



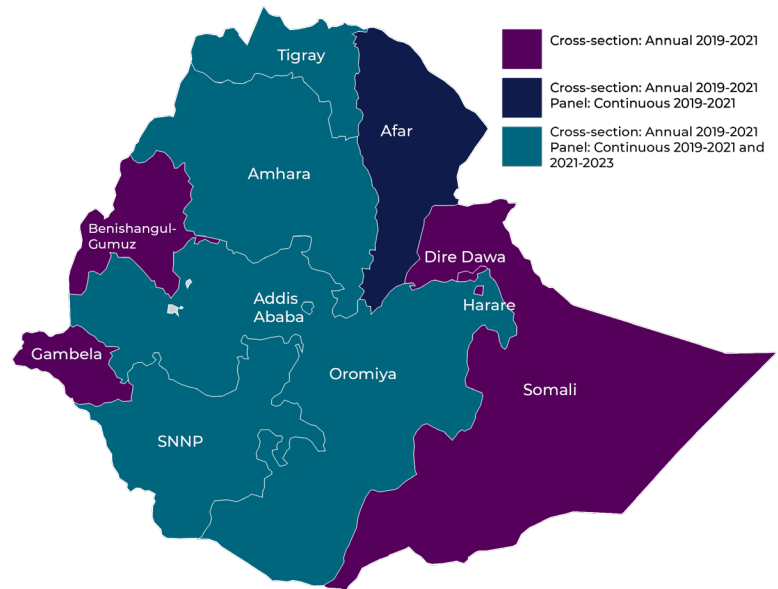
PMA ETHIOPIA: Guidance for Collaboration

June 2019



PMA Ethiopia Sample Design

Cross-sectional data are collected annually in all regions. Longitudinal data (following pregnant women through one year postpartum) are collected in two cohorts of women (2019-2021 and 2021-2023) in four large, predominantly agrarian regions: Tigray, Oromiya, Amhara, and Southern Nations, Nationalities, and Peoples' Region, and one urban region, Addis Ababa. Afar is included in the first cohort (2019-2021) of the longitudinal survey. Service delivery point data will be collected annually in all regions from 2019-2021 and in panel regions only in 2022. Survey data are collected from randomly selected areas throughout the country to provide representative estimates of key indicators at the national and sub-national level.



Due to the scope and size of the PMA Ethiopia project, we anticipate that collaborations will develop with interested parties over time. To facilitate discussion about collaboration, we encourage potential collaborators to review the questions below and develop responses to the extent possible prior to initial discussions. These questions will be necessary to answer during the collaboration process.

Who is the stakeholder and how will the data be used?

PMA-Ethiopia is committed to collecting actionable data that will inform policy and programs and/or improve measurement of key indicators already being collected in Ethiopia. Data collection activities must have identified stakeholders in Ethiopia, ideally within the Federal Ministry of Health or other key agencies, with an interest in using the data or supporting its collection.

Are the key indicators defined?

Who is the target population?

(e.g. all women age 15-49, all facilities offering FP services)

If the indicator includes language such as “comprehensive”, “adequate”, “high-quality”, “availability” etc., how is this language defined?

What is the level of representation needed (national/ sub-national)?



Collaborations with clearly identified stakeholders, measurable indicators with a focus on reproductive, maternal, and newborn care, and a plan for data use and dissemination will be prioritized.

Can the indicators be measured or the research question answered with the current sample size and design?

If not, what modifications are necessary? Costs will be higher if modifications to the sample are required (e.g. including measurement for very young adolescents age 10-14, inclusion of males, observational components of service delivery). The current sample size is approximately:

- Annual cross-sectional estimates of all women age 15-49 nationally - approx. **8250** women
- Panel estimates of pregnant women through 1 year postpartum (six regions) - approx. **3500** women
- Annual service delivery point survey of public and private health facilities – approx. **500**

How often does the indicator need to be measured?

- Is the indicator likely to change within a year? Two years?
- Is it necessary to gather information at multiple time points among the same women or facilities?

Who is responsible for analysis and dissemination?

- Are resources available to support analysis and communication materials development?
- What are the preferred final communication products (journal article, technical report, brief)
- Can data be made publicly available?

For organizations that are interested in further discussion, please contact:

- Linnea Zimmerman (linnea.zimmerman@jhu.edu)
- Solomon Shiferaw (solomonshiferaw@gmail.com)
- Assefa Seme (assefaseme@gmail.com)
- Selamawit Desta (sdesta@jhu.edu)