ጤና ሚኒስቴር - ኢትዮጵያ
MINISTRY OF HEALTH - ETHIOPIA

Primary Health Care Unit Quality Improvement Implementation Guideline



April 2026

Addis Ababa, Ethiopia



Primary Health Care Unit Quality Improvement Implementation Guideline

Contents

Forward IV
Acknowledgment V
Acronym/Abbreviations VI
1. Introduction 1
1.1. Background 1
1.2. Rationale 2
1.3. Objectives 2
1.4. Target Audience 3
1.5. Scope of the guideline 3
2. Fundamentals of Healthcare Quality in PHC 5
2.1. Definition of Health Care Quality 5
2.2. The Six Dimensions of Quality 5
2.3. The Quality Management Trilogy 5
2.4. Quality Improvement Models 5
2.4.1. The Model for Improvement 6
2.4.2. KAIZEN 6
2.4.3. Supplemental QI Methodologies 7
2.5. Quality Improvement in Primary Health Care 7
3. PHCU-QI Framework 10
4. PHCU-QI Implementation Strategies 14
4.1. Establish and functionalize the QI structure at all levels 14
4.2. Build capacity through training and coaching 15
4.3. Co-design PHCU-QI project 16
4.4. Apply QI methods and tools 16
4.5. Create learning systems and leverage the EPAQ platform 17
4.6. Strengthen data systems and data use 17
4.7. Integrate QI into Planning, Budgeting, and Reporting 17
4.8. Strengthen QI enablers and address system bottlenecks 17
5. PHCU QI cycle 19
6. PHCU-QI Implementation Arrangement 21
7. Role and Responsibility 23
8. Resources mobilization and utilization 28
9. Monitoring, Evaluation, and Learning 30
9.1. Monitoring 30
9.2. Evaluation 30
9.3. Core indicators for QI monitoring and evaluation 30
9.4. Learning in quality improvement 32
10. References 36
11. Annex 37
11.1. Terms of Reference (ToR): Health center performance monitoring and quality improvement team 37
11.2. Terms of Reference (ToR): Community Quality Improvement team 42
11.3. PHCU learning sessions guide 47
11.4. Cascading training guide 48
11.5. A guide for Co-designing the PHCU-QI project 53
11.6. PHCU QI workbook 54
11.7. PHCU Quality Improvement (QI) Logbook 56
11.8. Completed PHCU Quality Improvement (QI) Project Reporting Template 57
11.9. Indicators list 59
11.10. PHCU Quality Improvement Implementation Checklist 61

Forward

The Ministry of Health of Ethiopia is currently implementing the Health Sector Development and Investment Plan (HSDIP), a three-year strategic plan from 2023/24-2025/26. Improving the quality and equity of health care is one of the key pillars of the HSDIP. In line with this, the Ethiopian Ministry of Health has designed a national health care quality strategy to sustain quality and equitable health care in health facilities and the community as a whole. This Quality Improvement Projects Implementation Guideline for the Primary Health Care Unit (PHCU) complements the national health care quality transformation.

This guideline provides a structured framework for institutionalizing and sustaining quality improvement (QI) practices across Primary Health Care Units (PHCUs) in Ethiopia. Its overall objective is to address inconsistent care and gaps in service delivery by embedding QI as a routine, systemic, and team-based process.

The guideline outlines a model of intervention and implementation approach for continuous quality improvement at the PHCU level. The Ministry of Health (MOH) recommends two core integrated QI models: the model for improvement, a structured framework that uses the Plan-Do-Study-Act (PDSA) cycle to rapidly test and implement changes, and KAIZEN, a philosophy of continuous, incremental change used to improve productivity, quality, and safety by eliminating waste and optimizing workflow. The models are designed to strengthen quality improvement initiatives at the PHCU and communities by enhancing common understanding and the linkage between health facilities and community-level health services, facilitating the active engagement of the community to enhance demand for quality health services, and providing feedback on health care services through continuous scoring of communities that evaluates the PHCU facilities. Thus, the interrelated and complementary interventions and the collective effort contribute to improving the health outcome of the population.

The guideline enables PHCU to implement a continuous quality improvement program for facility-based and community health services and will standardize the implementation. The guideline is intended for use by all actors in the Ethiopian primary health care system, including health centers, health posts, and community structures. Thus, FMOH recommends that all stakeholders use the guideline while implementing quality improvement interventions for community-level health services to achieve the intended outcome.

Israel Ataro (BSc, MPH)

Lead Executive Officer, Community Engagement and Primary Health Care Lead Executive Office

Acknowledgment

The preparation and finalization of the Quality Improvement Projects Implementation Guidelines for the Primary Health Care Unit (PHCU) were made possible by a series of consultative workshops. Throughout this process, the valuable contributions of Regional Health Bureaus (RHBs), partners, and MoH LEOs (Community Engagement and Primary Health Care and Health System Quality Improvement LEOs) have been indispensable. This guideline is intended to serve as a practical tool to guide the implementation of quality improvement initiatives for health services at the PHCU level.

The Ministry of Health extends its sincere appreciation to all institutions and organizations for their commitment and collaboration in developing this document. Special recognition goes to the experts from government and partner organizations who have tirelessly dedicated their time, knowledge, and experience to ensure the successful production of this guideline. Their collective efforts were crucial in shaping a framework that will strengthen the delivery of quality health services across the primary health care unit level.

The Ministry of Health also acknowledges the technical and financial contribution of the IPHCSD project implemented by Amref Health Africa and JSI, whose support has been instrumental in advancing this work.

List of contributors:

1. Wondesen Nigatu, MoH
2. Kasahun Sime, MoH/JSI
3. Aklog Getnet, MoH
4. Kiflemariam Tsegay, MoH
5. Dr Hillina Tadesse, JSI
6. Wubishet Kebede- MSIE
7. Nesredin Nursebo, MoH
8. Dr Mikiyas Tefere, Amref Health Africa
9. Dr Berhanu Tamiru, MoH/Amref Health Africa
10. Dr Nuredin Jemal, Shashemene Hospital
11. Dr Derese Dessalegn, Sidama RHB
12. Tebibu Solomon, Addis Ababa City Administration Health Bureau
13. Meskerem Fikre, Addis Ababa City Administration Health Bureau
14. Dr Eskinder Wolka, IPHCE
15. Mohammed Amin, MoH
16. Woldemariam Hirpa, MoH
17. Edossa Adugna, MoH

Acronym/Abbreviations

ANC: Antenatal care
BHP: Basic Health Post
CE-PHCU-LEO: Community Engagement Primary Healthcare Unit Lead Executive Office
CHP: Comprehensive Health Post
CQI: Community Quality Improvement
CCFQI: Combined community-facility quality improvement
CQITs: Community Quality Improvement Teams
CSC: Community Scorecards
EPAQ: Ethiopian PHC Alliance for Quality
EPHCG: Ethiopian Primary Health Care Clinical Guidelines
GGI: Good Governance Indicator
HC: Health Center
HEP: Health Extension Program
HMIS: Health Management Information System
HP: Health Post
HSDIP: Health Sector Development and Investment Plan
IOM: Institute of Medicine
MoH: Ministry of Health
MOU: Memorandum of Understanding
NHIQ-SC: National Health Innovation and Quality Steering Committee
NMR: Neonatal Mortality Rate
NQSS: National Healthcare Quality and Safety Strategy
PDSA: Plan-Do-Study-Act
PHCU: Primary Health Care Unit
PM&QI team: Performance Monitoring and Quality Improvement Team
PNC: Postnatal care
QA: Quality Assurance
QC: Quality Control
QI: Quality Improvement
RHBs: Regional Health Bureaus
SOPs: Standard Operating Procedures
UHC: Universal Health Coverage
VHL: Village Health Leaders
WHO: World Health Organization
WoHO: Woreda Health Office
ZHD: Zonal Health Department

1



Introduction

1. Introduction

1.1. Background

Quality is currently on the agenda of the Sustainable Development Goals that target Universal Health Coverage (UHC) [1]. The World Health Organization (WHO), the Organization for Economic Co-operation and Development, and the World Bank emphasized that ensuring quality is a fundamental component of UHC [2]. Since PHC is planned to deliver essential health services as close to home as possible, it serves as a roadmap for universal health care coverage (UHC), which must be high-quality to achieve the health system's vision. The Lancet Global Health Commission estimated that high-quality health systems could prevent 8 million deaths yearly in low and middle-income countries (1).

Between 5.7 and 8.4 million deaths are attributed to poor quality care each year in low- and middle-income countries (LMICs), which represents up to 15% of overall deaths in these countries, while inadequate quality of care imposes costs of US $1.4–1.6 trillion each year, lost productivity in these countries (1). Sixty percent of deaths in LMICs from conditions requiring health care occur due to poor quality care, whereas the remaining deaths result from non-utilization of the health system (2).

Ethiopia's healthcare system is structured into three tiers: primary, secondary, and tertiary levels of care. Primary health care units provide essential primary health care, general hospitals offer secondary care, and specialized hospitals provide tertiary care. The first is the primary level of care that includes primary hospitals, *health centers, health posts (Basic and Comprehensive),* and community structures. The health posts are staffed by Health Extension Workers (HEWs) and other categories of health professionals, who work with Community Structures such as WDU, VHL, and Other Community Engagement structures, and provide a range of services, from preventive and basic curative services to community-based palliative care. The health centers supervise several health posts, provide more comprehensive outpatient and maternal services, and serve as the referral center for health posts. The *primary hospitals* offer more advanced care, including emergency, surgical, and inpatient care. The primary hospital serves as the first level of referral care above health centers [1] [2].

Achieving universal health coverage (UHC) with quality at its core requires that all individuals, regardless of location or socioeconomic status, have access to essential, safe, effective, and affordable health services. As the first point of contact for most people, primary health care units (PHCUs) are crucial to realizing this vision. Quality health care is a central pillar of Ethiopia's Health Sector Development and Investment Plan (HSDIP), which aims to build a high-performing, resilient health system [3].

During the HSTP I and II periods, there have been promising achievements in improving the quality of care through the institutionalization of quality improvement practices within health care facilities. This is driven by the introduction of the Ethiopian Hospital Alliance for Quality (EHAQ), Ethiopian PHC Alliance for Quality (EPAQ), the Ethiopian PHC clinical guideline (EPHCG), Ethiopian Hospital Services Transformation Guideline (EHSTG), and implementation of QI directives and initiatives [10].

However, ensuring consistent delivery of quality care across PHCUs remains a challenge. Embedding quality improvement (QI) as a routine, systemic, and team-based process within these units is essential for improving service delivery and patient outcomes. While several capacity-building efforts have taken place, including QI training based on a competency-based approach, the absence of a comprehensive implementation guideline has limited sustained and standardized practice.

This guideline aims to address this gap by providing a structured approach to institutionalizing quality improvement within PHCUs.

1.2. Rationale

Despite ongoing efforts to strengthen the health system, significant quality improvement (QI) challenges persist at the primary health care unit (PHCU) level. These include inconsistent care practices, limited use of data for decision-making, lack of systematic problem-solving approaches, and the absence of simplified, practical methods for internal QI processes at health posts. Although QI training has been introduced to build health worker capacity, the lack of a clear, context-specific implementation guideline has limited the translation of these competencies into routine practice. The 2019 National Assessment of the Health Extension Program (HEP) further highlighted constraints affecting quality service delivery, such as inadequate infrastructure at health posts, gaps in delivering comprehensive services aligned with community needs, health worker competency and motivation issues, shortages of essential drugs and commodities, and insufficient financing. Addressing these interrelated challenges is critical for institutionalizing QI as a routine part of service delivery at the primary health care unit (PHCU) level.

This guideline is therefore designed to provide practical, user-friendly, and context-appropriate direction for implementing QI initiatives within Ethiopian PHCUs. It aims to support systematic planning, implementation, monitoring, and sustainability of QI activities; strengthen collaborative learning; engage community-level structures in quality platforms; enhance inter-facility linkages for continuity of care; and align facility-level efforts with national priorities on quality, performance, and accountability. Improving quality at the PHCU level is fundamental to building resilient health systems and achieving equitable health outcomes, and it requires sustained political commitment, adequate resource investment, and strong partnerships among government, health care providers, and communities.

1.3. Objectives

General objectives

To provide practical and standardized guidance for implementing and sustaining quality improvement (QI) within Primary Health Care Units (PHCUs) in Ethiopia.

Specific Objectives

- Provide clear guidance for PHCUs to establish and operationalize functional quality improvement structures and defined roles across health centers, health posts, and community platforms.
- Strengthen community participation and co-ownership of quality improvement by promoting integrated community–facility partnership approaches.
- Support the institutionalization of QI by integrating it into routine planning, budgeting, reporting, and accountability systems to ensure sustainability and enable scale-up.

1.4. Target Audience

The PHCU-QI guideline targets all stakeholders involved in planning, implementing, supporting, and monitoring primary health care quality improvement in Ethiopia. These include the MOH, RHBs, Zonal/Sub city/Woreda health offices, Primary hospitals, HCs, HPs, and community-based structures, development and implementing partners.

1.5. Scope of the guideline

This guideline is intended for use by all actors working in quality improvement within Ethiopia's primary health care system, particularly at the Primary Health Care Unit (PHCU) level, focusing on health centers, their linked health posts, and community structures.

2



Fundamentals of Healthcare Quality in PHC

2. Fundamentals of Healthcare Quality in PHC

2.1. Definition of Health Care Quality

Quality in health care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (IOM, 2001). Beyond clinical excellence, quality represents the ethical application of medical science and technology to maximize health benefits while minimizing risks (Donabedian, 1988).

Health Care quality in Ethiopia is defined as a comprehensive and integrated care that is measurably safe, effective, people-centered, and uniformly delivered in a timely way that is affordable to the Ethiopian population and appropriately utilizes resources and services efficiently (National Healthcare Quality and Safety Strategy-NQSS).

2.2. The Six Dimensions of Quality

To ensure a holistic approach, PHC services must be evaluated against six core dimensions.

Dimension	Definition
Safety	Minimizing risks and preventing harm to patients.
Effectiveness	Providing evidence-based care that achieves beneficial results.
Patient-Centeredness	Respecting individual patient preferences, needs, and values.
Timeliness	Reducing delays for those who receive and those who give care.
Efficiency	Avoiding waste of resources, including time, supplies, and ideas.
Equity	Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, or socioeconomic status.

2.3. The Quality Management Trilogy

To maintain and improve healthcare standards, leadership must apply Systems Thinking through three core management elements:

1. **Quality Planning (QP)**: Designing a structure and allocating resources to close the gap between current performance and population needs.
2. **Quality Control (QC)**: A normative process involving Quality Assurance (QA) to ensure standards are met, errors are reduced, and current performance is monitored against benchmarks.
3. **Quality Improvement (QI)**: The continuous, iterative process of testing changes to shift whole-system performance and spread best practices.

2.4. Quality Improvement Models

The Quality Improvement model is a systematic framework used to continuously enhance health services through iterative testing and measurement. It serves as a structured approach to bridge the gap between current performance and desired health outcomes.

2.4.1. The Model for Improvement

The Model for Improvement is a structured framework used to accelerate quality improvement within the Ethiopian healthcare system. It is often described as the "vehicle" for change, providing the necessary structure to test and implement improvements. The primary framework for PHC improvement integrates three fundamental questions with the Plan-Do-Study-Act (PDSA) cycle:

The Three Fundamental Questions, the model begins by addressing three basic questions that guide any improvement effort:

- What are we trying to accomplish? This involves defining a clear, ambitious aim statement or charter.
- How will we know that a change is an improvement? This requires establishing measures and utilizing data to track performance and variation.
- What change can we make that will result in improvement? This involves developing change ideas—specific concepts aimed at stimulating improvement.

The PDSA Cycle

Once the above questions are answered, the model uses the Plan-Do-Study-Act (PDSA) cycle for small, rapid tests of change:

- Plan: Identify the change and how to test it.
- Do: Carry out the test on a small scale.
- Study: Observe and analyze the results.
- Act: Refine the change based on what was learned or prepare for larger-scale implementation.

2.4.2. KAIZEN

Kaizen is a fundamental and systematic management tool used to improve productivity, quality, and safety within all levels of health organizations. In the Ethiopian health sector, Kaizen is considered the "engine" that drives improvement, focusing on efficiency and cost reduction by eliminating waste and optimizing workflows. It is a philosophy of continuous, incremental change that involves every member of the workforce. The core of Kaizen implementation is the **5-S** framework—a sequence of activities designed to create a convenient, comfortable, and organized work environment to improve service preparedness and timeliness.

- **Sort (Seiri):** Identify and remove all unused or unnecessary items from the workspace.
- **Straighten/Set (Seiton):** Organize necessary items in a proper, logical order so they are easy to find and use during service provision.
- **Shine (Seiso):** Maintain high standards of cleanliness for all equipment, floors, walls, and windows.
- **Standardize (Seiketsu):** Establish the first three S's as daily norms. Develop checklists for each service area to reduce cycle time and waste while improving safety.
- **Sustain/Self-Discipline (Shitsuke):** Train staff to maintain discipline and adhere to these standards. Motivation can be fostered through competitions and rewarding good practices.

In the context of Primary Health Care Units (PHCUs), Kaizen is used to:

- **Eliminate Waste:** Reduce process unreasonableness and unnecessary movement of staff or patients.
- **Improve Flow:** Ensure that the workplace is organized to facilitate smooth service delivery.
- **Standardize Processes:** Use "Checklists" to ensure every activity is performed consistently and safely.

While Kaizen focuses on the environment and efficiency, it is most effective when integrated with the Model for Improvement. In this partnership, Kaizen provides the organized foundation (the engine), while the Model for Improvement provides the structured "vehicle" to test specific changes through Plan-Do-Study-Act (PDSA) cycles.

2.4.3. Supplemental QI Methodologies

While the Model for Improvement and Kaizen are the primary engines for change, the national strategy also acknowledges other global methodologies that can be integrated into the system:

- **Lean:** Focuses on maximizing value by minimizing waste in every process.
- **Six Sigma:** A data-driven approach aimed at reducing variation and defects in healthcare delivery.
- **Root Cause Analysis (RCA):** To investigate adverse events and prevent recurrence.
- **Total Quality Management (TQM):** To embed a culture of quality across the entire organization.

2.5. Quality Improvement in Primary Health Care

A Primary Health Care Unit (PHCU) is the basic service delivery and management structure of the Ethiopian primary health care system. It comprises one health center and its affiliated health posts serving defined kebeles. The health center provides comprehensive primary care services and serves as the technical, administrative, and referral hub, while health posts—staffed by Health Extension Workers (HEWs)—deliver essential preventive, promotive, and basic curative services at the community level.

From a PHCU Quality Improvement (QI) perspective, the PHCU operates as a single, integrated quality system. Leadership, data use, performance monitoring, and learning are coordinated across health centers, health posts, and Community teams. The health center leads QI planning, coaching, and measurement, while health posts implement context-specific improvements focused on service delivery and community engagement. Effective referral linkages, feedback mechanisms, and shared accountability across PHCU components are critical for continuity of care and sustained quality improvement.

QI focuses on improving processes within the health system and relies on team collaboration, patient-centeredness, and the reduction of waste and errors to increase efficiency and reliability (Batalden & Davidoff, 2007). Quality Improvement (QI) in health care is centered on continuously enhancing patient care and outcomes through systematic efforts.

The fundamental concepts include:

- **Continuous and Systematic Process**: QI is an ongoing cycle of identifying problems, implementing changes, measuring results, and refining processes to achieve better care (IOM, 2001).
- **Patient-Centeredness**: Improving quality means focusing on the needs, preferences, and values of patients to ensure care is respectful and responsive (IOM, 2001).
- **Data-Driven Decision Making**: Decisions about improvements should be based on reliable data and measurable outcomes rather than assumptions (Langley et al., 2009).
- **Teamwork and Collaboration**: QI relies on multidisciplinary teams working together across different departments to solve problems and improve processes (Batalden & Davidoff, 2007).
- **Systems Thinking**: Understanding how various parts of the health care system interact helps identify root causes of issues rather than blaming individuals (WHO, 2009).
- **Focus on Processes:** QI targets the processes of care delivery, recognizing that improving these will lead to better patient outcomes (Donabedian, 1988).
- **Use of Evidence-Based Interventions:** Improvements are guided by best available scientific evidence and clinical expertise (IOM, 2001).
- **Reduction of Variation and Waste:** Standardizing care processes reduces unnecessary variation and eliminates inefficiencies, leading to safer and more reliable care (Deming, 1986).
- **Measurement and Feedback:** Regular measurement of performance indicators and timely feedback to teams are critical to track progress and guide improvement efforts (Langley et al., 2009)

3



PHCU-QI Framework

3. PHCU-QI Framework

Effective and sustainable quality improvement in Primary Health Care Units (PHCUs) requires a robust, well-defined framework and a clear governance structure. This section outlines the conceptual model guiding QI efforts at PHCU. The framework integrates community and facility quality improvement efforts, aligns with national health priorities, and operationalizes quality strategies across communities, health posts, health centers, and primary hospitals.

The PHCU QI Framework is based on the principle that continuous improvement is integral to routine service delivery, not an isolated project. It integrates core concepts from nationally adapted QI models (e.g., Model for Improvement, PDSA cycles, KAIZEN) and aligns with the WHO health systems building blocks adapted specifically for the PHCU context.

The PHCU QI Framework is built on the following core components:

1. **Core primary care functions:**

    - **First contact accessibility** refers to the capacity of a primary care system to serve as the first point of contact, or a patient's entry point to the health system, for most of a person's health needs.
    - **Comprehensiveness** refers to the provision of holistic and appropriate care across a broad spectrum of health needs, ages, and solutions. Comprehensive primary health care can address a majority of promotive, preventive, curative, rehabilitative, chronic, and palliative service needs.
    - **Coordination of care** refers to the system's ability to oversee and manage patient care throughout treatment and across various sites of care to ensure appropriate follow-up, minimize the risk of error, and prevent complications. Coordination of care happens across levels of care and over time, and often requires proactive outreach on the part of health care teams and consistent tracking and communication of progress.
    - **Continuity** is the degree to which a patient experiences a series of discrete healthcare events as coherent and consistent with their medical needs and personal context. This requires fostering trusted relationships between health care providers and patients over time (relational continuity), ensuring information is communicated from one event to the next (informational continuity), and ensuring the process is managed in a timely, complementary, and effective way across providers (management continuity).
    - **People-centeredness** means organizing the health system around the comprehensive needs of people rather than individual diseases. This involves engaging with people, families, and communities as equal partners in promoting and maintaining their health - including through communication, trust, and respect for preferences, as well as ongoing education and support so that they can participate in health care decisions.

2. **Key Enablers:**

    - **Standardized Processes:** Clear, evidence-based clinical guidelines and SOPs.
    - **Information Systems:** Functional HMIS and CHIS, capacity for simple local data collection/ analysis, feedback mechanisms.
    - **Human Resources:** Trained staff with designated QI roles/time, supportive supervision.
    - **Supportive Environment:** Psychological safety for staff to report problems and test ideas, recognition for improvement efforts.
    - **Resources:** Basic operational budget allocation for QI activities (may include time, materials, and small incentives).

3. **QI Cycle:**

    - **Identify Opportunities:** Use data (routine HMIS, audits, patient feedback, staff reports), benchmarks, and standards to pinpoint areas for improvement.
    - **Analyze Root Causes:** Employ simple tools (e.g., Fishbone diagrams, 5 Whys) to understand *why* a problem exists.
    - **Develop & Test Changes:** Brainstorm potential solutions, select the most promising, and test them rapidly on a small scale using PDSA cycles.
    - **Implement & Scale:** Refine successful changes based on test results and implement them more broadly across relevant services or the entire PHCU.
    - **Monitor & Sustain:** Continuously track key indicators to ensure improvements are maintained and identify new opportunities. Embed successful changes into standard operating procedures (SOPs).
    - **Share & Learn:** Communicate results (successes and failures) within the PHCU, with other PHCUs, and with district/regional/national levels to foster collective learning.

4. **Key outcomes and impact**

    - **Improved patient experience and health status:** Adherence to evidence-based standards improves the accuracy and timeliness of care, ultimately supporting better clinical outcomes and patient experience of care.
    - **More efficient, cost-effective care:** Adherence to established standards also promotes the efficient use of resources and time. In addition, timely access to high-quality services allows patients to use the PHC system as the first point of contact with the health system, helping to reduce the utilization of emergency- or hospital-based services that may result in higher costs for the patient and health system.
    - **Trust in PHC as the first point of contact:** Over time, delivering reliable, useful services for a population can help to build patient trust in the health system and enhance the perceived value of PHC.
    - **Health equity:** Timely access to services is critical to achieving health equity for all populations; however, increased access to services will not translate to better health outcomes if these services are not of high quality. Marginalized populations, such as low-income and/or rural communities, are especially at risk of receiving poor-quality services.

- **Financial protection:** Facility hours and operations that align with patient needs and preferences help to mitigate additional costs for patients, such as those due to missed work hours or the need to find alternative childcare.
- **Resilience:** Quality and resilience are closely linked concepts. For health systems to be resilient, they require quality health services that are delivered prior to, maintained during, and improved upon following a public health emergency. Quality health services are pivotal during emergencies and serve as the interface between communities and the health system.

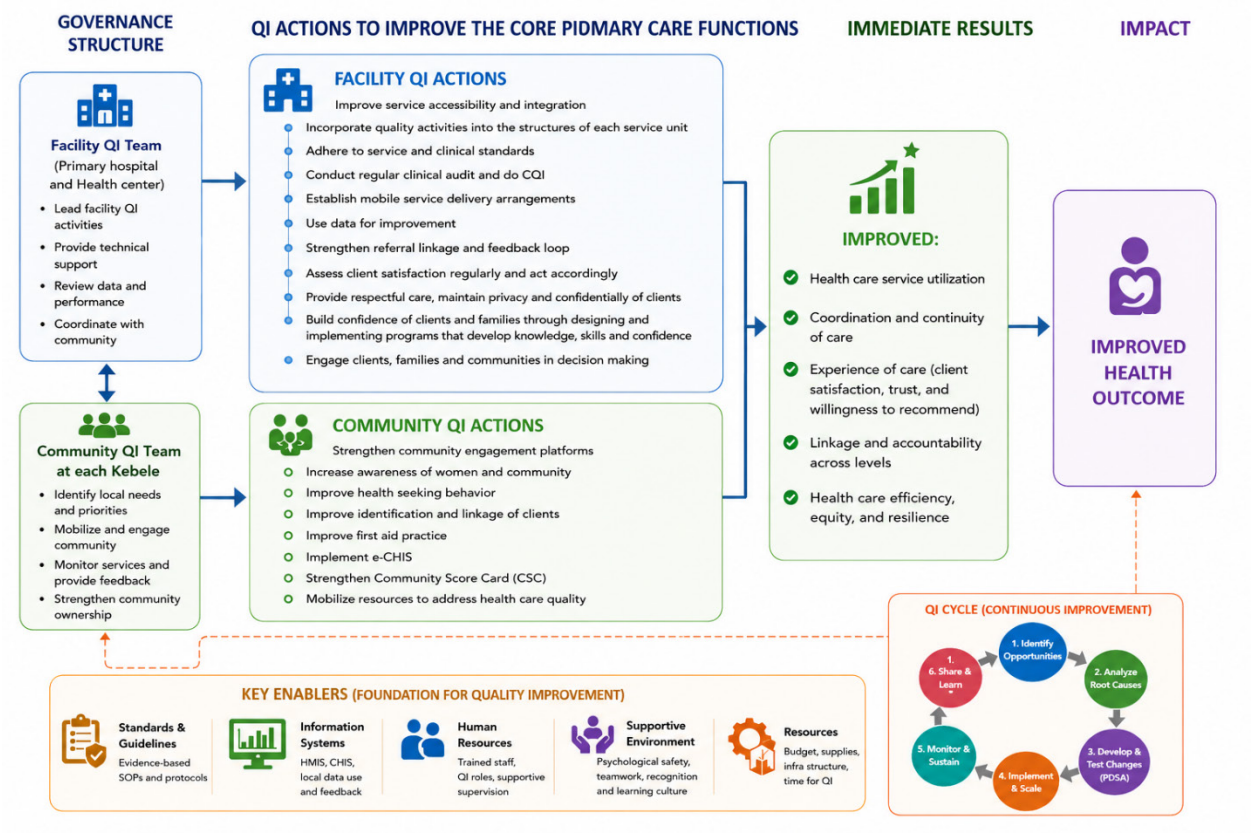

Figure 1: PHCU-QI framework

4



PHCU-QI Implementation Strategies

4. PHCU-QI Implementation Strategies

PHCU-QI implementation is guided by a collaborative approach that brings together health facilities and communities to jointly identify priority quality gaps, set improvement aims, and implement structured QI projects. Each PHCU, in partnership with its catchment kebele Community Quality Improvement (CQI) teams, applies standardized QI methods to improve service delivery, strengthen continuity of care, and enhance client experience. The implementation strategies are outlined below.

4.1. Establish and functionalize the QI structure at all levels

A functional QI governance structure is essential for the effective implementation of PHCU-QI. Existing quality teams should be strengthened, and new teams should be established where gaps exist. At the woreda level, the Woreda Health Office (WoHO) shall assign a QI focal person responsible for coordinating PHCU-QI implementation, ensuring functional reporting systems, and providing technical support and coaching to facilities.

At the health center level, the Health Performance Monitoring and Quality Improvement (PM&QI) team leads QI implementation across the PHCU. The PM&QI team should include:

- Medical director (chair),
- QI focal (secretary),
- HPDP core process owner,
- Curative core process owner,
- CHPU focal,
- HMIS focal,
- MCH head,
- Laboratory head,
- Pharmacy head,
- Admin and finance head, and
- Community representative from the HC board.

Based on the selected improvement priorities, the PM&QI team may establish sub-teams to support implementation, routine data collection, testing of changes, and monitoring progress.

At the CHP, the performance monitoring team, which is led by the head, will be leading and testing the combined community facility quality improvement effort at the CHP and the catchment Kebele.

At the kebele level, each kebele shall establish a Community Quality Improvement (CQI) team composed of selected community members and health post professionals. In kebeles with a Comprehensive Health Post, the assigned quality focal person from the CHP shall serve as a member of the CQI team. In settings where the health post is merged with the health center, the Health Extension Worker (HEW) based at the health center (merged HP) shall serve as a member of the CQI team. In kebeles served by a Basic Health Post, HEWs shall serve as members of the CQI team. Community members selected to serve on the CQI team should be respected by the community, willing to volunteer, recognized as role models, and have leadership roles or strong awareness of local health issues and community priorities.

The CQI team should be diverse and consist of approximately 12 members, including the

- Kebele manager (Chair),
- Health Extension Workers (Secretary)
- Village Health leaders (VHL) representative
- Women Development Army leaders' representative
- Teachers' representative
- Agricultural extension worker representative
- Kebele youth representative
- Gender affairs representative
- Religious leaders' representative
- Elders' representative

During team formation, attention shall be given to gender balance and equitable representation of all ketenas/gots within the kebele. The HEW supervisor or focal person at the health center shall provide regular support and follow-up to the CQI team. Both the health center QI team and kebele CQI teams shall have a formal TOR (annexed) and meet at least monthly. In addition, the health center QI team shall also convene a monthly joint review meeting/learning session with CQI chairpersons and secretaries to monitor progress, share learning, and revise PDSA cycles as needed.

4.2. Build capacity through training and coaching

Strengthening QI capacity is fundamental to ensuring that QI approaches are consistently applied at all levels. Capacity building shall be implemented through structured training, ongoing mentorship, and supportive coaching. At national and regional levels, experts from MoH, RHB, ZHD, and hospitals shall receive a five-day PHC-QI TOT, including theoretical sessions, project development, and teach-back practice.

At the facility level, selected health center staff (2–3) shall receive a five-day TOT using the PHCU-QI training guide and cascade training to the broader health center workforce through a seven-week onsite program (one day per week). For comprehensive health posts, the facility head and QI focal person shall receive a three-day TOT and cascade onsite training over four consecutive weeks. Basic health posts shall receive a one-day QI orientation at their catchment health centers, while CQI team members shall receive a one-day orientation delivered by trained health post staff. Upon successful completion, trainees shall receive certification stamped by the health center and signed by the heads of the health center and WoHO. Training guides for health centers, health posts, and CQI teams are annexed.

QI coaching is an essential mechanism to strengthen the application of QI methods and address implementation challenges. Coaching should follow the national Quality of Care coaching guide and be implemented through the established mentorship cascade system: WoHO to primary hospital, primary hospital to health centers, and health centers to health posts and CQI teams. Coaching should focus on strengthening teamwork, proper application of MFI, improving documentation, supporting data use, and resolving bottlenecks affecting implementation.

4.3. Co-design PHCU-QI project

PHCU-QI projects shall be co-designed through a structured process that ensures shared ownership between facility and community stakeholders. Co-design involves joint planning between the health center QI team and kebele CQI teams to develop a common understanding of priority quality gaps, define shared improvement aims, and agree on roles and responsibilities.

The co-design process includes conducting a pre-meeting catchment self-assessment, convening facility and community stakeholders, reviewing service performance and client experience, identifying and prioritizing key problems, setting a common aim, developing a QI project, and preparing an action plan. The co-design session shall be conducted at the PHCU level and take one full day. A standardized co-design guide is annexed.

4.4. Apply QI methods and tools

PHCU-QI implementation shall apply nationally endorsed QI approaches, primarily the Kaizen methodology and the Model for Improvement (MFI). Kaizen provides the foundation for improving service efficiency and the work environment by eliminating waste and streamlining workflows, while the Model for Improvement provides the structured approach for testing and scaling improvement interventions through PDSA cycles. These approaches should be implemented in a complementary manner to strengthen both service readiness and quality of care.

Kaizen shall be operationalized through the 5S framework: Sort, Set, Shine, Standardize, and Sustain. This approach supports improved organization of service areas, cleanliness, standard workflow, and consistent service readiness. The Model for Improvement shall guide the development and testing of QI projects by addressing three key questions—what the team aims to accomplish, how improvement will be measured, and what changes can lead to improvement—followed by iterative Plan–Do–Study–Act (PDSA) cycles. These methods shall be supported through standardized QI tools such as workbooks, run charts, checklists, and documentation formats.

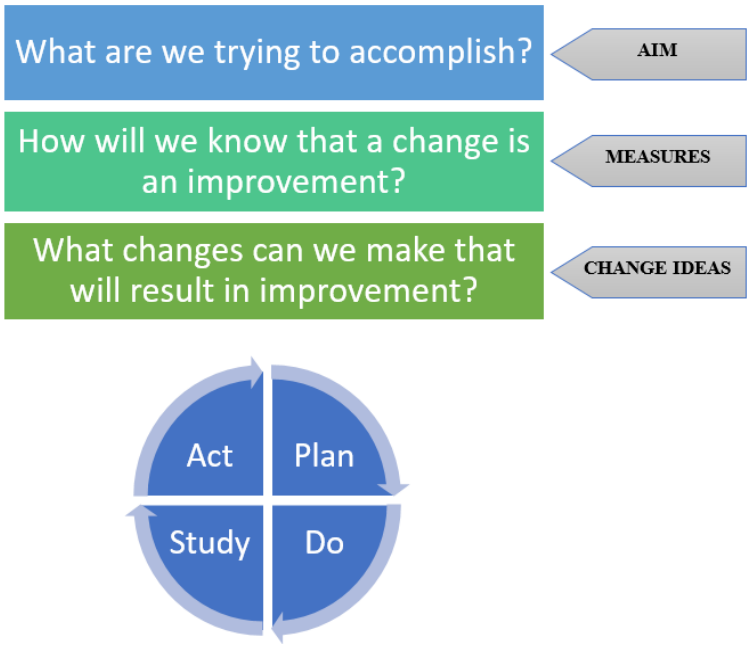

Figure 2: Model for improvement

4.5. Create learning systems and leverage the EPAQ platform

Collaborative learning is essential for strengthening performance monitoring, peer learning, motivation, and scale-up of best practices. PHCU-QI learning systems shall be institutionalized through regular review meetings and structured learning sessions. At the PHCU level, collaborative learning should be integrated into the monthly PHCU follow-up meetings involving health centers, health posts, and CQI team representatives.

At the woreda level, quarterly learning sessions shall be conducted through the Ethiopian Primary Health Care Alliance for Quality (EPAQ) platform to facilitate cross-PHCU learning, documentation of best practices, and shared problem-solving. Learning sessions should focus on reviewing performance data, reflecting on PDSA findings, and sharing successful interventions and lessons learned. A collaborative learning session guide is annexed.

4.6. Strengthen data systems and data use

Data is central to effective QI implementation, as it enables the identification of performance gaps, monitoring of progress, and evaluation of improvement interventions. PHCU-QI teams shall use multiple sources of data, including HMIS reports, service registers, patient records, surveys, client feedback tools, and direct observations. Both facility and community QI teams should track improvement using time-series data and display charts for visualization and discussion during review meetings.

In addition, QI workbooks (annexed) shall be used consistently by both facility and community teams to document improvement aims, indicators, PDSA cycles, results, and lessons learned. Strengthening routine documentation and data quality is essential to ensure that improvement decisions are evidence-based and aligned with local performance trends.

4.7. Integrate QI into Planning, Budgeting, and Reporting

To ensure sustainability, QI must be institutionalized within routine health system planning and management processes. PHCU-QI activities should be integrated into annual woreda, PHCU, and kebele plans, and resources should be allocated to support core QI functions. This includes budgeting for coaching visits, printing tools and job aids, conducting review meetings, and implementing minor facility improvements. Where applicable, performance-based financing mechanisms should be used to incentivize improved quality performance.

PHCU-QI progress and results shall be reported in accordance with national and regional reporting structures and timelines. Standard reporting tools, including the PHCU-QI activity reporting logbook (annexed), shall be used to ensure consistency and facilitate monitoring across levels of the health system.

4.8. Strengthen QI enablers and address system bottlenecks

QI interventions cannot be effective unless key system bottlenecks are addressed. PHCU-QI implementation must therefore include strengthening essential enablers that support service continuity and quality. These include routine monitoring of essential drugs and supply availability, ensuring functionality of equipment, managing workload and staffing constraints, and improving facility readiness through reliable water, sanitation, and power systems.

Strengthening these foundational enablers ensures that QI teams are able to implement changes effectively and sustain gains over time. It also supports improved service delivery capacity and enhances the overall readiness of PHCUs to provide safe, effective, and people-centered care.

5



PHCU QI cycle

5. PHCU QI cycle

The PHCU QI approach follows a structured five-step continuous quality improvement cycle. The cycle ensures that both facility and community actors jointly identify priority gaps, develop and test improvement ideas, monitor progress using data, and sustain successful practices through standardization and learning. The cycle promotes integration of QI into routine service delivery and strengthens linkage across the PHCU (health center, health posts, and community structures).

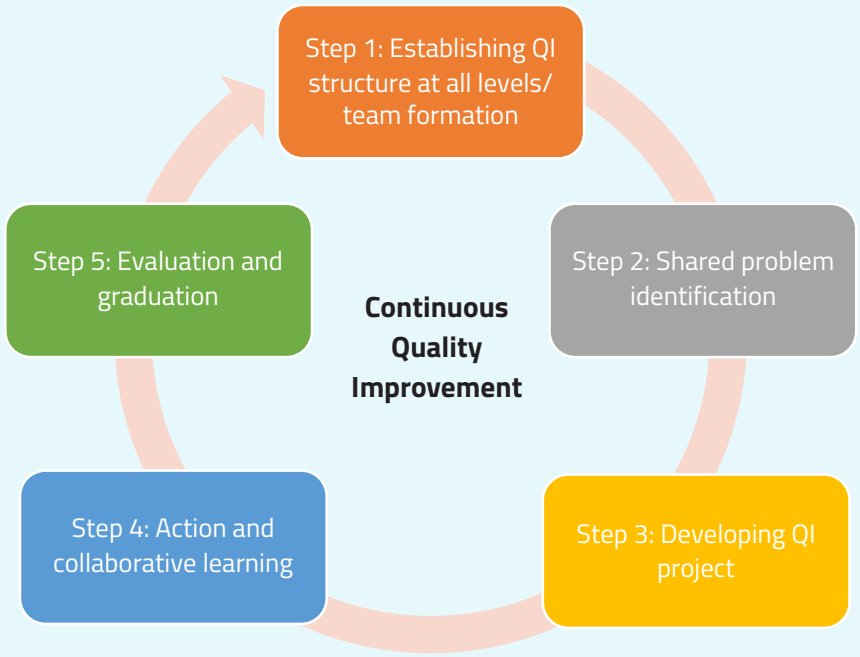

Figure 3: PHCU-QI Cycle

Step 1: Establishing QI structure at all levels/ team formation

The first step in PHCU-QI implementation is establishing and functionalizing QI structures at the health center, health post, and community levels. QI structures ensure that improvement work is coordinated, measurable, and sustained. The QI structures shall have clear TORs, trained/oriented in QI concepts and the PHCU QI approach,

Step 2: Shared problem identification

In Step 2, facility and community actors jointly identify and prioritize the most critical quality gaps affecting service delivery, utilization, and outcomes. This process begins with a structured gap assessment using routine HMIS data, service registers, supportive supervision findings, clinical audit results, and community feedback mechanisms such as scorecards and client complaints. The assessment should explore issues related to access, continuity of care, safety, service readiness, and patient experience, ensuring that both facility and community perspectives are captured.

After identifying multiple gaps, the PHCU QI team and CQI teams prioritize one or two problems using agreed criteria such as magnitude, severity, feasibility, alignment with national priorities, and community concern. The selected problem should be clearly defined in measurable terms and supported by baseline

data. This step ensures that improvement efforts are focused, evidence-informed, and locally relevant, with shared ownership between the health system and the community.

Step 3: Developing the QI project

Step 3 involves translating the prioritized problem into a structured QI project using the Model for Improvement. The team develops a clear aim statement that is specific, measurable, achievable, relevant, and time-bound, and then conducts root cause analysis using tools such as the fishbone diagram, 5 Whys, or process mapping to understand the underlying reasons for poor performance. Based on the root causes, the team generates feasible change ideas through brainstorming and consultation with community members. These change ideas are organized into a QI project charter and action plan that outlines responsibilities, timelines, required resources, and the approach for testing improvements. This step ensures that the QI intervention is well-designed and grounded in local evidence. The team then defines improvement measures, including outcome measures (to track the main result), process measures (to monitor whether key steps are implemented correctly), and balancing measures (to ensure that changes do not create unintended negative effects). These measures provide the basis for tracking progress and guiding decision-making throughout the QI cycle.

Step 4: Action, Coaching, and Collaborative Learning

Step 4 is the implementation phase where the PHCUs and CQI teams simultaneously test bundle of change ideas using Plan–Do–Study–Act (PDSA) cycles. Improvement actions are implemented first on a small scale, allowing teams to learn quickly and refine approaches before expanding. During implementation, teams collect and review data regularly, using run charts to visualize progress and guide adjustments. Routine documentation in QI workbooks and logbooks is essential to track what was tested, what worked, and what challenges emerged. (QI workbooks and log books are annexed)

QI Coaching is critical during this step to ensure quality implementation and problem-solving. Woreda and primary hospital teams provide QI coaching to health centers, while health centers provide coaching to health posts and community QI teams. Regular review meetings/follow-up meetings at the PHCU level and EPAQ sessions can be leveraged to integrate collaborative learning sessions to share experiences, document best practices, address barriers, and strengthen motivation. This step reinforces teamwork, accelerates learning, and supports continuous refinement of improvement interventions.

Step 5: Evaluation and Graduation

Step 5 focuses on evaluating results, institutionalizing successful changes, and preparing for sustainability and scale-up. The PHCU compares baseline and endline performance using the selected indicators and assesses whether the improvement aim has been achieved. Lessons learned should be documented, including what worked, what did not, and why.

Once improvement is demonstrated and sustained over time, the PHCU standardizes the successful practices by integrating them into routine systems such as SOPs, checklists, staff roles, and facility plans. Graduation and recognition can then be conducted through woreda or regional learning platforms to motivate teams and promote accountability. Finally, proven interventions should be spread to other health posts within the PHCU and shared across PHCUs through peer learning and EPAQ platforms. This step ensures that improvement gains are maintained and contribute to broader system strengthening.

6



PHCU-QI Implementation Arrangement

The Ministry of Health has prioritized healthcare quality as a foundational element of its national reform agenda, embedding it within the Health Sector Transformation Plans (HSTP I & II) and the National Healthcare Quality and Safety Strategy to enhance health outcomes and public trust. To transform these strategic goals into reality, the Ministry established a structured implementation arrangement for Primary Health Care Units (PHCUs) and community-level services that defines clear roles for national, sub-national, and international stakeholders. This framework ensures that operational efforts are seamlessly aligned with high-level policy objectives, fostering a coordinated environment for sustainable and impactful quality improvements across the entire health system. The following table illustrates the PHCU Quality Improvement structure and implementation arrangement:

Level	Leading role	Coordination Mechanisms
National	MoH (HSIQ-LEO & CE-PHC-LEO)	NHIQ-SC, JQEF, COP, Research Advisory Council
Regional	RHB (Quality and CE-PHC-LEO Director)	Steering Committee, TWG, Regional JQEF
Zonal/Sub City/Woreda	Quality Unit / Officer	Technical supervision and planning
Health Center	Quality Focal Person	Quality Committee
Health Post and community	HEWs / Community Leaders	Community Quality Team (CQT)

7



Role and Responsibility

7. Role and Responsibility

MOH (HSIQ and CE&PHC LEOs)

- Establish and maintain support teams to drive PHCU quality improvement implementation.
- Provide strategic leadership and guidance for quality improvement across PHCUs and community-level platforms.
- Lead the development and routine updating of QI implementation guides, training manuals, and job aids.
- Mobilize and allocate financial and technical resources to support QI initiatives.
- Advocate for quality improvement by engaging government bodies and development partners, promoting its importance at all levels of the health system.
- Build capacity through targeted training for health workers, managers, and Community Quality Teams (CQTs).
- Offer regular mentorship and coaching to strengthen ongoing learning and skill development.
- Establish Woreda and health center–level Learning Networks and Communities of Practice to facilitate continuous learning, knowledge sharing, and collaboration.
- Organize and facilitate the annual national PHCU QI learning session to promote cross-site learning and innovation.
- Develop and implement criteria for recognizing and rewarding high-performing PHCUs and outstanding QI practices.
- Ensure coordination and harmonization of all QI efforts across various Leadership Engagement Offices (LEOs), services, and implementing agencies.
- Oversee the implementation performance of PHCU and community-level QI initiatives.
- Evaluate the application of the PHCU and community QI implementation guide and training manual to inform continuous improvement.
- Documentation of success stories, challenges, and policy recommendations

RHB (Quality and CE&PHC Directorates)

- Strengthening the regional level Quality improvement implementation
- Endorse the Quality Improvement (QI) implementation guides, training manuals, and job aids
- Provide overall guidance and support for QI activities across the region.
- Strengthen the regional quality management structure and enhance coordination and collaboration platforms.
- Facilitate and organize regional-level learning sessions and sharing forums on PHCU QI best practices.
- Build capacity by delivering targeted training to health workers, facility managers, and Community Quality Teams (CQTs).
- Offer regular mentorship and coaching to support ongoing learning and skills enhancement.

- Monitor and evaluate the implementation of the PHCU QI guide and training manuals at the PHCU level
- Collect and submit a report to MOH quarterly
- Utilize quality Dashboards,
- Documentation of success stories, challenges, and policy recommendations

ZHD/Sub City & WoHO (Quality Officer /Unit)

- Strengthening quality management structures at the Zonal Health Department (ZHD)/Sub-city and Woreda Health Office (WoHO) levels.
- Establish ZHD/SC and WoHO level QI Coordination and collaboration platforms, including Technical Working Group, Community of practice (COP)
- Implement the PHCU Quality Improvement guide, training manual, and job aids across primary care settings.
- Provide capacity-building training for health workers and Community Quality Teams (CQTs).
- Deliver regular mentorship and coaching to health centers, health posts, and community stakeholders.
- Facilitate and organize annual summit or learning collaborative across PHCUs and communities to promote shared learning.
- Coordinate and support health facilities in effectively executing QI activities.
- Promote awareness and understanding of QI principles among all relevant stakeholders.
- Document best practices and success stories; organize learning visits to foster cross-site learning.
- Recognize and reward high-performing health facilities for excellence in QI implementation.
- Monitor and review QI performance at the health center and community levels to guide continuous improvement
- Collect and report quarterly to the regional Health Office
- Documentation of success stories, challenges, and policy recommendations

Primary Hospital (Quality Unit)

- Plan, implement, and provide mentorship and coaching for QI activities of catchment health centers and health posts
- Organize and facilitate quality improvement learning sessions involving health centers and health posts
- Documentation of success stories, challenges, and policy recommendations.

Health Center

- Strengthen the capacity of QI focal persons to coordinate quality improvement activities across health centers and catchment health posts.
- Establish a Performance Monitoring and Quality Improvement (PM-QI) team at the PHCU level.
- Conduct onsite training to all clinical staff and certify
- Lead the PHCU QI implementation
- Continuously identify and analyze healthcare service gaps and improvement opportunities.
- Oversee the implementation of QI initiatives at catchment health posts and within community QI teams.
- Provide quality improvement mentorship and coaching support to health posts and community-based teams.
- Deliver QI training for health post staff and community stakeholders.
- Organize and facilitate quality improvement learning sessions involving health posts and community representatives.
- Submit and present monthly progress reports from the PHCU to the Woreda Health Office and Health Center Management.
- Recognize high-performing health posts and community kebeles based on QI achievements.
- Support the development and implementation of community-level QI plans.
- Prepare a schedule for regular review meetings and ensure accurate documentation of meeting minutes.
- Provide performance updates from community teams to the health center QI committee.
- Documentation of success stories, challenges, and policy recommendations.
- Submit quarterly reports to WoHO/Sub City
- Utilize Quality Dashboards
- Ensure that QI projects are designed, implemented, and monitored using appropriate quality measures based on the quality gap assessment in the health center

Comprehensive and Basic Health Post

- Establish Community Quality Teams.
- Provide onsite QI training for all clinical staff and Community Quality Teams
- Conducting routine surveys or interviews to gather feedback on patient satisfaction and respectful care.
- Identify and analyze quality gaps at health posts.
- Design and implement quality improvement projects and activities together with the catchment HC.
- Support Community Quality Teams in planning and executing QI initiatives.
- Facilitating regular review of the Community Scorecard to track service performance.

- Conduct monthly meetings with Community Quality Teams.
- Provide onsite coaching and support to Community Quality Teams
- Track key indicators through QI dashboards, eCHIS, and using real-time data to guide improvement.
- Showcase QI activities during open house sessions.
- Submit and present reports to the catchment health center.
- Enhance demand for healthcare quality and patient safety.
- Strengthen community engagement and participation.
- Ensure standard procedures and formats are in place.
- Document best practices and challenges and share learnings across health posts/

Community Quality Improvement Teams (CQITs)

- Establish and operationalize Community Quality Improvement Teams.
- Implement QI activities at both the community and household levels.
- Utilize community conferences to drive and facilitate QI initiatives.
- Develop and execute annual quality improvement plans in alignment with the catchment HC.
- Design, test, and implement QI projects and interventions in alignment with the catchment HC.
- Actively participate in health facility–community engagement platforms.
- Submit monthly QI reports to the health post.
- Provide training for community members and families on quality improvement.

Local and International Implementing partner

- Provide both financial and technical support for implementing PHCU Quality Improvement across all levels of the health system.
- Assist in the development and dissemination of guidelines, tools, and training materials to build capacity at all levels—RHB, ZHD, WOHOF, health facilities, and the community.
- Deliver mentorship and coaching, alongside monitoring, evaluation, and follow-up, to ensure effective implementation of PHCU Quality Improvement.
- Advocate for policy integration and the long-term sustainability of PHCU Quality Improvement within the national health system.
- Support learning sessions at RHB, ZHD, WOHOF, and health facility levels.
- Document success stories, challenges, and policy recommendations to inform scale-up and sustainability efforts.

8



Resources mobilization and utilization

8. Resources mobilization and utilization

Resource mobilization is vital for enhancing healthcare quality through both human and material resources. By investing in training and capacity building, healthcare workers, leaders, and stakeholders can be equipped with the necessary skills for quality improvement. Engaging experts in healthcare quality further ensures that the development and implementation processes are guided by experienced professionals. Additionally, utilizing existing healthcare infrastructure and ensuring it is well-equipped with the necessary tools and technologies, along with maintaining a steady supply of essential medical and non-medical materials, supports the continuous improvement of healthcare services. This comprehensive approach underscores the importance of resource mobilization in achieving sustainable and high-quality healthcare.

Financial Resources can be:

- **Domestic Funding**: Leveraging government budgets through health care financing, local NGOs, and community contributions
- **International Funding**: Securing grants from international organizations and other global health initiatives

Resource Utilization

Effective resource utilization is crucial for improving the quality of healthcare services. By ensuring the optimal use of resources, healthcare providers can deliver services efficiently without wastage. Proper allocation and utilization of resources help meet the healthcare demands of the population, ensuring that essential services are available to those in need. This approach enhances the overall delivery of health services, making them more accessible and reliable. Efficient use of funds is a key aspect of resource utilization. Developing a clear budget and ensuring transparent financial management maximizes the impact of available funds. Prioritizing cost-effective interventions ensures that the highest value for money is achieved. Human resource management in healthcare quality improvement is also vital. Clearly defining roles and responsibilities ensures the efficient use of human resources, while continuous training and support help maintain high standards of care. Monitoring and evaluation systems are essential for tracking the progress and impact of quality improvement initiatives. Establishing feedback mechanisms allows for continuous improvement based on real-time data, ensuring that the implementation process is always evolving and improving.

9



Monitoring, Evaluation, and Learning

9. Monitoring, Evaluation, and Learning

9.1. Monitoring

Monitoring is the routine process of data collection and measurement of progress towards program objectives. Monitoring involves counting what we are doing. It also involves routinely checking the quality of services. Monitoring is a process that helps to identify problems early so that they can be corrected quickly. This requires data to be collected, compiled, and analyzed on a routine basis.

Monitoring Quality Improvement (QI) in Primary Health Care Units (PHCUs) is a routine, data-focused process used to measure progress towards program objectives and routinely check service quality. This process is vital for identifying service gaps and enabling corrective action by regularly collecting, compiling, and reporting data to determine if targets have been achieved. QI monitoring at various levels can occur on a daily, weekly, monthly, and/or quarterly basis.

9.2. Evaluation

Evaluation in Quality improvement examines the process in greater depth and helps to understand what the indicators are really telling. Evaluations help to take a closer look at the outcomes of interest and can help answer questions about what outcomes mean and what differences the program is making. Quality Improvement can be conducted at specific time periods (for example, at the end of the year or every two years). Evaluations can also involve research methods to systematically investigate a program's effectiveness. Similarly, QI evaluation may involve special studies and a specific research design, and may require a control or comparison group.

9.3. Core indicators for QI monitoring and evaluation

Indicators are specific metrics used to assess & track the quality of services provided, focusing on both the process & outcomes of care, in QI implementation. Selection of indicators should be informed by considerations of scientific soundness, relevance, usefulness for decision-making, responsiveness to change, and data availability. The core indicator set should be responsive to the information needs for monitoring progress and performance evaluation towards the main objectives and should cover inputs, outputs, outcomes, and impact indicators.

These indicators may help to identify areas needing improvement & measure the effectiveness of implemented changes.

Input indicators

These assess the resources available to deliver care, such as the presence of necessary equipment and trained personnel. The quality improvement team can identify specific input indicators based on the design and focus of each quality improvement project. Listed below are some commonly identified input indicators;

- Number of QI-trained health care workers
- Budget dedicated to QI
- Availability of basic amenities
- Availability and functionality of facility-level platforms like QI, DTC, and the PMT team

- Availability of guidelines, manuals, and tools
- Availability of essential medicines, medical equipment & supplies
- Availability of standard registers, reporting tools, and information systems
- Availability of an established referral system
- Availability of a functional quality improvement team
- Facility readiness score

Process Indicators

These indicators measure the steps involved in delivering care, such as the percentage of patients receiving a specific service, the time required to complete a particular procedure, and adherence to established protocols. Process indicators can be identified based on the specific improvement projects being implemented. Some examples of process indicators include:

- Proportion of Quality improvement projects completed
- HPRIG score
- EHCRIG score
- Facility readiness score
- Quality functionality index
- % of resources used as planned (e.g., drug utilization rate)
- Average waiting time before consultation
- % of procedures following infection prevention protocols
- % of adverse events reported and reviewed
- % of complaints addressed within a defined time
- % of patients referred with proper documentation
- % of patients receiving multiple services in one visit
- Continuity of care rate (follow-up visits completed)
- Availability of community members who participated in the quality improvement initiative

Outcome Indicators

Outcome indicator**s** track changes in health status, behaviors, functioning, or satisfaction that occur as a result of quality improvement interventions.

- Quality and Equity score
- Number of graduated/sustained QI projects
- Good governance indicator (GGI)
- Patient satisfaction score
- Quality functionality index
- IPC flat score
- User experience score

Impact Indicators

- Maternal mortality rate
- Infant mortality rate
- Neonatal mortality rate
- NCD mortality and morbidity
- Communicable disease morbidity and mortality

9.4. Learning in quality improvement

Learning in quality improvement refers to the continuous improvement process where project teams analyze past experiences, both successes and failures, to enhance future project performance. It involves actively seeking, capturing, and sharing knowledge gained during a project to improve procedures, optimize resource utilization, and transfer valuable insights to other projects. This process is crucial for organizational learning and project management effectiveness. Quality improvement teams in different areas will learn from each QI project implementation process and after its graduation. Some of the common QI learning platforms include: EPAQ/EHAQ, review meetings, best practice documentation and dissemination, town hall meetings, and supportive supervision. They may adopt, adapt, or abandon the change ideas, based on their findings and results achieved.

Supportive supervision and timely feedback

The QI support team or group is expected to conduct checklist-based supportive supervision and provide on-time feedback. While conducting QI supportive supervision, the following areas need to be considered.

- Review the previous report of QI
- Review previous feedback and action plan given to the QI team (if available)
- Review data and QI documents
- Discuss the progress and provide technical as well as administrative guidance
- Provide written feedback

Review meeting

The QI review meeting will be used to review the performance or implementation of QI activities/projects. The review meeting will be an important platform to understand the opportunities and challenges faced during the implementation of QI activities and the opportunity to learn from others. The review meeting shall be conducted in collaboration with other programmatic review meetings to ensure sustainability. It will be conducted at different levels. Additionally, the quality summit would be conducted on a national or regional level.

Mentorship and coaching

Mentoring and coaching programs are development initiatives that use one-on-one interactions to enhance individuals' skills, knowledge, and work performance. Mentoring typically focuses on long-term career development, personal growth, and leadership capacity, while coaching provides targeted support to address specific challenges or accelerate progress in a particular area. These programs benefit both the mentee or coach and the mentor or coach, who also develops their own leadership and communication skills.

The mentorship program for QI in PHCU should follow a hierarchical structure. Mentor teams at different levels (national, regional, and sub-regional) can adapt to their mentorship schedules and provide support at the facility level. In terms of frequency, regional and higher-level teams should aim to conduct mentorship on a quarterly basis whenever possible. In contrast, lower-level teams are encouraged to implement monthly mentorship plans, as most quality improvement projects typically have an implementation period of three to four months.

Key aspects of QI coaching include asking effective questions, facilitating self-discovery, providing constructive feedback, and supporting individuals in developing their own solutions. Coaching helps enhance skills, build confidence, improve decision-making, and strengthen overall performance. Senior teams, whether from within the facility or from external organizations, can provide coaching support to QI projects at the facility level to help identify challenges and ensure effective implementation and sustainability. QI coaches are expected to possess essential skills and adhere to guiding principles to make the coaching process effective.

Best experience documentation and sharing

To ensure the best experience, documentation, and sharing on quality improvement, it's crucial to adopt a structured approach. This includes using a consistent format, storing documents online, involving relevant stakeholders, reviewing and updating regularly, communicating effectively, and measuring the impact. By following these best practices, organizations can streamline workflows, improve knowledge transfer, and foster a culture of continuous improvement.

- The PHCU QI best practices for documenting and sharing PHCU QI project learnings and outcomes should consider the following major areas.
- Well-defining purposes and audiences
- Using a consistent framework and format
- Incorporate feedback and reflection
- Share learnings and outcomes widely and regularly
- Update and revise documentation and sharing practices

Documenting best practices offers several key benefits: it improves efficiency by enhancing quality while reducing costs and time, and it strengthens collaboration by minimizing misunderstandings through clear, standardized procedures. It also promotes employee engagement by supporting a culture of knowledge sharing, while enabling continuous process improvement. Additionally, documented processes make training and onboarding faster and more effective, help preserve critical knowledge to avoid gaps, and ensure higher quality outcomes by guiding team members to consistently produce better results with fewer errors.

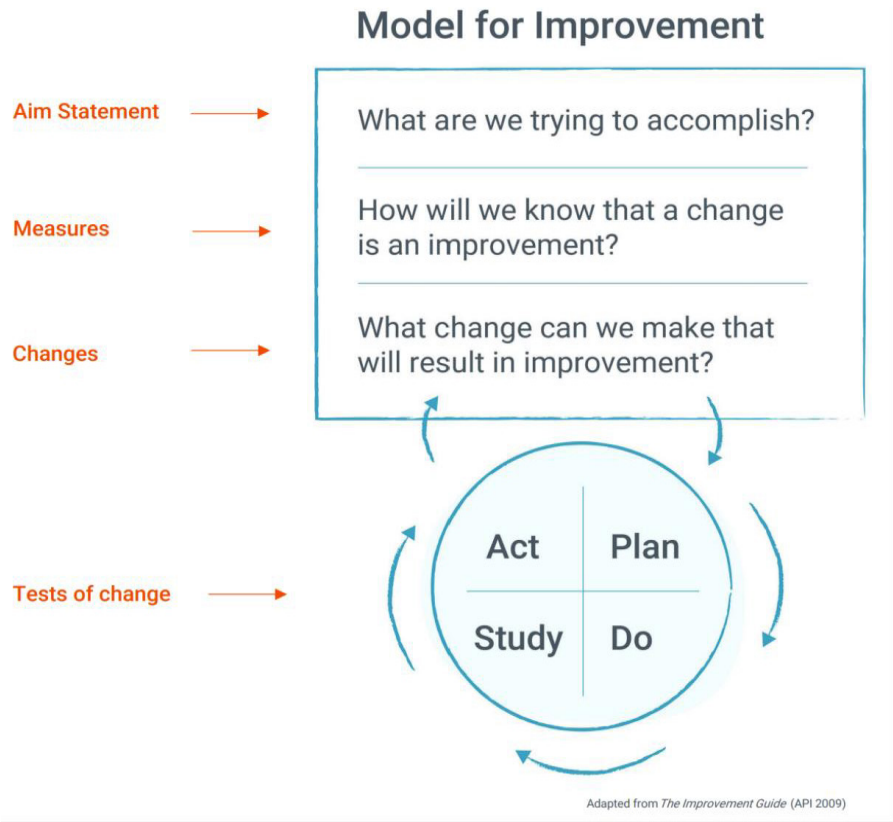

Figure 5: Monitoring, Evaluation, and Learning framework

Recognition Mechanisms

Recognition mechanisms are essential to motivate and sustain the efforts of healthcare workers and organizations involved in quality improvement initiatives. It is better to consider kind recognition and motivation mechanisms either separately or integrated with other initiatives or reforms, at all levels of implementation. At the national and regional level, it is possible to align with the quality summit, while it is also possible to think of any other alternatives within the rest of the hierarchy. Here are some potential recognition mechanisms for the implementation of health quality improvement in Ethiopia:

1. **Awards and Certificates**:
    - **Annual Awards**: Establishing annual awards for outstanding performance in quality improvement at various levels (e.g., hospitals, health centers, health posts, Woreda, Zone, Regional health bureaus, or Ministry of Health)
    - **Certificates of Excellence**: Providing certificates to individuals and teams who demonstrate significant contributions to quality improvement

2. **Public Acknowledgment**:
    - **Media Coverage**: Highlighting success stories and achievements in quality improvement through local and national media
    - **Public Ceremonies**: Organizing public ceremonies to recognize and celebrate the achievements of healthcare workers and facilities_
3. **Professional Development Opportunities**:
    - **Training and Workshops**: Offering opportunities for further training and professional development to those who excel in quality improvement initiatives_
    - **Conference Participation**: Sponsoring attendance at national and international conferences on healthcare quality_
4. **Incentives and Rewards**:
    - **Financial Incentives**: Providing financial bonuses or other monetary rewards for exceptional performance in quality improvement
    - **Non-Monetary Rewards**: Offering non-monetary rewards based on the local context
5. **Career Advancement**:
    - **Promotions**: Recognizing outstanding contributions to quality improvement with career advancement opportunities_
    - **Leadership Roles**: Providing opportunities for recognized individuals to take on leadership roles in quality improvement projects_
6. **Peer Recognition**:
    - **Peer-Nominated Awards**: Implementing peer-nominated awards to recognize colleagues who have made significant contributions to quality improvement_
    - **Recognition Boards**: Creating recognition boards in healthcare facilities to highlight the achievements of staff members

10. References

1. Crossing the global quality chasm: improving health care worldwide. Washington, D.C.: The National Academies of Sciences, Engineering, Medicine; 2018. Available from: http://nationalacademies.org/hmd/Reports/2018/crossing-global-quality-chasm-improving-health-care-worldwide.aspx
2. Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al. High-quality health systems in the sustainable development goals era: time for a revolution. Lancet Glob Health. 2018 Nov;6(11): e1196–252. https://doi.org/10.1016/S2214-109X(18)30386-3
3. Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al. High-quality health systems in the Sustainable Development Goals era: time for a revolution. The Lancet Global Health. 2018;6(11): e1196–e252.
4. WHO, OECD and the World Bank: Delivering quality health services: a global imperative for universal health coverage, Geneva: World Health Organization, Organization for Economic Co-operation and Development, and The World Bank. ; 2018. Licence: CC BY-NC-SA 3.0 IGO.
5. Federal Democratic Republic of Ethiopia, Ministry of Health. Ethiopian Health Sector Transformation Plan (HSTP) 2015
6. Ministry of Health-Ethiopia. Health Sector Development and Investment Plan, 2023/24
7. Ministry of Health-Ethiopia. The Health Extension Program Optimization roadmap, 2020, Addis Ababa, Ethiopia
8. Ministry of Health-Ethiopia. Health Sector Transformation Plan I & II, 2016-2023, Addis Ababa, Ethiopia
9. Ministry of Health-Ethiopia. National health care quality strategy, 2021, Addis Ababa, Ethiopia
10. Health Sector Transformation Plan II midterm review (MTR) report, 2023, Addis Ababa, Ethiopia
11. Donabedian, A. (1988). The quality of care: How can it be assessed? JAMA, 260(12), 1743-1748.
12. Institute of Medicine (IOM). (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. National Academy Press.
13. World Health Organization (WHO). (2006). Quality of care: A process for making strategic choices in health systems. WHO.
14. World Health Organization (WHO). (2017): WHO Community Engagement framework for Quality, People-Centered and Resilient Health Services
15. Batalden, P. B., & Davidoff, F. (2007). What is "quality improvement" and how can it transform healthcare? *Quality and Safety in Health Care*, 16(1), 2-3.
16. Institute of Medicine (IOM). (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy Press.
17. Langley, G. J., Moen, R., Nolan, K. M., Nolan, T. W., Norman, C. L., & Provost, L. P. (2009). *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd ed.). Jossey-Bass.
18. The transformative role of hospitals in the future of primary health care. WHO, 2018.
19. Quality improvement manual for community health services. Federal Democratic Republic of Ethiopia, Ministry of Health, December 2018.
20. Ethiopian Primary Healthcare Alliance for Quality (EPAQ) Implementation Guideline. Ministry of Health, September 2024
21. Ethiopian Primary Health Care Clinical Guidelines, Facility trainer's manual. Federal Democratic Republic of Ethiopia, Ministry of Health, 2018.
22. Heiby J. 2014. The use of modern quality improvement approaches to strengthen African health systems: a 5-year agenda. Int J Quality in Health Care 26 (2):117-123.
23. USAID Applying Science to Strengthen and Improve Systems Project. 2014. Quality Improvement. Technical Reference Material. Published by the Maternal and Child Health Integrated Program for USAID
24. Stover KE, Tesfaye S, Frew AH, Mohammed H, Barry D, Alamineh L, Teshome A, Hepburn K, Sibley LM. 2014. Building District-Level Capacity for Continuous Improvement in Maternal and Newborn Health. J Midwifery Women's Health; 59(S1): S91-S100.

11. Annex

11.1. Terms of Reference (ToR): Health center performance monitoring and quality improvement team

Background

Quality is a fundamental component of Universal Health Coverage (UHC) and a central pillar of Ethiopia's Health Sector Transformation Plans and the National Healthcare Quality and Safety Strategy (NQSS). Quality Improvement (QI) is a continuous and systematic process that strengthens health service delivery by identifying performance gaps, testing change ideas, using data for decision-making, and institutionalizing effective practices to ensure sustained improvement.

A Primary Health Care Unit (PHCU) is the basic service delivery and management structure of Ethiopia's primary health care system. It comprises a health center, its catchment health posts serving defined kebeles, and community structures. In recent years, Ethiopia has made notable progress in promoting quality improvement practices within health facilities. However, implementation has often been fragmented and facility-focused, with limited integration of health posts and community platforms into the quality system.

To address this gap, the PHCU-QI Guideline (2025) provides structured and practical guidance for institutionalizing QI as a routine, integrated, and collaborative process across the PHCU. A key element of this approach is the establishment and operationalization of a functional Health Center Performance Monitoring and Quality Improvement (PM&QI) Team, which serves as the central governance and coordination body for QI activities across the health center, linked health posts, and community quality improvement teams.

Purpose of this ToR

This Terms of Reference (TOR) defines the mandate, composition, roles, responsibilities, and working arrangements of the Health Center PM&QI team (hereafter referred to as the QI team). It is developed in alignment with the PHCU-QI Guideline and replaces or complements any prior committee-level guidance at the health center level. The TOR aims to:

- Establish a clear governance structure for QI within the PHCU as specified in the PHCU-QI Guideline.
- Define accountabilities for planning, implementing, monitoring, and reporting QI activities across the health center, health posts, and community.
- Align committee functions with the PHCU QI approach
- Ensure co-participation of community structures, particularly kebele Community Quality Improvement (CQI) teams, in PHCU quality improvement.

Objectives of the PHCU-PM&QI Team

General Objective

To lead and oversee continuous, data-driven quality improvement across the Primary Health Care Unit, ensuring that facility and community stakeholders jointly identify priority quality gaps, design improvement projects, test solutions, monitor progress, and sustain successful interventions.

Specific Objectives

- Establish and functionalize a QI governance structure at health center level as the lead body for PHCU-wide quality improvement.
- Co-design and implement PHCU QI projects jointly with kebele Community Quality Improvement (CQI) teams, ensuring shared ownership and community engagement.
- Build QI capacity of health center staff, health extension workers, and CQI teams through structured cascading training and ongoing coaching.
- Integrate QI into routine planning, budgeting, reporting, and accountability systems of the PHCU.

Composition of the QI Team

As specified in the PHCU-QI Guideline, the Health Center PM&QI team shall comprise the following members:

- Medical director (chair),
- QI focal (secretary),
- HPDP core process owner,
- Curative core process owner,
- CHPU focal,
- HMIS focal,
- MCH head,
- Laboratory head,
- Pharmacy head,
- Admin and finance head, and
- Community representative from the HC board.

Note: Based on selected improvement priorities, the QI team may establish sub-teams to support implementation, routine data collection, testing of changes, and monitoring progress. Sub-team leads shall be co-opted into the QI team as relevant.

Key functions of the team

- Ensure the QI team is formally constituted with this TOR and all members are trained in QI concepts.
- Support the establishment and operationalization of CQI teams at each catchment kebele per the CQI TOR.
- Establish sub-teams at the health center level based on selected QI priorities.
- Ensure monthly PM&QI meetings are conducted with documented minutes and action tracking.
- Use multiple data sources; HMIS reports, service registers, patient records, clinical audits, supervision findings, community scorecards, and client complaints, to identify gaps and measure improvement.
- Organize PHCU level co-design session involving HC team members and CQI team representatives, and co-design PHCU QI project with clear division of change ideas and action plan between health center and CQI teams for implementation.
- Apply QI tools and methods to test and implement QI projects.
- Provide coaching to health posts and CQI teams.
- Integrate QI collaborative learning into monthly PHCU follow-up review meetings, involving health center staff, HEWs, and CQI team representatives.
- Strengthen data systems and data use.
- Ensure consistent documentation of QI activities in QI workbooks and logbooks for all active projects.
- Submit monthly and quarterly PHCU QI progress reports to the WoHO and health center management using the standard PHCU-QI activity reporting logbook
- Participate in quarterly EPAQ woreda-level learning sessions for cross-PHCU learning.
- Document and share success stories, lessons learned, and best practices within the PHCU and at woreda forums.
- Include QI activities in the annual PHCU operational plan, with explicit budget allocations for coaching visits, printing tools, review meetings, and minor facility improvements.

Roles and Responsibilities

Chairperson: Medical Director

- Provide overall leadership for PHCU-QI implementation
- Convene and preside QI team meetings and joint PHCU review sessions
- Provide institutional leadership and create a supportive, blame-free environment for QI
- Ensure allocation of time, personnel, and operational resources for QI activities within the annual plan and budget
- Ensure accountability and follow-up of agreed QI actions
- Facilitate linkages with WoHO and other PHCUs
- Recognize and reward high-performing departments, health posts, and CQI teams based on QI achievements.

Secretary: QI Focal Person

- Coordinate and technically lead all QI activities at the HC and across the PHCU
- Organize monthly PM&QI meetings, prepare agenda, document minutes, and track actions.
- Lead the co-design process with health post teams and CQI teams using the standardized co-design guide.
- Train, mentor, and coach health center staff, HEWs, and CQI teams in QI concepts and tools, following the PHCU-QI cascading training model.
- Maintain the QI workbook, QI logbook, and completed QI project documentation in line with the formats annexed to the PHCU-QI Guideline.
- Prepare and submit monthly and quarterly QI progress reports to the WoHO and health center management.
- Serve as the liaison with the Woreda QI focal person and primary hospital QI unit for coaching and technical support.

Members

- Lead and support unit-level implementation of QI interventions.
- Identify and report quality gaps in their service areas using self-assessment, audit findings, and supervision reports.
- Participate in root cause analysis, development of change ideas, measures and PDSA plans.
- Ensure implementation of agreed action plans and PDSA cycles in their service area.
- Collect, validate, and report relevant data for QI monitoring.
- Participate in coaching and PHCU learning sessions.
- CHPU focal: Serve as the primary liaison between the health center QI team and all catchment health posts and CQI teams, provide regular onsite support and coaching to health post teams and CQI teams, compile health post and CQI team QI performance data.
- HMIS focal: Analyze and present routine HMIS data, service register data, and client feedback relevant to QI indicators at every team meeting, support QI sub-teams in defining improvement measures (outcome, process, and balancing measures) and establishing measurement plans, generate and display run charts or dashboards to visualize QI progress over time, ensure data quality, completeness, and timeliness in QI documentation and reporting, support community QI teams and health post teams in tracking indicators using eCHIS where available.
- Community Representative from HC Board: Represent the voice and expectations of the community and HC board in QI team deliberations, provide qualitative feedback on client experience, respectful care, and community satisfaction, support community mobilization for demand-creation and QI awareness activities.

Meetings and Working Arrangements

The Health Center PM&QI Team shall conduct regular meetings to ensure effective coordination, monitoring, and learning across the PHCU. The team will hold monthly internal QI meetings to review QI project progress, assess PDSA cycle findings, analyze indicator performance data, address implementation challenges, and agree on action points. A quorum shall be met when at least 60% of team members are present, including the Chairperson or a designated deputy. Decisions shall be made primarily through consensus; where consensus cannot be reached, decisions will be determined by a simple majority vote.

In addition, the team shall convene a monthly PHCU joint review and learning session with CQI chairpersons and secretaries to review QI performance, discuss updates, share learning from PDSA cycles, address common bottlenecks, and identify coaching and support needs.

The PM&QI Team will also participate in quarterly woreda EPAQ learning sessions to promote cross-PHCU learning, document and disseminate best practices, analyze barriers, and benchmark performance in collaboration with the Woreda Health Office and other PHCUs.

Meeting minutes shall be prepared within five (5) working days and shared with all members, and signed copies shall be filed in the facility's QI documentation folder. The QI Focal Person shall develop and communicate an annual meeting schedule at the beginning of each year to all team members and the Woreda Health Office.

Accountability and Reporting

The PM&QI Team is accountable to the Health Center Management and operates within the PHCU-QI implementation arrangement outlined in the PHCU-QI Guideline. The team shall compile and consolidate progress reports from the Community Quality Improvement (CQI) teams together with the health center QI performance report and submit monthly and quarterly reports to the Health Center Management and the Woreda Health Office (WoHO).

All reporting and documentation shall follow the standardized tools and formats provided in the PHCU-QI Guideline, including the PHCU QI Logbook, PHCU QI Workbook, and the Completed QI Project Reporting Template. In addition, the team shall maintain and update the QI dashboard on a monthly basis to support routine performance monitoring and data-driven decision-making.

Monitoring and Evaluation of Team Performance

The functionality of the PM&QI Team will be assessed using:

- Regularity of meetings and documentation completeness
- Number of QI projects designed and implemented
- Evidence of PDSA cycles applied
- Improvement in selected outcome/process indicators
- Evidence of standardization and sustainability of improvements
- Quality of reporting and participation in learning platforms (EPAQ)

Review and Amendment of the TOR

This ToR is valid for two years and shall be reviewed annually or when revisions are made to the PHCU-QI guideline or national quality strategy.

Approved by:	**Endorsed by:**
Medical Director / Health Center Head	*Woreda Health Office — Quality Officer*
Name: _____	Name: _____
Signature: _____	Signature: _____
Date: _____	Date: _____

11.2. Terms of Reference (ToR): Community Quality Improvement team

Ethiopia's primary health care system has long prioritized community engagement through established platforms such as the Health Development Army (HDA), Village Health Leaders (VHLs), the Community Health Information System (CHIS), and the Health Extension Program (HEP). Building on these structures, the PHCU-QI Guideline institutionalizes a formal Community Quality Improvement (CQI) Team at each kebele to serve as an organized community platform within the PHCU quality improvement system. This approach recognizes that meaningful and sustainable quality improvement cannot be achieved by health facilities alone, but requires active community ownership, participation, and shared leadership. The CQI Team strengthens this partnership by enabling communities to identify and prioritize service quality gaps, provide structured feedback, co-design PHCU-QI projects with health center and health post teams, and implement locally driven interventions that improve service utilization, client experience, and health outcomes.

Purpose of this ToR

This TOR defines the mandate, composition, roles, responsibilities, and working arrangements of the Community Quality Improvement team at the kebele level.

The TOR aims to:

- Formally establish the CQI team as the community-level QI governance structure within the PHCU.
- Define the roles and responsibilities of CQI team members, including the relationship with the health post and the health center QI team.

Objective of the CQI team

General objective

- To organize and lead community-level quality improvement efforts within the kebele, working in partnership with the health center QI team to identify priority health service quality gaps, implement improvement interventions, and strengthen community engagement in health service quality.

Specific objective

- Jointly identify and prioritize health service quality gaps affecting the community, co-design and implement QI projects with the health post team and the health center PM&QI team, ensuring shared ownership at all levels.
- Mobilize and educate community members on health service quality, patient rights, and respectful care.
- Strengthen community demand for quality health services and feedback mechanisms.
- Support standardization of successful QI interventions within the community for sustained improvement.

Composition of the CQI team

As specified in the PHCU-QI Guideline, each kebele shall establish a CQI team of approximately 10 members, drawn from diverse community structures. Composition shall ensure gender balance and equitable representation of "gots". Members include:

- Kebele Manager
- HEW from BHP or merged HP or CHP quality focal person in kebeles with CHP
- Village Health Leader representative
- Women Development unit leaders' representative
- Teachers' representative
- Agricultural extension worker representative
- Kebele youth representative
- Gender affairs representative
- Religious leaders' representative
- Elders' representative
- Additional community members as needed

Selection criteria for community members: Members shall be respected by the community, willing to volunteer their time, recognized as role models, hold leadership roles or have strong awareness of local health issues, and be committed to improving community health outcomes.

Position of the CQI team within the PHCU QI structure and its key functions

The CQI team is the community-level component of the integrated PHCU QI system. It operates in close partnership with the health post team and the health center PM&QI team, and is accountable upward through the PHCU reporting hierarchy.

The key functions of the CQI team include:

- Receive a one-day QI orientation delivered by trained health post staff, covering basic QI concepts, the PHCU-QI approach, and community roles in QI
- Participate in co-designing PHCU QI projects
- Implement QI projects and interventions at the HP, community and household levels

- Support demand generation for health services through community mobilization, health education, and defaulter tracing
- Compile community feedback and present findings at monthly CQI team meetings and the PHCU joint review session
- Track community-level indicators relevant to the active QI project, compile and present at the monthly PHCU joint review sessions
- Engage in collaborative learning activities with CQI teams from other kebeles within the PHCU catchment
- Maintain the CQI-level QI Workbook documenting the QI project aim, indicators, PDSA cycles, results, and meeting attendance
- Document best practices, success stories, and lessons learned

Roles and Responsibilities

Chairperson: Kebele Manager

- Convene and preside over all CQI team meetings.
- Provide community leadership and political support for QI activities at the kebele level.
- Ensure community mobilization, resource allocation, and participation in CQI activities.
- Endorse the annual kebele-level QI plan and community health improvement activities.
- Promote inter-sectoral collaboration with agriculture, education, gender, youth, and religious institutions for QI activities.

Secretary: Health Extension Worker or CHP quality focal person, where applicable

- Prepare CQI meeting agendas, facilitate meetings, document minutes, and maintain action trackers.
- Orient CQI team members in basic QI concepts
- Lead the technical aspects of CQI activities, including supporting root cause analysis, PDSA cycle planning, and data collection.
- Maintain the CQI QI Workbook and logbook, documenting all QI project activities, PDSA cycles, and results
- Compile and submit monthly CQI QI activity reports to the health center CHPU focal.
- Track community-level QI indicators and display progress charts for review at meetings.
- Represent the CQI team at PHCU joint review meetings and woreda-level forums.

Village Health Leaders (VHL) and WDU Representatives

- Mobilize households in their assigned areas for health service utilization and community QI activities.
- Collect and relay household-level health information, feedback, and concerns to the CQI team.
- Reinforce QI messages during household visits and community gatherings.

Multi-Sectoral Members (Teachers, Agricultural Extension, Youth, Gender, Religious Leaders, Elders)

- Represent their respective sectors and platforms in CQI deliberations and activities.
- Support community mobilization, awareness creation, and QI advocacy within their influence networks.
- Contribute sector-specific insights on barriers to health service quality and utilization (e.g., school-based health promotion, agricultural calendar conflicts, gender and religious norms affecting care-seeking).
- Facilitate QI awareness activities through school programs, community gatherings, religious events, and elder forums as applicable.
- Co-facilitate community conferences and QI showcase events.

Meetings and Working Arrangements

Most CQI team members are volunteers; therefore, meetings shall be scheduled at convenient times that minimize disruption to livelihoods and maximize participation. The CQI Team shall conduct monthly CQI meetings to review QI project progress including PDSA cycles, analyze community-level indicator data, discuss community feedback and scorecard findings, develop action plans, and escalate key issues to the health post as needed. In addition, the CQI Chairperson and Secretary (HEW) shall participate in the monthly PHCU joint review and learning sessions with the Health Center PM&QI Team and other PHCU actors to present CQI updates, share PDSA learning, engage in shared problem-solving, and receive coaching support from the health center or woreda teams. Emergency or ad-hoc meetings may also be convened when critical community health events or urgent quality and safety issues arise.

A meeting shall be considered valid when at least 60% of CQI members are present, including the Chairperson or Secretary. Decisions shall be made through consensus, and where consensus cannot be reached, a simple majority vote shall apply. All decisions and action points shall be documented in meeting minutes. The Secretary (HEW) shall record minutes during meetings, and signed copies shall be filed and maintained at the health post. Meetings shall be held at the kebele administration office, health post, or another accessible community venue agreed upon by members.

Accountability and Reporting

The CQI Team is accountable within the PHCU-QI implementation structure and shall maintain proper documentation using the CQI-level QI Workbook and related tools. The team shall submit monthly progress updates to the Health Center CHPU Focal Person and present its performance report during the monthly PHCU joint review and learning sessions. In addition, the CQI Team shall provide a monthly update on CQI activities and results to the Kebele Steering Committee to ensure transparency, local oversight, and continued community ownership of quality improvement efforts.

Monitoring and evaluation of the CQI team performance

CQI Team performance will be monitored based on:

- Regularity of monthly meetings
- Number of community improvement actions implemented
- Timely submission of progress reports
- Contribution to PHCU-QI project results
- Evidence of improved community trust, service utilization, and referral linkage

Review and Amendment of the TOR

This ToR is valid for two years and shall be reviewed annually or when major changes occur in PHCU-QI implementation guidance.

Approved by:	**Endorsed by:**
Kebele manager and HEW	*PM/QI team chairperson/HC medical director*
Name: _____	Name: _____
Signature: _____	Signature: _____
Date: _____	Date: _____

11.3. PHCU learning sessions guide

Kebele level

Monthly kebele-level steering committee meetings will review the CQI performance and share experiences.

PHCU level

Monthly reviews of catchment health post-performance ensure continuous monitoring, timely decision-making, and capacity building. These reviews enhance accountability, adapt service delivery to local needs, and foster experience sharing among health workers.

Woreda level

A quarterly EPAQ review meeting will be held with cluster health facilities (primary hospitals, health centers, health posts, and private facilities) to discuss program performance and share experiences.

Zonal level

Biannual EPAQ review meeting will be held with woredas, lead HCs, private facility representatives to discuss program performance and share experiences.

Regional/MoH level

Annual EPAQ review meeting will be held with regions, zones, woredas, lead HCs, private facility representatives to discuss program performance and share experiences.

11.4. Cascading training guide

National and Regional Training of Trainers (TOT)

- Participants will be from (MOH, RHB, ZHD, Hospitals, HC…)
- QI training sessions are organized and will be provided for 5 days
    - *3 days-Nine sessions*
    - *1 day-Project development*
    - *1 day-Teach back session*
- Training modality is hall-based, case-based, interactive lecture
- Two types of training materials needed (facilitator and participant manual for TOT)

Cascading training (training of facility trainers) for HCs and CHPS

- For HC training, 2 participants from HC (1 facility head and 1 QI focal) and 1 participant from WoHO (Quality focal) will be trained
- For CHP training, 2 participants from CHPs (1 facility head and 1 QI focal) and 1 participant from the catchment HC (Quality focal) will be trained
- For HC, QI training sessions are organized and will be provided for 5 days
    - *3 days-Nine sessions*
    - *1 day-Project development*
    - *1 day-Teach back session*
- For CHP, QI training sessions are organized and will be provided for 3 days
    - *2 days-5 sessions*
    - *1 day-Project development*
- Training modality is hall-based, case-based, interactive lecture
- Two types of training materials needed (facilitator and participant manual for TOT)
- Selected facility trainers should sign an MOU to serve for at least 6 months after taking the facility trainers training
- Health professionals who took the facility TOT are expected to cascade their training as well as develop quality improvement projects
- The catchment HC/CHP/private hospital will provide a one-day orientation on QI for all catchment basic health post staff, by inviting them offsite to the HC/CHP/private hospital premises.

On-site training at HC, CHP, and BHP levels

- On-site training should be conducted at the HC, CHP, and BHP levels
- The onsite training will take place at HC, CHP, and BHP
- Allocated training hours (1 ½ - 2 hours) training sessions
- Held onsite at an agreed-upon time at the facility, ensuring minimal disruption to clinical services

- In-service training at the facility so that staff can be trained together and can apply what they have learnt in practice
- On-site training should be conducted twice a week
    - For HCs and CHPs, both need 4 weeks to complete onsite training,
    - For BHP CQI team members, they will get orientation for 1 day at the HP by the trained staff of the HP
- Twice-weekly sessions allow for alternating between learning and practice because the sooner one uses what one learns, the better one can apply the new knowledge
- A team approach targeting all cadres of staff working across programmes within a facility, increasing coverage and creating opportunities to discuss quality improvement
- Target audiences of onsite training are health centers/CHP management team members, QI team members, all health care providers working across clinical areas, and HMIS focal points. For BHPs, all HP CQI committee members will be trained.
- Training materials and equipment needed
    - For HC, two types of training materials are needed (per facility, at least one copy of the facilitator and 5 copies of the participant manual for facility training)
    - For CHP, the QI participants' manual and PowerPoint will be used
    - For BHP, QI training notes received during the one-day orientation will be used
    - Additional tools used for onsite training are training records, a daily training evaluation format
    - Computer with LCD (If available), if not, use flip charts as slides
- Training records will be filled at the end of each session, which will serve as an attendance record at the HC/CHP level
    - QI onsite training trainers' record (attendance registers for each session)
    - QI onsite training session summary record (a summary of all sessions)
- All onsite training should follow the 4 steps and dedicated time per session
    - STEP 1 - Welcome
    - STEP 2 - Recap and problem-solving
    - STEP 3 - Train new topic
    - STEP 4- Prepare for next steps /sessions, fill in onsite training, and record closure
- A certificate stamped with the HC seal and signed by the heads of HC and WoHO will be awarded to all trainees upon successful completion of the 4-week onsite training, accompanied by training records to confirm attendance.
- On-site training tools are attached below

PHC QI on-site training trainers' record

After each training session, please send this form to the HC/CHP head and WoHO

Trainer's name: 1. **2.**		Region:	Zone:	Session number (1 to 4):	
Date (dd/mm/yyyy):		Woreda:		Circle sessions completed in this session:	
Duration (minutes):				Session 1	
Professional category		**Gender**	**Facility name**	Session 2	
Trainer 1:		**Trainer 1:**		Session 3	
Trainer 2:		**Trainer 2:**		Session 4	

Number of eligible trainees: _____

No.	Full name of the trainees	Gender	Profession	Role/Department	telephone	Signature
1						
2						
3						
4						
5						
6						
7						
8						

PHC QI on-site training session summary record

After completing the 4 training sessions, please fill out and send this form to the HC/CHP head, and WoHO.

Region: _____ Woreda: _____

Name of the health facility: _____

Trainers' name _____ and _____

Date: _____

Number of eligible trainees: _____

Sessions	Date	Duration of session (minutes)	Trainer name	Number of trainees	Trainer signature
Session 1					
Session 2					
Session 3					
Session 4					

PHC training Onsite training evaluation checklist

Session evaluation template (to be filled by each trainee anonymously and submitted to trainers)

Region: _____ Woreda: _____

Name of the health facility: _____

Trainers' name _____ and _____

Date: _____

Session: 1. __ 2. __ 3. __ 4. __

Instruction: Please read the following evaluation criteria and mark (X) on the score you think is appropriate.

Items	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
Content of the module/session					
Relevance of the module/session					
Mode of training delivery					
Relevance of case studies					
Training materials used					
Readiness/competence of the trainers/ facilitators in delivering the course					
Training venue and related logistics					
Workability or applicability of the training materials					

Additional comments if any: _____
_____
_____
_____.

Title of the quality improvement project working on: _____
_____
_____

11.5. A guide for Co-designing the PHCU-QI project

Co-designing the PHCU-QI project emphasizes the essential transition from a top-down approach to a collaborative co-design model by integrating the Health Center (HC) and CHP QI team with Kebele-level Community Quality Improvement (CQI) teams.

Below are the three phases to implement the Co-designing of the PHCU-QI project:

Phase 1: Pre-Design

A. PHCU Self-Assessment: Conduct a self-assessment of PHCUs performance using the "Donabedian model" that provides

B. A framework for examining health services and evaluating quality of health care

- **Structure**: The context in which care is delivered
    - Physical facility, equipment, and human resources, as well as organizational characteristics such as staff training and availability of committee and focal person.
- **Process:** Transactions between patients and providers
    - Diagnosis, treatment, preventive care, and patient education
    - How care is delivered, or interpersonal processes, which all encompass the way care is delivered
- **Outcome:** Effects of health care on the health status of patients and populations
    - Changes to health status, behavior, or knowledge, as well as patient satisfaction and health-related quality of life

N.B. PHCU Self-Assessment Information can be obtained from plan vs performance review, medical records, Clinical audit, interviews with patients and practitioners, CSC findings, ISS findings, feedback from guests, or direct observations of healthcare service.

C. Identify Gaps: Based on the selfassessment, compile and list all identified problems across the three dimensions.

D. Stakeholder Mapping: Ensure the QI Co-designing team includes HC and CHP QI teams and also the community QI team from all BHPs

Phase 2: The Co-Design meeting (The "Alignment" Phase)

- **Step 1: Problem Prioritization and Root Cause Analysis**
    - The QI Co-designing Team use the PHCU problem prioritization matrix to prioritize from the previously listed problem across the three dimensions
    - The QI Co-designing Team use Fishbone Diagram, 5 WHY or Problem TREE analysis to identify the Root Causes of the prioritized problem
- **Step 2: Defining the Common Aim**
    - The QI Co-designing team will draft an aim which must be **SMART** (Specific, Measurable, Achievable, Relevant, Time-bounded).
- **Step 3: Developing Change Ideas**
    - The QI Codesign Team will generate change ideas through brainstorming and benchmarking for the selected problem.

Phase 3: Action planning the Project

- Develop an action plan that specifies who will collect data, conduct mentorship, and review progress, while clearly defining the roles and responsibilities of the codesign team.

11.6. PHCU QI workbook

General Information

Region: _____ **Woreda:** _____ **Kebele:** _____

PHCU Quality Improvement (QI) Team Members

S.No	Name	Role
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		

Health Service Quality Improvement Project Plan

Date: _____

Identified PHCU Quality Problems (Priority Order)

1. _____

2. _____

3. _____

4. _____

5. _____

Selected / Prioritized Quality Problem

_____

Major Root Causes of the Problem

_____

_____

_____

Improvement Aim (SMART Goal Statement)

Describe the measurable, time-bound improvement goal:

_____

_____

Outcome Indicator

Outcome Indicator	Measurement Frequency	Data Source	Responsible Person

Change / Solution Ideas and Process Indicators

Change Idea (What, Where, How)	Implementing Body	Timeframe	Process Indicator

PHCU QI Implementation Meeting Attendance Register

Name	Meeting 1	Meeting 2	Meeting 3	Meeting 4	Meeting 5	Meeting 6

PHCU QI Project Implementation Monitoring

Implementation Period: From _____ To _____

Planned Change / Solution	Process Indicator	Implementation Report	Positive Observations	Challenges

11.7. PHCU Quality Improvement (QI) Logbook

This logbook will be used to document one Quality Improvement (QI) project per page or per log cycle to ensure clarity and focus. Entries should be updated regularly during update meetings, reflecting agreed actions, progress, and results. QI teams are encouraged to use simple, routine indicators from the HMIS or service registers to track improvement and avoid additional data collection burden.

Health Center / PHCU Name: _____ **Woreda/Zone:** _____

Reporting Period: _____

Date	Service Area	QI Problem	Root Cause (short)	Action / Change Tested	PDSA Result	Current Result	Remarks

Reviewed by (QI focal): _____ Signature: _____ Date: _____

Approved by (HC Head): _____ Signature: _____

11.8. Completed PHCU Quality Improvement (QI) Project Reporting Template

1. Basic Project Information

Facility / Community / PHCU Name: _____

Woreda / Kebele: _____

QI Project Title: _____

Service Area: ☐ MNCH ☐ OPD ☐ TB/HIV ☐ Nutrition ☐ Other _____

Project Start Date: _____ Reporting Period: _____

QI Team Leader / Focal Person: _____

2. Problem Statement

Briefly describe the PHCU QI problem Statement that has been addressed:

_____

_____

3. Aim Statement

What was the team trying to achieve?

_____

_____

4. Measures

a) Outcome Measures

Outcome Indicator	Baseline	Current Result	Remark

b) Process Measures

Process Indicator	Target	Achievement	Remark

c) Balancing Measures (if any)

Balancing Measure	Observation

5. What are the Changes Tested?

Tested changes: List all of the changes that are tested during the project period	Start date: (DD/MM/YY)	End date: (DD/MM/YY)	Effective? (Yes/No) Was there any improvement registered?	Comments: Note here any potential reasons why the change was or was not effective; also indicate any change in indicator value observed related to this change

6. Results and Learning

Run chart

Insert the run chart
Interpretation of run chart:

What worked well?

_____

Challenges / What did not work?

_____

Key lessons learned:

_____

7. Next Actions

Planned Action	Responsible Person	Timeline

8. Stakeholder Engagement

Key stakeholders involved: _____

How engaged: ☐ Meeting ☐ Feedback ☐ Training ☐ Other _____

9. Review and Approval

QI Team Review Date: _____

Reviewed By (Name & Title): _____

Signature: _____

Facility / Community Leader Approval: _____

11.9. Indicators list

Indicators' Definition

S.no	Indicator	Type of indicator	Definition	Data elements	Data source
1	Number of QI-trained health care workers	Input	Total count of clinical, administrative, and support staff who have completed either the 5-day TOT, cascading training, or the 7-week onsite QI training sessions.	Number of trained service providers	Admin Report
2	Budget dedicated to QI	Input	The total amount of domestic or international financial resources specifically allocated for QI activities, including materials, training, and small incentives.	Budget allocated for QI purposes	Admin Report
3	Availability of guidelines, manuals, and tools	Input	The presence of physical or digital copies of EPHCG, NQSS, checklists, and the PHCU QI Implementation Guideline at service delivery points.	List of available Guidelines/ Protocols	Observation
4	Facility readiness score	Input	A composite score derived from a standardized assessment of basic amenities, equipment functionality, standard precautions, diagnostic capacity, and the availability of essential medicines required for service delivery. Each tracer item is assessed and scored in binary form: a value of 1 if available and Functional at the time of assessment, and 0 if not available, across all domains	The sum of all domain scores is divided by the total number of domains.	Survey/ Program assessment
5	Functional QI Team	Input	A binary (Yes/No) indicator based on whether a multidisciplinary team exists and conducts regular monthly meetings with documented minutes.	Total meet scores divided by total expected scores	Observation during supervision
6	Proportion of QI projects completed	Process	The number of QI projects that have completed the 12–15-month implementation cycle divided by the total number of initiated projects.	Completed QI projects divided by total projects X100	Admin report
7	Average waiting time before consultation	Process	The time elapsed from a patient's arrival at the facility/health post to the start of their consultation with a health provider		
8	% of procedures following infection prevention (IPC) protocols	Process	The percentage of observed clinical procedures where staff adhered to all standard precautions (e.g., handwashing, waste segregation).		
9	Adherence to clinical guidelines	Process	The proportion of cases (e.g., ANC, delivery) managed in strict accordance with the Ethiopian Primary Health Care Clinical Guidelines (EPHCG), safe childbirth checklists, or specific services guidelines and protocols		
10	Community participation rate	Process	The number of community QI team members or representatives attending scheduled monthly reviews and joint planning sessions.		
11	Patient satisfaction score	outcome	A score derived from surveys or interviews assessing patient experiences regarding respect, confidentiality, and responsiveness to their needs.		
12	Quality and Equity score	Outcome	A metric identifying disparities in service access and outcomes between different socioeconomic or geographic groups served by the PHCU		

13	Continuity of care rate	Outcome	The percentage of patients who complete their scheduled follow-up visits (e.g., ANC 4+ or PNC) without default		
14	Sustained QI projects	Outcome	The number of "graduated" QI projects where improvements have been maintained for at least six months following the test phase and embedded into SOPs.		
15	Waste reduction rate (KAIZEN)	Outcome	The percentage decrease in "waste" such as unnecessary patient movement or expired supplies, following the implementation of the 5-S framework.		
16	Patient satisfaction score	Outcome	A score derived from surveys or interviews assessing patient experiences regarding respect, confidentiality, and responsiveness to their needs.		
17	Good Governance Index	Outcome	It is a composite indicator measured by weighing the scores of health facilities across three components: public grievance handling, service delivery, and health system building. It helps assess the status of good governance at the facility level and identify gaps among facilities to determine priority areas for improvement.	Total weighted score for a component covering Public Grievance Response, Service Delivery, and Health System Performance, expressed on a scale of 100.	Dashboard
18	EPHCG score	Outcome	Number of patient cards reviewed / Number of patient cards with correct protocol*100%	Number of patient cards reviewed / Number of patient cards with correct protocol*100%	EPHCG implementation audit
19	Model Households	Outcomes	Proportion of households that are currently modeled based on model household criteria	Number of households currently model households in the catchment divided by the total number of households in the catchment area times 100%	Family Folder (eCHIS)
20	High-performing PHCU	Outcome	Proportion of primary health care units that score 85% & above average based on agreed criteria	Number of high-performing PHCUs divided by the total number of PHCUs	Admin report
21	EPHCG implementation score	Outcome	It is the implementation of health center reform.	It is the proportion of EPHCG standards met out of the total expected standards	Das board Dis2
21	Institutional maternal deaths	Impact	The proportion of maternal deaths from any cause related to or aggravated by pregnancy or its management in the community (at home, on the way to HF, and in the HP) among those deliveries in a health facility.	Number of maternal deaths in health facility divided by the total number of deliveries in health facility X 100	Monthly report
22	maternal deaths in the community	Impact	Number of maternal deaths from any cause related to or aggravated by pregnancy or its management in the community (at home, on the way to HF, and in the HP)	Number of maternal deaths from any cause related to or aggravated by pregnancy or its management in the community (at home, on the way to HF, and in the HP)	Monthly report
23	Neonatal Mortality Rate (NMR)	Impact	The proportion of neonatal deaths at the facility within the first 28 days of life among the total live births attended by skilled birth attendants at health centers, clinics, and hospitals.	Number of facility neonatal deaths in the first 28 days of life divided by the total number of live births attended by skilled health attendant X 100	Monthly report
24	Immunization Coverage	Impact	The percentage of children in the catchment area who have received all age-appropriate vaccines as per the national schedule.	The percentage of children in the catchment area who have received all age-appropriate vaccines as per the national schedule.	Surrey
24	NCD Morbidity/Mortality	Impact		The incidence or death rate related to hypertension, diabetes, or mental health conditions within the community	

11.10. PHCU Quality Improvement Implementation Checklist

Facility Name: _____ **Date of Assessment:** _____
Woreda: _____ **Assessor Name:** _____

1. **Governance and Structure Setup**

   - **PM&QI Team Establishment:** The core Health Performance Monitoring and Quality Improvement Team is established at the PHCU facilities (HC and HP) **(Yes-------, No------).**
   - **Multidisciplinary Representation:** Team includes QI, CHPU, HMIS, MCH, Laboratory, Pharmacy, and Finance heads, plus a community representative **(Yes-------, No-------).**
   - **Community QI Team (CQT) Formation:** Each Kebele has a diverse 8-member team (including Kebele manager, HEWs, religious leaders, and teachers) **(Yes-------, No-------).**
   - **Regular Meetings:** A schedule exists for monthly facility QI team meetings to review project progress **(Yes-------, No-------).**

2. **Training and Capacity Building**

   - **Standardized Training:** Facility heads and QI focal points have completed the mandatory 5-day standardized training **(Yes-------, No-------).**
   - **Onsite Training:** The 7-week onsite training (1.5–2 hours weekly) is actively being conducted for all facility staff **(Yes-------, No-------).**
   - **Training Documentation:** Attendance registers are maintained for every onsite session to support staff certification **(Yes-------, No-------).**
   - **Trainer Commitment:** Facility trainers have signed a Memorandum of Understanding (MOU) to serve for at least 6 months post-training **(Yes-------, No-------).**

3. **KAIZEN (Workplace Organization)**

   - **Sort:** Unused or unnecessary items have been identified and removed from clinical and administrative workspaces **(Yes-------, No-------).**
   - **Straighten:** Necessary items are organized in a logical order for easy access during service provision **(Yes-------, No-------).**
   - **Shine:** A daily cleaning routine is established for all floors, walls, windows, and medical equipment **(Yes-------, No-------).**
   - **Standardize:** Checklists are utilized in each service area to ensure 5-S practices are daily norms **(Yes-------, No-------).**

4. **QI Project Cycle (Model for Improvement)**

   - **Gap Identification:** Service delivery gaps are identified via facility self-assessment and routine HMIS data review **(Yes-------, No-------).**
   - **Aim Statement:** A clear, ambitious aim statement is defined for each project (answering: "What are we trying to accomplish?") **(Yes-------, No-------).**
   - **Root Cause Analysis:** Fishbone diagrams or "5 Whys" are utilized to identify the underlying causes of problems **(Yes-------, No-------).**
   - **PDSA Implementation:** Small-scale Plan-Do-Study-Act cycles are documented for testing change ideas **(Yes-------, No-------).**
   - **Data Visualization:** Time-series charts are posted in the facility to track improvement and visualize progress for staff and visitors **(Yes-------, No-------).**

5. **Linkage and Collaborative Learning**

   - **EPAQ/EHAQ Engagement:** The Health Center participates in the Ethiopian PHC Alliance for Quality to share best practices **(Yes-------, No-------).**
   - **Supportive Supervision:** Monthly coaching and mentorship visits are conducted from the Health Center to linked Health Posts **(Yes-------, No-------).**
   - **Community Feedback Loop:** Community Scorecards (CSC) are reviewed regularly to align QI projects with community needs **(Yes-------, No-------).**
   - **Woreda Participation:** The facility participates in quarterly Woreda-level collaborative learning sessions (**Yes-------, No-------).**

6. **Monitoring and Sustainability**

   - **HMIS Reporting:** All QI reporting follows the national Health Management Information System timeframes **(Yes-------, No-------).**
   - **SOP Integration:** Successful change ideas are embedded into updated facility Standard Operating Procedures (SOPs) **(Yes-------, No-------).**
   - **Recognition Systems:** A mechanism is in place to reward high-performing staff or kebeles (e.g., certificates or public acknowledgement) **(Yes-------, No-------).**

Primary Health Care Unit Quality Improvement Implementation Guideline