PMA, a decade of innovation in family planning data:

Voices of the national survey directors

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Abstract

Introduction: With the loss of funding for standardized cross-national surveys, the family planning (FP) community is facing a future with dwindling resources and without a reliable data source for monitoring indicators. This study assessed lessons learned by country survey directors regarding the implementation of the Performance Monitoring for Action (PMA) household and facility surveys. PMA surveys had rapid turnaround, used a smartphone platform, relied on resident enumerator networks and had annual cadence. Over more than ten years, PMA conducted a total of 85 survey rounds that reached nearly 1 million respondents in 11 countries.

Methods: The 19 eligible principal investigators (PIs) were mailed a brief questionnaire in July 2025 and 14 returned it. In the same month, sixteen were interviewed virtually to follow up on their responses. Two team members conducted the interviews, which were recorded and transcribed. Together with written responses the data were analyzed for recurring themes independently and then compared to create the final list. Representative commentary is shared around the themes.

Results: As local voices, the PIs described how they adapted PMA's design innovations and engaged stakeholders to strengthen data use and survey sustainability. They highlighted PMA's contributions to program planning, improvements in FP services, and the development of trusted relationships with government partners. They also identified major challenges, including demands for broader geographic coverage, insufficient government resources, and uncertainty about future FP measurement.

Discussion: The PI reports demonstrate that locally owned, rapid high-quality surveys are possible in low-income settings. The PIs occupied roles of change agents, transacting around survey findings to solicit official response and exact program actions. The PI experiences built sustainable local capacity, created an appetite for useful annual FP data, and established a model that can inform the design of future health data systems.

Key Findings (3 bullets)

- PMA country directors/principal investigators (PIs) described how they adapted design innovations and engaged stakeholders to strengthen data use and survey sustainability.
- They highlighted PMA's contributions to program planning, improvements in FP services and the development of trusted relationships with government partners.
- They identified major challenges, including requests for broad geographic coverage, insufficient government resources, and uncertainty about future FP measurement.

Key Implications

- PI reports demonstrated that locally owned, rapid high-quality surveys are possible in low-income settings.

- PIs occupied roles of change agents, transacting around survey findings to solicit official response and exact program actions.
- PI experiences built sustainable local capacity, created an appetite for useful annual FP data, and established a model that can inform future health data systems.

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Introduction

After the 2012 London Summit on Family Planning, Melinda French Gates, then with the Bill and Melinda Gates Foundation (BMGF), one of the Summit's four agency sponsors, met with foundation staff and prioritized one of her concerns—the ability to track the progress toward the adopted goal of reaching an additional 120 million women and girls in 69 of the poorest countries to have access to contraception by 2020. She did not want to wait every five years or more for the results from the Demographic and Health Surveys (DHS) program. One of her senior staff recalled her saying clearly, "If we were in the private sector and we had to wait five years to know if we were successful or not, we would be bankrupt." This was the impetus for the creation of Performance Monitoring for Accountability 2020 (PMA2020), a global data collection initiative on family planning supply and demand. PMA2020 was funded by the BMGF and implemented by the Gates Institute (GI) at Johns Hopkins University and its institutional partners in eleven of the 69 low-income countries. These partners included research institutions, universities, and government agencies, all of whom built teams for continuous data collection and analysis, and stakeholder groups that used the data to inform local programs and policies.

In 2018 the project transitioned to Performance Monitoring for Action (PMA[a]) with technical support implemented by the GI and financial management support by Jhpiego. BMGF funding for PMA ended in December 2024, by which time the survey program had built a reputation for delivering high-quality survey data on an annual basis, measuring family planning (FP) supply,

[a] For simplicity, PMA will be used in this paper to refer to both iterations of the project.

demand and use indicators with values similar to those of the DHS and other large-scale surveys. The UNFPA's 2025 State of the World Report[1] mentions PMA as a potential platform to continue FP measurement,

> *Invaluable monitoring data on contraceptive agency, reproductive health, gender-based violence and many other areas of research could be lost if the DHS is unable to obtain new funding. … The smaller Generations and Gender Survey, currently implemented in 24 countries, and the Performance Monitoring for Action survey both collect family planning data, and could be expanded to a broader array of nations*. (p.117)

Having annual PMA data was key to informing and driving policy and program changes within and outside borders of survey countries. In addition to having an annual cadence, other innovations included simultaneously collecting data at the household, women and facility levels, using a mobile smart-phone based platform, deploying a decentralized network of resident enumerators, tailored data processing for quality checks and rapid turnaround, and generating and disseminating actionable results.[2] The latter outcome was critical for enabling decision makers to understand what was working, both at the facility and population levels, and what was not and to inform decisions that were sensitive and responsive to evolving needs.

PMA's survey design focused on a standardized set of family planning topics to address policies and program needs at national and sub-national levels.[2] In its second iteration, PMA implemented longitudinal surveys and a new cross-sectional panel design to fill a data gap — collecting information from the same women, households, and health facilities that provide FP and reproductive health services ("service delivery points", or SDPs) over time -- for regular tracking of progress and understanding of the drivers of contraceptive use dynamics and other behavioral changes, an approach not used by other large-scale surveys.[3] Along with its core family planning focus, the platform has also been used to collect data to inform other health issues, such as gender-based violence, abortion, COVID-19, maternal and child health, nutrition, water and sanitation, neglected tropical diseases, women's and girls' empowerment, menstrual

health management, schistosomiasis, and primary health care. Between 2013 and 2024, the survey teams completed 85 rounds of female, household, and SDP surveys, interviewing nearly one million participants.

Over the decade of PMA surveys, the country directors (also known as principal investigators (PIs)) acquired and acted on insights and experiences that ensured the desired data utilization outcomes were achieved for effective program monitoring. They were all local professionals and represented an oft-neglected source of "local voices" that can help institutionalize and sustain needed data systems.

Local voices reflect the meaningful participation, leadership and knowledge of individuals and institutions in locations served by global health programs. Research on this normative ideal has focused on not only whether local communities are heard but how their perspectives have shaped priority-setting, implementation, evaluation and assessments.[4,5] Structural power imbalances are also a focus to move local voice beyond being symbolic to an authentic force of system change.[6]

Capturing PMA PIs' experiences brings important added value as their reflections highlights how survey innovations were adopted, adapted, and institutionalized within country systems, thereby grounding global measurement debates in the realities of local practice.

In the field of population-level monitoring of development, the vacuum created by the dismantling of the U.S. Agency for International Development (USAID) in February 2025 has impacted funding for the three decades-long Demographic and Health Surveys (DHS) program[7], as well as Unicef's Multiple Indicator Cluster Surveys[8]. Many national statistical offices in low-income countries are unable to conduct DHSs with local resources alone and there is insufficient funding from other international donors, many of whom have also experienced cuts to their foreign assistance budgets. DHS data have been vital for monitoring progress in population

health, especially towards the Sustainable Development Goals.[9,10] The termination of BMGF resources for PMA has also impacted its regular survey coverage to now being dependent on occasional funding. More importantly, progress made in generating annual FP program data trusted by local national health authorities, donors and researchers stands to be lost, making capturing institutional memory through the local voices of the country survey directors particularly important. Future directions taken on re-designing and institutionalizing population health surveys will benefit from the perceptions, knowledge, and understandings of local survey leadership.

Objectives

This study aims to capture and analyze the insights and reported experiences of the PMA principal investigators across 11 countries. Using a local voices framework,[4,5] it seeks to understand how the PIs (1) adopted and adapted to innovations of PMA surveys over its decade of operation, (2) supported its annual implementation and expeditiously delivered key findings, and (3) viewed the future measurement of family planning indicators. The overarching goal is to use their insights to define design features essential to building an equitable and sustainable global survey platform.

Program description

Beginning with the first round in 2013 to the last in 2024, PMA surveys, implemented by the PIs and their teams, generated an extensive time series of key FP indicator values to track contraceptive supply, use and other reproductive health dynamics. Table 1 presents the 11 countries where PMA surveys were fielded, the number of annual rounds, whether the samples were designed to be representative at the national, subnational or both levels, and the institutional partners. A total of 85 survey rounds were completed, ranging from 10 rounds in Burkina Faso,

Democratic Republic of Congo and Kenya to two in Indonesia. Special pilot longitudinal surveys were additionally conducted, two in Ethiopia and one in Uganda. Most implementing partners were university-based or parastatal institutions, while one was a government agency (Niger). We provide a quick background of PMA survey design, followed by brief descriptions of the main innovations. Further details about PMA are available on the website (www.pmadata.org) and from key publications.[2,11,12]

Table 1. PMA survey sites, number of annual cross-sectional survey rounds completed, level of estimation and implementing institution

Country	Annual survey rounds completed	Estimation level		Implementing institution
		National	Sub-national*	
Burkina Faso	10	X	2 provinces	Institut Supérieur des Sciences de la Population (ISSP)
Dem. Rep. of Congo	10		2 provinces	Kinshasa School of Public Health
Cote d'Ivoire	6	X		École Nationale de Statistiques et d'Economie Appliquée of Abidjan
Ethiopia	8	X	6 regional areas	Addis Ababa University
Ghana	6	X		Kwame Nkrumah University of Science and Technology
India	7		1 state	Indian Institute for Health Management Research
Indonesia	2	X	2 provinces	BKKBN Gadjah Mada University, USU and Ujung Pandang
Kenya	10	X	9 counties under PMA2020, 11 under PMA	International Center for Reproductive Health
Niger	5	X	1 capital district	Institut National de la Statistique Du Niger
Nigeria	9		7 states under PMA2020, 2 under PMA	Center for Research, Evaluation Resources and Development
Uganda	12	X	4 regions	Makerere University School of Public Health

*Number of subnational areas for which sample was representative

Survey design

PMA employed a multi-stage cluster design with urban-rural and major regions as the strata. A representative sample of enumeration areas (EAs) or clusters was drawn from a master sampling

frame, usually provided by the national statistical agency in each country. Ahead of data collection, households, and key landmarks in each EA/cluster were listed, geolocated and mapped by resident data collectors. Within each EA/cluster, a random sample of households was selected. The survey aimed to include a sample size that would allow analysts to calculate a national (and/or subnational) estimate for the core indicator, modern contraceptive prevalence rate (mCPR), with a margin of error of ±3 percentage points (±5 percentage points at the subnational level). The target sample assumed an expected number of eligible women per household and accounted for non-response rates and loss to follow-up. All resident eligible females were contacted and consented for interviews.

In 2014 PMA began with four surveys at six-month intervals to build experience and confidence with the design before shifting to annual frequency for the next two years for a total of six cross-sectional rounds. A new sample of households at the cluster level was selected with each round. In 2019, with the transition to PMA, the number of countries was reduced to nine[b], while subnational coverage in Nigeria decreased from six to two states. A mixed cross-sectional and longitudinal sample design was implemented to obtain period and cohort estimates for key indicators. A baseline cohort of eligible women in selected dwellings provided the first cross-sectional round and those women consenting to be visited in the future comprised follow-up panels for the cohort. The Covid-19 epidemic interrupted the annual cadence, but data were collected via a phone interview for a COVID-19-specific 2020 round. Occasionally, PMA conducted on-site, face-to-face survey of consenting family planning clients as well as phone follow up surveys to assess contraceptive discontinuation and other dynamics.

PMA innovations

[b] Ghana and Indonesia sites were discontinued, in the former case because of changed Gates Foundation priorities and in the latter because the government implementing agency was able to pursue its data collection independently.

Mobile phone technology. At the outset PMA took advantage of the growing availability of mobile phones and their networks across the different country sites, especially in sub-Saharan Africa where connectivity was constrained and less reliable early on but more widespread and stable by 2024. The REs were trained to use smartphones to interview respondents with the various questionnaires, using the Open Data Kit (ODK) platform. One of ODK software's advantages was being able to capture data when the RE was offline and submitted later to a server. ODK also enabled programming for automated skip patterns, ranges of acceptable answers, and logic checks integrated into the survey form, overall increasing data consistency and quality.

Resident enumerators. PMA PIs recruited qualified female "resident enumerators" (REs), one for each cluster[c] and provided training and remuneration to conduct the PMA survey. The REs usually had a minimum of completed secondary education, residence in or near the sample cluster, technological savvy with mobile phones, language fluency, and the physical ability to move around the enumeration area.[11] Attrition was minimal, especially after the second round. The cost savings of recruiting, training and transporting new cadres of interviewers for surveys with less frequent cadence enhanced the appeal of the RE model. The PIs' relationships with the REs also proved to be enduring and resilient. Quantitative analysis of the survey responses conducted in the DRC suggested that increased familiarity with RE led to more accurate responses from PMA participants.[14]

Simultaneous data collection for facilities and households. For each enumeration area or cluster, the public and private health service delivery points (SDPs) serving it were selected for the

[c] PMA adopted a model established by the Government of India's Sample Registration System (SRS), which used local enumerators to record births and deaths in assigned sampling units. The SRS approach enabled a more rapid recording of vital events on a sample of households compared to the national vital registration system which was often incomplete and/or delayed in reporting.

facility survey. This allowed geographic linkage of SDPs with cluster respondents.[15] Public SDPs included the public health posts, district hospital and regional hospital. Up to three private SDPs (private clinic or pharmacy) within the EA/cluster were randomly selected from the EA listing. National and subnational health administration officials facilitated the PMA teams' contact with public sector facilities. Consent was obtained from each private provider who served as a facility respondent (private doctors, pharmacists, and other paramedical staff). In practice, SDPs comprised a panel sample from the outset since the underlying sample clusters largely remained the same within the two PMA iterations.

Rapid turnaround for data processing, data quality and dissemination. The technical support team at JHU worked with in-country data collection teams to ensure accurate recording of responses, uploading of records, numerous data quality checks, and executing a set of tools called PMA Analytics. The real-time ability to capture respondent data, process it for quality assurance and conduct analysis for reporting enabled PMA surveys to be completed in approximately six weeks and subsequently disseminated to stakeholder audiences at the national and subnational levels.

Operational autonomy. While this study aims to elevate insights and lived experiences of PMA PIs to appreciate the knowledge and understandings of local voices, the design of the overall survey program was initially defined for them by the GI/PMA team. As such there was a power structure imbalance typical to transnational research collaborations between high-income and low-income implementing partners. Even though the PIs did not have a role in PMA's initial conceptualization and technical design, as might be expected within a framework for co-creating global health[16,17], they were able to develop their own budgets, negotiate contract terms, independently recruit and staff teams, conduct data processing and analysis, and disseminate results directly with government, non-government officials and community leaders. After the

PMA launch, PIs became intimately involved in various innovations to the initial design, especially around survey content and the conduct of the survey in the midst of the COVID-19.

The PIs largely operated autonomously of GI/PMA within their country settings and assumed increasing responsibility over time for ODK programming, data cleaning routines, and planning subsequent survey rounds. The PIs met annually to share their experiences and progress and to learn from each other. A publication authorship protocol was established at the outset and PIs and their staff authored publications. PMA data was made publicly accessible online shortly after collection, allowing for more democratic access by researchers worldwide.[d]

Methods

Across the 11 PMA country sites, a total of 19 PIs and co-PIs were eligible to participate in this assessment. While nine sites had co-PIs, one lost a lead PI due to premature death in 2020 and another was led by a single PI. These 19 survey directors comprised the universe of key informants for this study.

All 19 PIs were emailed an 11-item structured questionnaire on July 7, 2025 and responses were returned by email from nearly all.[e] The questionnaire (provided in Appendix 1) solicited PI reflections on their PMA program experiences with respect to leading the survey teams, survey design, frequency, dissemination, partnerships and data utilization. They also were asked about their experiences following the discontinuation of PMA, areas for PMA improvement, perspectives on future organization and financing, potential for cross-country collaboration and thoughts about the consequences of the loss of DHS and PMA data, where applicable.

[d] The PMA publications list is available through Google Scholar: https://scholar.google.com/citations?user=gYAacPsAAAAJ&hl=en&authuser=1

[e] We did not receive a written response from the second PI in Indonesia or Niger. We also did not receive a written response from the Burkina Faso team before the scheduled video interview. For this team, the questionnaire was administered during the interview. We were unable to conduct a video interview with the PIs from the Niger team due in part to ongoing census preparations.

A video meeting was then scheduled with at least one key informant for each site attended by one or both members of the assessment team. Consent was obtained verbally to record the interview and to cite selected commentary in the report without attribution. Eleven interviews with the key informants were conducted in English, French or both and completed by July 28, 2025. During the virtual interview, the PIs were probed to explicate on and clarify their written responses. The virtual interviews lasted one hour on average. As might be expected, the virtual meeting discussions were richer in information, history, context and insights for future surveys, than the written responses.

The written questionnaire responses and transcripts of the virtual meeting interviews were reviewed by the two lead investigators. Each independently created a list of recurring points raised by the PIs, which were compared to construct a final list. The PIs reflections centered on the following themes: components of PMA survey implementation (the mobile phone platform, resident enumerators, annual cadence, data quality, mixed cross-sectional and longitudinal design); stakeholder interest in PMA data (geographic and content coverage); and sustainability. Excerpted comments from the PIs' written questionnaires or video interviews are presented to contextualize or illustrate the thematic points. Comments from questionnaire responses are noted as [QX] and from interviews as [INT]. The country source is abbreviated.

Results

Informant commentary on overall experience and impact is shared first.

Overall experience and impact

All PIs reported they found their experience with PMA to be positive, and a majority cited it as highlight of their careers as researchers. They were able to work on public health issues directly with government and development partners. All were willing to continue for another 5 to 10 years to lead PMA in their countries if resource support became available.

This program was a wonderful experience for me and the entire PMA team. The PMA survey revolutionized surveys at the INS level, with the availability of results much faster than other surveys. It paved the way for other tablet-based surveys organized by the INS. I appreciated the entire process of this survey, from the finalization of the collection tools (questionnaires, guides, and other documents), which was a sharing of experience between the Technical Unit (TU) and the country teams. All opinions were received, analyzed, and shared, and decisions were always made collegially. It's truly incredible; everything is shared with the country teams. Building the country teams' capacities was also a very interesting experience. Indeed, several workshops and meetings (in person and virtually) were organized throughout the program. This allowed the teams to be in sync with the TU and the project management team. [QX-NR]

Locally our experience with PMA as a brand has created trust in our abilities to deliver large scale surveys and slowly become a stop center for health surveys in the university…and in the country at large. [QX-UG]

The most enjoyable aspect was working hand-in-hand with our dedicated team of resident enumerators across diverse counties, ensuring that the data we collected was not only high quality but also reflective of the lived realities on the ground. The highlight of the experience was witnessing stakeholders actively engage with the findings, using the evidence to inform national conversations and decisions in SRH (sexual and reproductive health)/FP. That direct link and learning and generating comparable estimates with other surveys served as a powerful motivator through every round of the survey. [QX-KE]

<u>*Perspectives on survey implementation*</u>

Mobile phone platform. In 2013 smartphone technology was novel in PMA countries and its potential as a survey platform was both daunting and exciting.

The fact that it all began in Ghana with unchartered territory was very exciting and challenging for me. I remember spending nights trying to figure out which phone was best to use, where do we get funding to start since we didn't have funding readily available from the Gates Foundation, and of course what happens if the proof of concept didn't work out? [QX-GH]

We really enjoyed the initial surveys! It was a groundbreaking experience, marking what we believe was the first ever phone-based national survey…PMA provided a great opportunity to collaborate closely with the Ministry of Health and other crucial stakeholders. Our efforts led to significant, impactful changes in how data was utilized for evidence-informed decision-making. [QX-ET]

PMA's introduction of ODK software has since been adopted in Indonesia in several surveys, including by the implementing agency, the National Family Planning Coordinating Board (BKKBN) for its family welfare surveys.

Resident numerators. Many of the PIs spoke gratifyingly of working with the RE networks. REs constituted the backbone of the PMA survey infrastructure, being the points of contact closest to the sampled respondents and communities. They were relied upon to explain any discrepancies and anomalies that arose during data cleaning and could usually be reached quickly by phone. During some training events, experienced REs served as trainers, including occasionally of new supervisors. Several rose to higher team positions. Many of them have shared their gratitude with the PIs for being able to accumulate earnings to support family needs, especially children's schooling.

> *Developing the skills of local women in data collection was another great feature (of PMA), having an impact on their lives leading to empowerment. [QX-IN]*
>
> *I am amazed to hear stories from REs and supervisors about how much the PMA project has changed their lives. The financial development arising from project payments to them has been appreciated and used to change the lives of their families. [QX-UG]*
>
> *The resident enumerator component of PMA should be considered in any future national household design; it has several advantages including lower cost. [QX-GH]*

One PI spoke of the REs' collective wisdom, relaying how they advised on involving regional health staff to present survey results, thereby increasing local engagement and ownership of the PMA platform. When asked about the decision, the PI stated:

> *Well, it was something that first occurred to me. And I discussed it with the REs; that is the beauty of the REs and how we still have all the girls around. … If I call them today, they will all assemble here. … It's because of the open discussion, you know. An idea comes and we all look at it, and everybody has an opinion. We discuss it and arrive at something we think would be most beneficial for the country. And then we put it forward and it works. [QX-GH]*

Annual cadence. The annual cadence of the survey rounds was seen as acceptable by eight of the 11 PIs (India/Rajasthan, Nigeria, Ethiopia, DR Congo, Ghana, Kenya, Côte d'Ivoire and Niger), many citing their governments' needs for annual health planning information. The remaining PIs (Burkina Faso, Indonesia, Uganda) reported that a two-year interval for both the household and facility surveys would be preferable, in part due to infrequent change in indicator values and in

part due to governments' inability to act on earlier round findings in time for the next annual round.

> *For the household survey, I would say…that the annual frequency was enough. … However, there may be survey fatigue among respondents, especially when they feel things are not changing and yet a team returns to the same community to ask questions year after year. … For the Service Delivery Point survey, we were beginning to see real fatigue from facility respondents, especially if actions are not taken soon after the findings are released. [QX-UG]*
>
> *The annual frequency of survey was quite appropriate. The country government representative found it useful for preparing their annual plan [Project Implementation Plan] for reproductive health. [QX-IN]*
>
> *The indicator collection frequency was good. PMA made it possible to continuously provide family planning indicators in Côte d'Ivoire between 2017 and 2024, whereas the country did not have DHS data for the same period. PMA thus filled a data gap. [QX-CI]*

Data quality. Establishing the quality and credibility of PMA data was of paramount importance to all PIs; and yet until there could be a comparison with an estimate from an established data source, there was inevitably some hesitation and skepticism that persisted around PMA results. The comment below is representative of how PMA-data were initially evaluated and subsequently accepted by government officials.

> *PMA Ghana first reported the TFR was 3.7; at that time, it was not seen as credible until the DHS reported a very similar figure. As a result, the Ghana Health Service and health development partners began to tout PMA surveys as a credible but less expensive alternative to DHS. [QX-GH]*

A similar situation arose in Kenya when the modern contraceptive prevalence rate among married women of reproductive age surged based on PMA survey results but only gained credibility when the DHS replicated the estimate shortly afterward. In Kenya, non-government generated data that meets defined standards of quality are referred to as "citizen-generated" data and can be archived on government data websites. PMA survey data is now classified as such and can be found on the Kenyan National Bureau of Statistics website.

> *The pinnacle of the project was the official recognition of PMA data as citizen-generated data that the country could confidently use to inform decision-making. This*

> *acknowledgement served as a strong validation of the rigorous scientific standards maintained through the project's implementation and underscored its credibility as a reliable source of information for public policy and planning. … Due to the high credibility and utility of the PMA data, the project team was regularly invited to participate in critical technical working groups and national committees, further solidifying PMA's role as a trusted and influential data resource in Kenya's SRH/FP landscape. [QX-KE]*

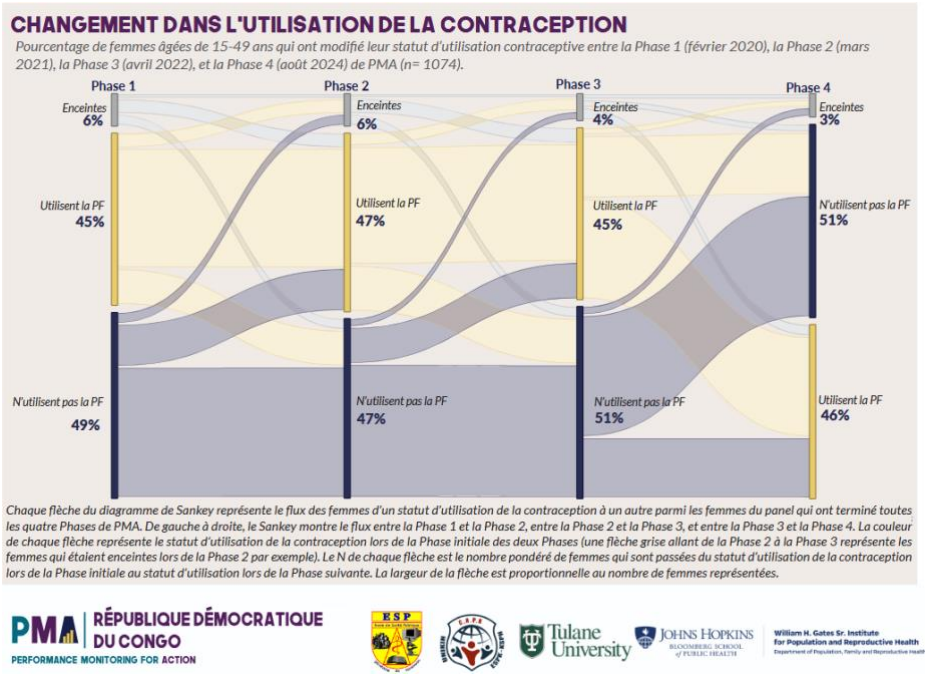
> *The main thing I learned from PMA that I would like to share with DHS and MICS (Multiple Indicator Cluster Surveys) and others is the rigor and quality control processes. I am convinced that PMA outpaces other surveys in training and quality control. [QX-NG]*

Cross-sectional and longitudinal design. Cross-sectional surveys have dominated the historical landscape of FP/RH data collection in low-income countries, but they are limited in their ability to explain trend changes. PMA panel data follow the same sampling units over time to allow same-unit comparisons and identification of causes or drivers of the change. PMA PIs spoke about the innovative inclusion of a cross-sectional design into a panel sample, allowing for tracking of both trends in contraceptive use and method composition, as well as of dynamics of contraceptive adoption and method switching:

> *Scientific rigors and robust methodology, especially its panel design, was another important and unique feature [of PMA]. [QX-IN]*

At disseminations, PMA teams presented data to showcase trends in indicators and explain how panels of users and non-users redistributed themselves over time. Sankey diagrams (see Figure 1) were a novel approach used to visualize how user groups switched methods and use status.

Figure 1. Illustrative Sankey diagram of contraceptive use dynamics in Kinshasa, DR Congo



Source:

https://www.pmadata.org/sites/default/files/data_product_results/Draft%20Brief%20Panel%20Data%20PMA%20V8.pdf

In particular, disseminations focused on dynamics of fulfilled contraceptive intentions where non-users from an earlier survey round could be followed to their adoption (or not) of contraception in a subsequent round. Similarly, discontinuation of contraceptive methods by type reportedly generated great interest.

For PMA Ethiopia, where two cohorts of pregnant and postpartum mothers and their newborns were followed at seven days, six weeks, six months and one year postpartum, the dynamics of safe pregnancy and birth and of child immunization provided unique information on the continuity of care. In one specific case, the PMA team shared that only 14% of the mothers received all four care services (4-plus antenatal visits, facility delivery, any postnatal care within six weeks and full infant immunization) and that intention to use at six weeks postpartum was 61% while actual behavior by one year was much lower at 6%. The health ministry was able to

act on the findings of discontinuous care, information that would not have been available from cross-sectional surveys.

Stakeholder interest in PMA data

PIs held dissemination events shortly after each round, as well as after some special topic rounds, organized together with national and local health officials and other stakeholders and donors. They reported that doing so annually strengthened collaboration and relationships. The meetings became anticipated opportunities for learning about the most recent survey findings, understanding survey methods, interpreting discrepancies, validating against other information sources and designing course corrections if needed.

> *The successes are easy to identify. I will give some examples for PMA since 2014 until 2024. It was one of the main sources of data for reproductive health, in general, including for the Ministry of Health, but in terms of use. Concretely, we can see that since the national FP plan. The first version 2013-2015, We participated in the development of the PMA was asked to set the targets to be achieved by 2015. [INT-BF]*
>
> *Collaboration between PMA and relevant ministries has facilitated the integration of PMA data into national policy frameworks, thereby strengthening public health strategies. [QX-DRC]*
>
> *I liked the model of subnational (regional) dissemination of findings…The model has been welcomed by partners and the districts' leadership. … The implementers get to ask questions and understand how the findings are generated. They also develop their own actions results from the findings, rather than researchers prescribing what they (implementors) should do. [QX-UG]*
>
> *The Ministry of Health has been utilizing PMA data for many years and its relevance continues to grow. Currently PMA is referenced in several strategic documents…PMA data highlighted a decline in the quality of family planning counseling, which led the MOH to develop and implement a corrective intervention in 2019. This intervention effectively reversed the downward trend. [QX-ET]*
>
> *The national level was very receptive to the PMA data, which was expected, judging by the quality of the participants in the various dissemination workshops organized between 2020 and 2024. The Ministry of Health, represented by the Director General of Health, chaired the various dissemination workshops. The National Assembly was also represented, as was the National Human Rights Council. [QX-CI]*

The PIs provided multiple examples of the use of PMA data by national health authorities and non-governmental stakeholders, especially for costed implementation plans.

> *We were again asked to set the targets for the second 2016-2020 Program, which still used PMA indicators, and the Burkina PMA team was entrusted the part of the targets to be achieved in the national program. We modeled this using PMA data. And recently, the third national family planning plan, which ran from 2021 to 2025, we also set targets, which would have been requested by the Ministry of Health to use PMA data and set the targets to be reasonably achieved. And there too, if you see all the figures on prevalence on the targets to be achieved in the three plans, there, it comes from the PMA, so that is really a use for monitoring national policies, really national policy documents. [INT-BF]*

These examples are compiled in Appendix 2, verbatim from PI questionnaire responses. At annual disseminations, interaction and discussion around the findings provided transparency and accountability for subsequent program actions as well. A few PIs noted that it was at times challenging to communicate PMA results that government officials were not fully prepared or willing to receive.

> *… new survey results may be out before the officials have had a chance to intervene based on the previous results… repeated reports of stockouts over several annual surveys finally pushed the state Ministry of Health to allocate funds for the purchase of contraceptive commodities… [QX-NG]*

Demand for national or subnational estimates. Expectedly, many PIs reported stakeholders desiring more data at national and subnational levels. Wherever PMA survey samples were only subnational, e.g., Nigeria and DR Congo, the PIs were disappointed in not being able to provide national level data on core indicators.

> *The government and other stakeholders were asking for PMA surveys in more states to fully accommodate Nigeria's size and diversity. [QX-NG]*
>
> *For the DRC, we prefer to obtain a national sample, if feasible, or alternatively to expand the number of provinces in the least favorable situation… [QX-DRC]*

However, they also received requests for indicator estimates at lower levels, such as local government areas in Nigeria. Similarly, where PMA coverage was only for the national level, PIs reported government officials' requests for subnational estimates.

> *The government suggested increasing the sample to provide district-level estimates, at least to high-priority districts. … Being able to provide results at the district level would*

have informed district planning which then makes it up to the state-level project implementation plan. [QX-IN]

Indeed, PMA Ethiopia PIs reported being unable to secure Federal Ministry of Health approval to conduct the surveys unless regional estimates were generated. This resulted in doubling the number of REs needed. Nearly all PMA PIs reported that national and subnational health planners sought indicators at their levels of administrative responsibility.

The length and content of the questionnaire, as well as the training (content, duration), are impeccable. What needs to change is the size of the sample of respondents. For the moment, the survey results are only representative at the national level and in Niamey. What is important is representativeness at the regional level (Niger has 8 regions). This is the main request of the Ministry of Health authorities, but also at the regional level, because each region wants to see the efforts it has made in terms of the level of indicators. [QX-NR]

Expanding survey content beyond family planning. Many PIs recommended expanding PMA survey content to include topics related to maternal and newborn health, nutrition and adolescent health. At the same time, PIs felt being responsive to government data needs had to be balanced against respondent burden in terms of interview duration. Several voiced the need to survey men about their roles in family planning decisions and practice.

…Retain core indicators for comparability across countries while other content could be intentionally and periodically reviewed to better reflect the specific country data gaps and evolving SRH/FP priorities. [QX-KE]

…PMA may maintain the base tool (FP) but be flexible and responsive to the stakeholder needs that include modules… So there is a need to further brand PMA as an important platform to generate and close the data gaps and also open up the platform for modules such as child health, non-communicable diseases, and promote the platform as a monitoring, evaluation and research platform. [QX-UG]

PMA's strength lies in its adaptability, continuously evolving to incorporate new measures over time. [QX-ET]

I would shorten the standard PMA questionnaires to give more room for solicited modules that would help answer burning questions of a variety of stakeholders. [QX-NG]

…We need to add information on early adolescence (10-14 years), especially including bullying and mental health. [QX-IO]

The questionnaire could address aspects related to risk behaviors, particularly regarding HIV and especially among young people/adolescents. [QX-CI]

…Adding men to the PMA household survey...because this has been demanded by partners at national and subnational levels a lot for a while. Men's surveys have unique challenges with response rates in the country, but these can be navigated. [QX-UG]

Other suggestions included incorporating a qualitative component to better understand changes, as well as integrating some PMA questions into government-led annual economic surveys to increase the chances of PMA's adoption by government.

Perspectives on sustainability of the PMA platform

Use of the PMA platform for non-FP surveys. In terms of operational sustainability, at least eight of the 11 PMA PIs reported conducting non-FP household and facility surveys under contract for other organizations. Across sites, the topics included water, sanitation and hygiene (WASH), adolescent health, abortion, drowning, Emergency Obstetric and Newborn Care (EmONC), syphilis in women, assisted technology for people with disability, schistosomiasis, measles and rubella, COVID exposure, and child vaccination. As one PI reported, the PMA brand has been enduring:

The last (PMA) survey was in 2017; yet we still continue to receive enquiries from health development partners who ask whether we intend to return to the annual surveys. Some partners have funded national surveys they contracted us to conduct on their behalf. [QX-GH]

Resources for continuation. While demand for using the PMA platform will likely continue and enable the teams and their REs to maintain and enhance survey skills, the original objective of ensuring annual estimates of FP indicators is at risk in the absence of a stable resource base. Nearly all PIs commented on the absence of local government funding for PMA surveys:

What I liked least was that its coverage did not take into account the whole country and the very low or non-existent involvement of the Congolese government in its funding. [QX-DRC]

Given the current challenges facing global health, it might be difficult for the local players to fund data collection initiatives. However, sustained advocacy targeting

> *government institutions and private sector could eventually yield results, especially at the county level where demand for localized data continues to grow. [QX-KE]*
>
> *Funding by local sources or with a combination of other donors does not look feasible at this time. [QX-NG]*

PMA sites where government officials were engaged over the long term with the design and development of surveys from the outset (e.g., Ghana, Ethiopia, Uganda, Kenya) appear to have better prospects at securing commitments of future financial support. Post PMA the Ghana team and the Ghana Health Service used the platform for an Emergency Obstetric and Newborn Care survey with partial government funding that was possible because of early direct collaboration. PMA Ethiopia presently has a five-year program funded by the Ethiopia office of the Gates Foundation that builds sustainability in technical human resources and skills capacity. Financial support in the future for the surveys from the Federal Ministry of Health may also be forthcoming. PIs for PMA Ethiopia also reported plans to establish a university-based training center on RMNCH Survey, Analytics and Translation (RSAT) which they hope to replicate in other regional universities in the country.

> *Our current priority is cultivating the next generation of experts who can run such surveys. We're doing this through short courses and postdoctoral training programs. [INT-ET]*

A regional platform model. When asked for their thoughts about pursuing a regional collaborative platform that was mutually owned and supported, PIs found the prospects appealing. A technical support unit could be established for each regional cluster. A clear benefit beyond the technical cooperation would be measuring core indicators in a standardized manner and having multi-country comparability. Another benefit of a platform cluster would be to serve

the Francophonic SSA countries as a group with linguistic homogeneity and stage of maturity in family planning data collection, measurement and reporting.[f]

> *Cross-country collaboration is essential as part of South-to-South capacity building. We believe countries bring diverse strengths, skills, and institutional capacities that can be leveraged through strategic cross-border partnerships. Joint evidence and knowledge-sharing platforms modeled after frameworks … can enable countries to share data, harmonize methodologies, and attract additional partners working in health data systems. Establishing a shared survey platform offers multiple benefits, including reduced maintenance costs, streamlined staffing, and enhanced standardization across countries. Integrating the PMA platform into existing regional economic blocks could unlock new funding opportunities and facilitate coordinated, synchronized data collection across member states. If well-positioned and politically supported, such regional collaboration can foster sustainability, local ownership, and greater policy impact across participating countries. [QX-KE]*

At the same time, the PIs were concerned that efforts to build local ownership and engage with government officials at the national and subnational levels would likely be compromised if current attention and energies were re-directed to building regional partnerships. Thus, while the regional cooperation concept was received positively, in practical terms few PIs could easily envision or embrace its materialization.

Future sources of FP indicator measurement. At present, the future of FP indicator measurement is anything but certain, at least in 10 of the 11 countries participating in the PMA program.[g] When queried about where such data is likely to be obtained going forward, most reported being unsure. India and Indonesia have strong ongoing government survey programs. In India the National Family Health Survey, primarily funded by the Government of India, conducted its sixth round (2023-24) although the results have not yet been publicly released. As noted above, Ethiopia PMA will proceed with foundation support over the coming five years. As noted

[f] PMA's global team had identified ISSP in Burkina Faso to provide assistance to the other Francophonic PMA teams in Niger and Côte d'Ivoire (PMA DRC having sufficient capacity), which it did although extra financial support was not built into its contract.

[g] Some countries with pending completion of DHS surveys/reports will be covered by bridge funding from BMGF. However, whether funding will rise to adequate levels in the future is unclear.

earlier, the Indonesian government recently reorganized its data collection authorizations and BKKBN (the National Family Planning Board) no longer conducts its annual family welfare surveys in which family planning data was collected. The DR Congo's PMA team completed its final round in 2024 but just in Kinshasa province and sees no clear path to future FP measurement in the country. The most common response has been that the health ministries will be relying on client statistics from the health management information system (HMIS). HMIS data covers primarily the use of public sector services, while the largely unmonitored private sector's role in delivering contraceptive and other SRH commodities has been growing quickly. The PIs' responses indicated that each country was having to chart its own path to replacing survey-generated FP data.

The PIs' recommendations for future PMA-like surveys are provided in Appendix 3. They noted that the design of national data collection should take into consideration the need for subnational estimates to follow state governance lines of authority. This is especially important in decentralized countries where states, provinces or districts can develop their own policies and programs and make budget decisions.

Disruptive endings. Although it was hoped PMA grant funding would be renewed and all country partners were aware that the final data collection rounds were looming. This did not make the eventual terminations any less jarring. Because of the time needed to introduce and build the PMA program's reputation as a reliable source for family planning data, terminations occurred when the country teams were gaining traction in establishing PMA's credibility and record. The PI comment below was echoed by other PIs.

> *The only concern that emerged was its discontinuation at the stage when it was achieving its high potential and popularity among local stakeholders. … The Government of Rajasthan's Health Secretary also sent an official request to the global PMA team to continue the project. … the Government program directors of nutrition and reproductive*

health indicated their interest in using the PMA platform…but this could not materialize due to the requirement of funds. [QX-IN]

Early shifts in PMA sponsorship of country sites were particularly disappointing to affected teams, leaving them feeling a breach of trust in their relationships with GI/PMA and donors.

Certainly, my lowest point was when Ghana was dropped from the PMA membership without a well-thought-out disengagement plan. Considering the fact that Team Ghana risked taking on the proof of concept without external funding—if the cake was now good to eat--then it was unfair to have treated Ghana that way. [QX-GH]

The decision limiting PMA surveys to [two states, down from seven] was a hard knock on the growing impact of the project, especially at a time when stakeholders were asking for expansion to more states. [QX-NG]

Discussion

The collective history of the global family planning and reproductive, sexual and family health fields is one that is heavily dependent on monitoring progress at the individual population level by conducting national, large-scale household surveys funded primarily by international donors.[18] Transitioning out of household surveys will require due diligence to improve the coverage, quality, and completeness of national HMIS data on FP measures to ensure quality and accuracy.

This study has focused on the perspectives of the PMA PIs, as key informants, in implementing the program, bringing credible data to in-country government and non-governmental decision-makers. Their knowledge, experiences and voices in guiding future decisions about health data measurement are an all-important source of local intelligence. The commentaries of PMA PIs reflect their acquired status as trusted data producers, who succeeded in integrating PMA findings into the fabric of national health statistics. Able to implement PMA surveys autonomously, with GI/PMA technical oversight from a distance, the PIs shared how they adapted innovative survey technologies for rapid data collection and processing, interacted with dispersed networks of hundreds of resident enumerators, and engaged with government and non-government partners around data of common interest to foster program accountability. They

reported on producing actionable results to support program planning, disseminating results to district and national stakeholders who could explain when expected changes did or did not materialize. These insights into data-informed systemic and sustainable changes are invaluable for global health monitoring purposes.

The efforts of the PMA PIs achieved the survey program's main objective, to generate data to monitor family planning indicator trends and use dynamics annually. The PIs in all 11 sites report now having enduring capacity, with many able to implement non-FP surveys independent of GI/PMA support. As one PI stated,

> *If we are able to demonstrate as we have done in the past, that the PMA platform is capable of providing high quality data with a quick turnaround time, at economically viable costs, we stand a good chance of being the preferred destination for funding. [QX-GH]*

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Appendix 1

Questions to PMA PIs

1. Please tell me about your experience as a PMA PI – what you enjoyed the most, what you disliked.
2. If resources had been available, would you have wanted to continue as a PMA PI? For how long?
3. From your perspective as PI, was the annual frequency of the surveys too often, not often enough, on just the right frequency? How did your country government representatives feel about the cadence of survey results received?
4. What would you change about the PMA surveys, e.g., questionnaire length, content, respondent sample, training, etc.
5. Did you feel the government and non-government audiences for PMA data were genuinely interested in the results? Why? Have any partners expressed disappointment in the discontinuation of PMA? What are they doing to fill the information gap, if anything?
    - Could you give us one or two specific instances where PMA data was used to inform national policies and programs?
6. Were you approached by other partners to use the PMA platform for other data gathering purposes? For what areas? Did any of these additional uses of the platform materialize?
7. Do you feel the PMA data have been adequately analyzed by researchers in your own country?
8. What circumstances would be necessary for the PMA survey platform to be funded by local sources? Or a combination of other donors and local sources?
9. Outside of survey procedures, what would you recommend for the future of PMA? How can it be improved?
10. Would cross-country collaboration between teams be useful, for example, opportunities for collaboration between country teams to maintain household data collection capacity and evidence sharing? What specific mechanisms, if any, do you recommend (regional consortia, cost sharing survey components or other shared platform elements)?
11. Have you been involved with the DHS or MICS surveys? If so, please share what experiences and what you learned from PMA, DHS or MICS that should be considered in any future national household survey design.
    - Are you aware that the DHS program has been discontinued for now due to loss of USAID funding?

Appendix 2

PI responses (verbatim) to question, "Could you give us one or two specific instances where PMA data was used to inform national policies and programs?"	
PMA DR Congo	Yes, many of the DRC's partners (UNFPA, CTMP as a whole) and government structures (PNSR, PNSA, academic institutions and others) regretted the cessation of funding for PMA. UNFPA had even made a commitment to contribute to PMA: we received $25,000 in 2023 and in 2025, we are still waiting for another sum which should go through the PNSR PTA according to UNFPA. PMA data are used by the PNSR and PNSA to write their strategic plans.
PMA Indonesia	I was PI for PMA 2020 for the first and second cycles only. Following cycles the survey was conducted by BKKBN and funded by them. The questionnaire was added to the issues of family welfare. The FP results were used by BKKBN for policy and program.
PMA Nigeria/Lagos	Yes, I feel the audiences for PMA data were genuinely interested in the results of the surveys because they admitted as much. Furthermore, in Lagos state where I oversaw data collection for PMA Phases 1-4, government officials used PMA data as a guide in decision making. I am told they often referred to the PMA power point slides, briefs and key indicator reports during high level meetings to make decisions.
PMA Nigeria/Kano	The government and other stakeholders were interested in PMA results. The indicators were being used for FP costed implementation plans in all the PMA states and stakeholders were asking for PMA surveys in more states to fully accommodate Nigeria's size and diversity. The PMA experience in Nigeria had more impact until the number of states was reduced from seven to two by the Foundation. This decision limiting PMA surveys to Lagos and Kano was a hard knock on the growing impact of the project, especially at a time when stakeholders were asking for expansion to more states.
PMA Ethiopia	The Ministry of Health has been utilizing PMA Ethiopia data for many years, and its relevance continues to grow. Currently, PMA is referenced in several key strategic documents, including the Health Sector Development Investment Plan (HSDIP) and Ethiopia's FP2030 Government Commitments, among others. PMA data highlighted a decline in the quality of family planning counseling, which led the FMoH to develop and implement a corrective intervention in 2019. This intervention effectively reversed the downward trend.
	Numerous non-governmental stakeholders have also emphasized the critical role PMA data plays in their day-to-day operations and donor engagements. Notably, Engender Health recently employed PMA data to identify high-volume facilities for their project aimed at enhancing service delivery and capacity to meet the demand for family planning services.
PMA Ghana	PMA data have provided evidence for family planning policies – promotion of LARCs among adolescents, diversification of the family method mix in Ghana, and task sharing in contraceptive provision.
PMA Uganda	Yes. As indicated above, there has been genuine yearning for annual data from PMA, and disseminations are well attended with good engagements. The results are accepted even when they do show challenges in progress to the targets. We have had many partners concerned about the discontinuation of PMA. Right from 2023 when we did not have a survey round, there were questions in the fora that we attend as PMA PIs (like the self-care expert group, and the Family planning Technical working group), about whether there would be findings for that year. It was welcome news to know that we had the 2024 survey conducted with the support from CIFF coming in handy. Unfortunately, as noted above, there is no financial commitment locally to fill the gap that PMA leaves.
	We have the National family planning costed implementation plans (I and II). These have used the mCPR from PMA to show baseline and set targets. The FP 2030 targets for Uganda are partly based on the PMA data.
	We have also the Uganda national population policy 2020 that the then director of national population council did acknowledge was accepted by the president after presenting a key slide on age at reproductive events form the PMA surveys.

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PMA Uganda (cont'd)	Data from PMA has been used in program and policy documentation as provided below, and the PMA team has been recognized by the Ministry of health, appointing the PMA Uganda investigators to various technical working groups, and National Steering committees. These include the Family Planning TWG, the National Steering committee to develop Uganda FP2030 commitments, the National Self-care Expert Group, and Equity steering committee. In these fora, when there is need for current data, the team has provided these from the annual PMA data results. Some partners, especially UNFPA has asked us to conduct secondary data analyses from the PMA data and other sources to address knowledge gaps. So far three areas have been flagged include increasing use of traditional methods, EC, women empowerment and unintended pregnancies. The PMA structure is increasingly being used to support several researchers; stakeholders have been impressed by the technical skills in designing, implementation and stakeholder engagements, skilled interviewers etc...
	The Ministry of Health has used and continue to use data from multiple rounds of PMA surveys to develop and contribute to key family planning policy and program goals for National Costed Implementation Plans (CIP), 2015-2020 and CIP II 2020-2025. Both CIPs use base indicators on mCPR from PMA. The Ministry of Health have been able to monitor at national level the new mode of delivery of Depo provera, through subcutaneous injection (Sayana Press), which has become more popular in the last 3 years of monitoring. PMA surveys are the only national level surveys that monitor DMPA-SC and self-injection. Contributing to understanding preferences and helping adjust to the demands of contraceptive users, and guide policy and programming especially identifying settings with inequitable access to these new products
PMA Niger	Yes, because they always come in large numbers to the results dissemination workshop at each phase. In addition, they use them in their annual programming and monitoring documents.
PMA Cote d'Ivoire	TRACK 20 uses PMA data for CPR estimates. The PMA research platform's indicators were used to develop Côte d'Ivoire's National Health Development Plan (NHDP) for the period 2021–2025.
PMA India	The local government was interested in PMA survey, and was keen for its continuation for a longer duration. They referred to the survey results in PIP, and discussed in several planning and implementation meetings. The government also sent official request to the global PMA team (letter by the health secretary, Government of Rajasthan) to continue the project.
PMA Burkina Faso	PMA data used to set target for National Health Plan (2013 - 2015, then 2016 - 2020) and for the specific National FP Plan (2021 - 2025) All the figures for prevalence against the targets to be achieved in the three plans come from PMA The second element that had never been seen before was that PMA data appears in the Ministry of Health's statistical yearbook. Previously the Ministry only included in its statistical yearbook the data it collected itself, but for three years in a row, until the end of the PMAs. Now PMA indicators have a prominent place in the report, and PMA is cited. Also, the data collection tool that the Ministry of Food and Health uses. They also used that to conduct what they called national consensus workshops on health indicators, and there too, PMA was invited to actually deliver the latest indicators on the subject so that they could use them to truly build all the national reproductive health indicators Multiple government seminars / workshops use PMA data as a basis for discussion. This is the case, for example, of our data on Covid-19 that we collected within the framework of the PMA.
PMA Kenya	Family Planning Costed Implementation Plan (FP-CIP). Several counties in Kenya used PMA data to develop/review their plans, as well as the national FP-CIP for 2021-2025.
	PMA data were used for commodity quantification at the national level and in county level several programs E4A-Mamaye, TCI) used the data to advocate for FP commodity budget allocations.

Appendix 3

The PIs reflected on the PMA platform and recommended future surveys take the following design elements into account.

- Adopt a modular approach conducted annually, with a core module for a limited set of key indicators
- Allow content for other modules to be appended in quarterly or semi-annual rounds
- Build in a male respondent sample to monitor male health, partner relationships, and family health roles
- Retain longitudinal panels to understand dynamics of change
- Secure in-country and external commitments of funding from the beginning and for at least a ten-year period
- Strengthen South-South collaboration around core content and using regional clusters (geographically and/or linguistically grouped)
- Support and expand analytic training at regional universities or research institutes to build the next generation of data scientists for development monitoring.