

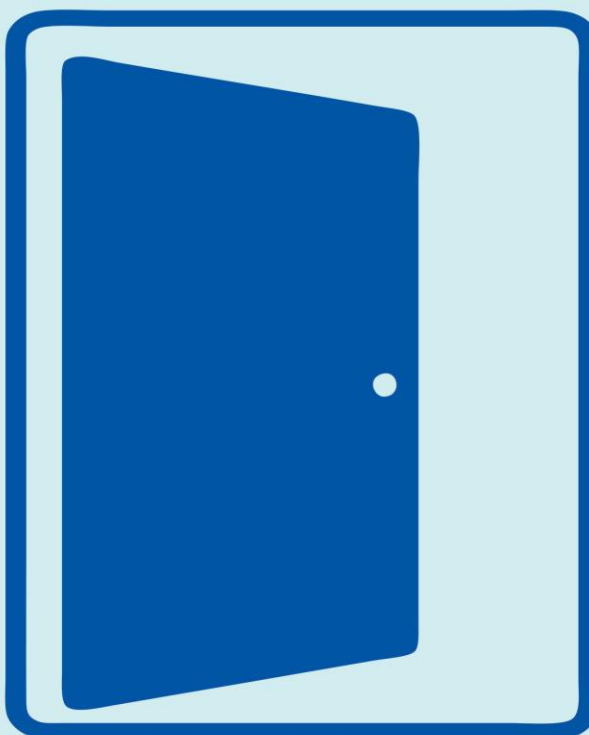
Republic of Kenya



Ministry of Health

# *The Best Practices in Health Sector*

**OPEN THE DOOR TO INNOVATIVE PRACTICES**



**REPORT FOR 2014/2015**

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## FOREWORD

The Constitution of Kenya 2010 enshrines the right to the highest attainable standard of Health, and further entrenches the principles of service delivery such as efficiency, transparency, accountability and equity. The Government of Kenya is committed to progressively achieve the right to health and further committed to improving access to quality and equitable health care to its citizens. The health sector is pivotal in the realization of vision 2030, and forms part of the social pillar in the vision 2030 developmental agenda.

Provision of equitable health requires huge investment in all components of the Health System. The Kenya Health Policy 2014-2018 provides a framework for investment in health under eight orientation areas, namely, Health Infrastructure, Health Products and Technology and Health Workforce, Health Information, Health Leadership and Governance and Health Research and Development. Scarcity of resources necessitates the need for targeted and cost effective investments in the various orientation areas.

Annual Performance Review has been institutionalized in the Health Sector as part of the accountability cycle. The main aim of the review is to identify progress made in implementation of the planned activities in order to inform decision making. In the year 2014/2015 the reporting of '**Best Practices**' was included as a crucial component of the Annual Performance Review.

Best Practices in the Health Sector are utilized in achieving objectives in different Health Sector Investment areas. The underlying principle of their utility is in their proven superiority in achieving results without using inordinate resources compared to common or usual practice and replicating the solutions adapted to similar health problems in other situations and contexts. The Health Sector has developed criteria for selection of Best Practices governed by various attributes of the best practice such as efficiency, cost- effectiveness, community involvement, sustainability and possibility of duplication. This report provides a comprehensive view of the Best Practice selection process and methodology in the sector. Both National and County Best Practices are described and the immediate impact of the various interventions in the provision of quality Health Care to Kenyans.

It is my sincere hope that all actors in Health shall rally behind the reporting and utilization of Best Practices to activate knowledge sharing mechanism, and to maximally utilize practical lessons in the health sector as effective tools to provide equitable, affordable and quality health care. I further encourage the sector players to consider the implementation and replication of best practices in different areas in the country.



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The Ministry of Health wishes to acknowledge the contribution of all the Best Practices Working Committee Members who participated in the development of the tools for evaluation and evaluating the submitted documented practices reported in the Performance Report 2014/2015.

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We are grateful to all Counties (CECs, Chief Officers, Directors and entire staff), heads of departments, Parastatals, Regulatory Bodies, Health Facilities and individuals whose contributions through documenting the best practices and providing information and inputs in this report enabled us to develop this great document which can be used and replicated for mutual learning.

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The Ministry would also like to thank all those whose names may have been inadvertently left out but who were either consulted during the development or who in one way or another contributed to the process of documentation, review and evaluation. We wish to state that without their contributions this work would not have been possible. We are greatly indebted to them.

Finally this Best Practices report was coordinated and prepared by the Monitoring and Evaluation Unit. The publication is made possible by the generous support of JICA.



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## EXECUTIVE SUMMARY

This report provides a detailed account of the Health Sector Best Practice reporting as part of the annual performance review FY 2014/15. It provides an outline of the reporting tool used along with the methodology that was employed to select the Best Practices for awarding and validation. The need for Best Practice interventions has been brought about by advancements in technology and a growing population, against a background of a constrained health budget. There is now a greater demand on health systems necessitating the need for cost effective interventions. This therefore warrants the identification and replication of Best Practices across the Health Sector in Kenya.

Attention is drawn to the utilization of Best Practices in different policy orientation areas such as Health Infrastructure, Human Resources and Service delivery. Modest improvements in various health indicators resultant of the implementation of Best Practices are highlighted. This is exemplified in Garissa County where all mothers attending Antenatal Care Clinics are supplied with a mama kit leading to increased skilled deliveries in the county and a reduction in maternal mortality. Innovativeness and inventiveness is underscored in Embu County where the *WhatsApp* mobile phone application is utilized in pharmaceutical commodity management. Sustainability, a key attribute in Best Practice implementation is demonstrated in the Moi Teaching and Referral Hospital where an efficient reorganization of staff duties saw the successful emergence of a 24 hour orthopaedic trauma theatre. Going forward it is recommended that different units in the Health Sector continue to report Best Practices as part of their annual performance. This will undoubtedly lead to replication of the applicable Best Practices in different parts of the country leading to impactful, efficient and cost effective service delivery.

## ACRONYMS

ANC	Antenatal Care
AWP	Annual Work Plan
CBO	Community –based Organization
CDH	County Director for Health
CEC	County Executive Committee (Member for Health)
CCO	County Chief Officer
CDOH	County Department of Health
CHEW	Community Health Extension Worker
CHMT	County Health Management Team
CHS	Community Health Strategy
CHV	Community Health Volunteer
COG	Council Of (County) Governors
COH	Chief Officer of Health
CPG	Clinical Practice Guideline
CRV	Civil Registration and Vital Statistics
CS	Cabinet Secretary (for Health)
DHMT	District Health Management Team
DMOH	District Medical Officer of Health
DMS	Director of Medical Services
DPHK	Development Partners in Health Kenya
EBM	Evidence-Based Medicine
EMMS	Essential Medicines and Medical Supplies
FP	Family Planning
HMT	Hospital Management Team
HRH	Human Resource for Health
HRM	Human Resource Management
HSC/IGA	Health Sector Coordination / Inter Governmental Affairs
HSSF	Health Sector Services Fund
HTA	Health Technology Assessment
ICC	Interagency Coordination Committee
ICTAK	Information Communication Technology Association of Kenya
JICA	Japan International Cooperation Agency
MCH	Maternal and Child Health
MNCH	Maternal, Neonatal and Child Health

MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOPHS	Ministry of Public Health and Sanitation
MSH	Management Sciences for Health
PO	Plan of Operation
PS	Principal Secretary (for Health)
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RTA	Renal Tubular Acidosis
TBA	Traditional Birth Attendant

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## INTRODUCTION

Vision 2030 provides stewardship in the long term development of the country. Health is one of the components of the social developmental pillars that would lead to attainment of the developmental agenda. Health performance and economic performance are intrinsically interlinked. Health care spending has gradually and consistently increased in an environment of limited resources, warranting efficiency and cost effectiveness in health interventions. Health is also adversely affected by external factors such as climate change, political instability and globalization. The health sector has made great strides in achieving its goals. For example, maternal mortality has moved from a high of 488/100,000 live births in 2009 to 362/100,000 live births in 2014. Infant mortality and under 5 mortality rate has declined from 52 per 1000 live births (2009) to 39 per 1000 live births in 2014 and 74 per 1000 live births (2009) to 52 per 1000 live births (2014) respectively. Various strategies are in place to ensure the sustainability of the gains that have been made as well as to combat any challenges. Amongst them is the use of Best Practices in service delivery interventions.

The concept of Best Practices is a combination of principles from Health Technology Assessment, Evidence Based Medicine and Clinical Practice guidelines. There are various definitions of what a best practice is; The Cambridge Dictionary describes a best practice as 'A working method or set of working methods that is officially accepted as being the best to use in a particular business or industry'. A Best Practice is generally accepted as being superior to other alternatives in producing the desired results.

Best practice theory is rooted in the improvement of effectiveness and efficiency in different systems. Its application is varied and cuts across different industries and sectors, with utilization in Human Resource Management in enhancing efficiency of Human Resources. It has also been utilized in environmental management in defining efficient and cost effective techniques in waste management.

In the health care context, *Best Practice* refers to the use of care and public health principles that are evidence based and known to promote high quality of care. Different service areas in the health care setting have utilized Best Practices. Globally, Best Practices have been used in evaluation of physician efficiency in hospitals and in the application of health behaviour change in enhancing treatment uptake and fidelity amongst patients.

The National and County governments in Kenya have utilized Best Practices as part of the Health Sector Strategic Plan in achieving Health Policy objectives. The Best Practices are implemented in the different policy orientation areas such as Health Technology and Products, Human Resources for Health and Health Infrastructure. The criterion for selecting a Best Practice

includes its evaluation in relation to its effectiveness, efficiency, relevance, sustainability and its replicability in other environments. Community involvement and innovativeness are also considered as important attributes of a Best Practice.

Best Practice selection in the Ministry involved the institution of a technical working group consisting of all pertinent stakeholders in the National and County governments. A reporting and scoring template was developed, taking into account various attributes of a Best Practice such as its efficiency, cost effectiveness and sustainability.

Garissa County was awarded first place in Best Practices in the 'Service Delivery Domain' FY 2014/2015, for its innovative and cost effective Best Practice; 'Provision of Mama Kits'. Implementation of this intervention led to improvement in maternal morbidity indicators as well as an increase in the number of skilled deliveries.

## BEST PRACTICE CRITERIA

For meaningful selection of a Best Practice there needs to be a criteria that justifies the Best Practice. Evidence shows that attributes such as efficiency, cost-effectiveness, sustainability, and partnership are essential in a Best Practice. While some of these attributes may be mandatory, some may be optional. The table below gives a description of the attributes considered necessary for Best Practice selection.

### Selection Criteria – Attributes

- **Effectiveness:** the practice **must work** and **achieve results** that are measurable
- **Efficiency:** the practice must produce results **with a reasonable level** of resources and time
- **Sustainability:** the practice must be **implementable over a long period of time** without any massive injection of additional resources
- **Replicability:** the practice **must be replicable** elsewhere in a similar environment
- **Relevance:** the practice must **address the priority** health problems in the target population
- **Leadership:** the practice must have **support from the relevant leaders**
- **Ethical Soundness:** the practice must **respect the current norms and rules of ethics** for dealing with human populations

Optional criteria include community involvement, innovativeness and partnerships. Community involvement includes the participation of the affected communities whereas partnerships include the involvement of various stakeholders. Innovativeness refers to the introduction of new methodologies to overcome present challenges.

## DOCUMENTED BEST PRACTICES FOR THE 2014/2015 FINANCIAL YEAR

### Garissa County- Best Practice in Service Delivery

#### **Provision of MAMA kits to pregnant mothers and incentives to Traditional Birth Attendants to improve skilled deliveries**

Garissa County's landscape is mostly arid - desert terrain, with inhabitants being mainly nomads. The county is ranked among the top 15 counties with high maternal mortality ratios. This could be attributed to the nomadic culture, which makes access to health facilities a challenge. Most mothers deliver at home with the assistance of Traditional Birth Attendants. Over the years, maternal mortality has remained high, while skilled deliveries have been on a constant low; there has been a low uptake of family planning services and postnatal and neonatal care and poor linkage of mothers to the health facilities. This prompted the County Health Management to visit Karamoja in Uganda to learn on best practices in improving maternal health. A practice that was found to be working in Karamoja was provision of MAMA kits and incentives for TBAs.

Garissa County Health Management Team adapted the practice. The team developed local guidelines on provision of Mama Kits and incentives for TBAs. A MAMA kit is a kit that contains the basic essentials of post-delivery. The health workers in the county were sensitized on the contents and provision of MAMA kits and incentives for TBAs. Through the Community Health Workers, TBAs were sensitized on the need for referring mothers to the facilities and sensitizing the community on provision of the kits in the facilities.



**Figure 1: Sample of MAMA Kit**

Provision of MAMA kits to mothers and incentives for TBAs was started with very minimal cost of Ksh. 300 per kit, which is feasible to implement the practice. The Free Maternity Services Fund allocated to the health facility has increased as the number of the deliveries increased, which sustainably covers the cost of deliveries leveraging on free maternity money. Besides this, the county government has adopted the practice and also budgeted for it. CEC for Health launched this program and has been supporting this practice.

This practice has contributed towards improving Maternal, Neonatal and Child Health outcomes. With the best practice in place, the following achievements have been observed:

- Deliveries increased from 36% in 2013 to 45% in 2015. The number of skilled deliveries increased from 6,571 to 9,704, an increase of 3,133 (48%) between the year 2013 and 2015.
- Family planning uptake increased from 3% in 2014 to 6% in 2015.
- Post-natal attendance increased from 25% in 2014 to 28% in 2015. The number of women attending postnatal clinic increased from 3,517 in the year 2013 to 6,646 in the year 2015; previously most of the facilities were either not providing postnatal services or not documenting. As a department of health in the county, through the provision of MAMA kits, mothers were motivated to come and seek these services.
- 4th ANC attendance increased from 30% in 2014 to 40% in 2015.
- Started to conduct and upload maternal deaths audits.
- Linkage of mothers to the facilities improved through use of TBAs. Enhanced partnership between the health workers and TBAs, resulting to better MNCH outcomes.

The practice was initially piloted in a few facilities/sub counties; the practice has now been replicated in all health facilities because the provision of MAMA kits and incentives can also be supported by the Free Maternity Funds which is available for all health facilities.



**Figure 2: A mother receiving MAMA kit after delivery**

A validation visit to Garissa County showed that the best practice is being implemented alongside other best practices which include:

1. Maternal shelters at locations close to the health facilities, which host pregnant mothers from far and who are close to delivering, enable them to access health services easily. This acts as a home away from home.
2. WhatsApp messaging which connects the facilities to the county team in case of stock-outs and need for referral.
3. Incentivizing (Gacanmaris) the TBAs with Ksh. 200 for every mother they bring in to deliver. These TBAs are allowed to be there during delivery of the baby for moral support, and in some occasions, allowed to deliver the baby in the facility together with the skilled worker.
4. Incorporating RMNCAH with CRVS by providing mothers who deliver at a health facility with birth certificates for their babies after completion of the measles vaccination.
5. Incentivizing the Community Health Extension Workers (CHEWs) with Ksh. 200 for every woman they bring to the facility. These CHEWs are assigned to 20 households each, which they know very well and thus enable to tell when a member of these households are pregnant, sick etc. The CHEWs are connected to the chiefs, who provide security during referral.
6. Tickler boxes to track defaulters of immunization and Antenatal Clinic Visits. These are boxes with 12 slots each representing a month of the year. Once a baby is vaccinated, their card is put into the tickler slot for the month of the next vaccination. This way, any child defaulting can be known and traced either by calling or through the CHEWs.
7. Enhanced referral system with 2 ambulances per sub county and motor bikes for the CHEWs to pick those who cannot make it to the facility.



**Figure 3: Tickler boxes to track defaulters of immunization and Antenatal Clinic Visits**



8. Introduction of alternative birthing through birth cushions, which is the traditional Somali way of birthing by squatting.

The practice has proven to be effective, efficient and relevant to the people of Garissa County. The cost of a MAMA kit is Ksh. 300 and motivation to the TBAs is KSH. 200 for each delivery they refer to the facility. The practice is currently sustained using the free maternity reimbursement money. This practice can easily be replicated in other facilities and counties by visiting Garissa County and learning from them. Considering that all free deliveries are reimbursed by the government, the facilities can buy the basic essentials after delivery and provide to mothers after delivery to attract them to utilize the facilities.



**Figure 4: Birth cushions**

## **Embu County- Best Practice in Health Technologies and Products**

### **Formation of a county commodity security/exchange team on WhatsApp social platform**

There has not been an established system of communication between various facility in-charges in Embu. This meant that a health facility had little room if any to air its needs to the rest of the team and also receive such communication from them. As a result of this, little or no redistribution ever took place. This led to the expiry of lots of health commodities which would otherwise have helped provide health care to several patients.

The county pharmacist formed a WhatsApp group named “county commodity committee”. All commodity Managers were made members. It started with compilation of the mobile phone numbers of all staff who handle commodities in the county and confirming that they are all on the WhatsApp platform. The agenda of the group was introduced and all the members unanimously agreed to support the initiative. Administration rights were given to the DMOHs and sub county pharmacists. The key inputs into the Best Practice include: mobile phone coverage, airtime, communication skills, commodity management knowledge, smart phones and human resources.



A large number of health workers in the county own a smart phone. This in return translates to very good coverage of the WhatsApp application. In effect, there is little to no investment associated with this innovation. Sending messages on the WhatsApp platform makes the officers incur negligible data charges. The Health department does not have to provide the infrastructure and airtime. It is done as a team effort that works towards enhancing efficiency and addressing the issues of expiry and stock-outs. The approach is easily sustainable since the mobile phone technology on which it rides keeps on getting better every day. Also the gap it addresses will continually exist and the users have found utility in being platform members. There are zero financial requirements required to run this platform. It is based on the commitment and self-dedication on the part of the health workers who are enjoying the benefits of the platform directly. The leaders in the county have been instrumental in the formation and success of this platform. The Director, the Chief Officer of Health (CoH) and the CEC are all members of the group and have continually reassured the members of their support of the good work being done. This active participation has served as much-needed moral support, which has seen staff gain morale and provide useful feedback.

This commodity group has seen a lot of action since its inception. Sub county pharmacists are always busy facilitating the collection of commodities and transferring them to needy sites. It has become much easier to source commodities for sites that run out of essential items and priority program commodities. This has seen:

- Zero or near zero commodity losses via expiry.
- Improved county health commodity security.
- Improved communication links and lowering of costs.
- Heightened sense of responsibility on the roles of various managers in safeguarding commodities in their custody.
- Improved access to health products and technologies by the patients.



**Figure 5: Demonstration of commodity management through mobile phone**

The platform is now 101 members strong and aims to hit the 200 mark within the next few months so as to cover all the commodity users in the county. It is a very simple model to replicate

in most counties in Kenya; this is due to near-universal mobile phone and internet availability. There are minimal resource requirements and the only technical expertise required is the knowledge of mobile phone use. No donor funding or lengthy paperwork is required in this case.

A validation visit conducted in Embu County showed that the practice is used in the county albeit to a limited extent and hence the need to reinforce its use.

## **Kenya Medical Supplies Agency- Best Practice in Health Technologies and Products**

### **Logistics Management Information System**

KEMSA has been struggling with challenges of poor commodity orders with various errors from facilities and counties, lack of order tracking and visibility by the facilities and lengthy order turnaround times. In an effort to overcome the challenges, KEMSA developed an online, computer based solution. The process started with consultations with the public health sector stakeholders to identify the challenges. A solution development committee with membership drawn from MOH facilities and KEMSA was established; the committee developed the specifications and led in the development of the online, computer based solution which was then rolled out to the counties and facilities. The CEO KEMSA has been in the frontline in leading the project implementation. CECs of health, county and facility pharmacists in the various counties have given their go-ahead and supported the LMIS training and implementation in their counties/facilities. KEMSA has put in place skilled personnel to support the system in the long term. The practice is currently being replicated in the remaining 20 counties.

Implementation of this practice has realized the following achievements:

- Counties and health facilities are able to place their order in a timely and accurate manner from anywhere.
- Counties and health facilities are able to track the status of their orders in real-time.
- Provides counties and health facilities with visibility on real-time KEMSA stock status.
- County pharmacists are able to manage the ordering process of facilities under their charge online.
- Improved program management by allowing for continuous program monitoring, optimal resource allocation, improved program supervision and quality and sound programmatic decision making.
- Improved health commodity policy decisions, by providing data for decisions at any time, at any level, and in any amount of detail needed, unlike survey data.

- Improved accuracy of procurement decisions by providing data on what commodities are actually in demand and used, helping supply chain managers avoid procuring unpopular or unnecessary commodities or procuring inappropriate quantities.
- Provides better control and accountability by enabling a program to control the flow of commodities, maintaining accountability for commodities and reporting the use of commodities purchased with public funds or donor loans.

Implementation of this best practice has earned KEMSA the category "Best use of ICT in health" by ICTAK, and also by the Computer Society of Kenya as having the "Best E-health Application".

## **Moi Teaching and Referral Hospital- Best Practice in Service Delivery/Human Resources for Health**

### **Introduction of 24 Hours Trauma and Referral Hospital in Uasin Gishu County**

As a referral hospital covering Western region, one of MTRHs mandate is to provide specialized healthcare and this covers trauma care. With exponential increase of trauma cases occasioned by RTAs, particularly increase of RTAs as a result of boda boda use, the demand for trauma care in hospitals became more evident. This resulted in challenges of providing responsive trauma care. Some of the specific challenges were:

- Overcrowding of patients in surgical wards. Long theatre lists scheduled for trauma operations. In many cases this led to cancellation because of non-availability of surgeons, theatre supplies and delayed preparation.
- Prolonged length of stay of trauma patients because of missed theatre schedule.
- Increased consumption of trauma theatre supplies.
- Low customer satisfaction in surgical department.

To reverse these challenges, Organization of Theatre Services saw it necessary to ensure an effective and efficient delivery of trauma care in the hospital. Recognizing the challenge, management held meetings with stakeholders to deliberate on the challenges and develop strategies to improve health services in the surgical department. One of the theatres was set aside specifically for trauma operations, to be run for 24hrs. Another preparation was recognizing the need for continued availability of theatre supplies. To ensure this was achieved, critical suppliers were prioritized for payment. It had been noted that delayed payment was affecting the relationship between the suppliers and the hospital. On implementation, the clinicians committed to undertake operations per day without compromising on the quality of

care. Review meetings were held on regular intervals to review progress, challenges and re-strategize where necessary for sustained implementation of the practice.

There was no funding used to have a dedicated theatre since what was required was reorganization of available theatres. Health personnel were already in place and no funds were spent in getting additional staff. Internally generated funds (user fees) were used to ensure suppliers' availability by paying them within the reasonable aging schedule. The CEO was directly involved in the planning and implementation of the practice through attending planning meetings, review meetings and dedicated provision of resources. The hospital holds Annual Forums with the community and the youth in order to engage them on challenges experienced while receiving care and how best these challenges can be addressed. In addition, MTRH holds stakeholders forum with the county hospitals on issues touching on delivery of care with respect to referral modalities and collaboration.

With the implementation of the practice, trauma operations increased from 600 per month to 800 per month, a 25% increase. Initially patients would wait for as long as 6 days to have an operation, but this has reduced to less than one day. Bed occupancy in surgical wards was above 100% i.e. patients sharing a bed was common. Currently one bed one patient is the practice and bed occupancy has reduced to below 100%.

## **West Pokot County Best Practice**

### **Mother's waiting home (maternal shelters)-kiror**

Mother waiting home (KIROR) is a home away from their home and outside the health facility.

West Pokot is one of the counties that has been experiencing a high burden of maternal and perinatal deaths and increased number of recto vaginal fistula and vesical vaginal fistula, which are related to maternal complications such as ruptured uterus, sepsis, postpartum haemorrhage and cephalopelvic disproportion due to early marriage and obstructed labour. These complications have been associated with long distance to the health facility. This prompted the County Health Management Team to carry out maternal audit at the facility level. An assessment was conducted at the facility level to identify the type of human resource, infrastructure and health products in a maternity ward. This led to the establishment of the waiting homes; Kabichbich, Ortum and Kapenguria Referral Hospital. The county government works closely with the partners. The partners support in the construction of the homes and donate beds and the county government provides other necessities such as food, water and security. In these homes, mothers are monitored during labour; this has led to reduction of late referral to the hospital hence reduced maternal mortality.

The implementation of this practice has led to an increase in the number of skilled deliveries due to proximity to the health facility. It has also contributed to the reduction of maternal and perinatal deaths.

## Other Best Practices

Other best practices were submitted from various organs as listed below. These practices range from various adaptations of information technology to provisions of incentives to fast-track positive change. Despite the positive submissions, there was a lack of utilization of the recommended reporting template, leading to difficulty in scoring because of scarcity of information.

Organization	Description of Best Practices
KEMRI	<b>“KEMRI’s Text IT”</b> . This is the Institute’s text messaging platform designed to improve early infant testing for HIV in Kenya as a strategy to deliver HIV-related information and encourage increased attendance for prevention programmes.
KEMRI	<b>“A research proposal tracking system”</b> . This is an electronic tracking system for scientific proposals from submission to the final stage of review.
KMTC	<b>“An e-learning program in Health Records and Information Pre-service Course”</b> . The new approach to teaching has helped to address the shortage of teaching staff. More students are reached using fewer resources (HR). KMTC has fully embraced ICT and the program is institutionalized, therefore it is sustainable.
Health Sector Coordination	<b>“Group communication platform”</b> . Introduced group communication between national IGA team and CECs for Health, created to facilitate timely sharing of information and response to inquiries from counties. CECs and national IGA team networked through WhatsApp technology. Information sharing between the two levels of government has since then improved.
Vihiga	<ul style="list-style-type: none"> <li>• Procurement and use of 7 Tuk Tuks, ‘ambulance mashinani’ to facilitate referral systems.</li> <li>• VCRH has a hot line managed by the nursing officer.</li> <li>• Refurbishment and rebranding of the VCRH.</li> <li>• Incentives for mothers who deliver under skilled birth attendants.</li> <li>• Extending clinic days for MCH/FP even on weekends and public holidays.</li> </ul>

Organization	Description of Best Practices
	<ul style="list-style-type: none"> <li>Motorcycles used as ambulances for referral to safe delivery points.</li> </ul>
<b>Homabay</b>	<ul style="list-style-type: none"> <li>Involvement of local CBOs and NGOs to tap resources towards community initiated programs like WADAGI initiative whose aim is to reduce negative health indicators.</li> </ul>
<b>Migori</b>	<ul style="list-style-type: none"> <li>E -platform for communication in the entire county.</li> <li>Mama packs provided in maternity upon delivery.</li> </ul>
<b>Machakos</b>	<ul style="list-style-type: none"> <li>Inspection and assurance committee for EMMS supplies.</li> <li>Expertise movement of mental health in 3 health facilities.</li> <li>Expert movement of Diabetic &amp; Hypertensive clinic: Nguluni locality had many clients and the Machakos team thought to start the clinic there. It was also started in Mitaboni Health centre, which is continuing up to today.</li> <li>Use of phone to remind pregnant mothers on hospital delivery and ANC care – Muumandu H/C.</li> <li>IGA Dairy goat keeping.</li> <li>Paqua laboratory to improve on water safety in 2 facilities through Plan Kenya – In Masinga Sub County.</li> </ul>
<b>Makueni</b>	<ul style="list-style-type: none"> <li>Maternity open days.</li> </ul>
<b>Lamu</b>	<ul style="list-style-type: none"> <li>Open Defecation free community in Manda Maaweni through construction of pit latrines and converting existing quarry into pit latrines.</li> <li>Mother friendly services by providing mother-baby package with basic hygiene items to all mothers delivering at the facility.</li> </ul>
<b>Taita Taveta</b>	<ul style="list-style-type: none"> <li>Free medical care and service to persons over 65 years old.</li> </ul>
<b>Kajiado</b>	<ul style="list-style-type: none"> <li>Web page for the county to facilitate a dynamic health department.</li> <li>To contribute towards reduction of maternal mortality ratio and under five mortality rate (MDGs 4&amp;5)</li> </ul>
<b>Turkana</b>	Lokichar Health Centre has carried out training of TBAs and CHVs.
<b>Kiambu</b>	Use of cheap phones in community health units.

## PROCESS OF SELECTION

The process of identification of best practice starts immediately after launch of implementation of the annual work plan with each entity documenting its practice or implementation. As defined, best practice is “knowledge about what works in specific situations and contexts, without using inordinate resources to achieve the desired results, and which can be used to develop and implement solutions adapted to similar health problems in other situations and contexts”. A committee was appointed to assess the documented best practices submitted

during the annual performance review 2014/2015. A total of 13 submissions were made and a detailed report from entities requested to facilitate scoring using the 10 criteria thus:

1. **Effectiveness:** The practice must demonstrate that it can work and achieve results that are measurable and clearly show the contributions to health outputs; improvement of access, demand for services, and/or quality of care or improved results concerning health indicators compared to previous year's performance.
2. **Efficiency:** Must produce results with a reasonable level of resources and time. The practice should demonstrate that cost effectiveness and resource (time, material, and human) utilisation to deliver the expected outputs is minimal, and no use of inordinate extra resources.
3. **Relevance:** Must address the priority health problems in the target population. The practice must be able to demonstrate high relevancy of the practice to health priority areas and prioritised population.
4. **Ethical soundness:** Must respect the current rules of ethics for dealing with human populations. Respect of human rights, transparency is observed.
5. **Sustainability:** Must be implementable over a long period of time without any massive injection of additional resources. Preparedness of internal conditions/resources to facilitate continuity of the practice in the county.
6. **Possibility of duplication:** Must be replicable elsewhere in a similar environment. Delivery of outputs without extra ordinate material, financial, human resources.
7. **Involvement of partnerships:** Must involve satisfactory collaboration between several stakeholders. Partnership among health workers of the county is key and should be demonstrated.
8. **Community involvement:** Must involve participation of the affected communities. Communities' participation in planning, implementing, or monitoring of the practices documented.
9. **Political commitment:** Must have support from the relevant national or local authorities with demonstrated initiatives of people to lead the practice.
10. **Innovativeness:** Ideas or methods which innovate to solve health problems.

A tool was prepared using the details on the scoresheet following the weighting scores as shown in table 1. The tool allowed for five (5) independent scores for each documented best practice to allow for the average scores. If four out of five scores then the tool could not allow the end scores as a cross check for allowing all the five minimum independent scores. The results are as displayed in Figures 6, 7, 8 and 9 below.

### BEST PRACTICES SCORING

This was based on the key domain areas outlined in the Kenya Health Policy 2014-2030, based on the eight (8) investment areas, which are meant to realize six (6) policy objectives. This was

to achieve the various results that will better access to service delivery, improve quality of care and increase demand for services. See Table 1 for Best practices scoring criteria.

**Table 1 Score Sheet of Best Practices**

Criteria	Specifications	Details
1.Effectiveness	Clear contributions to health outputs; improvement of access, demand for services, and/or quality of care	<ul style="list-style-type: none"> <li>▪ Improvements of Access <ul style="list-style-type: none"> <li>- improvement of physical access</li> <li>- improvement in financial access</li> <li>- improvement in socio-cultural access</li> </ul> </li> <li>▪ Improvements of Demand for Services <ul style="list-style-type: none"> <li>- improving awareness</li> <li>- improving health seeking behaviour</li> </ul> </li> <li>▪ Improvements in Quality of Care <ul style="list-style-type: none"> <li>- improving client experiences</li> <li>- assuring client/patient safety</li> <li>- ensuring effectiveness of care</li> </ul> </li> </ul>
	Clear contributions to improved results concerning health indicators compared to the previous year's performance	Improvement in of relevant indicators, comparing last year and this year
2.Efficiency	Ensured cost effectiveness and resource (time, material, and human) utilisation to deliver outputs	Reasonable volume of inputs used to improve health indicators compared to the previous year
		Shortened period to improve health indicators
		No extraordinary resources invested
3.Relevance	High relevancy of the practice to health priority areas and prioritized population	Addressing health priorities of the country
		Addressing health priorities of the county
		Addressing priority challenges of the facility
		Justifiable people targeted
4.Sustainability	Preparedness of internal conditions/resources to facilitate continuity of the practice in the county	Availability of necessary human, financial, physical resources
		Internalization of improved work procedure to maintain the quality of the practice
5.Leadership	Initiatives of people to lead the practice	Presented clear visions/plans, active monitoring of the processes, or smooth coordination by concerned leaders

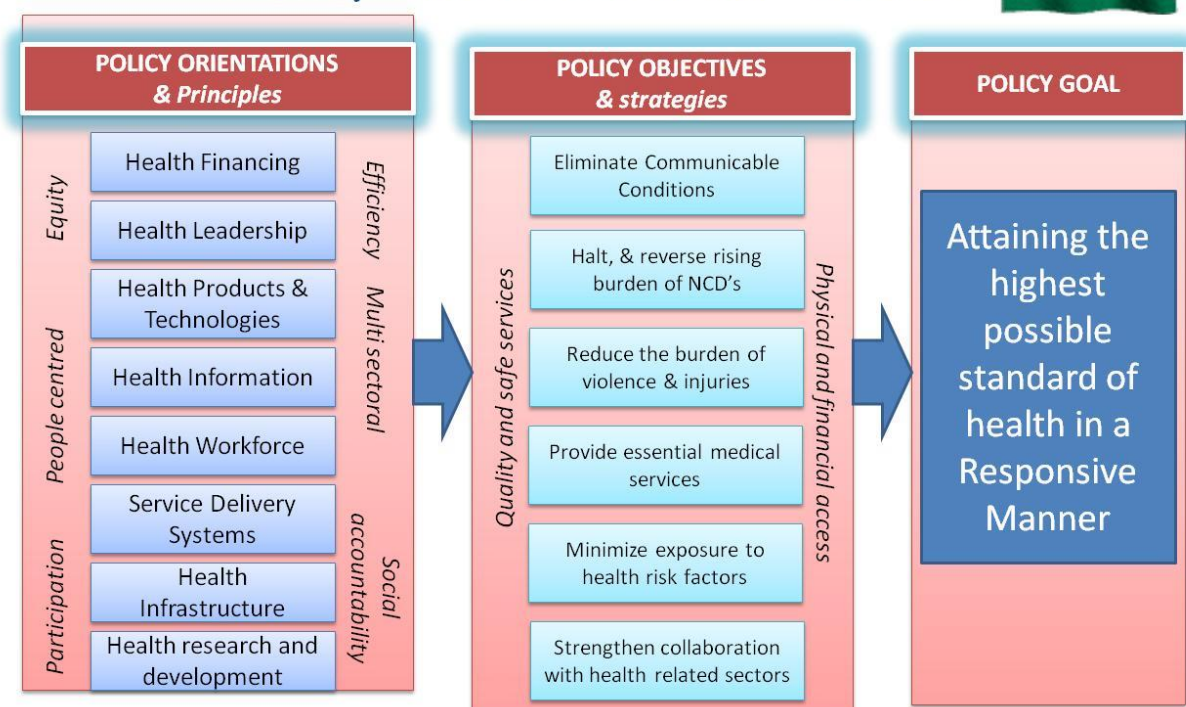


Criteria	Specifications	Details
6.Replicability	Delivery of outputs without extra ordinate material, financial, human resources	No requirement of extraordinary amount/types of resources for the practice
		No use of highly demanding skills, knowledge and abilities which belong to limited persons
	Special conditions	No other special conditions necessary to implement the practice
	Clear procedures of implementation	Existence of documented/recorded clear implementation steps and procedures of the practice
7.Ethical soundness	Respect of human rights	Consideration and respects for socio-cultural aspects of relevant population
	Encouragement of anti-corruption	No corruption/misuse of resources in the implementation stage
	Reinforcement of transparency	Ensured transparency in implementation processes
8.Partnerships	Partnership among health workers of the county	Different levels of stakeholders mobilized for the practice
	Partnership with other stakeholders	Number of partners who contributed to planning and implementation of the practice
9.Community involvement	Communities' participation in planning, implementing, or monitoring of the practices	Communities' initiatives in planning stage of the practice
		Measurable/observed contributions of communities to the practice (physical/labour, financial, ideas, skills, materials etc.,)
10.Innovativeness	Ideas or methods which innovated to solve health problems	Newly created ideas to improve health performances in the county
		Existing ideas but different methods used in the implementation processes

### BEST PRACTICES SCORING BY DOMAINS

This was based on the key domain areas outlined in the Kenya Health Policy 2014-2030 based on the eight (8) investment areas, to realize six (6) policy objectives. This was to achieve the various results that will better access to service delivery, improve quality of care and increase demand for services. See Figure 5 below;

# Policy Framework for Health



**Figure 5: Kenya Health Policy framework 2014-2030**

## SCORING TOOL / TEMPLATE

The scoring included a score sheet with readme instructions and scores for each of the areas. A scoring tool and scale was also developed to provide the weighting scores with minimum scoring of 5 independent scores to generate an index as seen in Figure 6 below;


County name	Score	Score	Score	Score	Score	Comments
MTRH						
 Hover over a guideline for more information, examples of good practice and importance to the overall user experience.	Evaluator_1	Evaluator_2	Evaluator_3	Evaluator_4	Evaluator_5	Optional - Provide a short rational for the score, such as a description of the issues found, examples of good practice and the likely impact for users.
Health System Domain	1					
1a Effectiveness .	Enter score	Enter score	Enter score	Enter score	Enter score	
1b Effectiveness .	Enter score	Enter score	Enter score	Enter score	Enter score	
2a Efficiency	Enter score	Enter score	Enter score	Enter score	Enter score	
2b Efficiency	Enter score	Enter score	Enter score	Enter score	Enter score	
2c Efficiency	Enter score	Enter score	Enter score	Enter score	Enter score	

Figure 6: Template/Tool used for scoring

## SCORING SCALES

An agreed scoring scale was developed to allow average weighting scores, with agreed criterion scale of 1, 2, 3 and 4 i.e. 1 for lowest score and 4 for highest score (**see sample scores below**);

1. Absence of evidence (1 as a score)
2. Minimal evidence (2 as a score)
3. Moderate evidence (3 as a score)
4. Sufficient evidence (4 as a score)

Comments for feedback sections.

## Scores

Health System Domain	3	4	Kericho				
			Scale	Wan	Ann	MIR	Mwan
1a Effectiveness .			Minimal Evidence	Minimal Evidence	Minimal Evidence	Minimal Evidence	Minimal Evidence
1b Effectiveness .			Moderate Evidence	Absence of evidence	Absence of evidence	Minimal Evidence	Moderate Evidence
2a Efficiency			Minimal Evidence	Sufficient Evidence	Absence of evidence	Minimal Evidence	Minimal Evidence
2b Efficiency			Sufficient Evidence	Minimal Evidence	Moderate Evidence	Moderate Evidence	Minimal Evidence

Figure 7: Scored results in the template

The scoring was then categorized according to the health investment areas as follows:

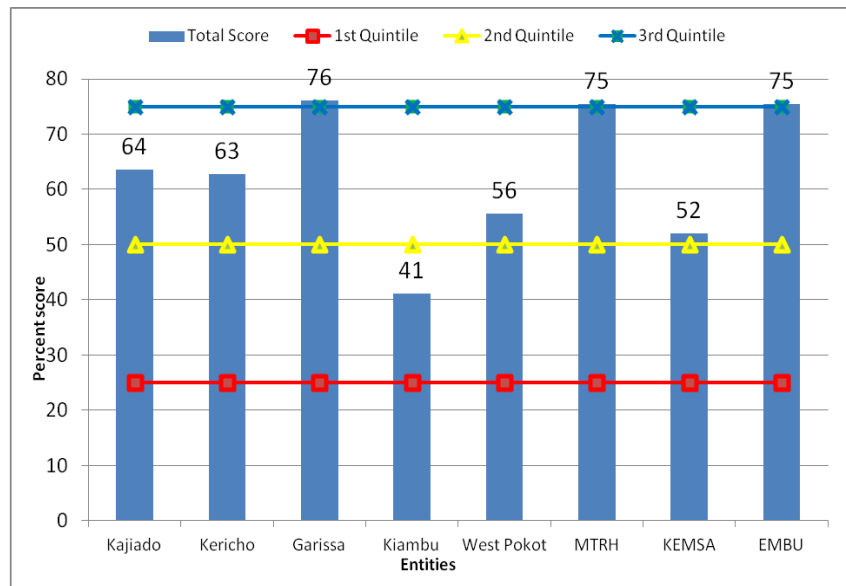
1. Organization of Service Delivery,
2. Human Resources for Health,
3. Health Infrastructure,
4. Health Products and Technologies
5. Health Information,
6. Health Leadership,
7. Health Financing,
8. Health Research

**Note:** Each case could either fall in either category or in two categories depending on how it is documented.

## **RESULTS of SELECTION**

A total of the 8 candidate cases were presented as best practices to the TWG. These was an independent committee which reviewed the documents and generated one scorer for each of

the 13 signature domains and the ranking then used quintiles based on overall score, generated as an index for the five independent scores in the template using the scoring criteria. See Figure 8 for the overall scores for the best practices for replicability and mutual learning presented by quintiles below;



**Figure 8: Overall best practices scores by entity**

Three entities best practices (Garissa, MTRH and Embu) were categorized in the upper quintile score, while four entities (Kajiado, Kericho, West Pokot and KEMSA) were categorized in the lower upper quintile and one entity (Kiambu) was in the Middle quintile. Over 10 entities submitted best practices in the annual performance report but less than 10 were able to comprehensively document them as shown in Figure 8 above.

	Kajiado	Kericho	Garissa	Kiambu	West Pokot	MTRH	KEMSA	EMBU
Domain Name	Score	Score	Score	Score	Score	Score	Score	Score
1.E ffectiveness	73%	50%	83%	45%	63%	85%	48%	73%
2.E fficiency	48%	62%	65%	35%	50%	82%	52%	77%
3.Relevance	74%	68%	78%	53%	74%	74%	41%	79%
4.Sustainability	65%	70%	78%	40%	70%	63%	53%	85%
5.Leadership	70%	75%	85%	30%	50%	90%	75%	90%
6.Replicability	73%	56%	83%	38%	43%	68%	48%	78%
7.Ethical soundnes	45%	52%	57%	40%	42%	78%	52%	67%
8.Partnerships	60%	65%	70%	45%	50%	75%	55%	55%
9.Community inv	55%	65%	80%	35%	45%	60%	45%	35%
10.Innovativeness	65%	75%	85%	45%	50%	55%	65%	80%

**Figure 9: Overall results per entity and domain score**

**Effectiveness:** The results were scored using the red, amber and green light in the various domain areas. In the domain area of effectiveness, four entities had best score (MTRH, Garissa, Kajiado and Embu) with 85%, 83%, and 73% respectively while in two entities, Kiambu (45%) and KEMSA (48%), documentation was weak.

**Efficiency:** Generally, documentation was weak across all entities in this important domain area with only two entities MTRH (82%) and EMBU (77%) having best score while Kiambu (35%) and Kajiado (48%) were weak.

**Relevance:** The cases documented showed that five entity cases were more relevant as documented. The entities that showed more relevancy were Embu (79%), Garrissa (78%) and Kajiado, MTRH and West Pokot (74%) respectively. KEMSA (41%) case was weak in documentation for relevancy.

**Sustainability:** Most of the cases did not clearly show how sustainability was in the practice apart from Embu (85%) and Garissa (78%) cases. Kiambu case (40%) demonstrated weakness in this domain.

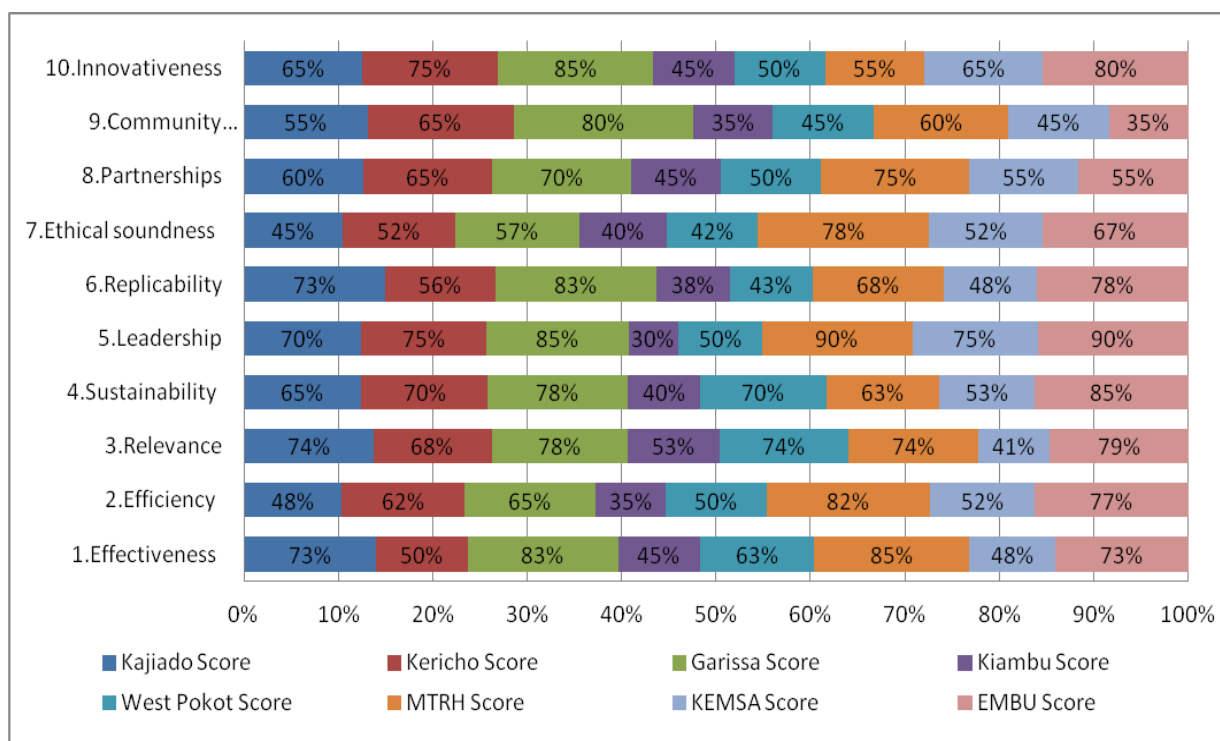
**Leadership:** In the demonstration of leadership to support replication and implementation, five entities Embu (90%), MTRH (90%), Garissa (85%), Kericho (75%) and KEMSA (75%) had best scores while, Kiambu (30%) case demonstrated weakness in leadership.

**Replicability:** Three cases scored over 70% in terms of the replicability with highest scores realized by Garrissa (83%), Embu (78%) and Kajiado (73%) while, least documented in terms of the case replicability was in Kiambu (38%), West Pokot (43%) and KEMSA (48%).

**Ethical soundness:** Most of the cases did not demonstrate ethical soundness apart from MTRH (78%).

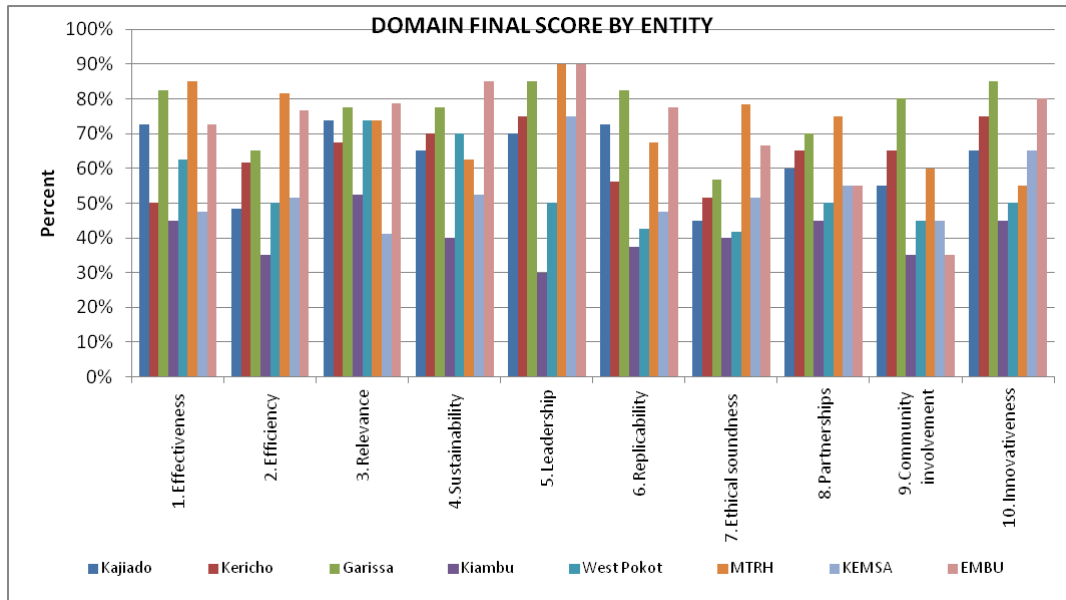
**Partnerships, Community and innovativeness (Optional):** Though these were optional areas, documentations to build a strong case remain a big challenge.

### National Domain scores

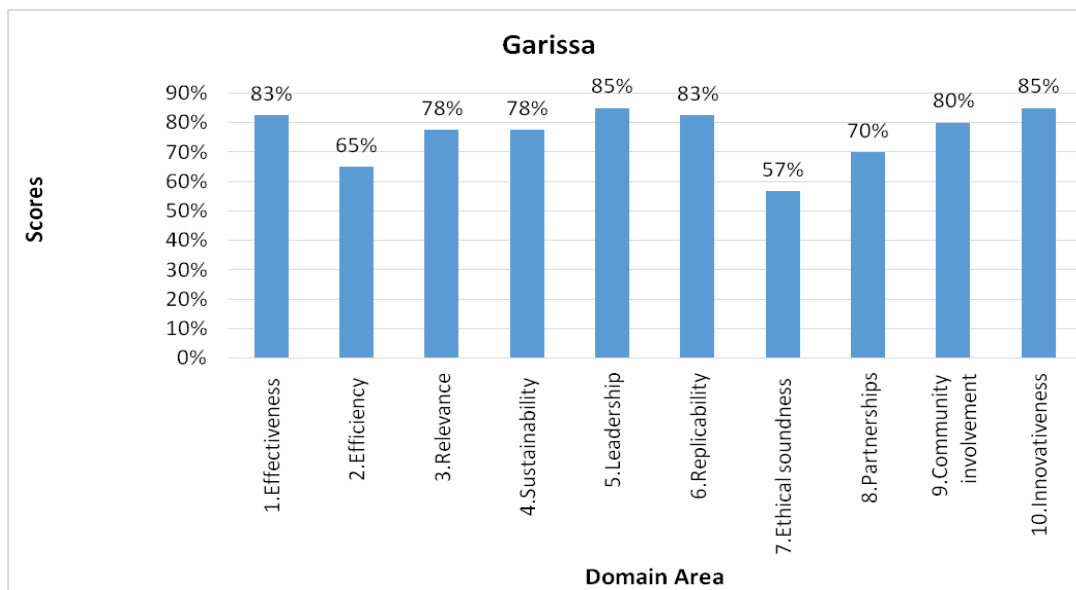


**Figure 10: Entity results by domain areas**

The overall mean score for the domain areas was 62% with five areas recorded as weak and lacking adequate documentations with information that could support the cases. These were Efficiency (59%), Replicability (60%), Ethical Soundness (54%), Partnerships (59%) and Community involvement (53%) of the cases (see Figure 9, 10 and 11). None of the cases had all domain areas scoring above the mean score.



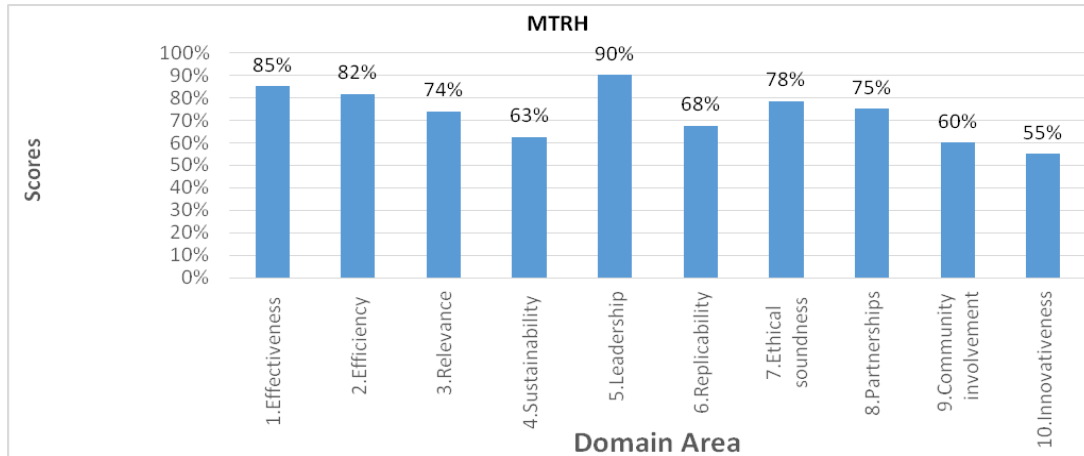
**Figure 11: Domain Score by Entity**



**Figure 12: Garissa Best practices score**

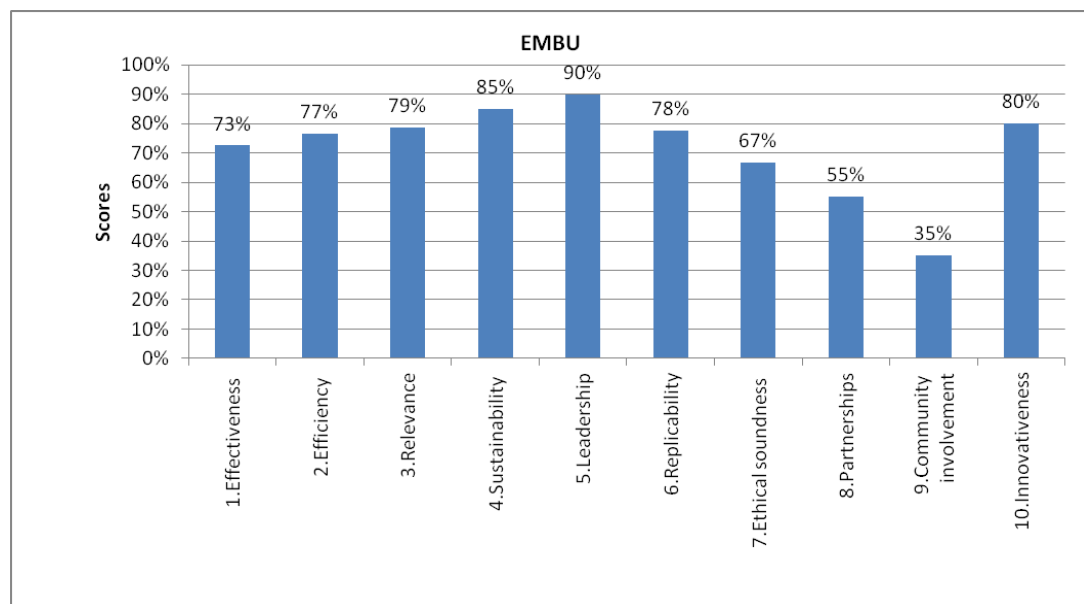
The Garissa best practice case was generally good with over 80% scores, more so in innovation, replication, effectiveness and mutual learning with good leaderships, while the critical areas to be strengthened were ethical soundness, efficiency and partnerships as shown in Figure 12 above.





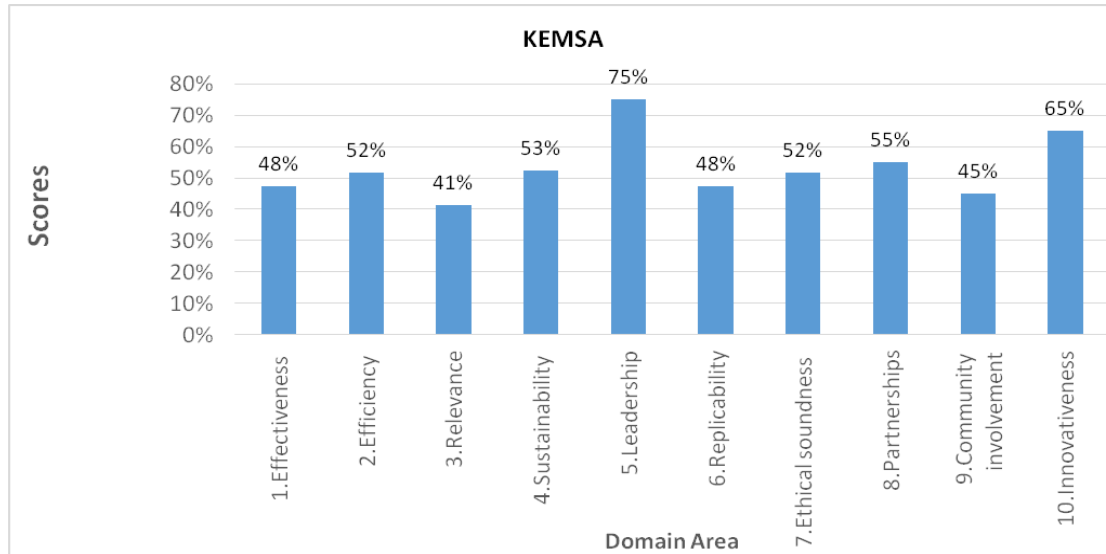
**Figure 13: MTRH case scores**

The Moi Teaching and Referral case scored well over 80% in leadership, effectiveness, and efficiency. The weakest areas were in innovativeness, community involvement, sustainability and replicability.



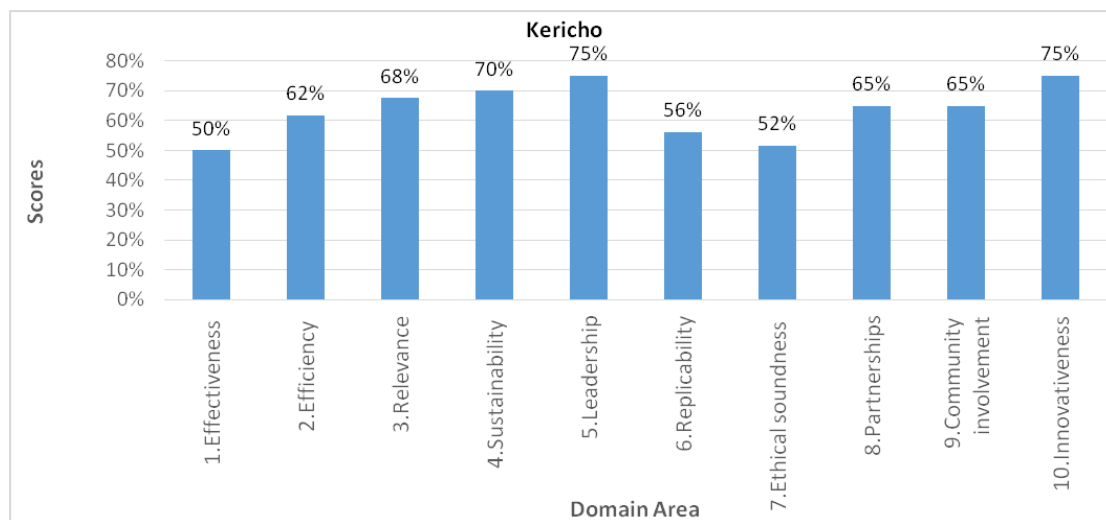
**Figure 14: Embu Best practice score**

The Embu case was best in areas of leadership, sustainability and innovativeness with over 80% while, areas that were weak were community involvement, partnerships and ethical soundness.



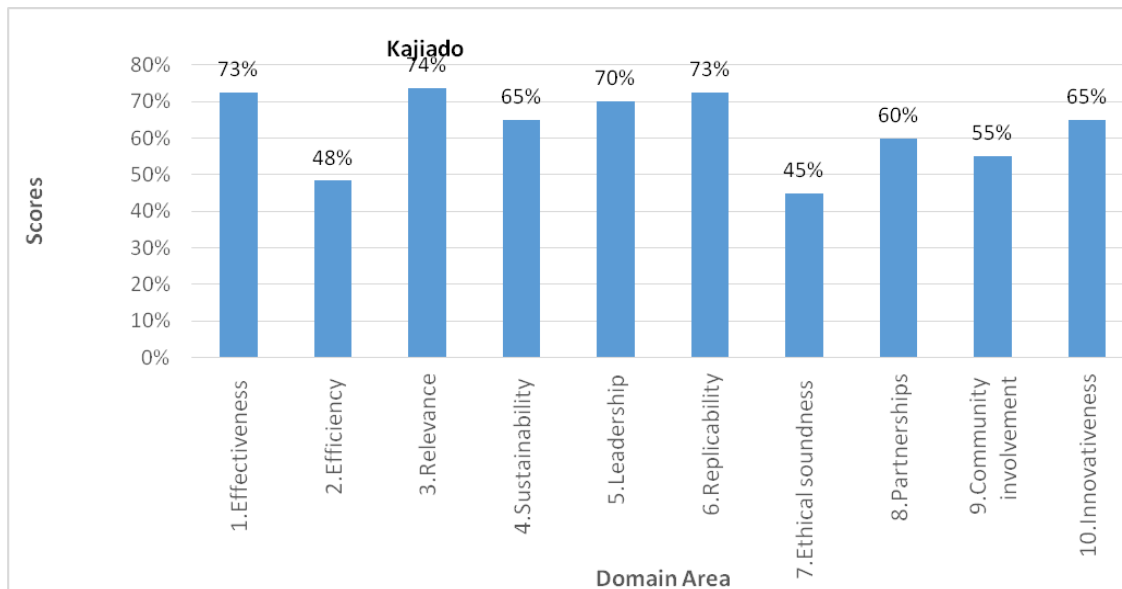
**Figure 15: KEMSA case score by domain**

The KEMSA case was best in areas of leadership and innovativeness with over 65% while areas that were weak were community involvement (45%), relevance (41%), effectiveness and replicability (48%). The rest were slightly above 50% but below the average score.



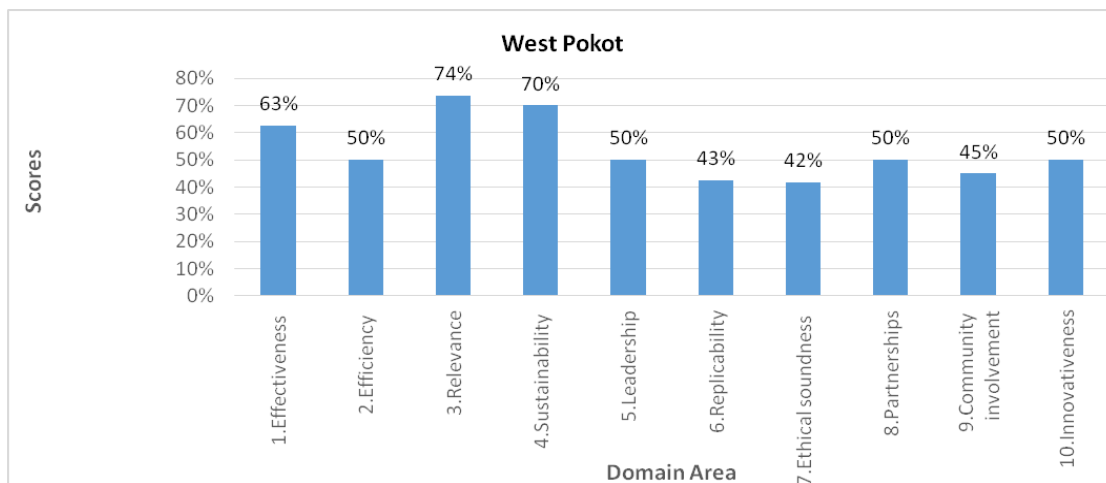
**Figure 16: Kericho case score by domain**

The Kericho case was best in areas of leadership, innovativeness and sustainability with over 70% while areas that were weak were ethical soundness (52%), effectiveness (50%) and replicability (56%). The rest were modestly scored slightly above the minimum score of 62%.



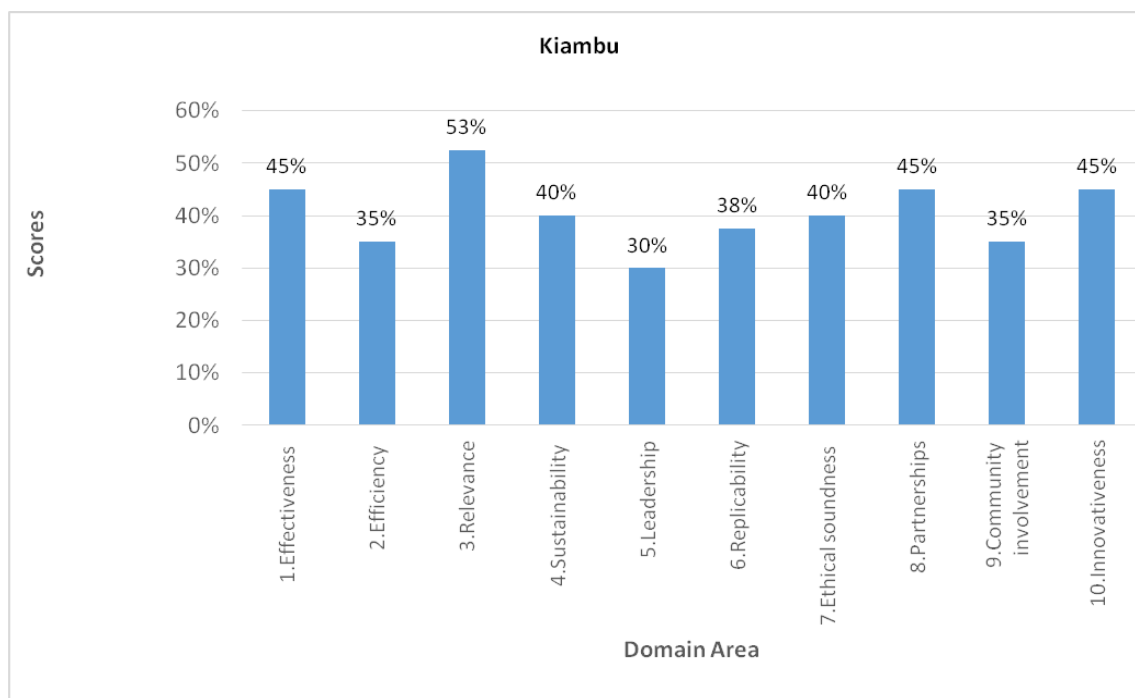
**Figure 17: Kajiado case score by domain**

The Kajiado case was best in areas of relevance, effectiveness, leadership, and replicability with over 70% of the scores while, areas that were weak were ethical soundness (45%), efficiency (48%) and community involvement (55%). The rest were modestly scored slightly above 62%.



**Figure 18: West Pokot case score by domain**

The West Pokot case was best in areas of relevance, sustainability and effectiveness, with over 62% of the scores while, areas that were weak were ethical soundness (42%), replicability (43%), efficiency, partnerships, innovation and leadership with an average score (50%).



**Figure 19: Kiambu case score by domain**

The Kiambu case was best in areas of relevance (53% only) while, due to poor documentation, the rest of the areas were weak with an average score of less than 50%.

## CONCLUSION AND RECOMMENDATIONS

Best practice is a framework for the classification of information for purposes of maintaining or improving effectiveness and efficiency in the health care system to achieve better accessibility to services, improved quality of care and increased demand for services. The best practice activities, disciplines and methods are available to identify, implement and monitor available evidence in health care system for the purposes of mutual learning and replicability. The practice is measured using an agreed scoring scale that is developed to allow average weighting scores and uses a criterion scale of 1, 2, 3 and 4 i.e. 1 for lowest score and 4 for highest. It includes comments for feedback sections.

It is imperative that public health activities and health policies are developed using the best available evidence. The current results were around three areas, addressing Health Technology Assessment (HTA), Evidence-Based Medicine (EBM) and Clinical Practice Guidelines (CPGs), by which evidence is synthesized either as an evidence base (EBM and most HTA) or in the form of recommendations (CPGs and some HTA) for different decision purposes in health care.

These activities/areas gain input mainly through four disciplines: clinical research, clinical epidemiology, health economics and health services research. The different disciplines are related to each other in three 'domains': Input, dissemination/implementation and monitoring/outcome. These provide evidence on the (potential) effects of health care interventions and policies, on ways to implement them and on ways to monitor their actual outcome without using separate approaches.

Resources should be devoted to increase the quality and quantity of both primary and secondary research as well as the establishment of networks to synthesize, disseminate, implement and monitor 'best practice'. The three main barriers to adoption of a best practice are: inadequate knowledge about current best practices, lack of motivation to make changes involved in their adoption, and inadequate knowledge and skills required to do so. Therefore, the commitment to sharing success with others is paramount in improving health care. The result of sharing best practice approaches could help provide a framework that could give stakeholders greater returns on investments and better health outcomes, including management of information to encourage replicability and mutual learning across the health sector.

To strengthen best practice identification and utilization, the following points are recommended:

1. Encourage replication of best practices across all levels of the health systems in Kenya

2. For purposes of mutual learning, further sensitization and rolling out of the best practices is required.
3. Sharing of the best practices during forums, such as county health stakeholder forum, health congress, and inter-governmental forum among others.

# Guideline on the Best Practice Selection in Health Sector

First Edition

October 2016

## 1. Background

Vision 2030 provides stewardship in the long term development of the country. Health is one of the components of the social developmental pillars that would lead to attainment of the development agenda. Health performance and economic performance are intrinsically interlinked. Health care spending has gradually and consistently increased in an environment of limited resources warranting the need for efficiency and cost effectiveness in Health interventions. Health is also adversely affected by external factors such as climate change, political instability and globalization. Kenya still faces challenges in attaining its health goals. Child mortality remains a challenge, with poor nutrition leading to unacceptably high stunting levels. Maternal mortality stands at 510 deaths per 100,000 live births. Various strategies are in place to combat these challenges, amongst them the use of the Best Practices in service delivery interventions.

The concept of the Best Practices is a combination of principles from Health Technology Assessment, Evidence Based Medicine and Clinical Practice guidelines. There are various definitions of what a best practice is. The Cambridge dictionary describes a best practice as 'A working method or set of working methods that is officially accepted as being the best to use in a particular business or industry'. A Best Practice is generally accepted as being superior to other alternatives in producing desired results. The theory of the Best Practice is rooted in the improvement of effectiveness and efficiency in different systems. Its application is varied and cuts across different industries and sectors.

A Best Practice must be: a

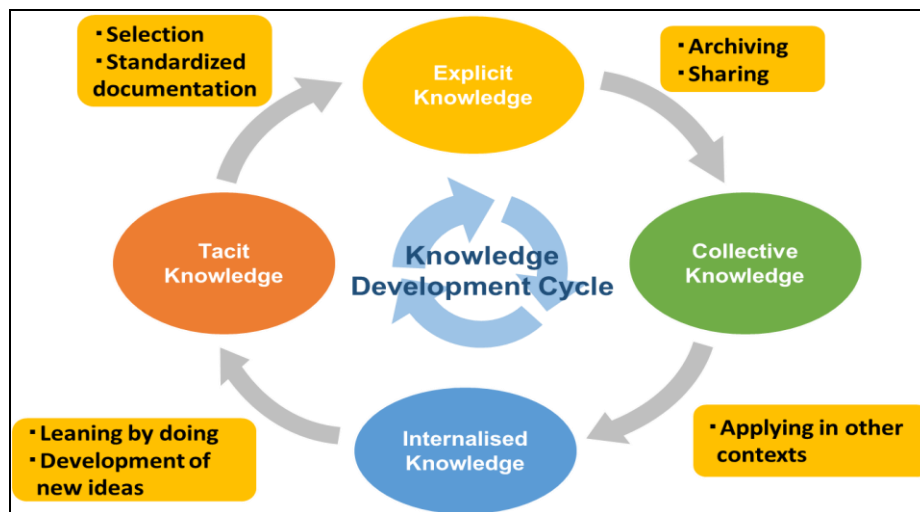
1. Practice which **attains certain results**
2. Practice which contributes to **attaining your objectives**
3. Practice which creates results **in an efficient way**
4. Practice which is **applicable in other contexts**

In the health service context, the Best Practice refers to the use of care and public health principles that are

evidence-based and known to promote high quality of service. Different service areas in the health care setting have utilized the Best Practices. Globally, the Best Practices have been used in evaluation of physician efficiency in hospitals and in the application of health behaviour change in enhancing treatment uptake and fidelity amongst patients.

The National and the County governments of Kenya have utilized the Best Practices as a part of the Health Sector Strategic Plan in achieving Health Policy objectives. The Best Practices are implemented in different policy orientation areas such as Health Technology and Products, Human Resources for Health, and Health Infrastructure. The criterion of selecting Best Practices includes Effectiveness, Efficiency, Relevance, Sustainability, and Replicability in other environments. Community involvement and Innovativeness are also considered as important attributes of Best Practices.

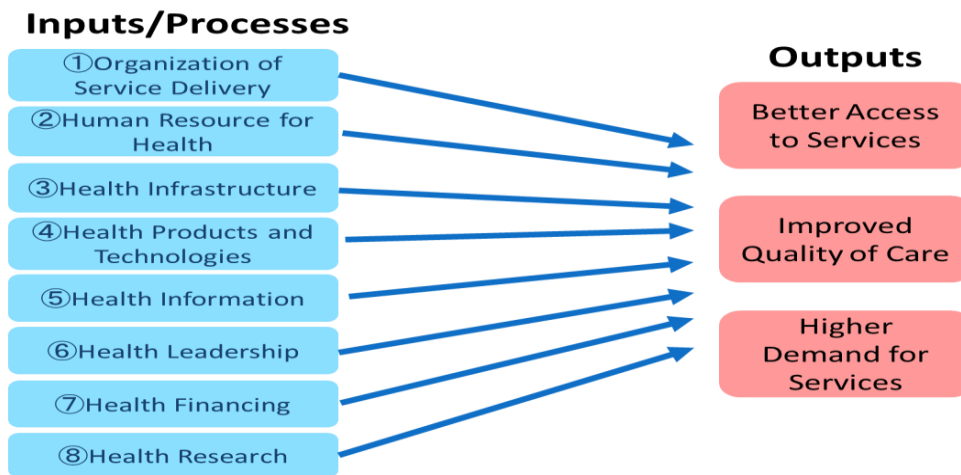
The Best Practice is one of the practical methods of “knowledge management”. Knowledge management is a system which manufactures tangible information from human experiences and wisdom so that they can be shared among others to improve efficiency, effectiveness and quality of their work. The figure below shows a conceptual framework of knowledge management. In this regard, the Best Practice needs to be selected through proper criteria, documented in a standardized manner, shared with all stakeholders, and is expected to be applicable to many others.





## 2. Eight Categories of the Best Practice in Health Sector

The Best practice falls in one or more of the three output categories of the KHSSP. They are: Improving access to services; improving quality of care; and improving demand for health services. The Inputs/Processes categories of the KHSSP which contribute to the three outputs shall be used as the categories of the Best Practice in the health sector.



## 3. Criteria to Choose the Best Practice

Best Practices have to be selected based on the following six essential criteria. Any Best Practice needs to meet all the “essential criteria”. If a Best Practice meets one or more of the “optional criteria”, they are regarded as more value-added cases.

Essential Criteria	Optional Criteria
1. Effectiveness	8. Partnership
2. Efficiency	9. Community Involvement
3. Relevance	10. Innovativeness
4. Sustainability	
5. Leadership	
6. Replicability	
7. Ethical Soundness	

### (1) Effectiveness

Evidence that the practice works, and achieved measurable results.

### (2) Efficiency

Evidence that the practice produced results with a reasonable level of resources and time.

### (3) Relevance

Evidence that the practice is addressing one or more priority health challenge(s).

(4) Sustainability

Evidence that the practice can be implemented over a long time without significant additional resources.

(5) Leadership

Evidence that the practice gained robust Initiatives and leadership of persons who are responsible for the issue during its planning, implementing and monitoring.

(6) Replicability

Evidence that the practice is able to be replicated elsewhere, under similar conditions.

(7) Ethical soundness

Evidence that the practice respected the current local and global norms and rules of ethics.

(8) Partnerships

Evidence that the practice secured appropriate involvement of different service delivery actors in the implementation.

(9) Community involvement

Evidence that the practice secured appropriate participation of beneficiaries and affected communities.

(10) Innovativeness

Evidence that the practice innovated or introduced something new.

#### **4. The Best Practice Selection Committee**

The Best Practice Selection Committee (BPSC) was established for fair and legitimate selection of the Best Practice. The BPSC is constituted of members drawn from all the health sector stakeholders attached as Appendix 2.

#### **5. Overview of the Process of the Best Practice Selection**

The Best Practices are selected as part of the Annual Sector Performance Review (APR) practice. Selected Best Practices are documented in the Annual Sector Performance Report and awards are granted at the Intergovernmental Health Sector Consultative Forum (IGF). Following is the overview of the selection process.

Step		Activity	Ideal Timeline
(1)	Reporting of candidate Best Practices by County governments, the departments of the ministry, and SAGA	All entities should fill reporting forms for all of their candidate Best Practices and submit them to the BPSC.	1 <sup>st</sup> week of September
(2)	Scoring and preliminary selection of winners	1) The BPSC categorizes submitted candidate Best Practices into the eight Best Practice Categories. 2) The BPSC prepares a shortlist of the preliminary selection of the Best Practices using the <i>Evaluation Sheet of Best Practice</i> .	2 <sup>nd</sup> week of September
(3)	Validation of the preliminary winners	The BPSC organizes validation visits to observe real situations of the preliminary selected Best Practices.	3 <sup>rd</sup> week of September
(4)	Final selection of award winners	The BPSC consider the results of the above scoring and the validation visits and select award winners for the eight award categories. Overall Number one winner, runner-up and the third place are also selected.	Last week of September
(5)	Awarding ceremony at IGF	The winners of the awards by category and overall No.1, 2 and 3 are prized at the earliest Intergovernmental Health Consultative Forum.	October
(6)	Preparations of the Best Practice Report and the Annual Sector Performance Review Report, and dissemination	The BPCS prepares a Best Practice Report of the year, and the M&E Unit make necessary arrangement to include the award winning Best Practices in the Annual Sector Performance Report of the year. These reports are distributed to the counties, the ministry departments, SAGAs, and other stakeholders.	November

## 6. Reporting of the Best Practice

The selection process of the Best Practice begins with collecting candidate cases of the Best Practice from the counties, departments of the MOH and SAGAs. The Best Practice Reporting Format (Appendix 3 and an example as Appendix 4) has to be prepared by each applicant following the instructions below.

### (1) Title of Best Practice

Write a title which can be easily understood and conveys the nature of the practice.

### (2) Region of Operation in County

Write the name of sub-county and the county.

(3) Input/Process

Select ones which are applicable to the Practice and give a check mark. You can select more than one category.

(4) Output

Select ones which are applicable to the Practice and give a check mark. You can select more than one category.

(5) Outcome

Select ones which are applicable to the Practice and give a check mark. You can select more than one category.

(6) Description

[Expected Outputs]

What was the specific challenge concerned BEFORE the best practice was in place? Explain the situations or challenges you faced before you started the Practice.

[Processes]

What was done? How was it started, prepared, implemented? List the activities necessary to prepare and to implement the Practice in periodical order.

[Key Inputs]

Describe the critical/essential inputs necessary for the “process” above. They may include human resource, materials and financial inputs.

[Outputs]

What was achieved directly by the best practice AFTER the best practice was in place? Explain the changes or achievements brought by the practice with objective evidence. Showing the changes/achievements with relevant data and figures is recommended. Also, comparison between BEFORE and AFTER of the Best Practice is necessary.

[Conditions]

What were the prerequisites to make the Best Practice work? List indispensable preconditions for successful implementation of the Best Practice. They may be critical inputs, supporting environment, special knowledge/skills and others.

(7) Effectiveness

Evidences that the Best Practice works, and achieved measurable results. Explain reasons why you think the Best Practice brought the “outputs” above.

(8) Efficiency

Evidences that the Best Practice produced the outputs with a reasonable level of resources and time. Explain how the inputs (fund, HR, material and time) used for the Best Practice are not special and the amount of the inputs are not excessive.

(9) Relevance

Evidence that the Best Practice is focused on addressing a clear priority health challenge. Explain if the Best Practice is in line with the national and county priorities outlined in any of policy and/or strategy documents and/or the AWP. List exact documents which can be referred.

(10) Sustainability

Evidence that the Best Practice is implementable over a long time without need for significant additional resources. Explain how you can assure that the Best Practice can be continued with regard to finances for the practice, skills and knowledge of the workers, internalization of the Best Practice to the organization, and support from the leadership.

(11) Leadership

Evidence that there was involvement of the appropriate leadership in the planning/monitoring of the Best Practice. Explain how the leaders (Governor, CEC, CO, CDH, facility managers, community leaders and so on) were involved in the Best Practice, and how they supported it. Show concrete actions taken by the leaders as evidence.

(12) Replicability

Evidence that the practice is able to be replicated elsewhere, in similar conditions. Explain the reason why there would be just a little difficulty for others to replicate the Best Practice with regard to financial implications, technical difficulties, lack of special external support and other aspects.

(13) Ethical Soundness

Evidence that the Best Practice respects the current norms and rules of ethics for dealing with human population in the area. Explain how there is no ethical issue involved in the Best Practice.

(14) Others (if applicable)

[Partnership]

Evidence that the Best Practice involves appropriate collaboration with important stakeholders. Explain if the Best Practice involved key stakeholders for good collaborations.

[Community Involvement]

Evidence that the Best Practice involves participation of the affected communities. Explain if the Best Practice gained active participation from the community.

[Innovativeness]

Evidence that the Best Practice innovates or introduces new methodologies and/or approaches to overcome the challenge more effectively than ever. If the Best Practice adopted/introduced

methodologies or approaches which had never been tried before, explain the reason why they were adopted/introduced, how they were different from the conventional ones, the difficulties faced in adoption/introduction, and benefits of the new methodology/approach.

## **7. Preliminary Selection of Award Winners**

Award winning Best Practices are preliminarily selected following the steps below:

- 1) Check the fulfillment of the report format of the submitted Best Practices.
- 2) Categorize the submitted Best Practices according to the award categories.
- 3) Score the submitted Best Practices using the scoring sheet (Appendix 5).
- 4) Select the ones with a score of more than 60 in total AND which gained minimum point in every “essential criteria”.
- 5) Rank the Best Practices by categories and decide the first prize of each category.

## **8. Validation of the Award Winning Best Practices**

Once the preliminary award winners are selected, they are visited by the validation teams formed by the BPSC to confirm that the Best Practice is actually in place as reported. If the reality of the Best Practice is different from the information given by the report, the Best Practice in question may lose its privilege of award winning, and runner-up Best Practice may be given the chance. In this case, the runner-up Best Practice is subject to the same validation by the BPSC.

The validation teams prepare their validation visits using the “Planning Format for Best Practice Validation/Documentation Visit” (Appendix 6), and the findings are recorded in the “Recording Format for Best Practice Validation/documentation Visit” (Appendix 7). The results of the validation visits are reported to the BPSC for final decision making.

## **9. Final Selection of Award Winners and Commendation**

Considering the results of the preliminary selection and the validation visits, the BPSC makes final decision on the award winners of each category of the Best Practice and the overall winners, runner-up and the third place. All the winners are provided with certificates and extra prizes. Awarding ceremony takes place during the earliest IGF meeting.

## **10. Report Preparation and Dissemination of the Best Practices**

A Best Practice Report is prepared by the BPSC and disseminated at the Health Congress (or the Health Summit) of the year, and uploaded to the MOH website for public access.

Additionally, M&E Unit of the MOH makes necessary arrangement to include the award winning Best Practices in the APR Report of the year.

## **11. Adoption and Utilization of the Best Practices**

Strengthening mechanisms for sharing of the Best Practices and for promoting replication within county, at inter-county level as well as national level is a key to fully utilize the Best Practices. This is under discussion in

the BPSC and this section will be added in detail once strategy and method are decided at the BPSC. The BPSC will consider possible ways of setting up information sharing and mutual learning mechanism of the Best Practices.

## Appendix 1

### TOR of the Best Practice Selection Committee

#### 1. Background and Objective of the Committee

The constitution of Kenya-2010 under the bill of rights guarantees Kenyans the right to the highest standards of health. The health sector, through the Health Policy 2014-2030 and the Kenya Health sector strategic Plan 2014-2018 and other sector strategic documents have committed to progressively work towards achieving this right to highest standards of health. One of the strategies, among many others, is through identification of best practices in the health sector that contribute to the attainment of the health sector goal and objectives. The best practices would then be shared with other stakeholders for purposes of mutual learning and replication.

A best practice is defined as knowledge of what works in specific situations and contexts without using inordinate resources to achieve the desired results and which can be used to develop and implement solutions adaptable to similar health problems in other situations and context. Through the health sector annual reviews, the sector has planned to identify the best practices in the sector for purposes of reward and mutual learning as well as replication.

Hence the team to carry out this task has been appointed with the following TORS.

#### 2. TOR, expected activities and deliverables

	TOR	Activities	Deliverables
1.	Adoption of selection method and procedure.	-Review the existing draft selection methodology and procedure (proposal made at the Performance Review meeting). -Identify/classify the categories for awards.	Overall methodology, selection criteria, scoring format, award category, authority of selection and timeline are finalized and adopted.
2.	Collection of necessary information of candidate cases.	-Request planning entities e.g. counties, parastatals, regulatory bodies, national level to elaborate their Best Practice following the adopted agreed-on guidelines.	Fulfilled reporting formats of all the candidate cases.
3.	Scoring and ranking according to the award category.	-Score the candidate Best Practice cases based on the selection criteria and the scoring guideline. -Decide the best, runner up and the 3rd for each award category. -Prepare a report -Submit the report to PS.	A report submitted to PS which shows the top 3 cases for each awarding category (proposal). Summary bulletin which can be shared with stakeholders.
4.	Identify effective mechanisms for dissemination of the Best Practice, encouragement of replication, and monitoring.	-Develop a roadmap/ proposals for replication of the best practices. -Resource mobilization for the awards and for replication. -Identify any difficulties and challenges in dissemination and encouragement of replication. -Identify solutions to these difficulties and challenges.	Proposal on the mechanisms for dissemination and encouragement of replication.
5.	Review of selection method and procedure.	-Review the activities and achievements of the committee.	Proposal on improvement of methodology and procedure based on lessons learnt.



## Appendix 2

### Member Organizations of the Best Practice Selection Committee

	<b><i>Organization</i></b>
1	Secretary of the Council of County Health Executives (Chair of the Committee)
2	Chair, CECs
3	Representative from Dept. of Administrative Services, MOH
4	Representative from Dept. of Health Sector Coordination and Intergovernmental Affairs, MOH
5	Representative from Dept. of Standards and Quality Assurance, MOH
6	Representative from Dept. of Curative and Rehabilitation Services, MOH
7	Representative from M/E Unit, Dept. of PPHCF, MOH
8	Representative from Dept. of Policy, Planning and Health Care Finance, MOH
9	Representative from Community Health Unit, Dept. of PPS, MOH
10	Representative from Dept. of Preventive and Promotive Services, MOH
11	CDH, Nairobi County, Chair of CDH Forum
12	CDH, Migori County, Vice-chair of CDH Forum
13	KEMRI
14	DPHK
15	JICA
16	WHO
17	UNFPA
18	Measure-Evaluation, PIMA
19	KHF
20	Aga Khan Hospital
21	HENNET
22	Any other co-opted member

## Appendix 3

### Best Practice Reporting Format

<b>1. Title of Best Practices:</b> _____	
<b>2. Region of Operation in County:</b> _____	
<b>3. Input/Process:</b> <input type="checkbox"/> Organization of Service Delivery, <input type="checkbox"/> HRH, <input type="checkbox"/> Health Infrastructure, (tick applicable) <input type="checkbox"/> Health Products & Technologies, <input type="checkbox"/> Health Information, <input type="checkbox"/> Health Leadership, <input type="checkbox"/> Health Financing, <input type="checkbox"/> Health Research	
<b>4. Output:</b> <input type="checkbox"/> Better Access to Health Services, <input type="checkbox"/> Improved Quality of Care, (tick applicable) <input type="checkbox"/> Higher Demand for Services	
<b>5. Outcome:</b> <input type="checkbox"/> Eliminate Communicable Conditions, <input type="checkbox"/> Halt/reverse NCD, <input type="checkbox"/> Reduce Violence & Injuries, (tick applicable) <input type="checkbox"/> Provide Essential Health Care, <input type="checkbox"/> Minimize Risk Factor Exposure, <input type="checkbox"/> Strengthen Cross Sectoral Collaboration	
<b>6. Description</b>	<b>[Expected Outputs]</b> (BEFORE the best practice was in place, what was the specific challenge concerned?)
	<b>[Processes]</b> (What was done? How was it started, prepared, implemented?)
	<b>[Key Inputs]</b> (Describe the critical/essential inputs for the process above: human resource, material, financial)
	<b>[Outputs]</b> (AFTER the best practice was in place what was achieved directly by the best practice? Describe tangible changes/benefits.)
	<b>[Conditions]</b> (What were the prerequisite to make the best practice work?)
<b>7. Effectiveness:</b> Evidence the practice works, and achieved measurable results	
<b>8. Efficiency:</b> Evidence the practice produced results with a reasonable level of resources and time	
<b>9. Relevance:</b> Evidence the practice is focused on addressing a clear, priority health challenge	
<b>10. Sustainability:</b> Evidence the practice can be implementable over a long time without need for significant additional resources	
<b>11. Leadership:</b> Evidence there was involvement of the appropriate leadership in the planning / monitoring of the practice	
<b>12. Replicability:</b> Evidence the practice is able to be replicated elsewhere, in similar conditions	
<b>13. Ethical Soundness:</b> Evidence that the practice respects the current norms and rules of ethics for dealing with human populations	
<b>14. Others (if applicable)</b>	<b>- Partnership</b> (Evidence that practice involves appropriate collaboration with important stakeholders):  <b>- Community Involvement</b> (Evidence that the practice involves participation of the affected communities):  <b>- Innovativeness</b> (Evidence that the practice innovates or introduces new methodologies and/or approaches to overcome the challenge more effectively than ever):

## Appendix 4

### Example of the Best Practice Reporting

<b>1. Title of Best Practices:</b> <u>Provision of Mother-baby package for increase of skilled delivery .</u>	
<b>2. Region of Operation in County:</b> <u>AAA Sub-county, BBB County .</u>	
<b>3. Input/Process:</b> ✓ <b>Organization of Service Delivery, HRH, Health Infrastructure, Health Products &amp; Technologies, Health Information, Health Leadership, Health Financing, Health Research</b>	
<b>4. Output:</b> <b>Better Access to Health Services, Improved Quality of Care, ✓ Higher Demand for Services</b>	
<b>5. Outcome:</b> <b>Eliminate Communicable Conditions, Halt/reverse NCD, Reduce Violence &amp; Injuries, ✓ Provide Essential Health Care, Minimize Risk Factor Exposure, Strengthen Cross Sectoral Collaboration</b>	
<b>6. Description</b>	<p><b>[Expected Outputs] (BEFORE the best practice was in place, what was the specific challenge concerned?)</b></p> <ul style="list-style-type: none"> <li>- Low rate of skilled delivery at facility</li> <li>- Lack of coordinated cooperation between the facility and CHVs and TVAs</li> </ul> <p><b>[Processes] (What was done? How was it started, prepared, implemented?)</b></p> <ol style="list-style-type: none"> <li>1. Preparation of a manual for mother friendly services and delivery of mother-baby package</li> <li>2. Training to health workers of the facility for the provision of mother friendly services</li> <li>3. Induction to CHVs and TVAs for the practice and propagation at the community</li> <li>4. Procurement of mother-baby package</li> <li>5. Implementation of mother friendly services and delivery of mother-baby package at discharge</li> </ol> <p><b>[Key Inputs] (Describe the critical/essential inputs for the process above: human resource, material, financial)</b></p> <ul style="list-style-type: none"> <li>- Basic hygiene items</li> <li>- Incentives for CHVs and TVAs</li> <li>- CHVs, TBAs</li> </ul> <p><b>[Outputs] (AFTER the best practice was in place what was achieved directly by the best practice? Describe tangible changes/benefits.)</b></p> <p>Skilled deliveries at the health facility increased from 10 to 33 deliveries from 2012 to 2015. 230% increase in 3 years.</p> <p><b>[Conditions] (What were the prerequisite to make the best practice work?)</b></p> <ul style="list-style-type: none"> <li>- Motivated and functional CHVs and TVAs</li> <li>- Capacity of facility to accept increased delivery</li> </ul>
<b>7. Effectiveness:</b> Evidence the practice works, and achieved measurable results	Skilled deliveries at the health facility increased from 10 to 33 deliveries from 2012 to 2015. For the 33 deliveries, no maternal death neither new born mortality was observed. The mothers explained that the mother-baby package was attractive for them and CHVs and TVAs explanation was helpful for them.
<b>8. Efficiency:</b> Evidence the practice produced results with a reasonable level of resources and time	PBF was used for purchase of the mother-baby package and incentive to CHVs and TVAs and no other extra finance was necessary. Average annual expense for the practice was xxx KSH.
<b>9. Relevance:</b> Evidence the practice is focused on addressing a clear, priority health challenge	The practice is in line with the national and county priorities outlined in the County Health Sector Strategic Plan, Kenya Health Policy and the Vision 2030.
<b>10. Sustainability:</b> Evidence the practice can be implementable over a long time without need for significant additional resources	Through this practice, motivations of the CHVs and the TBAs have been further enhanced, which will contribute to the continuity and sustainability of the practice. The Free Maternity Services Fund allocated to the health facility has increased as the number of the deliveries increased, which will sustainably cover the cost of deliveries. A manual for the practice has been developed and a material for induction to CHVs and TVAs is available, which has enabled standardization of the work.
<b>11. Leadership:</b> Evidence there was involvement of the appropriate leadership in the planning / monitoring of the practice	CEC for Health launched this program and has been supporting this practice since then. CO supported to be sure this practice is well captured in the budget plan.
<b>12. Replicability:</b> Evidence the practice is able to be replicated elsewhere, in similar conditions	The practice can be replicated in all health facilities because the RBF and the Free Maternity Funds are available for all health facilities and manuals and induction material are available. No other special conditions are necessary for this practice.
<b>13. Ethical Soundness:</b> Evidence that the practice respects the current norms and rules of ethics for dealing with human populations	No ethical issues have been involved in this practice.
<b>14. Others (if applicable)</b>	<ul style="list-style-type: none"> <li>- <b>Partnership</b> (Evidence that practice involves appropriate collaboration with important stakeholders):</li> <li>- <b>Community Involvement</b> (Evidence that the practice involves participation of the affected communities):</li> <li>- <b>Innovativeness</b> (Evidence that the practice innovates or introduces new methodologies and/or approaches to overcome the challenge more effectively than ever):</li> </ul>

## Appendix 5

Scoring Sheet of Best Practices				
Criteria	Specifications	Details	#	Weight
1.Effectiveness	Clear contributions to health outputs; improvement of access, demand for services, and/or quality of care	■ Improvements of Access - improvement of physical access - improvement in financial access - improvement in socio-cultural access  ■ Improvements of Demand for Services - improving awareness - improving health seeking behaviour  ■ Improvements in Quality of Care - improving client experiences - assuring client/patient safety - ensuring effectiveness of care	①	10
	Clear contributions to improved results in concerning health indicators compared to the previous year's performance	Improvement in concerning indicators, comparing last year and this year	②	5
2.Efficiency	Ensured cost effectiveness and resources (time, material, and human) utilisation to deliver outputs	Reasonable volume of inputs used to improve health indicators compared to the previous year	③	5
		Shortened period to improve health indicators	④	5
		No extraordinary resources invested	⑤	5
3.Relevance	High relevancy of the practice to health priority areas and prioritised population	Addressing health priorities of the country	⑥	4
		Addressing health priorities of the county	⑦	4
		Addressing priority challenges of the facility	⑧	4
		Justifiable people targeted	⑨	3
4.Sustainability	Preparedness of internal conditions/resources to facilitate continuity of the practice in the county	Availability of necessary human, financial, physical resources	⑩	5
		Internalization of improved work procedure to maintain the quality of the practice	⑪	5
5.Leadership	Initiatives of people to lead the practice	Presented clear visions/plans, active monitoring the processes, or smooth coordination by concerning leaders	⑫	10
6.Replicability	Delivery of outputs without extraordinary material, financial, human resources	No requirement of extraordinary amount/types of resources for the practice	⑬	3
	Special conditions	No use of highly demanding skills, knowledge and ability which belong to limited persons	⑭	2
		No other special conditions necessary to implement the practice	⑮	3
	Clear procedures of implementation	Existence of documented/recorded clear implementation steps and procedures of the practice	⑯	2
7.Ethical soundness	Respect of human rights	Consideration and respects to socio-cultural aspect of relevant population	⑰	4
	Encouragement of anti-corruption	No corruptions/misuses of resources in the implementation stage	⑱	3
	Reinforcement of transparency	Ensured transparency in implementation processes	⑲	3
8.Partnerships	Partnership among health workers of the county	Different levels of stakeholders mobilised for the practice	⑳	5 *either/both
	Partnership with other stakeholders	Number of partners contributed to plan and implement the practice		
9.Community involvement	Communities' participation in planning, implementing, or monitoring of the practices	Communities' initiatives in planning stage of the practice Measurable/observed contributions of communities to the practice (physical/labour, financial, ideas, skills, materials etc.,)	㉑	5 *either/both
10.Innovativeness	Ideas or methods which innovated to solve health problems	Newly created idea to eradicate improve health performances of the county	㉒	5 *either/both
		Existing idea but different methods used in the implementation processes		
<b>*Minimum total points to be selected as a Best Practice is 60 or above.</b>				
<b>*Minimum points per category has to be attained to be selected as a Best Practice.</b>				

## Appendix 6

Planning Format for Best Practice Validation/Documentation Visit		
<b>General Information</b>		
1. Entity to visit		2. Date: From                      to
3. Team to visit (please write names)		
4. Availability of Budget	<input type="checkbox"/> Confirmed ( Name:                      )	<input type="checkbox"/> Not yet confirmed
5. Contact to county and contact information	<input type="checkbox"/> Contacted the county	<input type="checkbox"/> Not yet communicated (who will do?                      )
	(Contact person and mobile #:                      )	
<b>Information of Best Practices</b>		
6. Title of Best Practice		
7. Site of Best practice		
8. Summary of Best Practice		
9. Insufficient/ lacking information in their report	<i>*insufficient information need to be collected through this filed visit</i>	
10. Types of information to collect (tick applicable)	11. Targets/ Persons to meet/ Offices to visit/ facilities to visit/ Documents to collect	12. Information to collect/ to confirm (Describe details)
<input type="checkbox"/> Interview <input type="checkbox"/> Focus Group Discussion <input type="checkbox"/> Documents/Records <input type="checkbox"/> Questionnaire <input type="checkbox"/> Observation <input type="checkbox"/> Others		

10. Types of information to collect (tick applicable)	11. Targets/ Persons to meet/ Offices to visit/ facilities to visit/ Documents to collect	12. Information to collect/ to confirm (Describe details)
<input type="checkbox"/> Interview <input type="checkbox"/> Focus Group Discussion <input type="checkbox"/> Documents/Records <input type="checkbox"/> Questionnaire <input type="checkbox"/> Observation <input type="checkbox"/> Others		
<input type="checkbox"/> Interview <input type="checkbox"/> Focus Group Discussion <input type="checkbox"/> Documents/Records <input type="checkbox"/> Questionnaire <input type="checkbox"/> Observation <input type="checkbox"/> Others		
<input type="checkbox"/> Interview <input type="checkbox"/> Focus Group Discussion <input type="checkbox"/> Documents/Records <input type="checkbox"/> Questionnaire <input type="checkbox"/> Observation <input type="checkbox"/> Others		
<input type="checkbox"/> Interview <input type="checkbox"/> Focus Group Discussion <input type="checkbox"/> Documents/Records <input type="checkbox"/> Questionnaire <input type="checkbox"/> Observation <input type="checkbox"/> Others		
12. Expected Deliverables	(i.e. field report, photos, interview videos, copy of documents produced by the county)	
Submitted by		
Date: _____	Name: _____	
Position: _____	Signature: _____	

## Appendix 7

Recording Format for Best Practice Validation/Documentation Visit			
Basic Information			
1. Title of Best Practice			
2. Entity visited		3. Date:	From                      to
4. Team visited			
Category	Validated Information from the Report and the Visit		
5. Implementation processes of the practice (what was done, how it was done, who were involved and what are the key elements of success?)	<Reported>		
	<Actual>	<Source of Evidence>	
6. Outputs of the practice and effectiveness (Are there any clear contribution to health outputs?, Are there any improvements in health indicators compared to previous years?)	<Reported>		
	<Actual>	<Source of Evidence>	

7. Efficiency of the practice and resources invested (What are resources mobilized and use for the practice?, Volume of inputs are reasonable?, No extraordinary resources are invested?)	<Reported>	
	<Actual>	<Source of Evidence>
8. Relevance of the practice (Is the practice relevant to health priorities of communities, facilities, counties, or the nation?)	<Reported>	
	<Actual>	<Source of Evidence>
9. Sustainability of the practice (Has improved work procedures institutionalized to maintain the practice?(i.e. guidelines), Are required resources available to continue the practice?)	<Reported>	
	<Actual>	<Source of Evidence>



10. Leadership of the practice (Are there clear visions/ plans presented by the leaders?, Are there active monitoring of the processes?, Has smooth coordination by concerning leaders been observed?)	<Reported>	
	<Actual>	<Source of Evidence>
11. Replicability of the practice (No extraordinary resources should have used, and no special conditions should be required for the practice. The Processes should be documented or recorded.)	<Reported>	
	<Actual>	<Source of Evidence>
12. Ethical soundness of the practice (The practice shall be planned and implemented with respects to human rights. Transparency of the activity need to be ensured.)	<Reported>	
	<Actual>	<Source of Evidence>

