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Community Scorecards Transform Health Service Delivery in Kisumu County

County:	**Kisumu County**		
Sector/s:	**Health**	**Sub-sector/Theme:**	**Primary Healthcare / Community Health Systems / Social Accountability**
Keywords: (for search in the online platform)	**Kisumu County, Community Scorecard (CSC), Korando Community, Health Service Delivery, DANIDA PHC Programme, social accountability, participatory monitoring, health systems strengthening, primary healthcare, community engagement, health equity, Kenya, Maarifa Centre, success stories**		
Target Audience:	**Counties**		
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Introduction:

St. Marks Lela dispensary, located in Kisumu County, began as a Level 2 health facility and has since been upgraded to a Level 3 health facility (health centre). It serves a catchment population of approximately 12,000 people. The health facility has three Community Health Units (CHUs) linked to it i.e. Lower Korando, Upper Korando, and Otonglo. The facility offers a range of health services, including Outpatient Services (OPD), special clinics, laboratory services, maternal, newborn and child healthcare services and a pharmacy services.

The facility is overseen by a Health Facility Management Committee, which represents the broader community. This committee is involved in the budgeting process, approves expenditures, and acts as a bridge between the facility and the community.

Previously, the lack of structured feedback channels posed a significant challenge and communities had no formal mechanism to voice their concerns, while health providers received little meaningful data on patient experiences. This created a cycle that frustrated residents who avoided clinics, leading to worsening health outcomes and further strain on the health system.

To address this, the County Government of Kisumu, through the Health Facility Management Committee led efforts to conduct community dialogue sessions to provide a platform for community, service providers and local stakeholders to express their health concerns, and collaboratively develop solutions geared to improve health services within the facility. During these discussions, the health facility identified widespread dissatisfaction with some of the services provided. Key challenges included understaffing which left health workers overburdened and demotivated, persistent medicine stock-outs due to weak supply chain management, and limited infrastructure budgets that left the health facility without basic security measures such as perimeter fencing.

These findings highlighted the need to conduct a Community Scorecard (CSC) assessment to enhance service delivery. The CSC is a structured tool that enables community members to evaluate health services, similar to a "report card", and facilitates joint planning for improvements. Similar approaches have yielded positive results in other counties, such as improved clinic cleanliness in Makueni and reduced maternal mortality in Nakuru. However, common challenges remain, including resistance to feedback from health workers, fear of victimization and sustaining community engagement over time.

Implementation of the practice (*Solution Path*):

The initiative was rolled out by the County Government of Kisumu in 2020. However, it faced challenges due to the lack of national guidelines with a common set of performance indicators. The Community Scorecard (CSC) guidelines were thereafter developed in 2021 to provide standard operating procedures for promoting transparency, action, and accountability in the collection, interpretation, and use of information from service users in the health and related sectors.

During the Financial Year 2022/2023, the DANIDA PHC program supported the facility through training, organizing community dialogue meetings, and implementing preventive and promotive interventions. Other activities supported by the program included dialogue days, action days, integrated outreaches, payment of incentives to Community Health Promoters (CHPs), household visits, and data review meetings. During these meetings, the top diseases affecting the community, such as skin infections, upper respiratory tract infections (URTIs), malaria, and diarrhea, were reviewed. The program also supported Reproductive, Maternal, New-born, Child, and Adolescent Health (RMNCAH) trainings and referrals from the community to the facility.

At the facility level, the process began with a 3-days training of Community Health Committees (CHCs) on how to use the Community Scorecard. The training enabled them to guide discussions

and collect feedback from community members about health services provided at St. Marks Lela Health Centre.

During the community scorecard session, the community members openly shared their perspectives and experiences concerning the quality and accessibility of health services. Health workers from the facility, along with representatives from the Sub-County Health Management Team, and other partners, actively participated in the discussions, listening to community concerns, responding to questions, and collaboratively working toward practical solutions.

Figure 1: Targeted dialogue on ANCs and immunization of U5s held in Jan 2025

The CHCs then led scoring sessions where community members rated the health services based on things like the quality of healthcare services, availability of drugs and diagnostics, responsiveness to community needs, and assessment of health insurance among other 9 indicators scored. This gave a clear picture of the main issues and strengths in the health system.

A feedback meeting followed up at the facility to review the results of the scorecard where it includes the HFMC, the facility staffs and some members of SCHMT were present and scores were given with explanations of the on the scoring by the community members.

Thereafter, a community scorecard interface session was conducted which brought stakeholders, including health workers, community members, CHCs, and partners who worked together, to develop an action plan. They agreed on what needed to be done, who would do it, and when. This would be then monitored on a quarterly basis.

Community Health Promoters (CHPs) played a key role in follow-up activities, including:

- Weekly household visits to offer health education and minor treatment;
- Tracing children and pregnant women who missed vaccines or check-ups (defaulter tracing); and
- Referring people to the facility for further care.

This approach brought the community and health providers closer together. It encouraged open conversations, joint problem-solving, and stronger ownership of health services. Today, the CHCs continues to lead quarterly meetings to check on progress and keep the community involved in improving healthcare.

Results of the practice (*outputs and outcomes*)

- Outpatient visits at the facility rose significantly from 100 to 450 clients per month indicating growing community trust in the health facilities and its services. Antenatal care

(ANC) attendance and community referrals also increased. To improve service delivery, the health facility introduced a Service Charter and reduced waiting times by involving Community Health Promoters in a revolving manner in triage at the registration desk.

Figure 2: An immunization outreach held at Kateng' village.

- Facility staff now actively participate in community meetings, action days, and dialogues, listening to concerns and co-creating solutions. Community members feel empowered to give feedback, which is taken seriously. Quarterly community scorecard follow up sessions are held, followed by updating the joint action planning between CHCs and health workers. Support groups formed during these sessions continue meeting for up to a year, sharing health information and promoting community-led solutions.
- To ensure safety and better service delivery, the health facility constructed a secure perimeter fence. A dedicated CHP desk was also established to support client registration and tracking community referrals.
- Trained CHCs now lead scorecard sessions, facilitate community dialogues, and help address local health challenges. CHPs conduct household visits, provide health education, offer minor treatment, and trace defaulters, especially among children and pregnant women. Their increased visibility and effectiveness have earned them greater recognition and trust within the community.
- Quarterly dialogue and scorecard follow up sessions are now institutionalized and supported by trained CHCs. The model has been successfully replicated in other wards, using existing local structures such as schools and village leadership. This approach ensures sustainability and minimizes costs.

Lessons learnt:

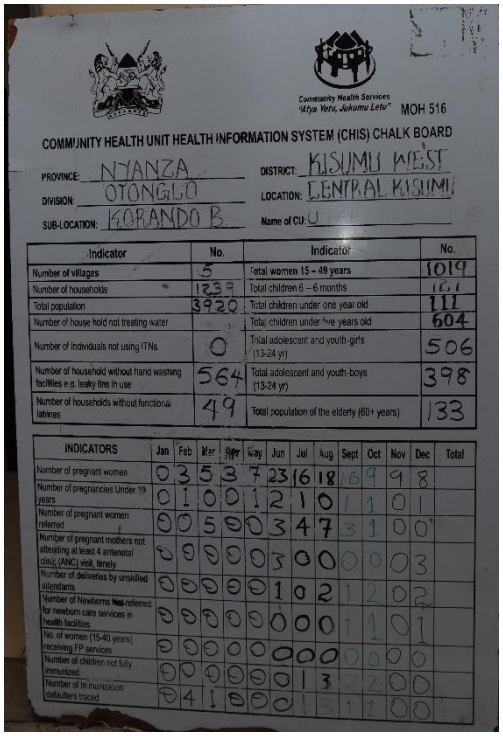
- Community meetings proved to be an affordable yet a powerful tool for raising awareness and driving behaviour change.
- Integrating services like treatment, immunization, and health education during outreach activities is effective in improving access and utilization of these services efficiently.
- As trust in health services increased, more people began seeking care early, leading to better maternal and child health outcomes.
- Active community participation in healthcare decisions has fostered a sense of ownership and accountability.
- Developing shared work plans between health facilities and communities has improved service delivery, strengthened partnerships, and changed health-seeking behaviour.
- Well-trained CHPs significantly improve service delivery and positively impacted key health indicators.
- When equipped with essential supplies, CHPs effectively manage minor ailments at the community level, reducing the burden on health facilities.
- CHCs, supported by Health Facility Management Committees (HFMCs), can effectively lead scorecard sessions and provide feedback that helps facilities respond to the community needs.
- Sustainable health interventions require continuous, meaningful engagement and ownership from the community.
- Tools like the Community Scorecard enable communities to assess service quality, identify gaps, and hold providers accountable.
- Building lasting relationships with local health authorities and communities is key to sustaining progress and scaling impact.

Recommendations:

- Increased allocation of resources to scale up the initiative and ensure additional Community Health Units (CHUs) benefit from similar support.
- Deepen community participation by enhancing dialogue forums, empowering Community Health Committees (CHCs), and maintaining continuous feedback mechanisms.
- Provide ongoing training, incentives, and a supportive work environment to motivate Community Health Promoters (CHPs) and ensure long-term commitment. Expand supportive supervision structures.
- Conduct more integrated outreach activities and health education programs to address diverse community health needs and improve service reach.
- Collaborate with local NGOs, women's groups, and faith-based organizations to mobilize communities and promote inclusive health initiatives.
- Organize exchange programs with other Counties to share best practices, enhance skills, and promote innovative community health solutions.
- Improve funding mechanisms to enhance service delivery and boost CHP motivation and performance.
- Create forums for Counties to share evidence-based interventions and lessons learned, fostering innovation and collaboration.

- Broaden the scope of DANIDA PHC Level 1 support to cover more community units and improve access to basic care.
- Implement targeted initiatives to increase male participation in community health and family support.
- Work towards universal registration of community members under the Social Health Authority (SHA) to ensure access to essential health services.

Photo Gallery



COMMUNITY HEALTH UNIT HEALTH INFORMATION SYSTEM (CHIS) CHALK BOARD

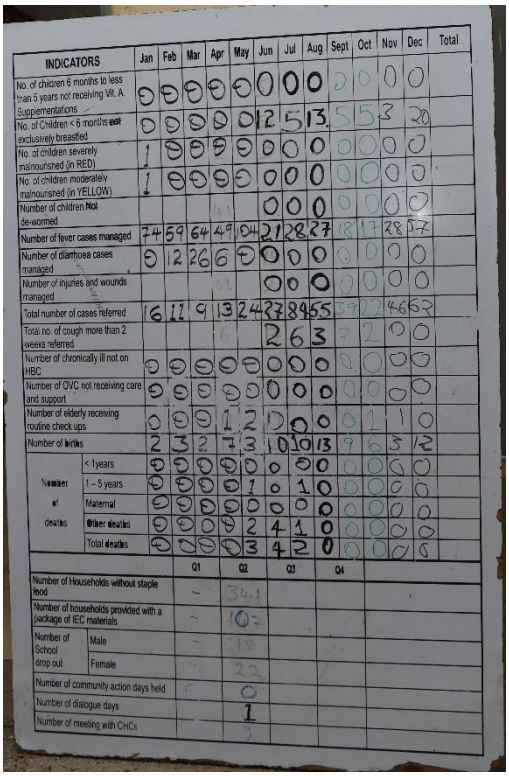
Community Health Services "Afya Yetu, Jukumu Letu" MOH 516

PROVINCE: NYANZA DISTRICT: KISUMU WEST
DIVISION: OTONGLO LOCATION: CENTRAL KISUMU
SUB-LOCATION: KORANDO B Name of CU:

Indicator	No.	Indicator	No.
Number of villages	5	Total women 15 – 49 years	1019
Number of households	1239	Total children 6 – 6 months	161
Total population	3920	Total children under one year old	111
Number of house hold not treating water		Total children under five years old	604
Number of individuals not using ITNs	0	Total adolescent and youth-girls (13-24 yr)	506
Number of household without hand washing facilities e.g. leaky tins in use	564	Total adolescent and youth-boys (13-24 yr)	398
Number of households without functional latrines	49	Total population of the elderly (60+ years)	133

INDICATORS	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total
Number of pregnant women	0	3	5	3	7	23	16	18	16	9	9	8	
Number of pregnancies Under 19 years	0	1	0	0	1	2	1	0	1	1	0	1	
Number of pregnant women referred	0	0	5	0	0	3	4	7	3	1	0	0	
Number of pregnant mothers not attending at least 4 antenatal clinic (ANC) visit, timely	0	0	0	0	0	3	0	0	0	0	0	3	
Number of deliveries by unskilled attendants	0	0	0	0	0	1	0	2	1	2	0	2	
Number of Newborns referred for newborn care services in health facilities	0	0	0	0	0	0	0	0	1	1	0	1	
No. of women (15-40 years) receiving FP services	0	0	0	0	0	0	0	0	0	0	0	0	
Number of children not fully immunized	0	0	0	0	0	0	1	3	2	2	0	0	
Number of Immunization defaulters traced	0	4	1	0	0	0	1	3	1	1	0	0	

Figure 3: A photo of the Community Health Unit Health Information System (CHIS) Chalk Board



INDICATORS	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total
No. of children 6 months to less than 5 years not receiving Vit. A Supplementations	0	0	0	0	0	0	0	0	21	0	0		
No. of Children < 6 month's exclusively breastfed	0	0	0	0	0	12	5	13	5	5	3	20	
No. of children severely malnourished (in RED)	1	0	0	0	0	0	0	0	0	0	0	0	
No. of children moderately malnourished (in YELLOW)	1	0	0	0	0	0	0	0	0	0	0	0	
Number of children Not de-wormed						0	0	0	0	0	0	0	
Number of fever cases managed	74	59	64	49	04	21	28	27	18	17	28	57	
Number of diarrhoea cases managed	0	12	26	6	0	0	0	0	0	0	0	0	
Number of injuries and wounds managed						0	0	0	0	0	0	0	
Total number of cases referred	6	11	9	13	24	37	39	55	39	22	46	53	
Total no. of cough more than 2 weeks referred						2	6	3	3	2	0	0	
Number of chronically ill not on HBC	0	0	0	0	0	0	0	0	0	0	0	0	
Number of OVC not receiving care and support	0	0	0	0	0	0	0	0	0	0	0	0	
Number of elderly receiving routine check ups	0	0	0	1	2	0	0	0	0	1	1	0	
Number of births	2	3	2	7	3	10	10	13	9	6	3	12	
Number of deaths: < 1 years	0	0	0	0	0	0	0	0	0	0	0	0	
Number of deaths: 1 – 5 years	0	0	0	0	1	0	1	0	0	0	0	0	
Number of deaths: Maternal	0	0	0	0	0	0	0	0	0	0	0	0	
Number of deaths: Other deaths	0	0	0	0	2	4	1	0	0	0	0	0	
Number of deaths: Total deaths	0	0	0	0	3	4	2	0	0	0	0	0	

		Q1	Q2	Q3	Q4
Number of Households without staple food			34.1		
Number of households provided with a package of IEC materials			107		
Number of School drop out	Male		18		
	Female		22		
Number of community action days held			0		
Number of dialogue days			1		
Number of meeting with CHCs					

Figure 4: A photo of the Community Health Unit Health Information System (CHIS) Chalk Board

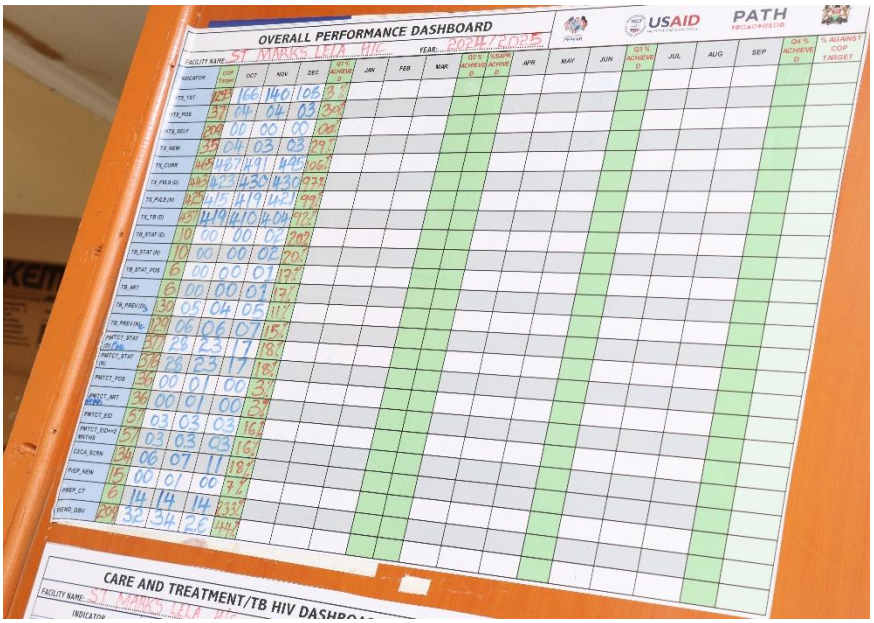


Figure 5: The overall performance dashboard at St. Lela Dispensary

Figure 6: A training session with the identified CHCs and stake holders on CSC.

Figure 7: Community members discussing challenges faced at both the facility and community levels during an engagement forum.

Figure 8: Feedback session during the scoring session with the community members

Figure 9: Facility staffs participating in dialogue

Figure 10: A photo of St. Marks Lela Rainbow Dispensary