Performance Monitoring for Action (PMA) project is fueling a data revolution to guide family planning programs. Data are key to informing and driving policy and program changes around the world. High-quality data—collected frequently, turned-around quickly, and locally owned—help decision makers understand what is working and what is not, enabling decisions that are more sensitive and responsive to evolving needs.

PMA surveys collect actionable data on a variety of family planning topics that inform policies at national or sub-national levels. The project implements cross-sectional surveys and a new longitudinal panel design to fill a data gap. The surveys provide information for regular tracking of progress and for understanding the drivers of contraceptive use dynamics—information that is not currently measured by other large-scale surveys. While having a core family planning focus, the data collection platform can be used for other health strategies. To date, the platform has been used to collect data for guiding programs in maternal and child health, nutrition, water and sanitation, neglected tropical diseases, and primary health care.

*Formerly Performance Monitoring and Accountability 2020 (PMA2020)

**The PMA Advantage**
- Collects actionable information for regular tracking of progress and for understanding the drivers of contraceptive use dynamics
- Highly-trained cadre of female data collectors collecting data in their own communities
- Rapid turnaround results enabled by smartphone technology and short interview times
- Innovative panel design follows the same women and households for multiple years
- High-quality data collected at frequent intervals
- Geographically-linked data collected from both households and health facilities
- Builds local data collection capacity

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WHAT WE DO

The next phase of PMA builds on the success of PMA2020 by adding an innovative panel design: following the same women and households for multiple years, helping measure changing contraceptive use. Questions have been added to capture community norms, women’s agency, and individual intentions and are customized to better meet the needs of country governments and stakeholders.

Data are collected from households, women, health facilities, and family planning clients to better understand levels and changes in contraceptive access, equity, quality, and choice. PMA validates, aggregates, and prepares those data into tables and graphs that are available to the public with the underlying data. Customized data are shared with key stakeholders within weeks of collection.

PMA uses mobile technology and a network of female data collectors trained to collect data using smartphone technologies. These local data collectors are the backbone of PMA. They are recruited from the surveyed areas to conduct interviews within their own communities.

PMA Ethiopia’s survey project differs from our other countries in that it is designed to generate data on a variety of reproductive, maternal, and newborn health (RMNH) indicators that can inform national and regional governments. The project implements cross-sectional and cohort surveys with a focus on measuring RMNH comprehensiveness of care services, and the barriers and facilitators to such care.
PMA is responsive to host-country government and stakeholders’ needs for independently valid and high-quality data. PMA collects data using four linked survey methodologies:

- **Longitudinal household and female survey**: with an embedded cross-sectional household and female survey
- **Service delivery point (health facilities) survey**: linked to the surveyed communities
- **Client exit interview survey**: linked to the service delivery point

### Longitudinal household and female survey

1. A nationally or regionally representative number of enumeration areas are selected. Households are systematically sampled from those enumeration areas for inclusion in the survey round, using random selection.

2. All women age 15–49 years old in the selected households are eligible for interview. They are asked questions about their background, births, fertility preferences, use of family planning methods, and other information that is helpful to policymakers and program administrators for improving access to and quality of family planning services.

3. Data collectors follow up with all previously interviewed households and women to collect updated information about what has happened to them over the past 12 months. This provides information across time, or longitudinally, and can be used to show, for example, which women adopt a family planning method or discontinue use and why.

### Service delivery point survey

1. Up to 3 private health facilities and 3 levels of public health facilities are selected for interview. Staff are interviewed to provide information on the quality and readiness to provide family planning. The same facilities are interviewed every twelve months, at the same time as the household and female survey.

2. Family planning clients are approached for interview as they leave selected facilities. They are asked about the services provided to them to better understand the quality of care. These interviews take place at the same time and at the same facilities included in service delivery point survey. In some geographies, these same clients will be interviewed again six months later to learn about new method use, continued method use, switching, or discontinuation.
PMA is implemented by local universities and research institutions in partnership with the Bill & Melinda Gates Institute for Reproductive Health at the Johns Hopkins Bloomberg School of Public Health and Jhpiego.

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PMA welcomes inquiries from potential partners. Send inquiries to info@pmadata.org.

1) Democratic Republic of Congo (Kinshasa and Kongo Central): University of Kinshasa
2) Ethiopia: Addis Ababa University School of Public Health
3) Uganda: Makerere University School of Public Health
4) Kenya: International Centre for Reproductive Health Kenya
5) Nigeria (Kano and Lagos): Centre for Research, Evaluation, Resources, and Development (CRERD)
6) Burkina Faso: The Higher Institute of Population Sciences (ISSP), University of Ouagadougou
7) Niger: National Statistical Institute (INS)
8) India (Rajasthan): Indian Institute of Health Management Research
9) Côte d’Ivoire: National School of Statistics and Applied Economics of Abidjan (ENSEA)