



Improving Health Services through the Community Score Card at Miritini CDF Health Centre

County:	Mombasa County		
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Introduction

For residents around Miritini CDF Health Centre in Mombasa County, seeking healthcare was once accompanied by several challenges. Patients faced long waiting times, inadequate medicines, poor infrastructure and limited security. The facility also had few nurses, while laboratory services were affected by a shortage of technical staff.

Some of these challenges were raised through the Community Score Card (CSC) process. According to Justin Hadera, Chairperson of the Community Health Committee (CHC), residents had concerns about the services they received, including delays, inadequate supplies and gaps in the facility environment. The concerns gave the community an opportunity to move beyond raising complaints to participating in finding practical solutions.

At the registration point, for instance, patients took an average of 15 minutes to be served. Laboratory services were no different due to only one laboratory technologist available to handle samples and process results. In the maternity unit, some expectant and new mothers reported poor treatment and negative attitudes from staff. Ambulance delays also affected emergency referrals.

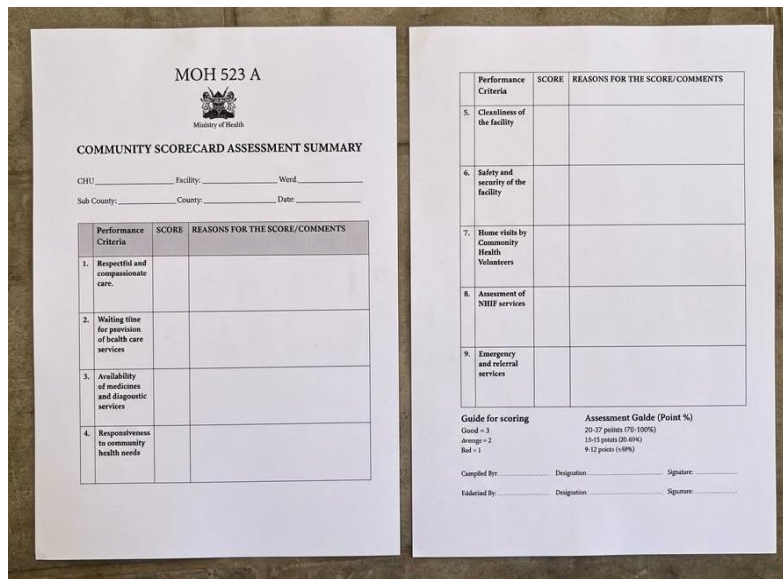
The challenge, therefore, was not simply identifying what was going wrong. There was a need for a structured mechanism through which residents could raise concerns, engage health workers and agree on actions that could be followed up.

It was against this background that the Community Score Card became an important part of service improvement at the facility. The approach was introduced through the African Leaders Malaria Alliance (ALMA) and later received support from the Stretchers Project before being taken up by the facility and the County Government of Mombasa. The CSC provides residents with a formal platform to assess services, share their experiences and participate in identifying areas that require attention.

Implementation of the practice:

At Miritini, the process is anchored by the Community Health Committee, which serves as a link between the health facility and the community. The Committee is made up of members elected by the community to represent different groups and geographical areas. Its membership includes representatives of persons with disabilities, youth, older persons and religious groups, ensuring that health concerns from across the community are brought to the facility and discussed.

Before each engagement, CHC members mobilize residents through public address systems, door-to-door outreach and direct engagement with people visiting the facility. This helps community members understand the purpose of the exercise and participate in assessing the services they receive.



The image shows a two-page template for a Community Score Card (CSC). The left page is titled 'MOH 523 A' and 'Ministry of Health'. It includes a section for 'COMMUNITY SCORECARD ASSESSMENT SUMMARY' with fields for CHU, Facility, Ward, Sub County, County, and Date. Below this is a table with three columns: 'Performance Criteria', 'SCORE', and 'REASONS FOR THE SCORE/COMMENTS'. The table lists four criteria: 1. Respectful and compassionate care, 2. Waiting time for provision of health care services, 3. Availability of medicines and diagnostic services, and 4. Responsiveness to community health needs. The right page continues the table with criteria 5 through 9: 5. Cleanliness of the facility, 6. Safety and security of the facility, 7. Home visits by Community Health Volunteers, 8. Assessment of NHHF services, and 9. Emergency and referral services. Below the table is a 'Guide for scoring' section with a table showing point values for different score ranges (Good = 3, Average = 2, Bad = 1) and a corresponding percentage of points (75, 50, 25). At the bottom, there are signature lines for 'Completed By' and 'Initiated By' with fields for Designation and Signature.

Figure 1: Community Score Card Template

The first phase involves community members scoring the facility against nine indicators. These include respectful and compassionate care, waiting time, availability of medicines and diagnostic services, responsiveness to community needs, cleanliness, safety and security, home visits by Community Health Promoters, SHA services, and emergency and referral services.

The process does not end with the scores. Once the community assessment is completed, the CHC presents the findings to service providers. Health workers respond to the issues raised and explain the challenges affecting service delivery. The two sides then meet during an interface meeting or baraza to agree on practical actions.

Humphrey Otieno Owuor, Community Health Assistant at Miritini CDF Health Centre, explained that the feedback generated through the process is useful beyond service assessment. He noted that the comments help the facility identify areas requiring attention and inform budgeting and prioritization, allowing resources to be directed towards issues raised by the people using the facility.

This has created a direct connection between community concerns and facility planning. Feedback is considered when determining priorities, while agreed actions are recorded in a Community Score Card

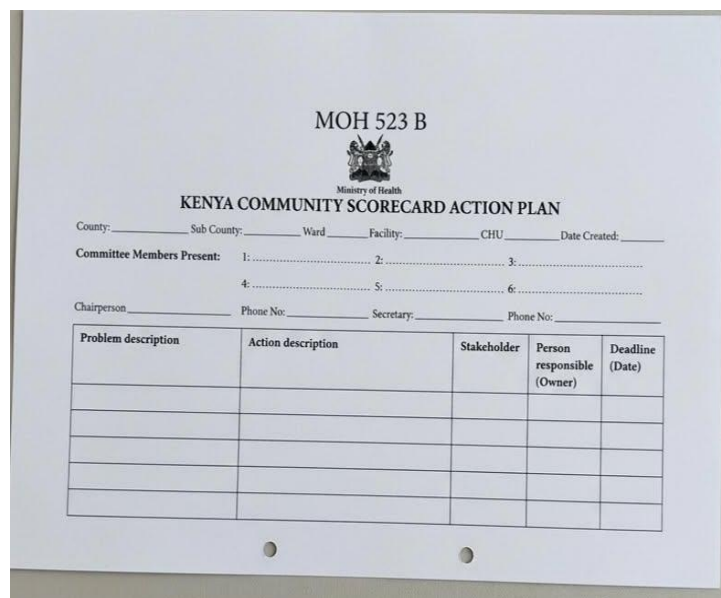


Figure 2: Community Score Card Action Plan

Action Plan for follow-up. The CHC monitors implementation, and the facility keeps previous scorecards and action plans to track progress over time. Issues that fall outside the nine indicators are captured under the Any Other Business (AOB) section of the dialogue minutes.

The County Government has also responded to some of the priorities emerging from the engagements. The facility is currently undergoing renovation and has received four newly deployed nurses. It has also acquired two new maternity and delivery beds, strengthening its capacity to respond to identified service needs.

Results of the practice:

The value of the CSC is most visible in the changes recorded at the facility. One of the issues raised by service users was the long waiting time at registration. Patients previously spent an average of 15 minutes at the registration point. Following discussions between the Facility Health Management Committee and staff, the turnaround time reduced to 10 minutes. The improvement was linked to greater staff responsiveness and adherence to the facility's service charter.

Medicine availability has also improved. The facility previously experienced insufficient and poorly matched supplies. Through the CSC process, medicine availability became one of the issues considered during planning and budgeting. The facility now receives medicines that are better aligned with the needs of the population it serves.

The most notable changes have been recorded in Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) services. Concerns raised about maternity care prompted discussions between community members, health workers and facility management. Changes in staff attitude

and service delivery were followed by increased use of maternity services, with facility records showing deliveries rising from 23 to 66 within three months.



Figure 3: New Maternity Beds bought as a result of Community Score Card Dialogues

The facility has also created a secluded section specifically for youth consultations, providing a more private and youth-friendly space where young people can seek services and discuss their health concerns. The consultations are conducted by youth health practitioners, which helps create an environment where young people can access appropriate services with greater comfort and confidentiality.

The gains have extended to immunization and reproductive health services. Immunization uptake has improved by about 85 per cent, while the number of defaulters has fallen from more than 1,000 to fewer than 50. The facility has also recorded more than a 50 per cent increase in cervical cancer screening and reproductive health consultations among teenage girls and women.

The shift is also evident in maternal health-seeking behaviour. The facility now records minimal to zero home deliveries, which community and facility representatives associate with increased awareness and engagement around facility-based care.

For Mr. Hadera, the changes demonstrate the importance of giving residents a recognized platform to raise concerns and participate in solutions. The CSC has strengthened the relationship between the facility and the community by giving residents a greater sense of ownership of the health centre.

The scorecard has also created space for residents to assess their experiences with SHA services, which forms part of the nine indicators. This allows community feedback on access and quality of care to be brought into facility discussions.



Lessons learnt:

Miritini's experience shows that community feedback can become a practical driver of service improvement when it is connected to a clear process for action. The value of the CSC lies not simply in the scores, but in what happens after the scores are generated.

The dialogue between service users and providers has created space for both sides to understand the challenges affecting service delivery and agree on realistic actions. Facility responsiveness has been equally important. Where concerns raised by the community have received attention, improvements have been recorded in areas such as registration, maternity services and medicine availability.

The process has also demonstrated the importance of community ownership. Because CHCs are drawn from the community and represent different groups, they provide a trusted channel for mobilizing residents and bringing their experiences into facility discussions.

Maintaining records has strengthened this process further. Previous scorecards and action plans provide a record of issues raised, commitments made and progress achieved. This institutional memory allows the facility to build on previous engagements rather than starting afresh each time.

At the same time, sustainability remains a challenge. The CSC is resource-intensive, and limited funding has affected the regularity of the exercise. Although the process was designed to take place quarterly, some sessions have been skipped because of resource constraints. At Miritini, the exercise has therefore been conducted semi-annually during FY 2024/2025 and FY 2025/2026.

The CHC also requires greater support to perform its role effectively. Members have limited training despite their responsibilities in community oversight, while, unlike Community Health Promoters, they are not remunerated nor recognized for their work.

Conclusion:

For the Community Score Card to deliver its full potential, stakeholders at Miritini identified the need for dedicated budgetary support to ensure that the dialogues, mobilization and follow-up activities can take place consistently. Regular training of CHC members is also necessary to strengthen their capacity to facilitate community engagement, document concerns and monitor agreed actions.

There is also a need to formally recognize CHCs as important actors within the health system. Their role goes beyond mobilizing residents. They connect communities to health facilities, facilitate dialogue, communicate service delivery concerns and follow up on commitments.



Miritini's experience demonstrates what can happen when community feedback is given a clear pathway to action. A concern raised by a patient can become a discussion, a commitment, a budget priority and, ultimately, a measurable improvement in service delivery.

The Community Score Card has therefore become more than a tool for scoring health services at Miritini CDF Health Centre. It has created a feedback loop that brings the community into the process of improving its own health facility, turning community voices into action and action into better care.

Further reading:

- Kenya Community Scorecard Guidelines for Social Accountability in Primary Health Care by the Ministry of Health



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Photo Gallery:



Figure 4: Participants during the Community Score Card documentation exercise



Figure 5: Tents used during the Community Score Card Dialogues



Figure 6: Secluded section for youth consultations



Figure 7: CHA, CHC and CoG Staff during the County Score Card Documentation Exercise