



Ministry of Health

Kenya Community Scorecard Guidelines for Social Accountability in Primary Health Care





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Kenya Community Scorecard Guidelines

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Preface

In 2006, Kenya adopted a community-based approach (Community Health Strategy), as articulated in the second National Health Sector Strategic Plan (NHSSP II: 2005-2010). Community Health Strategy emphasized a more proactive approach of promoting individuals and communities' health to prevent the occurrence of diseases.



Community health is one of the flagship projects in Kenya's vision 2030 and is recognized as the level 1 of health care in the Kenya Health Act, 2017. Kenya is a signatory to Astana Declaration (2018) which highlighted the importance of community health services in advancing Universal Health Coverage. The Kenya Community Health policy 2020-2030 therefore provides policy direction for community health services.

Kenya has adopted primary health care as the approach to deliver universal health coverage and this is well articulated in the Kenya's Primary care strategic framework 2019- 2024 which gives prominence to community based primary health care. In order to increase demand for primary health care, there is need to inculcate social accountability to balance between demand and supply sides of service provision. The third edition of the community health strategy 2020-2025 aims at building the capacity of individuals and households to know and progressively realize their right to equitable, good quality health care and demand services as provided for in the Kenya constitution 2010. This aspiration will be partly realized through implementation of community score card.

Development of these community scorecard guidelines was an all-inclusive process involving counties and community health stakeholders. These guidelines are aimed at providing a framework for implementation of the community scorecard to enhance social accountability in primary health care.

A handwritten signature in blue ink, appearing to read 'Patrick O. Amoth', written in a cursive style.

Dr. Patrick O. Amoth, **EBS**

Ag. Director General for Health

Foreword

The community scorecard (CSC) is a community-led governance tool which brings primary healthcare facilities, local government structures and the community together to promote action, accountability and responsiveness to community needs.



It empowers community members to take action to improve health outcomes when assessments reveal issues that need to be addressed. Implementation of the community scorecard involves participation of each of the entities as well as other relevant stakeholders in understanding, measuring, and responding to the community's perceptions and needs.

The development of these guidelines was a culmination of efforts from various stakeholders. The writing process entailed face to face and virtual meetings by the Ministry of Health, County Health Management Teams, Implementing and Development partners. These guidelines provide a national framework for implementation of the community scorecard in the country in a harmonized and coordinated way.

A handwritten signature in black ink, appearing to read 'A. Mulwa', with a long horizontal line extending to the right.

Dr. Andrew M. Mulwa

**Ag. Director Medical Services,
Preventive & Promotive Health**

Acknowledgement

The Community Health Score card guidelines 2021 has been developed through a consultative and participatory process that included partners and stakeholders involved in the implementation of Community Health Services in the country. The Ministry of Health acknowledges the contributions, commitment and technical support from all stakeholders who participated in the face-to-face meetings and the many virtual meetings that culminated in these final guidelines.



Our appreciation goes to the officers at the Division of Community Health Services led by Dr. Maureen Kimani who steered the writing process. I particularly wish to thank John Wanyungu, Deputy Head, Division of Community Health and Head, M&E at the Division of Community Health for day-to-day coordination of the development of these guidelines.

Our gratitude also goes to national officers from various MoH Divisions for their invaluable contribution during the writing process. In addition, we appreciate the technical and financial support from ALMA, UNICEF, AMREF Health in Kenya, Living Goods, LVCT Health and Lwala Community Alliance amongst others. Our appreciation also goes to MoH leadership who provided an enabling environment for the development of this document and to the Council of Governors who convened county stakeholders meeting to review and validate the document. Finally, we are indebted to ALMA and AMREF who provided financial support for the development, design and layout of this guidelines. The full list of contributors is annexed.

A handwritten signature in blue ink, appearing to read 'Dr. Salim Hussein'.

Dr. Salim Hussein

Head, Department of Primary Health Care

List of Abbreviations

ALMA	African Leaders Malaria Alliance
AMREF	African Medical Research Foundation
CCHFP	County Community Health Focal Person
CHA	Community Health Assistant
CHAP	Community Health Action Plan
CHC	Community Health Committee
CHMT	County Health Management Team
CHU	Community Health Unit
CHV	Community Health Volunteer
CSC	Community Scorecard
CSO	Civil Society Organization
DCH	Division of Community Health
HFMC	Health Facility Management Committee
KHIS	Kenya Health Information System
LVCT	Liverpool Voluntary Counseling and Testing for HIV
M&E	Monitoring and Evaluation
MCA	Member of the County Assembly
MOH	Ministry of Health
NHIF	National Hospital Insurance Fund
NVIP	National Vaccine and Immunization Program
PHC	Primary Health Care
PWD	People Living with Disability
RMCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SCCHFP	Sub County Community Health Focal Person
SCHMT	Sub County Health Management Team
UNICEF	United Nations Children Education Foundation

1.0 Introduction and Background

The Ministry of Health is committed to ensuring social accountability for quality of health services through implementation of Community Score Card. This is anchored on the rights-based approach recognizing that every Kenyan has a right to the highest standards of health as enshrined in the Kenyan constitution 2010. Social accountability tools are increasingly being recognized as a means of improving the quality and coverage of service delivery and *governance 1* (World bank 2020).

Community scorecard is an accountability tool that is a citizen driven measure that enhances civic involvement. The scorecard can be used to gather service users' feedback on the quality of health services provided. The information obtained help to improve communication between communities, local leaders and service providers. Accountability is the obligation of power holders to take responsibility and be answerable for their actions. Social accountability is therefore a concept in governance that denotes “being answerable for” and refers to strategies that employ information and participation to demand fairer, more effective public services, responsive to the people. It is an approach towards building accountability that relies on civic engagement ensuring direct and/or indirect participation of citizens and civil society organizations (CSO) in exacting accountability (Malena, Forster *et al.* 2004).

Kenya Community Health Strategy 2020 – 2025 advocates for institutionalizing of social accountability in the quality of primary healthcare services, create a platform for strategic partnership, accountability among stakeholders and related sectors at all levels.

The Kenya Implementers Manual for Social Accountability in the Health Sector 2015 recognizes that the components of social accountability are (i) transparency and information sharing, (ii) compliment and complaints handling mechanisms, and (iii) community participation. The community scorecard identifies these components as vital to provision of quality health services at all levels.

1 Constitution of Kenya, Vision 2030, and the Kenya Health Policy 2013 - 2030.

In Africa, a number of countries use community score cards to strengthen social accountability systems by engaging their citizens, groups and their representatives in overseeing government and private sector conduct in delivery of quality health services. Ghana, Ethiopia, Malawi, Senegal, and Zambia among others have established community scorecards as vital tools for citizens and service providers to work collaboratively with the shared objective of closing the gap between the supply and demand for the quality of services and redressing service failures. The use of the community scorecard in Ethiopia and Ghana has shown that the tool is very powerful in putting communities at the center of delivery of quality health services, mobilizing community resources, building trust between service providers and clients, and enhancing community ownership and participation.

In Kenya, various health related scorecards have been used by various programs such as Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), malaria, nutrition and National Vaccine and Immunization Program (NVIP). The scorecards have been proven to be valuable in enhancing program management and accountability resulting in improving coverage of health services. Whereas these scorecards are primarily focused on the supply side of health services, the community scorecard will focus on the demand side of the health service delivery.

Prior attempts to implement community scorecard in some of the counties - Nairobi, Migori, Kakamega and Kisumu proved elusive since there were no national guidelines with a common set of performance indicators at the time. Different partners used different approaches and indicators to implement community scorecard in those counties. These guidelines provide a national framework for implementation of the community scorecard in the country.

2.0 Purpose of the Community Scorecard (CSC)

The scorecard will promote community ownership and participation in their own health. This in turn will ensure provision of quality health services, empowering communities to take active part in monitoring quality and coverage of health services provided in primary health facilities and give structured feedback to health authorities.

2.1 Objectives of the Community Scorecard

The community scorecard guidelines 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 other related sectors.

The objective of the community scorecard is to:

- Provide an opportunity for community members to provide inputs in the quality of health services that they receive at the primary health facility and community level
- Enable facility and community service providers to understand and appreciate health outcomes in their communities
- Promote ownership in communities towards quality health service provision
- Enable policy makers accommodate community needs for relevant resource allocation

3.0 Rationale for Community Scorecard Guidelines

Governments have focused on the supply side of health services with a view to improve coverage of different health interventions with limited focus on the demand side. It is now evident that utilization of health services goes beyond provision of health services hence it is important to consider the demand side which is domiciled in the community. Since the establishment of Community Health Services in Kenya in 2006, various organizations have come up with innovative social accountability approaches towards improving health outcomes at the community level. However, these approaches have neither been standardized nor mainstreamed by the Ministry of Health. The MOH has now found it necessary to develop CSC guidelines that informs the processes of community participation to hold the service providers and community members accountable to the quality of health services provided.

4.0 Mainstreaming Community Scorecard in Health Sector

The Community Score Card shall leverage the existing primary health care structures from level 1 to 4 to ensure sustainability and accountability of service provision. These structures include but are not limited to Community Health Committees (CHC), Health Facility Management Committees (HFMC), community dialogue days, community action days, Community Health Action Plan (CHAP) and data review meetings, among others. The CSC will also leverage on the existing health information system structures. The scorecard works best in primary health care facilities because they have a clearly defined catchment area and offer basic care services that are easily understood by community members. The CSC can also work at level 5 and 6 provided there is a clear-cut definition of the catchment community and the governance structure of the referral facility as well as understanding of the complexity of services provided at the tertiary level.

The MOH through the Division of Community Health Services will provide oversight in the implementation of the Community Scorecard. Additional structures to support implementation of community scorecard include the Community Health Workforce, the health facility teams, County and sub-County Health management teams.

According to the Community Health Policy (2020-2030), CHCs are responsible for providing oversight of community health units. In this regard, CHCs will lead implementation of CSC between communities and the primary health facilities.

The community scorecard shall be digitized and linked to the Kenya Health Information System (KHIS) to increase access to data, timely feedback, evidence-informed decision making and action. It will be anchored on the national Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) scorecard platform and will form part of the other MoH scorecards.

5.0 Principles of Community Scorecard

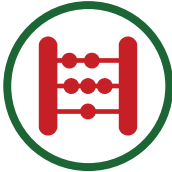
The CSC implementation is guided by the following six (6) principles:



1. Participation: Involve the community members, local leaders, health managers, implementing partners and health service providers in a joint problem identification, decision-making and action.



2. Transparency: Openly share and receive feedback on how health services are being experienced by the community members.



3. Accountability: All stakeholders are held to account for the commitments they make and areas of responsibilities officially held



4. Informed decision making: The stakeholders make decisions based on data and evidence generated.



5. Responsibility: The stakeholders shall be responsible for following through the action plans jointly agreed with the community to ensure continuous improvement of the quality of services.



6. Confidentiality: The information provided by community members will be anonymous and will not be used to victimize anybody.

6.0 Conditions for the Community Scorecard Process

The following conditions should be considered for the scorecard process to be successfully implemented:

- The CSC assessment sessions must have a representation of youths, women, the elderly, people living with disability among others and should observe the two thirds gender rule
- Community scorecard meetings should be held in a neutral place such as school or church/mosque where community members will feel free to air their views without fear or intimidation
- All the teams that participate in the community scorecard process should be adequately trained on their roles, responsibilities and deliverables
- Functional community health committees and facility health management committees
- The Community Health Assistants (CHAs), Community Health Volunteers (CHVs), facility staff and FHMC members shall **NOT** be in attendance during the CSC assessment session.

7.0 Community Scorecard Implementation Steps

The CSC comprises of 6 steps which can be summarized into two components namely, the scoring and action planning sessions. Every quarter the CHC convene communities for:

1. **Scoring session** where community votes to score indicators about the quality of health services and
2. **Action plan session** that creates community health action plans to solve the problem identified during the scoring session.

The six steps of CSC implementation are:

Step 1: Understanding the community's perceptions and developing indicators

The Kenya MOH through the Division of Community Health (DCH) consulted widely with stakeholders to understand community perceptions and came up with a list of 9 CSC indicators as follows:



Indicator 1: Respectful and compassionate care.



Indicator 2: Waiting time for provision of health care services.



Indicator 3: Availability of medicines and diagnostic services



Indicator 4: Responsiveness to community health needs



Indicator 5: Cleanliness of the facility



Indicator 6: Safety and security of the facility



Indicator 7: Home visits by Community Health Volunteers



Indicator 8: Assessment of NHIF services



Indicator 9: Emergency and referral services

These indicators will be reviewed from time to time based on changing and emerging needs.

Step 2: Training for the CSC

Training is an essential part in ensuring successful implementation of the community scorecard. It will be cascaded as follows:

- The Ministry of Health through the Division of Community Health will train the County Health Management Teams (CHMTs) and Sub-County Health Management Teams (SCHMTs) on the community scorecard
- The CHMT and SCHMT will train the Health Workers, CHAs, HFMC, CHCs, CHVs, local politicians and administrators

The CHMT and SCHMT will be trained as CSC trainer of trainers. Training of the CHMT and SCHMT will focus on enhancing their understanding of the context of the CSC in Kenya, CSC indicators, scorecard process as well as their role in coordinating implementation of the scorecard in their respective counties. Training of the CHAs, CHVs, HFMC, CHCs, local administration and local political leadership will equip them with a deeper understanding of the CSC process including the scorecard indicators, scoring, and action planning process. The training of all teams should make use of participatory learning methods such as demonstrations and role plays.

Step 3: Conducting the community scorecard assessment

This is a quarterly activity which is conducted during community dialogue meeting. The scorecard assessment will be conducted by a team of at least 4 CHC members led by the CHC Chair or his/her appointee. The composition of the scorecard assessment meeting will include the following:

- a) The CHC chairperson/acting chairperson
- b) The CHC members (at least 3 members)
- c) Local administration (area chief/sub-chief)
- d) Community members (at least 20)

Community members' representation should include youth, men, women, the elderly, PWDs, local leaders, religious leaders etc.)

Scorecard assessment will be done in 3 phases namely:

Phase 1: Introduction

1. The CHC chair **OR** any other CHC member selected to facilitate CSC assessment session informs community members during quarterly community dialogue meeting/CSC meeting on the importance of the community scorecard.
2. The facilitator reassures community members that the assessment is conducted only to get the community feedback on the quality of services provided at the local health facility with the aim of improving service delivery.
3. The facilitator explains that responses received will be anonymous and will not be used for punitive measures, however it will be used to improve service delivery.
4. The facilitator explains that the process will help identify the priority areas and give recommendations for improvement

Phase 2: Explain the Purpose of the CSC

The facilitator explains the following as the objectives of the CSC:

1. Capture community perceptions of health services by assessing the health facility and CHU and recording on form A, guided by the indicators
2. Monitor service quality and respond to community needs through generation of action plans.
3. Enable health workers and community members to understand and relay community needs and perceptions.
4. Reinforce action and accountability of the primary health care delivery system

Phase 3: The community scorecard assessment process:

The facilitator:

1. Explains to community members that they will discuss nine indicators to assess their experience with health care delivery at their link facility and community health unit. Each indicator will receive score of 1 - 3: (1 – bad / 2 -Average / 3 - Good)
2. Uses **table 1 (Community Scorecard Indicator Definition and Scoring Guide)** to guide discussions for 5-10 minutes on each indicator. Then the community members rate the facility to reach consensus on the score through a majority vote. The score is then entered in form A. For example, the facilitator will ask the participants to consider indicator #1. They discuss for 5-10 minutes, then the facilitator asks how many score it as **1 - bad, 2 - average and 3 - good**. The facilitator records the score that received a simple majority as well as reasons/comments for the score.
3. Summarizes discussions and ensures all scores and reasons/comments are recorded for each indicator on **Form A (Community Scorecard Assessment Summary)**
4. The CSC assessment team presents its report during the feedback meeting with the health facility team

Step 4: Facility visit and feedback

CSC assessment team visits the link facility to present CSC report to the health facility feedback meeting attended by the following:

- a. HFMC
 - b. Facility staff led by facility in-charge
 - c. CHC team
 - d. SCCHFP – Chair
 - e. PHC coordinator – where available
 - f. CHA
 - g. Other ad hoc members as deemed necessary
-
1. The facility in-charge takes the CSC assessment team on a tour of the facility to acquaint themselves with the infrastructural and service delivery aspects of the facility.
 2. The Chair (SCCHFP) prepares the team to receive the CSC assessment report
 3. CSC assessment team presents their scores and explanations for the scores.
 4. The team discusses the shared report and draws a joint action plan with clear timelines and responsible persons
 5. **Form B (Kenya Community Scorecard Action Plan)** should be used to document the action plan.

Step 5: Facility-Community interface meetings

Convened by the SCCHFP/PHC coordinator

This meeting is composed of:

- a. SCCHFP
- b. PHC Coordinator where available
- c. Facility staff
- d. HFMC
- e. CHC
- f. Local political leaders
- g. Local administration
- h. CHA
- i. CHVs
- j. Community members

1. The chair of the HFMC/ CHC presents the joint action plan drawn during the facility feedback meeting.
2. The joint action plan is discussed, actions for the facility and the community agreed upon and timelines determined.
3. Three copies of the action plan (Form B) are prepared and dispatched as follows: A copy is submitted to the SCMOH for follow up and or action, a copy is given to the facility in-charge to be posted at the facility and actions entered to the RMNCAH scorecard platform and the last copy is given to the CHC chair.
4. A copy of Form A is submitted to the sub-county Health Records and Information Officer (HRIO) for entry of the scores into KHIS 2.

Step 6: Taking action and follow-up

1. The M & E unit in the Division of Community Health, Community Health Services Focal Persons (CHSFPs) at the county and sub-county level, facility in-charge, and CHA conduct monthly follow ups on the actions.
2. The SCMOH will take responsibility for the implementation of the action plan at the sub-county level.
3. The CHA and the facility in charge takes the lead in following up of the action plans at the community and facility level respectively.
4. The CHA could leverage on the action days to implement the community actions.
5. Progress is shared in the monthly review meetings at the respective levels.

Table 1: Community Scorecard Indicator Definition and Scoring Guide

Indicator	Definition	Discussion Points <i>Probe using the discussion points for each indicator</i>	Scoring: 1-Bad (Red); 2-Average (Yellow); 3-Good (Green) <i>After 5-10-minutes discussing the indicator, put the issue to a consensus vote and record a majority score on a scale of 1-3)</i>
Indicator 1: Respectful and compassionate care.	Provide person-centered care with respect and empathy	You feel respected by the health workers when he/she attends you	Bad – 1 Average – 2 Good – 3
	Effective communication with clients or accompanying family members	Health workers take time to explain to you your condition and what you need to do	
		Health workers pay attention to your concerns	
	Observation of the patients' privacy	You feel the healthcare workers serve you in a private space	
		Health workers keep information received confidential (do not disclose to third parties)	
Indicator 2: Waiting time for provision of health care services.	The waiting time refers to the time when the patient arrives at a service station to the time, he/she receives first service.	You feel that you are normally served within reasonable time as provided by the service charter	Bad – 1 Average – 2 Good – 3

Indicator	Definition	Discussion Points <i>Probe using the discussion points for each indicator</i>	Scoring: 1-Bad (Red); 2-Average (Yellow); 3-Good (Green) <i>After 5-10-minutes discussing the indicator, put the issue to a consensus vote and record a majority score on a scale of 1-3)</i>
Indicator 3: Availability of medicines and diagnostic services	Medicines and diagnostics services	You normally get the prescribed medicines from the health facility	Bad – 1 Average – 2 Good – 3
		You normally get the prescribed laboratory tests from the health facility	
		Missed laboratory service because electricity was not available at the health facility	
Indicator 4: Responsiveness to community health needs	Participation in community dialogue meetings	Facility staff participate actively in community dialogue meetings	Bad – 1 Average – 2 Good – 3 Not Applicable - 9 (If no prior CSC assessment)
	Responsiveness to community grievances	Facility staff respond promptly to community grievances	
	Responsiveness to community scorecard action points	Facility staff respond to community scorecard action points	Not Applicable - 9 (If no prior CSC assessment)

Indicator	Definition	Discussion Points <i>Probe using the discussion points for each indicator</i>	Scoring: 1-Bad (Red); 2-Average (Yellow); 3-Good (Green) <i>After 5-10-minutes discussing the indicator, put the issue to a consensus vote and record a majority score on a scale of 1-3)</i>
Indicator 5: Cleanliness of the facility	Availability of running water	Facility has running water	Bad – 1 Average – 2 Good – 3
	Clean toilets	Facility has clean toilets	
	Handwashing facilities with soap and water	Facility has handwashing stations with soap and running water	
	General cleanliness of the facility	Facility surfaces, floors, windows and doors, ceiling, walls, and the compound kept clean	

Indicator	Definition	Discussion Points <i>Probe using the discussion points for each indicator</i>	Scoring: 1-Bad (Red); 2-Average (Yellow); 3-Good (Green) <i>After 5-10-minutes discussing the indicator, put the issue to a consensus vote and record a majority score on a scale of 1-3)</i>
Indicator 6: Safety and security of the facility	Appropriate waste disposal	Facility and its environs free from medical waste (used gloves, face masks, syringes/needles, bandages etc.)	Bad – 1 Average – 2 Good – 3
	Separate toilets for both gender with lockable doors	Existence of separate toilets for both men and women with lockable doors	
	Reliable power supply	Facility has back up system to ensure electricity during blackouts	
	Presence of security personnel	Presence of security guards at the facility during the day and night	
	Facility fenced with a gate	Facility is fenced and has a manned gate	
	No overgrown grass/ bushes at the facility	Presence of overgrown grass/bush within the facility compound	

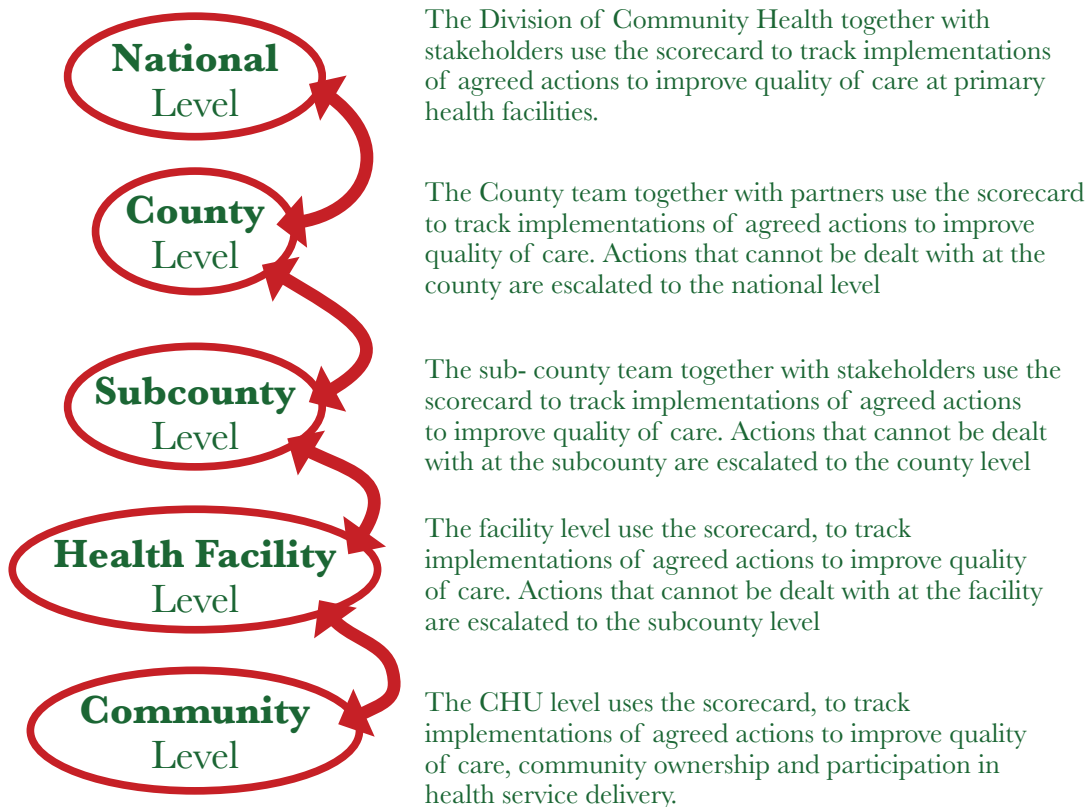
Indicator	Definition	Discussion Points <i>Probe using the discussion points for each indicator</i>	Scoring: 1-Bad (Red); 2-Average (Yellow); 3-Good (Green) <i>After 5-10-minutes discussing the indicator, put the issue to a consensus vote and record a majority score on a scale of 1-3)</i>
Indicator 7: Home visits by Community Health Volunteers	Community Health volunteers conduct home visits on a regular basis	Receive home visits from Community Health Volunteers at least once in 3 months	Bad – 1 Average – 2 Good – 3
		Receive any health services from the community health volunteers whenever they visit your home. Please explain the nature of the service	
Indicator 8: Assessment of NHIF services	How well health facilities are providing NHIF accredited services	Health facility accept NHIF cards	Bad – 1 Average – 2 Good – 3 Not Applicable - 9 (If the facility is not accredited by NHIF)
		Access health services (consultation, laboratory tests, and medicines) with your NHIF card at the health facility	

Indicator	Definition	Discussion Points <i>Probe using the discussion points for each indicator</i>	Scoring: 1-Bad (Red); 2-Average (Yellow); 3-Good (Green) <i>After 5-10-minutes discussing the indicator, put the issue to a consensus vote and record a majority score on a scale of 1-3)</i>
Indicator 9: Emergency and referral services	Access to emergency (ambulance) services	Normally get ambulance services promptly (from county health department) whenever you have a medical emergency	Bad – 1 Average – 2 Good – 3
	Bi-directional referral services (Community-Facility-Community)	Referred by the community health volunteer from the community to the health facility for further management of your condition	
		Referred from the health facility to the community for continuity of care at home	
		Referrals from the community by the community health volunteers honored by the link facility	

Scoring: Each indicator is discussed using the discussion points and given a score or a rank ranging from 1 to 3. Facilitator records the score that received a simple majority as well as reasons/comments for the score. A score of 3 will be good and denoted by a green colour; a score of 2 will be average and denoted by a yellow colour whereas a score of 1 will be poor and denoted by a red colour in the scorecard platform. The expected highest score from scoring the 9 indicators is 27 points whereas the lowest score is 9 points. A overall score of 20 – 27 points (70-100%) will be classified as good; a score of 13-19 (50-69%) will be average whereas a score of 9-12 points (<49%) will be bad.

8.0 Community Scorecard Data flow and Review Process

Once the community scorecard assessment and action plan development processes are completed, a duly filled Form A will be submitted to the sub-county HRIO to enter the scores into KHIS 2. A duly filled Form B will be submitted to the facility in-charge to enter the actions into the RMNCAH scorecard platform. The scorecard platform is available online on www.rmncan.org and accessed via a username and password. All stakeholders will be assigned a username and password to enable them access and use the platform. Training on the scorecard platform will be part of the CSC roll out plan. The platform will pull data from the KHIS 2 for visualization as a scorecard. It allows for disaggregated and granulated visualization of data for different hierarchical units (national, county, sub-county etc.). The scorecard will be integrated into existing performance review processes. At facility and community levels, the scorecard will be used to track implementation of actions whereas in the other levels, the scorecard will be reviewed, bottlenecks identified, and actions taken to improve quality of health services provided at primary health facilities. The table below details data flow, scorecard review and feedback mechanisms.



The interface meeting between the facility and community finalizes the action plan prepared during the facility visit and feedback meeting and summarizes it in Form B, which is then entered into the scorecard action tracker.

At the community level, the facility and CHU are assessed, and Form A completed, then entered into KHIS 2.

9.0 Roles and Responsibilities

Table 2: Role of Stakeholders in implementation of Community Scorecard

Stakeholders	Role
National (MOH)	<ul style="list-style-type: none"> • Develop and disseminate policy guideline on Community Score Card • Capacity building • Lead resource mobilization • Monitoring and Evaluation, Accountability and Learning (MEAL). Including Operation Research • National advocacy for Community Score Card including championing the implementation and use of CSC • Addressing action points from lower levels
County (CHMT)	<ul style="list-style-type: none"> • Adopt and Coordinate Community Score card implementation. • Conduct training, support supervision and coaching of the teams. • Resource allocation/mobilization • Monitoring and Evaluation, Accountability and Learning (MEAL). Including operation research • Coordination of CSC stakeholders and Partners at the County level • Addressing action points from lower levels
Sub-County (SCHMT)	<ul style="list-style-type: none"> • Conduct training, support supervision and coaching of the teams • Resource mobilization • Monitoring and Evaluation, Accountability and Learning (MEAL) • Coordination of CSC stakeholders and Partners at the sub-county level • Addressing action points from lower levels
Health Facility committee	<ul style="list-style-type: none"> • Implementation of the CSC • Resource mobilization • Monitoring and Evaluation, Accountability and Learning (MEAL).

Stakeholders	Role
Community Health committee	<ul style="list-style-type: none"> • Implementation of the CSC • Provide leadership and oversight of CSC • Plan, coordinate and conduct community dialogue and health action days • Hold quarterly consultative meetings with link facility on the CSC
Civil Society Organization / Community-Based Organizations / Faith-Based organization	<ul style="list-style-type: none"> • Raise awareness of the general public on CSC and its role in the community. • Align their ongoing and future support to CSC implementation • Enhance Accountability of both National, County governments on their obligations to the citizenry in relation to implementation of CSC.
Partners	<ul style="list-style-type: none"> • Support implementation of the CSC • Advocacy for adoption of CSC by the implementing partners
Academia and Research Institutions	<ul style="list-style-type: none"> • Routinely conduct research to generate evidence and learning to inform future improvements of the CSC work • Support the National and County governments in knowledge translation (use research evidence in policy- and decision making) in order to foster increasing appreciation and use of evidence –based decision making for community health.

10. Annexes

Annex 1: FORM A



Ministry of Health

COMMUNITY SCORECARD ASSESSMENT SUMMARY

NAME OF FACILITY.....NAME OF CHU(s).....
COUNTY.....SUB-COUNTY.....
WARD.....
QUARTER YEAR.....DATE.....

	Performance Criteria	SCORE	REASONS FOR THE SCORE/COMMENTS
1.	Respectful and compassionate care.		
	Provide person-centered care with respect and empathy		
	Effective communication with clients or accompanying family members		
	Observation of the patients' privacy		
2.	Waiting time for provision of health care services		
	Time patient takes to receive services		
3.	Availability of medicines and diagnostic services		
	Medicines and diagnostics services		
4.	Responsiveness to community health needs		
	Participation in community dialogue meetings on a quarterly basis		
	Responsiveness to community grievances		

	Performance Criteria	SCORE	REASONS FOR THE SCORE/COMMENTS
	Responsiveness to community scorecard action points		
5.	Cleanliness of the facility		
	Availability of running water		
	Clean toilets		
	Handwashing facilities with soap and running water		
	General cleanliness of the facility		
6.	Safety and security of the facility		
	Appropriate waste disposal		
	Separate toilets for both gender with lockable doors		
	Regular power supply		
	Presence of security personnel		
	No overgrown grass/bushes at the facility		
7.	Home visits by Community Health Volunteers		
	Community Health Volunteers conduct home visits on a regular (at least quarterly) basis		
8.	Assessment of NHIF services		
	How well health facilities are providing NHIF accredited services		
9.	Emergency and referral services		
	Access to emergency (ambulance) services		
	Presence of bi-directional referral services (Community to facility and facility to community)		

Guide for scoring

Good – 3

Average – 2

Bad – 1

Assessment Guide (Point %)

20-27 points (70-100%)

13-19 points (50-69%)

9-12 points (<49%)

Compiled By:

Designation:

Signature:

Endorsed By:

Designation:

Signature:

Annex 2: FORM B



Ministry of Health

KENYA COMMUNITY SCORECARD ACTION PLAN

County: _____ Sub County: _____ Ward _____

Name of Facility: _____ Date Created: _____

Committee Members Present:

1: 2: 3:

4: 5:

Chairperson: _____ Phone No: _____

Secretary: _____ Phone No: _____

Problem description	Action description	Stakeholder/ Collaborators	Person responsible (Owner)	Deadline (Date)

11. References

1. Kenya Vision 2030 (2007)
2. Kenya Health Act, 2017 (No. 21 of 2017)
3. The Astania Declaration on Primary Health Care – WHO/World Health Organization. 25th October 2018
4. Kenya Community Health Policy 2020 – 2030
5. Kenya Primary Health Care Strategic Framework – 2019 – 2024
6. Kenya Community Health Policy 2020 – 2025
7. The Constitution of Kenya 2010
8. Kenya Implementers Manual for Social Accountability in Health (2015)







Ministry of Health

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Kenya Community Scorecard Guidelines

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