments as important service-enabling inputs, particularly facility infrastructure, staff accommodation, maternity spaces, water and sanitation, ambulances, roads, facility rehabilitation and selected equipment. These investments were perceived to improve access, facility readiness and referral systems. Stakeholder-perceived enablers included timely funding, coordination, technical appraisal, community participation, monitoring, alignment with district health priorities and recurrent health-system support. Delayed implementation, procurement challenges, weak coordination, uneven feedback, staffing gaps, medicine shortages and limited recurrent support constrained the translation of completed projects into day-to-day PHC services. CDF should therefore be understood as an enabling financing pathway rather than a complete service-delivery intervention. Its contribution to PHC could be strengthened through alignment with district health priorities, technical review, recurrent health-system inputs, functionality-based monitoring and clearer community feedback and accountability mechanisms.

Keywords Constituency Development Fund, Decentralised Health Financing, Health Systems Strengthening, Primary Health Care, Service Delivery.

Introduction

Primary health care forms the foundation of equitable, responsive and sustainable health systems by bringing essential services closer to communities. It requires an integrated, multisectoral approach combining clinical care, public health action, community participation and action on the social determinants of health [1]. The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) identify governance, financing, workforce, infrastructure, medicines, information systems and community engagement as interdependent levers that strengthen Primary Health Care [2].

Rural households may experience long travel distances, poor road networks, seasonal isolation, limited transport options and fewer health workers, all of which can delay care seeking and reduce continuity of preventive, promotive, curative and rehabilitative services. These barriers are particularly significant for maternal and child health, communicable-disease control, emergency referrals, immunisation, disease surveillance, medicine availability and follow-up care for chronic conditions [3]. Strengthening Primary Health Care in such contexts therefore requires more than expanded clinical services; it also requires investment in the physical, logistical and governance conditions that make health facilities accessible, usable and trusted by the communities they serve [4, 5].

Zambia's National Health Strategic Plan 2022–2026 adopts this health-system framework and prioritises prevention, health promotion and services delivered closer to communities, supported by infrastructure, medicines, human resources, financing, leadership and governance [6]. These commitments highlight the need for financing mechanisms that respond to local service-delivery needs while remaining aligned with the wider health system. Decentralised financing mechanisms such as the Constituency

Development Fund are therefore well positioned to complement central financing for Primary Health Care.

Zambia's decentralised policy direction is to deepen financing by moving resources, planning responsibility and accountability closer to communities. The Constituency Development Fund Act No. 1 of 2024 provides for the decentralisation of the management, disbursement, utilisation and accountability of the Fund, positioning Constituency Development Fund as a fiscal decentralisation mechanism through which community-identified needs can be prioritised, financed, implemented and accounted for within local governance structures [7]. The Fund is allocated across three components: community projects (60%), youth, women and community empowerment (20%), and secondary boarding school and skills development bursaries (20%) [8]. Although Constituency Development Fund is not a dedicated health financing instrument, its recent expansion has created greater fiscal space for communities and local authorities to finance health infrastructure and other service-enabling inputs [7, 8].

Constituency Development Fund is therefore relevant to Primary Health Care because it can respond to local service-delivery gaps that may take longer to address through centralised planning and sector-specific budgets. In practice, communities often identify needs that are closely tied to whether health services can function, including staff houses, maternity annexes, health posts, boreholes, sanitation facilities, bridges, feeder roads, solar power and transport support. Although these investments may be recorded as community projects rather than health-sector expenditure, they still affect whether Primary Health Care services are accessible, reliable and responsive to local expectations. This makes Constituency Development Fund a useful pathway for examining how decentralised development resources interact with district health systems, especially where health needs are clear at

community level but still require technical appraisal and recurrent support before they can become functional services [9].

For Primary Health Care, Constituency Development Fund-supported investments matter most when they strengthen connected service inputs such as infrastructure, staff accommodation, water and sanitation, transport, equipment, governance and community participation. International evidence identifies water, sanitation, hygiene, waste-management and electricity services as fundamental requirements for safe and quality care in health facilities, particularly in rural and resource-constrained settings [10, 11]. However, these inputs only become valuable when they are also linked to staffing, medicines, referral systems, maintenance and routine operating support [9]. The central concern in this study is that completed Constituency Development Fund projects do not automatically improve Primary Health Care service delivery, especially when they are not matched with wider health-system requirements. Stakeholders may also judge success differently: communities may value visible projects that bring services closer, local authorities may view completed projects as evidence of responsiveness, and health-sector actors may ask whether the projects improve service delivery through supporting staffing, utilities, equipment, referral capacity and recurrent operations.

Existing assessments of Constituency Development Fund often focus on allocation levels, visibility or completion, with less attention to access, readiness, responsiveness, referral capacity and perceived quality [21, 22]. This gap is particularly important in rural districts such as Lufwanyama, where Primary Health Care is strongly shaped by distance, staff accommodation shortages, water and sanitation needs, and referral and road-access constraints. Understanding this relationship requires attention to stakeholder perspectives because Constituency Development Fund-

supported health investments are planned, approved, implemented and experienced by different actors who do not always define success in the same way.

To support multisectoral action and community participation, several actors are involved at district and community levels. Local authorities coordinate Constituency Development Fund processes and ensure compliance with public-finance and procurement procedures. District Health Offices provide technical guidance on service readiness, referral needs, staffing and facility standards, while health-facility staff assess whether investments improve day-to-day service delivery. Community members identify local priorities and judge whether projects reduce access barriers and respond to expressed needs. These perspectives are complementary but can create tension when roles are poorly defined, when visible community priorities differ from technical and data-informed health-sector priorities, or when completed infrastructure is not matched by medicines, equipment, health workers or maintenance resources.

The health systems strengthening literature shows that functional Primary Health Care depends on the interaction of service delivery arrangements, workforce, financing, information systems, medicines and technologies, and leadership and governance. Capital investments are therefore necessary, but they are not enough unless they are supported by other health system inputs [12]. Decentralisation literature makes a similar point: local financing can strengthen responsiveness, but only when local governance is matched by institutional capacity and accountability [12, 13], and when reforms are understood within their institutional, socio-economic and geographic context [14].

Evidence from Sub-Saharan Africa also shows that decentralisation produces mixed results when authority, resources and local capacity are not well aligned [15, 16].

Community participation can improve services when community voice is connected to formal planning, technical appraisal and feedback mechanisms; however, community influence weakens when accountability practices remain unclear [17, 18]. Evidence from Zambia similarly suggests that participation and social accountability are stronger when community actors, health workers and formal interfaces are clearly linked and feedback channels are functional [19, 20]. In Zambia, Constituency Development Fund is legally framed as a decentralised financing mechanism for community-identified priorities, but Zambia-specific studies show that its effectiveness depends on transparent planning, sound financial management, technical capacity and monitoring. These studies have identified bottlenecks in planning, monitoring, transparency and implementation [21, 22].

Broader work on health decentralisation in Zambia also points to difficulties in translating policy intent into meaningful community participation, partly because of constrained governance and weak stakeholder collaborative frameworks [23, 24]. Recent evidence strongly suggests that Constituency Development Fund may support maternal and child health, but its contribution depends on prioritisation, governance, implementation and sustainability [25]. Taken together, this literature suggests that Constituency Development Fund's contribution to Primary Health Care is conditional rather than automatic, and that there is still limited empirical evidence on how rural Zambian stakeholders experience Constituency Development Fund-supported investments as part of functional Primary Health Care service delivery.

Lufwanyama District provides a relevant case for examining these issues because rural Primary Health Care delivery in the district is shaped by dispersed settlements, variable facility readiness, transport and referral constraints, and continuing demand for health-related community projects. In such a context,

Constituency Development Fund can potentially reduce inequities by financing locally prioritised investments that take safer and more functional health services closer to communities. At the same time, the district illustrates the risk that decentralised capital investment may remain disconnected from recurrent health-system requirements if planning, technical review and accountability mechanisms are weak. Examining stakeholder experiences in Lufwanyama therefore contributes context-specific evidence on how decentralised development financing is understood and operationalised within rural Primary Health Care service delivery.

The study was guided by three related theoretical perspectives. Health Systems Strengthening Theory helped explain why Constituency Development Fund-funded infrastructure requires staffing, medicines, referral systems and operating resources before it can function as part of Primary Health Care [2, 9]. Decentralisation and Decision Space Theories explained why community priority-setting and local-authority decision-making require technical capacity, institutional support and accountability to improve responsiveness [12-14]. Social accountability concepts framed the role of community voice, feedback and answerability when these are formally linked to planning and monitoring systems [17, 18]. Together, these perspectives position the Constituency Development Fund as an enabling financing pathway rather than a complete Primary Health Care intervention and provide an analytical basis for identifying factors that enable or constrain its contribution to service delivery.

The main objective was to examine stakeholder perspectives on how Constituency Development Fund investments contribute to functional Primary Health Care service delivery in Lufwanyama District, Zambia, and to identify perceived factors that enable or constrain the contribution of Constituency Development Fund investments to Primary

Health Care service delivery. The specific objectives were to: (1) explore stakeholder perspectives on how Constituency Development Fund investments contribute to functional Primary Health Care service delivery; (2) examine how stakeholder participation, technical appraisal and local governance influence the identification, prioritisation, implementation and monitoring of Constituency Development Fund-supported Primary Health Care investments; (3) identify perceived factors that enable or constrain the contribution of Constituency Development Fund investments to Primary Health Care service delivery; and (4) propose practical recommendations for strengthening the alignment of Constituency Development Fund investments with district health priorities, recurrent health-system inputs and community accountability mechanisms.

Materials and Methods

Study Design

This study used a qualitative single-case design informed by interpretivist and constructivist assumptions, with Lufwanyama District treated as the case [26-28]. The design was appropriate because the study aimed to understand how stakeholders made sense of Constituency Development Fund investments in relation to Primary Health Care support, participation, constraints and possible improvements. The focus was therefore on meanings, experiences and implementation conditions rather than on measuring project statistical outputs. Lufwanyama, a predominantly rural district in Copperbelt Province, Zambia, was selected because Primary Health Care access and readiness are shaped by long distances between communities and facilities, gaps in staff accommodation, water and sanitation needs, referral challenges, road-access constraints and limited operational support.

The single-case approach allowed the study to examine Constituency Development Fund-

supported Primary Health Care investments as they occurred within a real district governance and service-delivery environment. Rather than separating Constituency Development Fund projects from the institutional setting in which they were planned and implemented, the design enabled attention to the interaction between local authority procedures, district health planning, facility-level service conditions and community expectations. This was important because the study's concern was not only whether projects had been completed, but how stakeholders interpreted their contribution to functional Primary Health Care in relation to access, readiness, coordination, recurrent support and accountability.

Study Population and Sampling

The study population included stakeholders with direct knowledge of Constituency Development Fund-supported Primary Health Care investments in Lufwanyama District. Participants were drawn from the Local Authority, District Health Office, health facilities and community structures, including Neighbourhood Health Committees (NHCs) and Ward Development Committees (WDCs). Forty participants were purposively sampled [26]: five Local Authority officials, five District Health Office officers, ten health-facility staff members or in-charges from five selected facilities, and twenty community representatives from the selected facility catchment areas.

Participants were eligible if they were aged 18 years or older, willing to provide informed consent, had served in their role or lived in the community for at least one year, and had direct involvement in or knowledge of Constituency Development Fund-supported Primary Health Care planning, implementation, monitoring, service delivery or community priority-setting. Participants were excluded if they did not have direct knowledge of Constituency Development Fund-supported health projects or were unable or unwilling to provide consent.

The selected facilities reflected variation in rural Primary Health Care delivery conditions, including distance from the district centre, catchment population, availability of staff accommodation, referral challenges, water and sanitation needs, and evidence of previous or ongoing Constituency Development Fund-supported health-related investments at the facility or within its catchment area [28, 29]. This variation enabled the study to capture both relatively better-served and more constrained service environments, thereby strengthening understanding of how Constituency Development Fund investments were experienced across different local implementation contexts.

Purposive sampling was used because the study required participants who could provide information-rich accounts of Constituency Development Fund planning, implementation and Primary Health Care service delivery rather than a statistically representative sample. Local Authority officials were selected for their knowledge of Constituency Development Fund administration, project approval, procurement and monitoring; DHO officers were included for their technical understanding of facility readiness, staffing, referral needs and health-sector priorities; health facility staff and in-charges were selected because they experienced the operational effects of Constituency Development Fund-supported investments; and community representatives were included because they reflected local perceptions of access, participation, responsiveness and satisfaction.

Data Collection

Data were collected using semi-structured key-informant interview (KII) guides, in-depth interview (IDI) guides and a document-review checklist. Each tool was aligned with the four study objectives. Key-informant interviews were conducted with Local Authority officials because of their roles in Constituency Development Fund planning, approval,

procurement, implementation and monitoring. In-depth interviews were conducted with DHO officers, health-facility in-charges or staff, and community representatives. Interviews lasted approximately 20–30 minutes and were conducted in July 2026 in locations that ensured privacy and confidentiality [28, 29]. Written informed consent was obtained before each interview.

The interview guides were organised around the study objectives and included open-ended questions on understanding of Constituency Development Fund, perceived links between Constituency Development Fund investments and Primary Health Care service delivery, participation in priority-setting, technical appraisal, implementation experiences, monitoring, feedback, barriers and recommendations. Probing questions were used to obtain examples of specific projects and to clarify how participants distinguished between project completion and service functionality. Interviews were conducted in a manner that allowed participants to speak from their institutional or community experience while avoiding disclosure of personally identifiable information about service users or other individuals [29, 30].

With consent from participants, interviews were audio-recorded and supplemented with field notes. A document review checklist was used to extract information from Constituency Development Fund guidelines, district and facility planning documents, Integrated District Plans, reports and committee records. The review focused on project identification, approval, implementation status, monitoring and evidence of community participation, and helped triangulate participant accounts.

Document review complemented the interviews by providing contextual evidence on how Constituency Development Fund-supported health-related projects were identified, recorded and monitored. Reviewed documents were used to compare participant accounts with available administrative and

planning records, including references to project type, implementation stage, responsible structures and evidence of consultation [29]. The document review was not treated as a separate quantitative audit; instead, it supported triangulation and helped identify areas where stakeholder narratives converged with or differed from recorded planning and implementation information.

Data Analysis

Audio recordings were transcribed, checked for accuracy and organised by participant category and data source. The data were analysed thematically using Braun and Clarke's six-phase approach: familiarisation, initial coding, searching for themes, reviewing themes, defining and naming themes, and producing the final interpretation [31]. Coding combined deductive categories based on the four study objectives with inductive codes derived from participants' accounts. Saturation was assessed throughout data collection and analysis across participant categories and facilities and was considered reached when no new themes emerged concerning Constituency Development Fund financing, facility readiness, coordination, community responsiveness or health-system constraints [30].

The coding process began with repeated reading of transcripts and field notes to identify recurring ideas related to the four objectives. Deductive codes included categories such as stakeholder understanding, participation, technical appraisal, governance, facility readiness, access, referral capacity, recurrent inputs, implementation barriers and recommendations. Inductive codes were added when participants raised issues not fully captured by the initial framework, including feedback gaps, political visibility, post-completion functionality and perceived differences between visible infrastructure and usable services. Codes were then grouped into broader themes and checked against the

original data to ensure they remained grounded in participant accounts [31].

Theme development involved comparing patterns across stakeholder groups and across the selected facility catchment areas. This helped identify whether a finding reflected a shared district-level concern or a perspective specific to a particular participant group. For example, community representatives tended to emphasise access, visibility and feedback, while health-sector participants more often emphasised staffing, equipment, utilities and recurrent inputs. Local Authority officials focused on procedures, approvals, procurement and accountability. Bringing these perspectives together enabled the analysis to interpret Constituency Development Fund's contribution to Primary Health Care as conditional on coordination among community priorities, local governance processes and health-system requirements.

Coding and theme development were documented in an audit trail that recorded code definitions, changes to the coding framework, theme development decisions and links between themes and supporting extracts. Themes were reviewed against the full dataset and compared across participant categories and document sources to assess coherence, distinctiveness and explanatory value.

Trustworthiness

Trustworthiness was strengthened through triangulation of interview and document-review evidence, comparison across stakeholder groups, an audit trail of sampling, coding and theme development, reflexive notes, and thick description of the study setting [32]. Data were anonymised using participant codes and stored securely with access limited to the researcher. The study followed applicable ethical procedures for health research in Zambia, guided by respect for persons, beneficence and justice; participants received information on study purpose, procedures, confidentiality and their right to withdraw

before providing written informed consent. Formal approvals are detailed under Ethical Approval below.

To reduce the risk of misinterpretation, emerging codes and themes were repeatedly compared against original transcripts, field notes and document-review extracts. Attention was paid to similarities and differences across Local Authority officials, DHO officers, facility staff and community representatives, since each group occupied a different position in the Constituency Development Fund-Primary Health Care implementation chain. This comparative reading helped distinguish shared concerns from category-specific perspectives and supported a more balanced interpretation of the findings [32].

Reflexivity was maintained throughout data collection and analysis by noting how the researcher's assumptions about decentralised financing, Primary Health Care needs and community participation could influence interpretation. Field notes were used to record contextual observations, interview conditions and emerging reflections after data collection sessions. During analysis, these reflections helped distinguish participant meanings from the researcher's prior expectations and supported transparent interpretation of how Constituency Development Fund was experienced across administrative, health-sector and community positions.

Results

Findings are presented in line with the four study objectives. Participants represented four stakeholder categories: Local Authority officials, DHO officers, health facility staff or in-charges, and community representatives.

Stakeholder Perspectives on Constituency Development Fund Investments in Primary Health Care Service Delivery

Stakeholders most often linked Constituency Development Fund to investments such as

health facility infrastructure, staff accommodation, maternity spaces, water and sanitation, facility rehabilitation, road rehabilitation, ambulances, solar power, furniture and selected equipment. They valued these investments because they reduced practical barriers to Primary Health Care, improved facility readiness and supported referral services. Participants generally saw Constituency Development Fund as strengthening the conditions needed for service delivery rather than providing clinical services directly.

In rural settings, these conditions included shorter travel distances, better staff accommodation, improved water and sanitation, more space for maternity care, stronger referral systems, and basic infrastructure and equipment. For example, road improvements, together with bridge construction, were viewed as service-enabling investments because they connected communities, health posts, health centres and referral facilities more reliably, particularly during the rainy season, and supported more consistent movement of medicines, vaccines and other commodities to lower-level facilities. Ambulances were identified as a critical complement, reducing delays in moving emergency cases, pregnant women with complications and critically ill patients to higher-level care, as a DHO officer explained:

“For facilities in hard-to-reach areas, medicines do not always arrive on time because the roads become bad, especially during the rainy season. Even when supplies are available at district level, reaching some health posts can take longer than expected.”

— DHO officer, IDI-5

Solar power for cold-chain equipment, computers for data management, and lighting for security and night emergencies were also highlighted, alongside staff accommodation and furniture, as contributors to facility readiness. Water, sanitation, hygiene, waste-management and electricity services were

described as fundamental requirements for safe and quality care in health facilities, particularly in rural and resource-constrained settings. A health facility in-charge described how these investments improved day-to-day service conditions:

“At this facility, staff houses, lighting and simple furniture have made a big difference because we are now staying within the clinic premises and patients can be attended to properly, even during the night.”

— Health facility in-charge, IDI-6

Stakeholders did not define Constituency Development Fund’s contribution to Primary Health Care in the same way. Community representatives tended to emphasise proximity and visible improvements. Local Authority officials often focused on whether projects were completed on time and responded to community demand. Health-sector participants judged investments by whether they improved readiness, referral capacity, staffing and continuity of routine services. As one facility in-charge observed, a community may celebrate a new structure because it is visible, while facility staff may ask whether it has enough staff, water, power and supplies. Overall, stakeholders viewed Constituency Development Fund as useful for Primary Health Care, but they also stressed that its value depended on whether projects became usable service inputs rather than visible structures alone.

“When the health worker stays near the facility, people have more confidence because they know someone can attend to emergencies even after normal working hours. Staff housing is therefore not just a comfort issue; it affects access.”

— Health facility in-charge, IDI-7

Participants further noted that the value of Constituency Development Fund-supported infrastructure was greater when investments addressed multiple bottlenecks simultaneously. A staff house, for example, was viewed not only as accommodation but also as a means of

improving staff retention, after-hours availability and the perceived reliability of the facility. Water and sanitation investments were linked to infection prevention, maternity care, patient dignity and staff working conditions. Participants also associated water-supply projects with animal health, household gardening, income generation and nutrition. These accounts show that stakeholders judged Constituency Development Fund contributions not solely by physical completion but by whether investments supported routine service continuity, reduced barriers experienced by patients and providers, and contributed to wider community health.

Participation, Technical Appraisal and Local Governance

Participants reported that community-level involvement occurred mainly through the identification of needs at community and ward levels, engagement with local authority structures, and consultation with health-sector actors. Community representatives viewed participation as a means of raising long-standing Primary Health Care challenges, including distance, inadequate maternity space, poor water and sanitation, limited staff accommodation and facility congestion. They also perceived participation as strengthening local ownership and supporting the sustainability of approved investments.

Conversely, participants from the health sector noted that community-identified projects were not always informed by technical assessments of service-delivery bottlenecks. Projects were more likely to address actual needs and align with district health priorities when District Health Office staff, facility staff, local authorities and community structures worked together. Where coordination was weak, a completed project could still lack equipment, staff, medicines, utilities or maintenance arrangements.

“The community can tell us what they need, but sometimes the prioritisation process moves faster than the technical assessment. As a result, some health facilities have been constructed in unsuitable places that do not meet our criteria.”

— DHO officer, IDI-8

District Health Office participants supported community involvement but called for stronger technical appraisal, while Local Authority officials emphasised procedural and accountability requirements. Community representatives described limited feedback after submitting requests as a persistent bottleneck. They were not always informed how submissions had been reviewed, prioritised or acted upon, leaving them with the impression that their priorities were not valued.

“We are asked to submit our priorities in the community, but after submitting them we do not always hear what happened. People start thinking their views were ignored, even when maybe the project was still being processed.”

— Community representative, IDI-14

Community and health-facility participants described their involvement as uneven across the different stages of health-related project cycles. Community representatives reported that, although they were consulted when needs were identified, their involvement declined during technical review, procurement, implementation monitoring and post-completion assessment. Facility staff similarly reported that consultation sometimes occurred only after decisions had been made, limiting their ability to advise on infrastructure layout, equipment requirements, water sources, power supply and staffing implications. This reduced the likelihood that completed investments would immediately function as service-delivery assets.

“Sometimes we only see the contractor on site after decisions have already been made. If we, as local health workers are consulted earlier, we can advise on things like water

situation, power, patient flow and where the rooms should be placed.”

— Health facility staff member, IDI-9

Perceived Factors that Enable or Constrain the Contribution of Constituency Development Fund Investments to Primary Health Care Service Delivery

Stakeholders identified factors that enabled or constrained the contribution of Constituency Development Fund investments to Primary Health Care service delivery. Enabling factors included timely funding, coordination between local authorities and health-sector actors, technical appraisal, community participation, monitoring and alignment with district health priorities. Together, these factors strengthened alignment between investments, service-readiness requirements and accountability processes. Constraints included delayed approvals, procurement bottlenecks, limited technical capacity, weak communication, staffing shortages, medicine gaps, inadequate maintenance, weak feedback loops and poor links between capital projects and recurrent operational support.

Participants noted that local authorities could finance infrastructure through Constituency Development Fund but lacked authority over health human resources, medicine supply or recurrent health financing, which are centrally funded; as a result, some Constituency Development Fund-supported facilities improved physical readiness without guaranteeing functional clinical services.

“The Fund can build structures, but if there are no health workers deployed in time, or no medicines or operating funds available, the community will still complain that services have not improved.”

— Local Authority official, KII-2

From the District Health Office perspective, projects prioritised without adequate technical input risked responding to visible community demand while failing to address staffing,

equipment, utilities or referral readiness; one community representative described how Ward Development Committee decisions could bypass Neighbourhood Health Committees and select projects based on political visibility, without asking what the health post needs. Local Authority officials, in turn, presented approval delays as a major bottleneck, while noting that procurement procedures were meant to protect public funds, so delays were not always negligence but were intended to ensure accountability.

Community representatives also noted that preventive and community-based priorities, such as community-based malaria activities, were harder to accommodate within Constituency Development Fund because they were viewed as recurrent rather than capital activities, creating a perceived gap between community health priorities and the kinds of investment Constituency Development Fund typically supports.

A recurring concern was the mismatch between capital works and recurrent service inputs. Participants explained that new or rehabilitated health facilities funded through the Constituency Development Fund still required health workers, medicines, equipment, waste-management arrangements, electricity or solar systems, water points, transport support and maintenance budgets to operate effectively. When these recurrent inputs were delayed or absent, communities sometimes perceived that the Constituency Development Fund had failed, even when the local authority had completed the approved infrastructure component. This finding shows why project success should extend beyond construction completion and why Constituency Development Fund monitoring should include functionality indicators.

“A building on its own does not treat patients. If there is no nurse, no drugs, no water or no equipment, then people will still travel elsewhere even when the structure is there.”

— DHO officer, IDI-11

Stakeholder Recommendations

Stakeholders recommended that proposed Constituency Development Fund health infrastructure projects include a clear facility-readiness justification, DHO technical review, links to district health plans and evidence of community consultation. They also called for better feedback to communities after project submissions, stronger implementation monitoring, and practical indicators for assessing whether completed projects improve access, readiness, referral capacity, water and sanitation, staffing, medicine availability, equipment functionality and community satisfaction. Participants saw stronger coordination between Local Authorities, District Health Offices, health facilities and community structures as necessary to ensure that Constituency Development Fund investments respond to both visible community priorities and less visible service-delivery gaps.

“If the District Health Office and the local authority sit together before approval, it becomes easier to know whether a proposed project will really support services or whether another facility need is more urgent.”

— DHO officer, IDI-12

Across the four objectives, stakeholders understood Constituency Development Fund investments as useful but conditional contributors to Primary Health Care. The strongest perceived contributions were health facility infrastructure, staff accommodation, maternity space, water and sanitation, roads, ambulances, solar power and equipment. Participation created opportunities for engagement, but limited feedback, weak coordination and gaps between community preferences and technical appraisal reduced

effectiveness. Constituency Development Fund's contribution to functional Primary Health Care depended on whether capital investments were linked to other health-system inputs, reinforcing the study's central argument that Constituency Development Fund is an enabling financing pathway, not a complete Primary Health Care intervention.

Stakeholders further suggested that Constituency Development Fund-supported Primary Health Care projects should include a simple pre-approval checklist and a post-completion functionality review. The pre-approval checklist would confirm whether the proposed project addresses an identified district health priority, whether technical officers have reviewed the site and design, and whether recurrent requirements have been discussed with the responsible health authorities. The post-completion review would assess whether the investment is in use, whether it has the necessary staff, medicines, utilities and equipment, and whether communities have received feedback on its status and expected benefits.

"When a project is completed, there should be a visit to check whether it is helping services. Completion should not just mean the building is handed over; it should mean the facility can use it."

— Local Authority official, KII-4

Discussion

The findings indicate that stakeholders in Lufwanyama District viewed Constituency Development Fund investments as useful but conditional contributors to Primary Health Care service delivery, rather than as a direct source of clinical services. Investments in facility construction, rehabilitation, maternity spaces, water and sanitation, staff accommodation, solar power, roads and ambulances were valued because they addressed practical barriers to access, readiness, referrals and day-to-day service continuity. This aligns with health systems strengthening literature, which shows

that financing improves service delivery when it is translated into connected system inputs rather than isolated capital projects [2, 9].

In Lufwanyama, Constituency Development Fund-supported infrastructure became meaningful when it improved facility usability, staff availability, referral movement, cold-chain support and patient access. This supports the view that financing contributes to Primary Health Care through its interaction with workforce, medicines, technologies, service organisation and operational support, not through construction alone. The findings on roads, ambulances and medicine distribution also point to an indirect pathway: stakeholders experienced these investments as referral-system inputs that helped emergency movement, maternal referrals and commodity distribution. This interpretation is consistent with evidence on rural Primary Health Care access, referral systems and community-based referral and follow-up in Zambia [3–5], although these qualitative findings should not be read as measured clinical outcomes.

These findings suggest that Constituency Development Fund should be treated as a catalytic input within the local health system, not as an independent community programme. Its contribution lies in removing specific bottlenecks that prevent Primary Health Care facilities from functioning well, especially in rural settings where geographic isolation and infrastructure gaps are closely connected to access. Constituency Development Fund can strengthen the "hardware" of Primary Health Care, such as buildings, staff houses, water points, transport assets and energy systems.

Evidence on water, sanitation, hygiene, waste-management and electricity services in health facilities reinforces the importance of these inputs for safe and quality care [10, 11]. However, these investments depend on complementary "software" functions, including planning, supervision, maintenance, staff deployment, supply-chain responsiveness and community trust. Without these functions, an

investment may be visible and politically appreciated but only partly useful for service delivery. This distinction helps explain why stakeholders valued Constituency Development Fund while still worrying that completed projects sometimes remained underused or produced fewer benefits than expected.

The findings on participation, technical appraisal and governance show that Constituency Development Fund created local decision space for communities and local authorities to identify health priorities, but this was most effective when combined with DHO technical appraisal and facility-level evidence. This aligns with Bossert's decision-space perspective and later work by Bossert and Mitchell, which argue that decentralisation improves responsiveness only when local authority is matched by institutional capacity and accountability [12, 13].

The findings also relate to Abimbola et al.'s emphasis on the role of local context in shaping decentralised reforms [14], which is evident in Lufwanyama, where rural distance, staffing and referral constraints shaped how Constituency Development Fund investments were experienced. Community participation alone did not guarantee improved service delivery when project selection was not linked to technical review, implementation capacity and feedback mechanisms. This finding is consistent with social-accountability literature showing that community structures strengthen responsiveness only when formally linked to planning, answerability and communication systems [17-20].

The study also shows that local participation means more than asking communities to submit project requests. Meaningful participation requires a continuous loop: communities identify needs, technical actors assess feasibility and service relevance, local authorities communicate decisions, and communities receive feedback on implementation progress and functionality after

completion. When this loop is incomplete, participation can feel one-sided. Communities provide information about their needs but may not receive a clear explanation of how those needs are ranked, funded or deferred. In Lufwanyama, this weakened the accountability value of Constituency Development Fund because communities were more likely to see the Fund as responsive only when projects were approved, rather than understanding the technical, budgetary and procedural reasons why some priorities could not be funded immediately.

Stakeholders identified coordination, technical appraisal, monitoring, alignment with district health priorities and recurrent health-system support as factors that enabled Constituency Development Fund investments to contribute to Primary Health Care service delivery. These factors aligned investments with service-readiness requirements and accountability processes. Approval delays, procurement bottlenecks, weak technical input, staffing shortages and medicine gaps constrained that contribution. These findings are consistent with health-systems-strengthening literature, which emphasises interactions among financing, workforce, medicines, information systems, governance and service organisation [9], and with regional evidence from Sub-Saharan Africa showing mixed decentralisation outcomes where resource transfer, implementation capacity and accountability systems remain incomplete [15, 16].

Lufwanyama's experience reflects this pattern: Constituency Development Fund improved visible service-enabling conditions, but its effect on Primary Health Care remained conditional on health workers, medicines, referral arrangements and recurrent financing that fall outside local authority control. The findings also align with Zambia-specific literature: Chama and Sichone and Dar show that decentralised health service delivery in Zambia has been limited by weak participation,

incomplete devolution and constrained local capacity [23, 24], while Casey et al. and Chambaka and Mutono-Mwanza identify planning, monitoring, transparency and implementation bottlenecks in Constituency Development Fund processes more broadly [21, 22]. This study extends that literature with Primary Health Care-specific evidence of how such bottlenecks affect facility readiness, referral capacity, maternity services, water and sanitation, staffing and recurrent service support.

These findings further show that rural equity is a practical implementation issue, not only a policy objective. In districts such as Lufwanyama, communities far from referral facilities often experience distance, poor roads, transport delays, staffing shortages and commodity interruptions as overlapping barriers. A Constituency Development Fund-funded road, ambulance, staff house or maternity annex may therefore promote equity when it reduces the disadvantage faced by remote populations. However, this equity effect is weakened when investments are distributed without systematic attention to service coverage gaps, referral catchments, population need, seasonal access problems and facility readiness. If Constituency Development Fund is to advance Primary Health Care equity, project selection should be informed by both community voice and district-level evidence on underserved areas, high-burden catchments and facilities with the greatest readiness constraints.

These findings support the study's stakeholder recommendations: facility-readiness justification, formalised DHO technical review, and stronger feedback and accountability mechanisms follow directly from evidence that Constituency Development Fund works best when community priorities are balanced with health-sector evidence and recurrent support. This is consistent with social accountability literature showing that community voice initiatives can shift expectations from informal favours toward

service entitlements [20], and with calls to map the multiple actors and interfaces involved in Primary Health Care co-production and accountability [19]. Methodologically, the qualitative single-case design enabled in-depth interpretation of how four stakeholder categories understood Constituency Development Fund within Lufwanyama's rural service-delivery context, with triangulation across interviews, field notes and documents strengthening this interpretation.

The study's findings also have implications for sustainability. Many Constituency Development Fund-supported health investments are capital-intensive, but their long-term contribution depends on recurrent arrangements that are often outside the Constituency Development Fund approval cycle. A staff house requires maintenance; a maternity annex requires equipment, water, electricity, privacy arrangements and skilled staff; an ambulance requires fuel, drivers, servicing and referral coordination; and solar systems require maintenance and replacement planning. If sustainability is not considered at project appraisal stage, Constituency Development Fund can unintentionally create unfunded obligations for the health sector and local authority. This suggests that sustainability screening should also become part of the approval process for Constituency Development Fund-supported Primary Health Care projects, with explicit attention to who will operate, maintain and finance the asset after completion.

An important implication is that Constituency Development Fund monitoring for health investments should move from an output-based orientation to a functionality-based orientation. Counting the number of health posts, staff houses, maternity annexes or water points completed provides useful accountability information, but it does not show whether Primary Health Care delivery has improved. Functionality-based monitoring would ask whether services are closer to

communities, whether health workers can remain on site, whether pregnant women have safer spaces for delivery, whether referrals move faster, whether facilities have reliable water and power, and whether patients experience improved responsiveness. Such indicators would make Constituency Development Fund reporting more relevant to Primary Health Care outcomes while remaining practical for local authorities and health offices.

At policy level, the findings suggest that Constituency Development Fund does not need to become a health-sector fund to contribute more effectively to Primary Health Care. What is needed is stronger integration between Constituency Development Fund planning and existing district health planning systems. This could include routine participation of DHO technical staff in project appraisal, use of facility-readiness evidence during prioritisation, alignment with Integrated District Plans and district health plans, and joint monitoring after completion. These measures would preserve the community-driven character of Constituency Development Fund while reducing the risk that projects are selected mainly for visibility, political appeal or immediate public demand without enough attention to service-delivery functionality.

Conclusion

Stakeholders in Lufwanyama District viewed Constituency Development Fund investments as important but conditional contributors to Primary Health Care. The investments strengthened service-enabling inputs, including infrastructure, staff accommodation, maternity spaces, water and sanitation, transport, selected technologies and facility readiness. Alignment with district health plans, technical appraisal, coordination, community participation, monitoring, accountability and recurrent health-system support enabled their contribution to service delivery. Delayed implementation, procurement bottlenecks, staffing shortages,

medicine gaps, maintenance needs, weak feedback loops and inadequate recurrent financing constrained the translation of completed projects into usable services.

The Constituency Development Fund is best understood as an enabling financing pathway rather than a stand-alone service-delivery mechanism. The study recommends that health-project approvals require alignment with district health plans, documented facility-readiness gaps and recurrent-input commitments; that District Health Office technical review assess workforce, financing, medicines, referral links, utilities, maintenance and sustainability; that local authorities, Constituency Development Fund committees, health facilities and community structures provide clear feedback on project decisions; and that completed investments be monitored using functionality indicators, including access, maternity space, water and sanitation, staffing, referral capacity, equipment, medicines and community satisfaction.

Limitations and Future Research

This qualitative single-case study does not claim statistical generalisability beyond Lufwanyama District, but it offers context-specific evidence and transferable lessons for comparable rural settings. Inclusion of administrative, health-sector, facility and community perspectives, together with triangulation of interviews, field notes and documentary evidence, strengthened contextual credibility. Future quantitative, mixed-methods, comparative and longitudinal studies should assess effects on service utilisation, access, waiting times, referrals, maternal and child health uptake, staffing, medicines, equipment and maintenance, and examine how participation, technical appraisal, procurement, accountability and feedback influence functionality, sustainability and community trust. Longitudinal follow-up is particularly important because benefits may emerge only

after recurrent inputs are secured and facilities have operated for sufficient time.

Conflict of Interest

The authors declare no conflict of interest.

Acknowledgements

The authors are grateful to the stakeholders and participants who supported this study and generously shared their time, experiences and perspectives. The authors also acknowledge Texila American University for its academic and institutional support.

Ethical Approval

Ethical clearance was granted by ERES Converge (Ref. 2026-Jul-001), with permission from the Cabinet Office Decentralisation Unit (Ref. DS/2/29/2) and relevant provincial and district authorities. All participants provided written informed consent before interviews. Confidentiality was maintained through participant codes, and no personally identifiable information is reported. Because of

confidentiality requirements, the qualitative data are not publicly available but may be obtained from the corresponding author on reasonable request, subject to applicable ethical approvals.

Author Contributions

Mukuka, J.M.: Conceptualisation, Methodology, Investigation, Formal Analysis, Writing – Original Draft. Kooma, E.H.: Supervision, Writing – Review & Editing. Both authors approved the final manuscript.

Data Availability

Qualitative data are not publicly available because of participant confidentiality. De-identified data may be requested from the corresponding author, subject to reasonable request, ethical approval and institutional permission.

Funding

No specific funding was sourced or declared for this study.

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