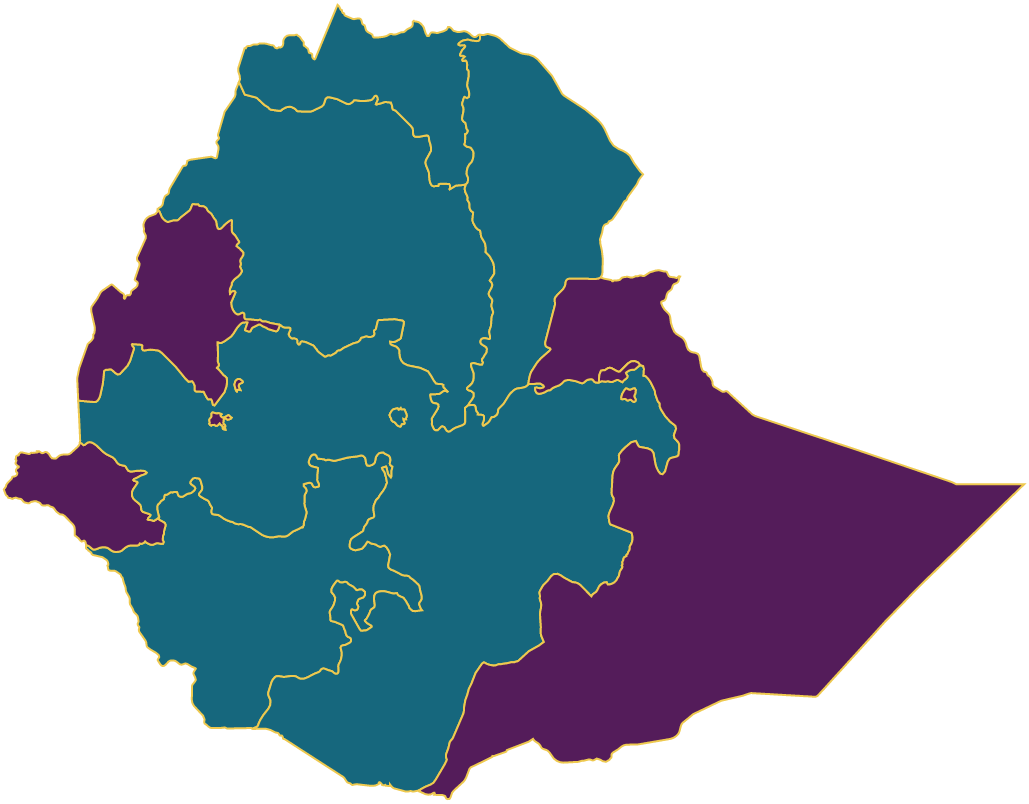
PMA ETHIOPIA

PERFORMANCE MONITORING FOR ACTION

Regional Results Brief, 2019



ADDIS ABABA UNIVERSITY

MINISTRY OF HEALTH-ETHIOPIA

CSA

ETHIOPIAN PUBLIC HEALTH ASSOCIATION

JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

BILL & MELINDA GATES INSTITUTE for POPULATION and REPRODUCTIVE HEALTH

PMA ETHIOPIA
PERFORMANCE MONITORING FOR ACTION

ABOUT PMA ETHIOPIA

Performance Monitoring for Action Ethiopia (PMA Ethiopia) builds on the previous success of PMA2020/Ethiopia and PMA Maternal and Newborn Health study in the Southern Nations, Nationalities and Peoples Region (SNNPR).

PMA Ethiopia is a five-year survey project 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 to fill a data gap—collecting information not currently measured by other large-scale surveys with a focus on measuring RMNH comprehensiveness of care services, and the barriers and facilitators to such care. PMA Ethiopia uses mobile technology and a network of trained female resident enumerators (data collectors) to collect data.

Survey implementation is managed by Addis Ababa University, School of Public Health (AAU/SPH) in collaboration with regional universities, the Federal Ministry of Health and the Central Statistics Agency. Technical support is provided by the Bill and Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health. The grant is managed by the Ethiopian Public Health Association (EPHA). Funding is provided by the Bill & Melinda Gates Foundation.

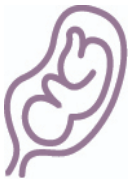
UNIQUE FEATURES OF PMA ETHIOPIA

- Designed to track annual progress and provide more information on why trends are occurring
- Offers stakeholders and program implementers important insights on contraceptive user dynamics and allows data users to track against progress towards select Sustainable Development Goals
- Gathers additional information on contraceptive attitudes, reproductive coercion, partner preferences and other innovative and important measures not captured in other surveys

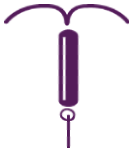
PMA ETHIOPIA
PERFORMANCE MONITORING FOR ACTION

ABOUT PMA ETHIOPIA

PMA Ethiopia is a nationally representative survey measuring key reproductive, maternal, and newborn health (RMNH) indicators, including:



Antenatal Care (ANC)



Family Planning (FP)

Reproductive empowerment, fertility intention, and community norms

Health facility readiness and quality of care

Cross-section and health facility data collection took place between October 2019 and December 2019, from 9,108 households (99% completion rate), 8,827 women in the cross-sectional survey (98.4% completion rate), and 800 facilities (98% completion rate). For the longitudinal survey, a total of 32,791 women were screened for eligibility. The screening process identified 2,898 women as eligible to be enrolled in the panel survey, and, of these, 2,893 consented to participate in the survey (99.8% enrollment rate).

Cross-sectional data, including a health facility based survey, 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 (SNNPR), and one urban region, Addis Ababa. Afar is included in the first cohort (2019-2021) of the longitudinal survey.

This report includes results from data collected in six regions from three different surveys:

SDP SURVEY

The Service Delivery Point (SDP) survey provides health system trends annually. It includes all levels of public health facilities (health posts, health centers and hospitals) that serve each data collection area, in addition to up to 3 private health facilities within the kebele.

PANEL SURVEY

Field staff completed a census of all households in the enumeration areas. The census was used to identify and enroll currently pregnant or recently postpartum women (<8 weeks). Field staff conduct interviews at enrollment and at 6 weeks, 6 months, and 1 year postpartum. Results in this report are from currently pregnant women at enrollment.

CROSS-SECTION SURVEY

A listing frame was created from the census or listing activity and from this list, field staff select 35 households in each data collection area. In each of the 35 households, data collectors administer a household questionnaire and a female questionnaire of all women aged 15-49 in those households.

For sampling information and full datasets, visit www.pmadata.org/countries/ethiopia.

PMA|ETHIOPIA
PERFORMANCE MONITORING FOR ACTION

OVERALL KEY FINDINGS SUMMARY

The report presents a summary of key findings from the PMA Ethiopia 2019 survey, focusing primarily on regional-level results. Below is an overview of the results from the cross-sectional, service delivery and baseline of the longitudinal PMAET 2019 surveys.

MATERNAL HEALTH

- Most women report wanting their pregnancy, but Oromiya and SNNPR show high unwanted pregnancy rates
- Early ANC remains low, with significant gaps in comprehensive ANC
- Postpartum family planning counseling needs significant improvement if it is to be impactful

FAMILY PLANNING

- PMA Ethiopia has detected increased use of long-acting methods, particularly implants
- Regional variation in key family planning indicators are also noted
- Most women have generally positive attitudes towards contraception, but a significant percentage have concerns that require improved counseling and messaging

SERVICE DELIVERY POINT

- The number of skilled personnel in health facilities trained on implant removal is improving
- Other indicators on method availability and quality of counseling declined
- Stock availability of essential medicines for labor and delivery is lower in health centers and private sector

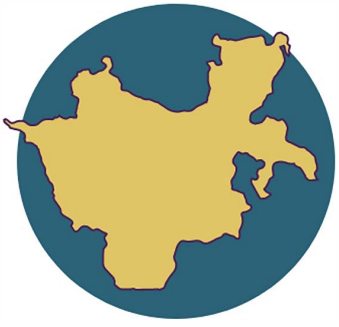
Users who are interested in viewing a more comprehensive overview of key findings for each of the following regions, as well as for overall national findings, can click the region below or visit pmadata.org/countries/ethiopia.

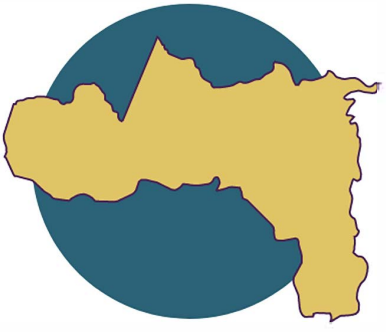

ADDIS ABABA


AFAR


AMHARA


OROMIYA


SNNPR


TIGRAY

PMA ETHIOPIA
PERFORMANCE MONITORING FOR ACTION

LIST OF INDICATORS IN BRIEF

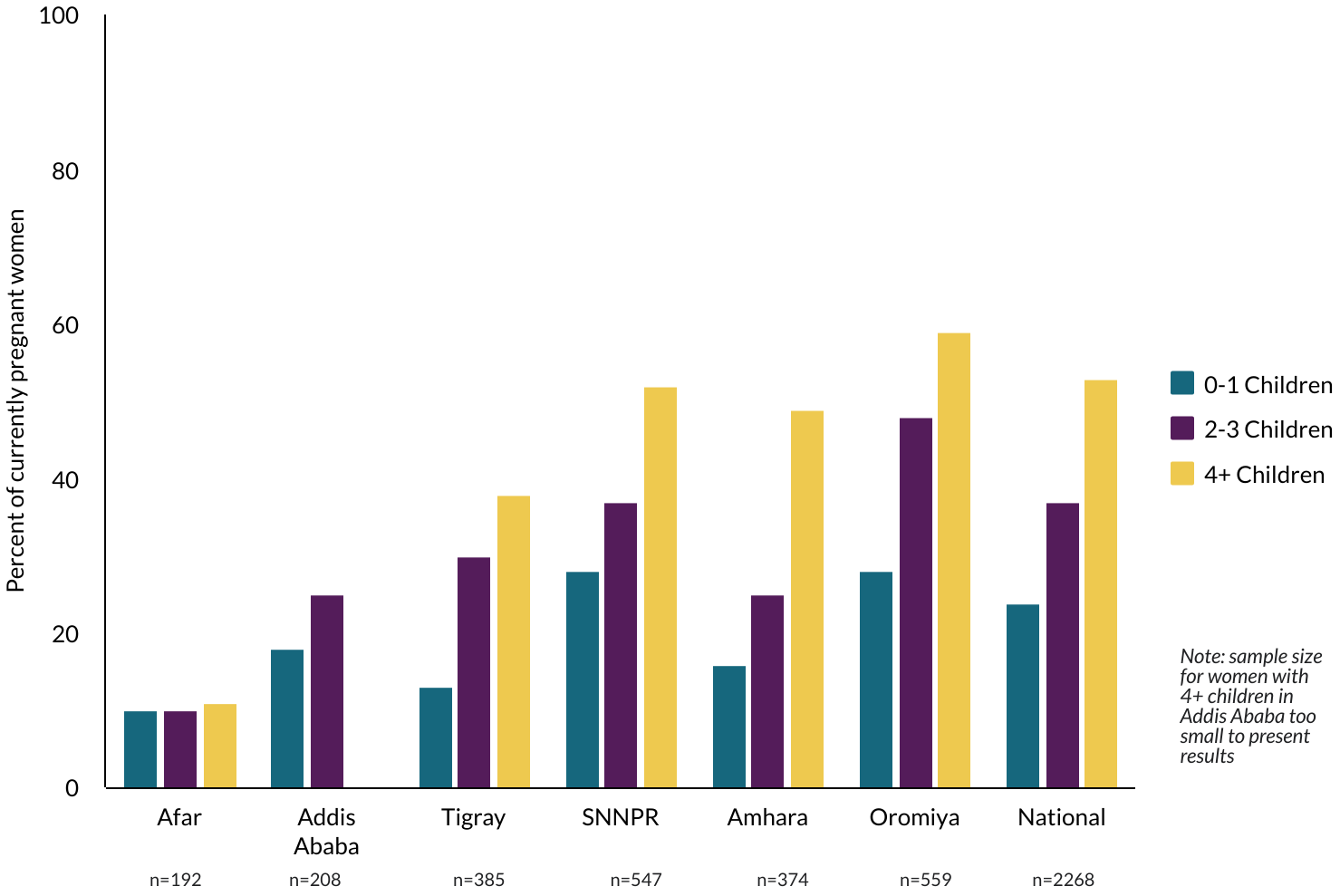
MATERNAL HEALTH

FAMILY PLANNING

SERVICE DELIVERY POINT

UNINTENDED BIRTHS

Figure 1. Percent of currently pregnant women who report wanting their current pregnancy later or not at all, by parity and region



KEY FINDINGS ON UNINTENDED PREGNANCY

- The percentage of women who did not want their current pregnancy increases with parity
- There is a missed opportunity to meet the needs of high parity women who desire to limit or further space their pregnancies
- A significant percentage of women could benefit from improved contraceptive access
- Regional variation is clear in the percentage of women who wanted their pregnancy later or not at all

ANTENATAL CARE (ANC)

Figure 2. Percent of currently pregnant women who received ANC, from any provider including Health Extension Worker (HEW), by gestational age and region

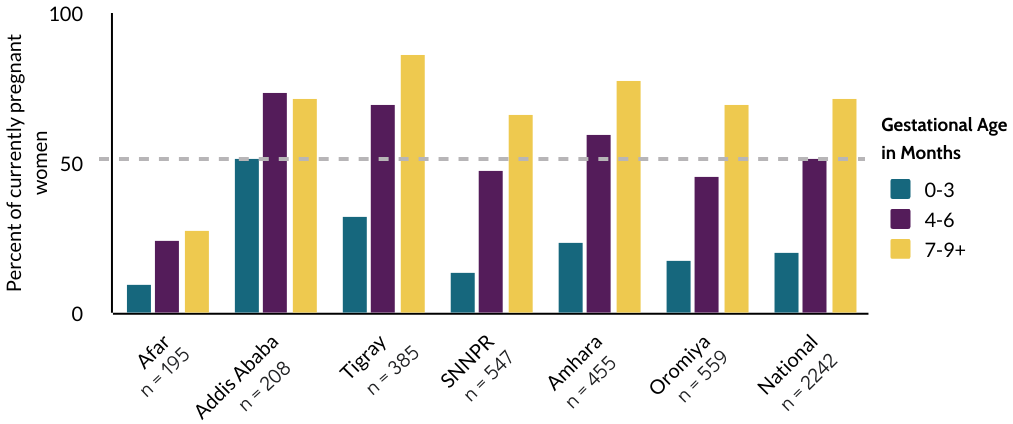


Figure 3. Percent of currently pregnant women who received blood pressure, urine, and stool test, were tested for syphilis and HIV, and took iron, by gestational age and region

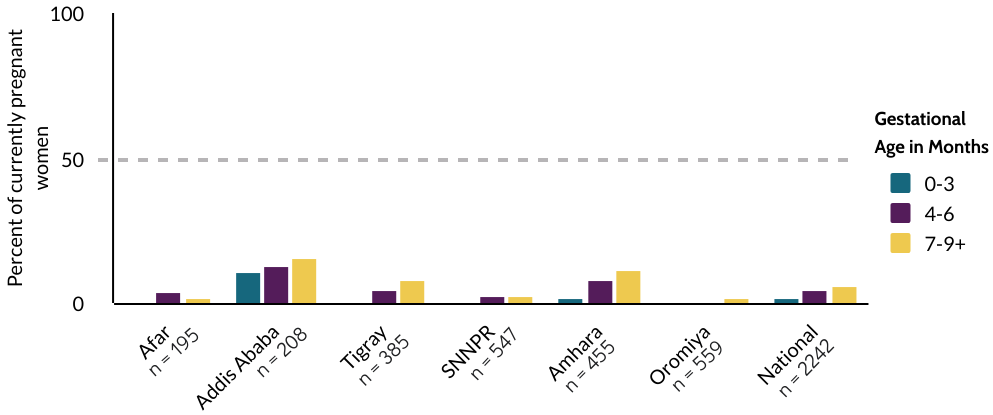
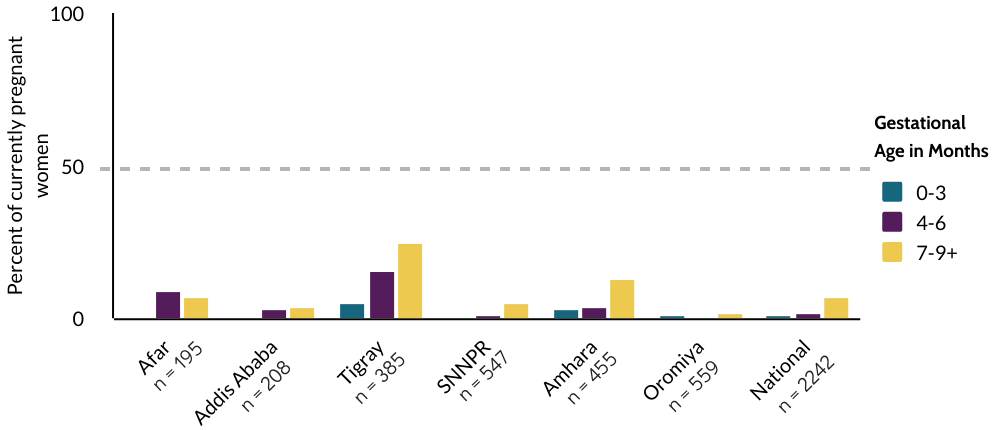


Figure 4. Percent of currently pregnant women who discussed all birth preparedness and complication readiness topics at ANC visit, by gestational age and region*



KEY FINDINGS ON ANC

- ANC coverage increases with trimester of pregnancy; early ANC is low
- 28% of women who are 7-9+ months pregnant have not received any ANC
- Fewer than 10% of women at any gestational age have received all ANC components
- Majority of pregnant women do not get counseling on birth preparedness and complication readiness through their pregnancy
- Only 16% of women 9 months pregnant reported receiving counseling on PPFP as part of ANC (data not shown)

** Topics include place of delivery, delivery by skilled birth attendant, arrangement for transport for delivery, where to go if pregnancy danger signs are experienced, and the following danger signs in pregnancy: severe headache with blurred vision, high blood pressure, edema/swelling, convulsions/fits, and bleeding before delivery.*

MODERN CONTRACEPTIVE PREVALENCE RATE (mCPR)

Figure 5. Trends in modern contraceptive prevalence rate (mCPR) among all women by region, 2014-2019

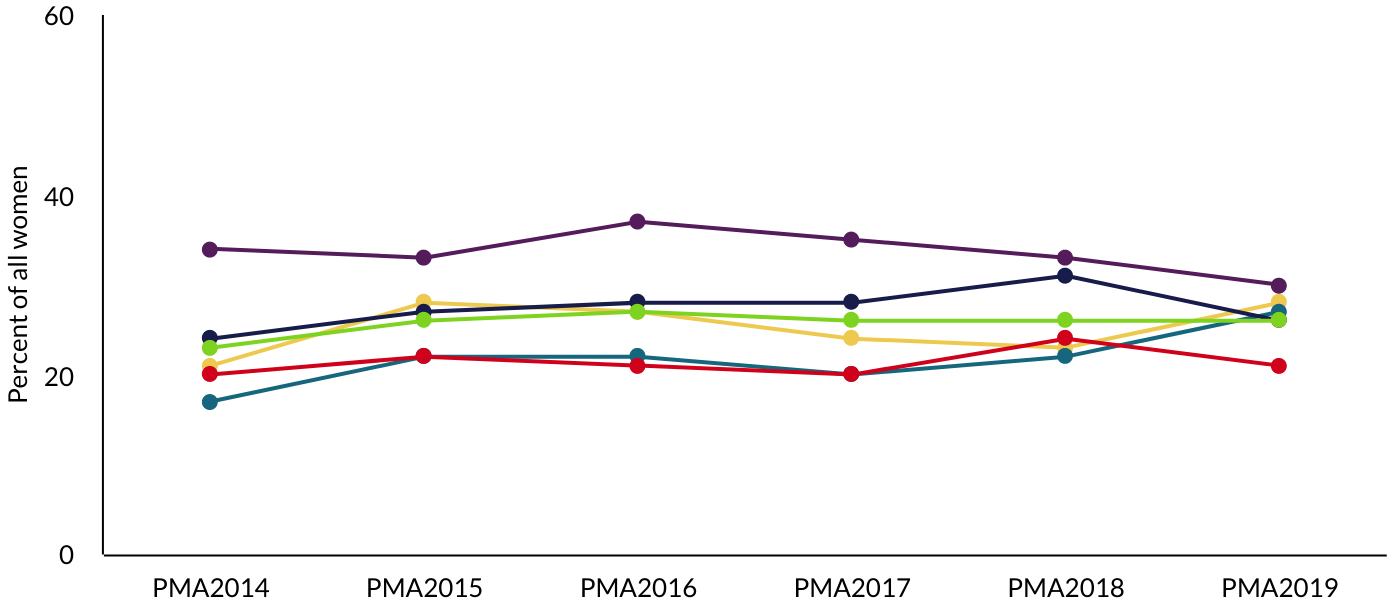
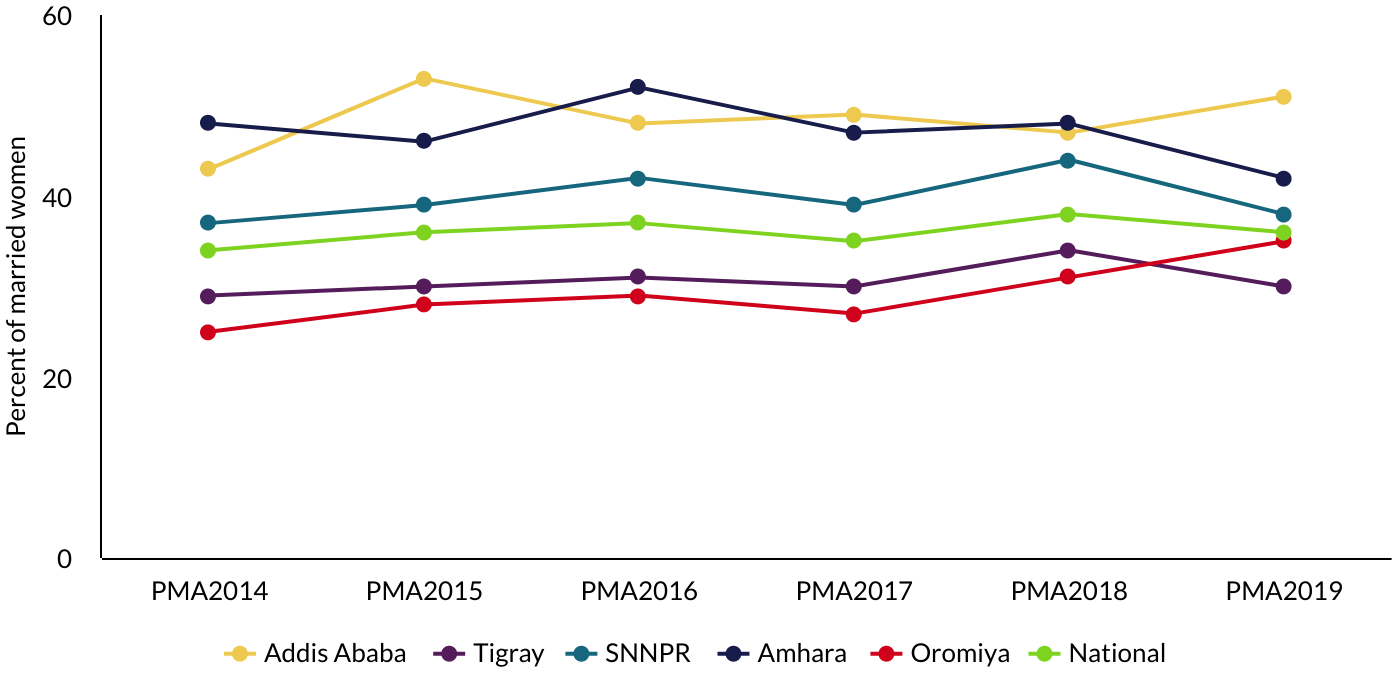


Figure 6. Trends in modern contraceptive prevalence rate (mCPR) among married women by region, 2014-2019



KEY FINDINGS ON CONTRACEPTIVE USE

- Nationally, there is a steady growth of mCPR among all women from 2014 to 2019
- No statistically significant change in mCPR among all women between 2018 and 2019
- No statistically significant change in mCPR among married women between 2018 and 2019

UNMET NEED and DEMAND SATISFIED

Figure 7. Percent of women aged 15-49 with unmet need for contraception, by region

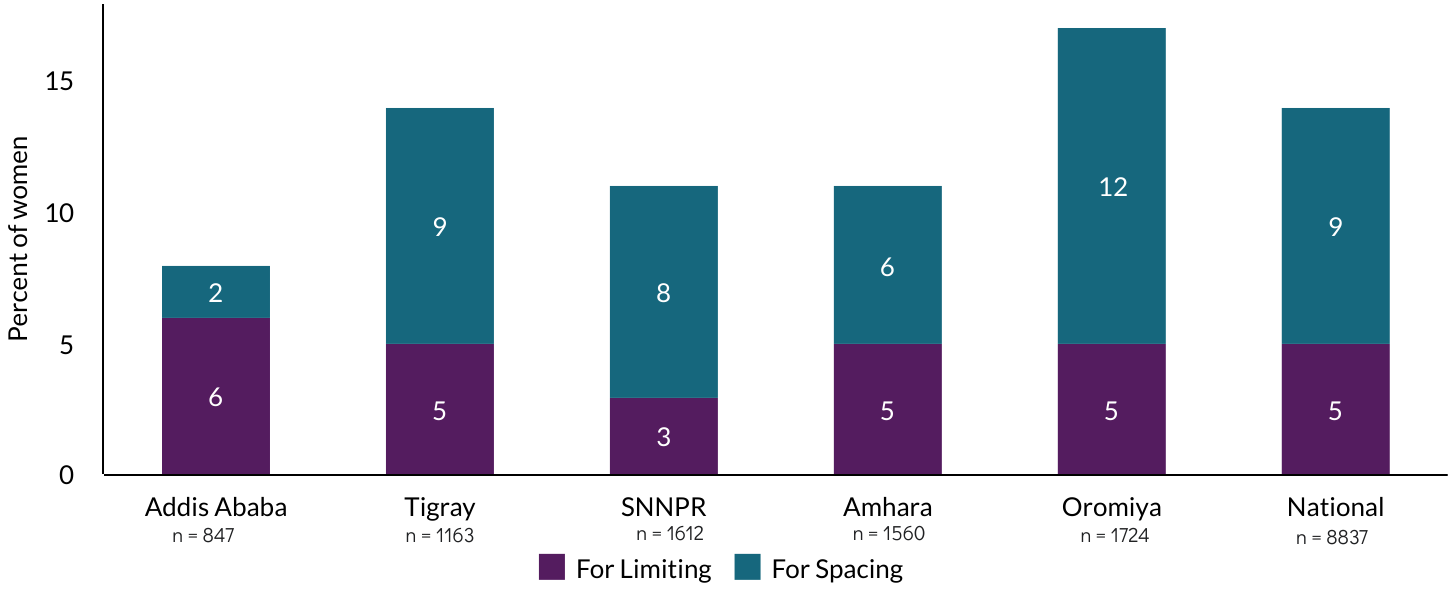
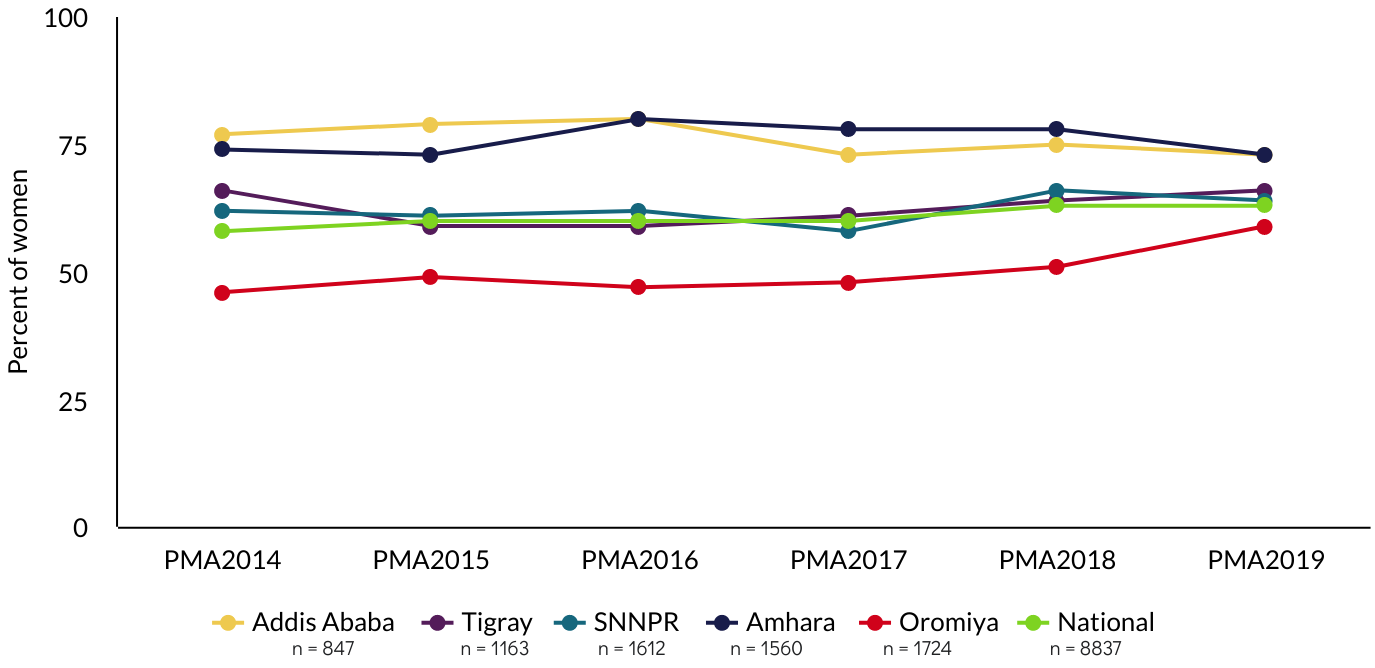


Figure 8. Trends in percent of women aged 15-49 with demand satisfied by a modern method, by region

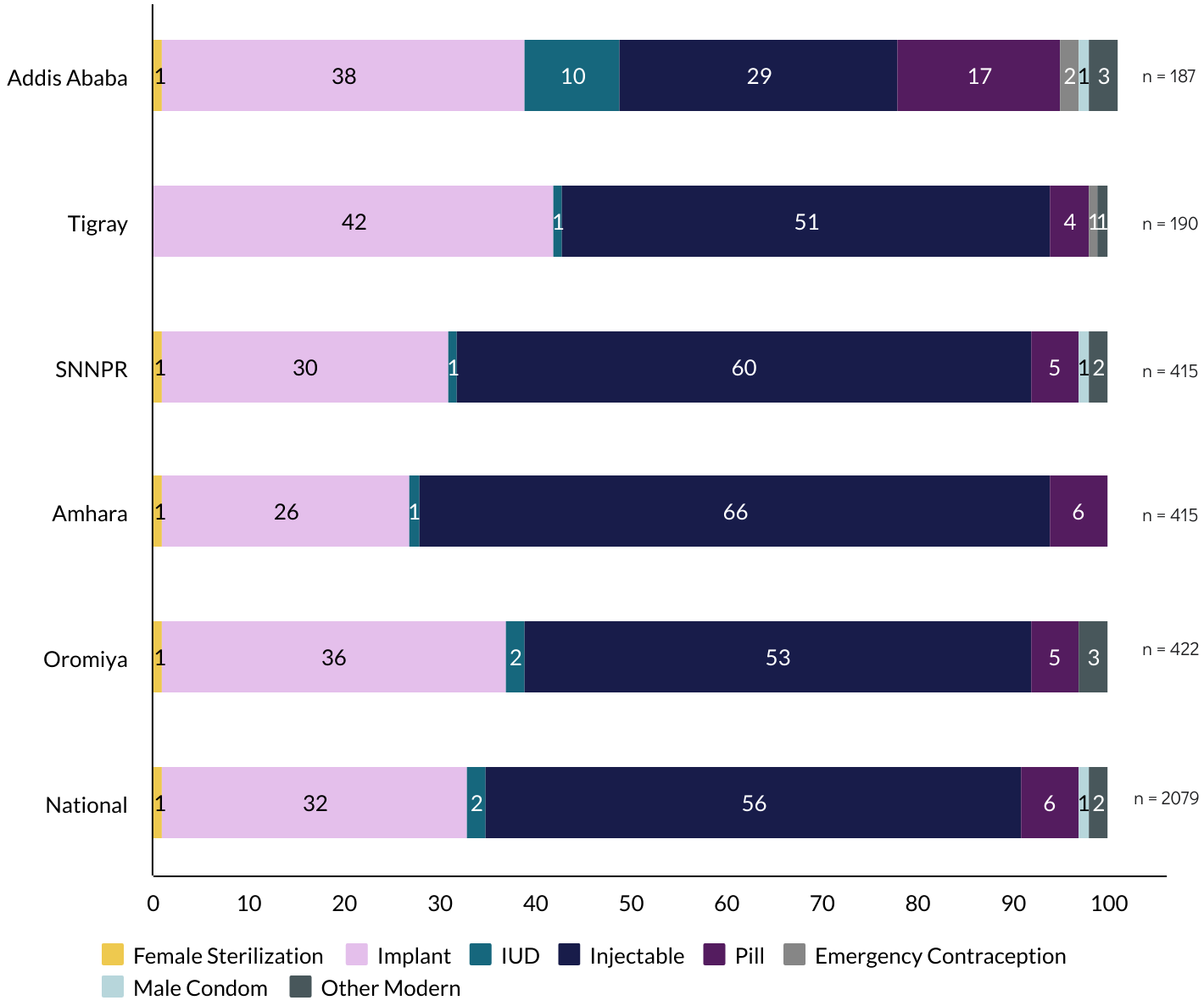


KEY FINDINGS ON UNMET NEED FOR FAMILY PLANNING

- Demand satisfied remained relatively constant between 2018 and 2019
- Oromiya has the highest level of unmet need for contraception (17%)

METHOD MIX

Figure 9. Modern contraceptive method mix among married women, by region



KEY FINDINGS ON METHOD MIX

- Method mix showed increased use of long-acting methods
- Implant use increased from 25% to 32% of the total modern method mix among married women from 2018 to 2019 (2018 data not shown)
- IUD use accounts for 10% of the modern method mix among married women in Addis Ababa

REPRODUCTIVE TIMELINES

Figure 10. Percent of women age 18-24 who experienced reproductive events by age 18, by region

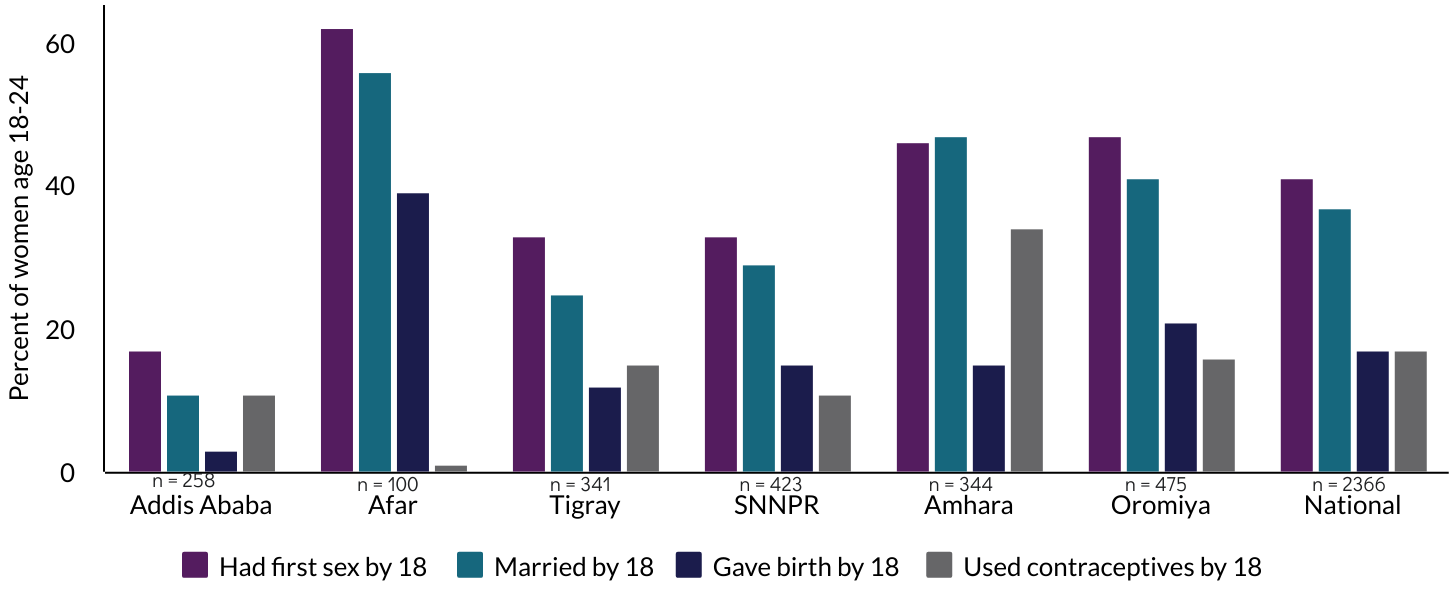
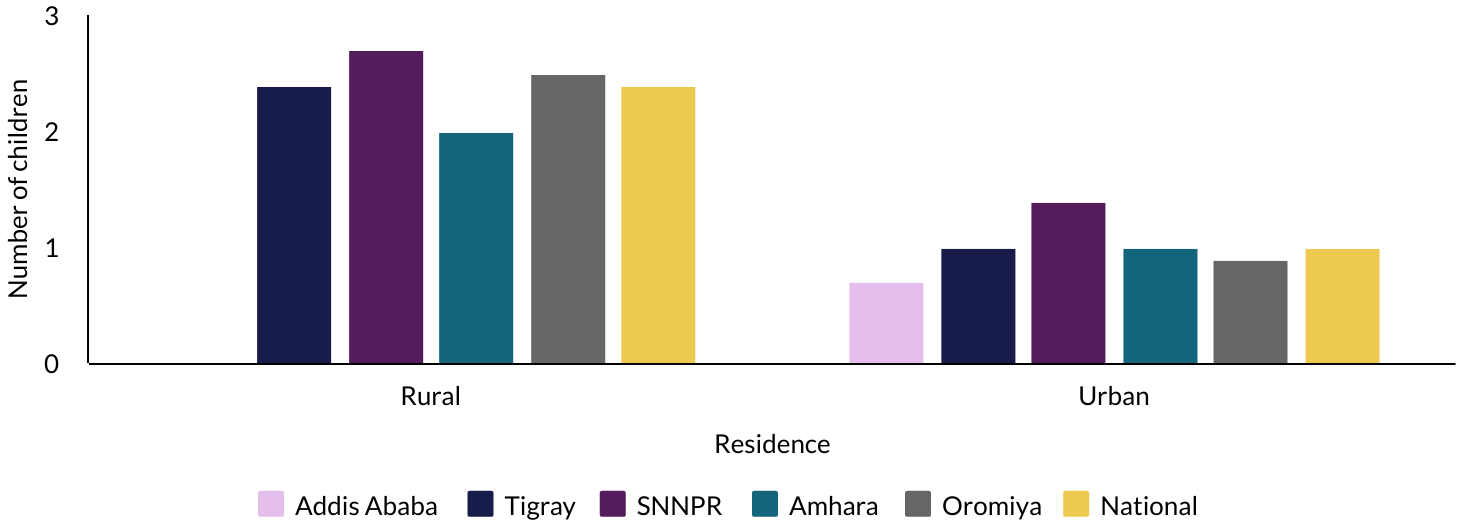


Figure 11. Mean number of children at first contraceptive use among all women who have used contraception, by residence and region



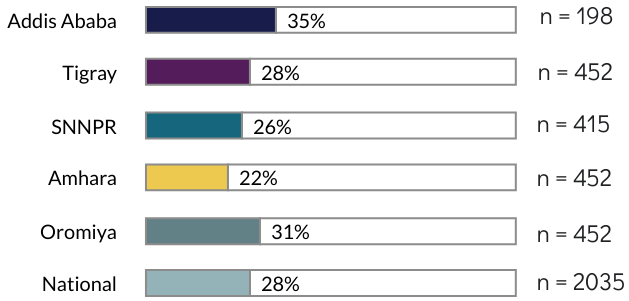
KEY FINDINGS ON REPRODCUTIVE TIMELINE

- Women in Afar, Amhara, and Oromiya start sex earlier and get married earlier than women in Addis Ababa, Tigray, and SNNPR
- Women in Amhara are more likely to begin using contraception by age 18 than women in other regions
- Across regions, on average, rural women give birth to two children before starting contraception for the first time, while urban women start contraception after their first birth

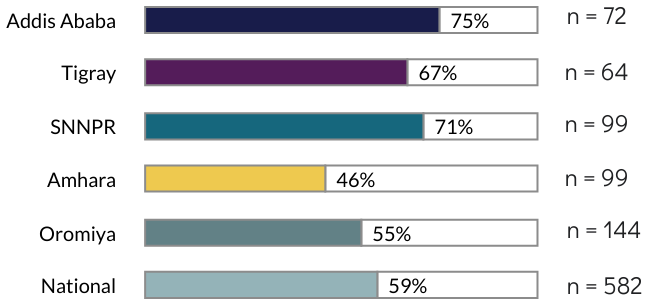
QUALITY OF FAMILY PLANNING COUNSELING

Figure 12(a-d). Percent of women who were told about side effects, what to do about side effects, of other methods, and the possibility of switching methods:

12a. When you obtained your method were you told by the provider about side effects or problems you might have?

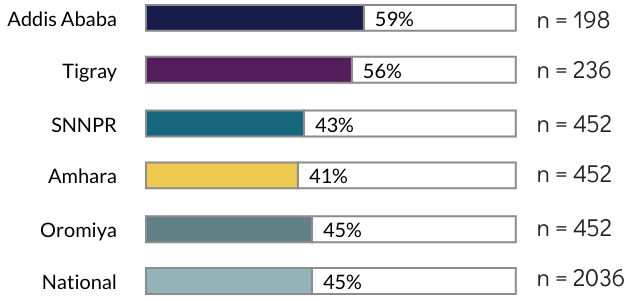


12b. Were you told what to do if you experienced side effects or problems?*

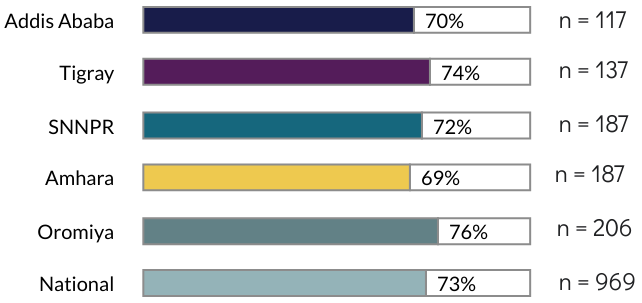


** Asked only among women who were told about all side effects*

12c. Were you told by the provider about methods of FP other than the method you received?



12d. Were you told that you could switch to a different method in the future?*



** Asked only among women who were told about other methods*

KEY FINDINGS QUALITY OF FAMILY PLANNING COUNSELING

- Fewer than one in three women are told about method side effects, and among those, only about half are told what to do if they experience side effects
- About half of women are told about other methods of family planning

WOMEN'S AND GIRLS' EMPOWERMENT INDEX

The Women's and Girls' Empowerment (WGE) Index examines existence of choice, exercise of choice, and achievement of choice domains across pregnancy, family planning, and sex outcomes in married/in union women. Presented results are only for the existence of choice domain for family planning. Scores from the family planning empowerment statements listed below were summed and divided by number of items (5) for average WGE family planning score:

- *If I use FP, my body may experience side effects that will disrupt relations with my partner.*
- *If I use FP, my children may not be born normal.*
- *There will be conflict in my relationship/marriage if I use FP.*
- *If I use FP, I may have trouble getting pregnant the next time I want to.*
- *If I use FP, my partner may seek another sexual partner.*

Range for the WGE family planning score is 1-5, with a score of 5 indicating highest empowerment.

Figure 13a. Mean WGE FP existence of choice, by education and region

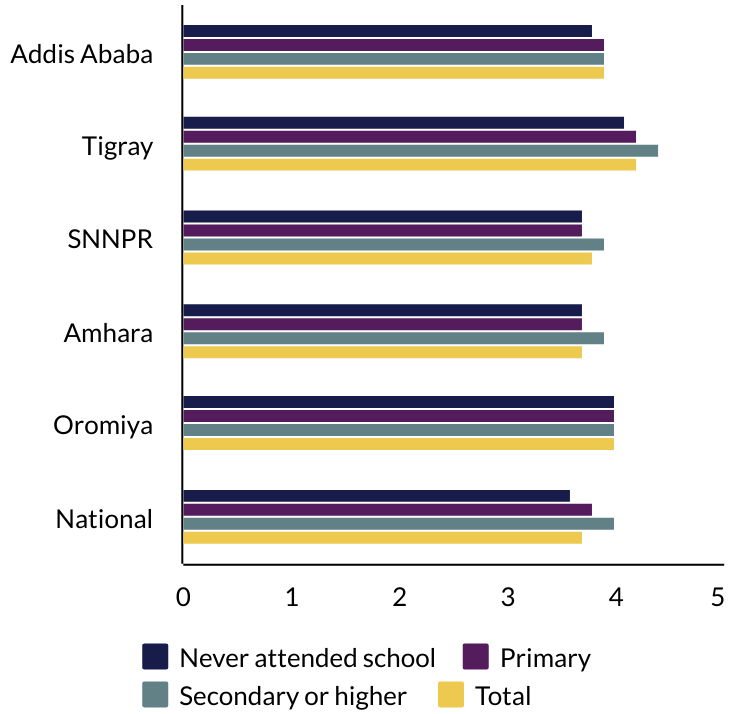
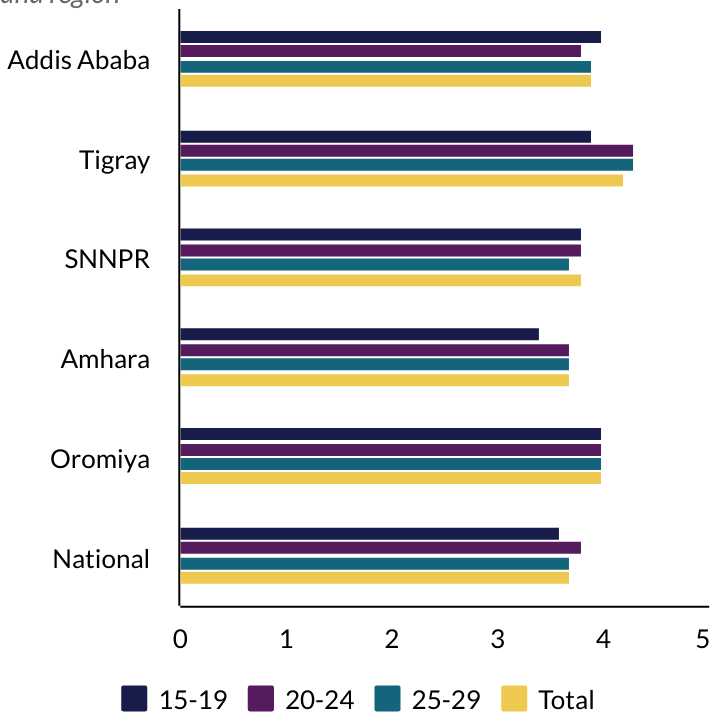


Figure 13b. Mean WGE FP existence of choice, by age and region



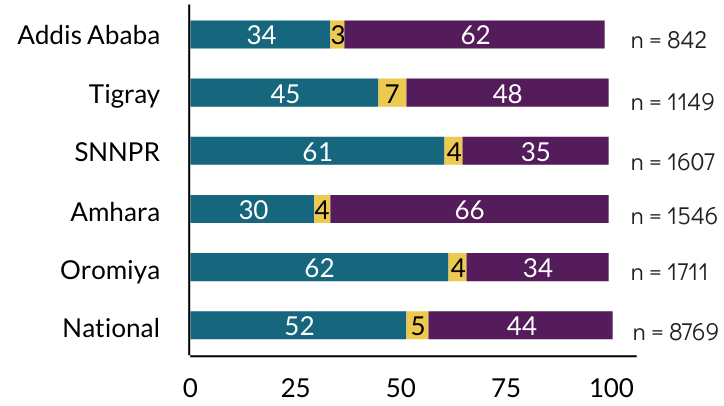
KEY FINDINGS

- Educated women report higher levels of empowerment for family planning

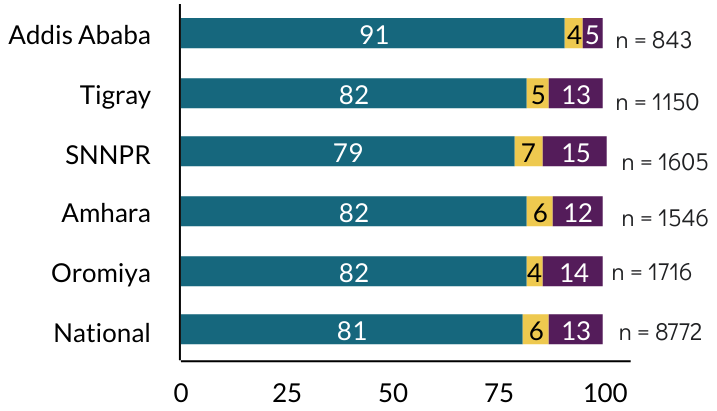
PERSONAL ATTITUDES TOWARDS CONTRACEPTION

Figure 14(a-d). Percent of women age 15-49 who personally agree with statements made about contraceptive use

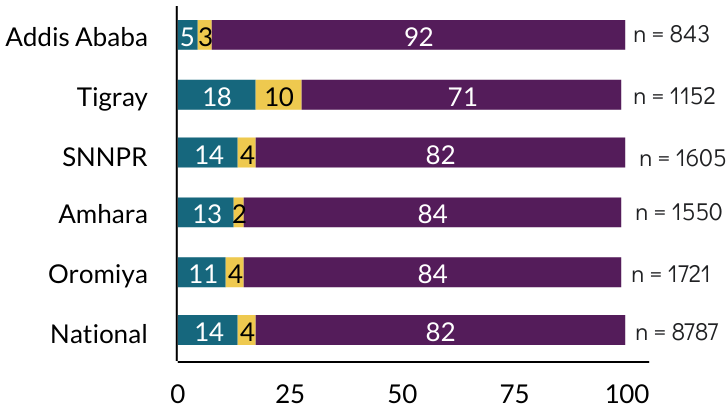
14a. "It is acceptable for a woman to use FP before she has a child."



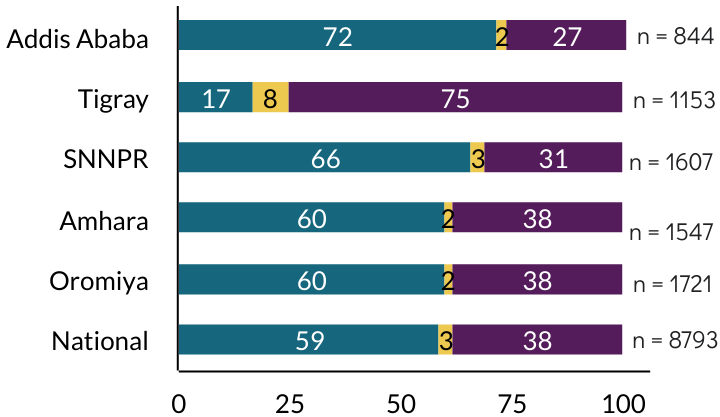
14b. "Women who use FP are considered promiscuous."



14c. "Couples who use FP are financially responsible."



14d. "Women should be the ones to decide about FP."



KEY FINDINGS

- Approximately half of women indicate that it is not acceptable for a women to use family planning before she has a child, though there is much regional variation
- About two-thirds of women disagree that women should be the ones to decide about family planning, though fewer than 1 in 5 women in Tigray disagrees

FEES FOR SERVICE AND FACILITY READINESS

Figure 15. Percent of facilities where FP clients have to pay fees to be seen by a provider even if they do not obtain family planning, by region

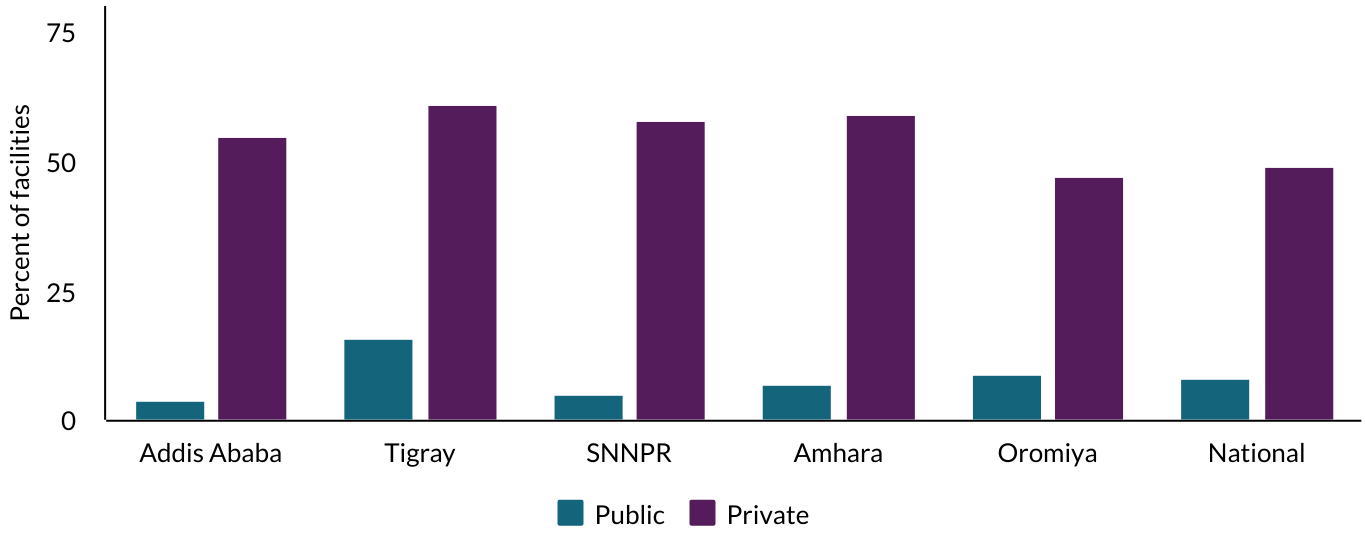


Figure 16. Percent of facilities that provide IUDs and have a trained staff member for IUD removal, by region

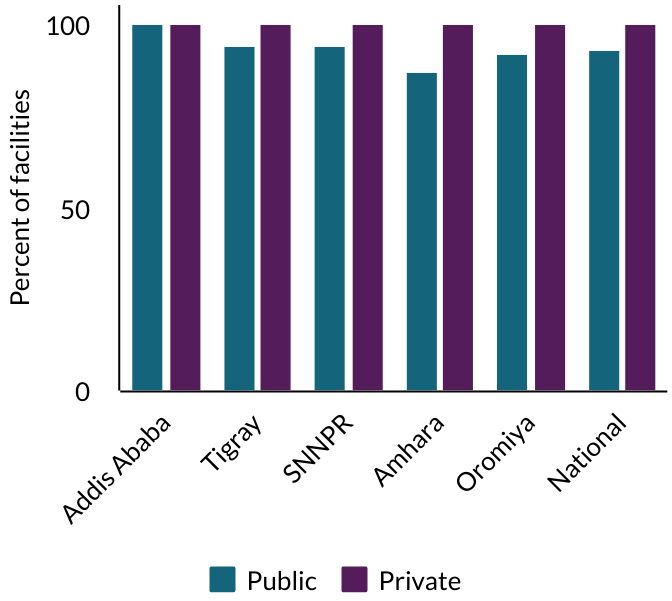
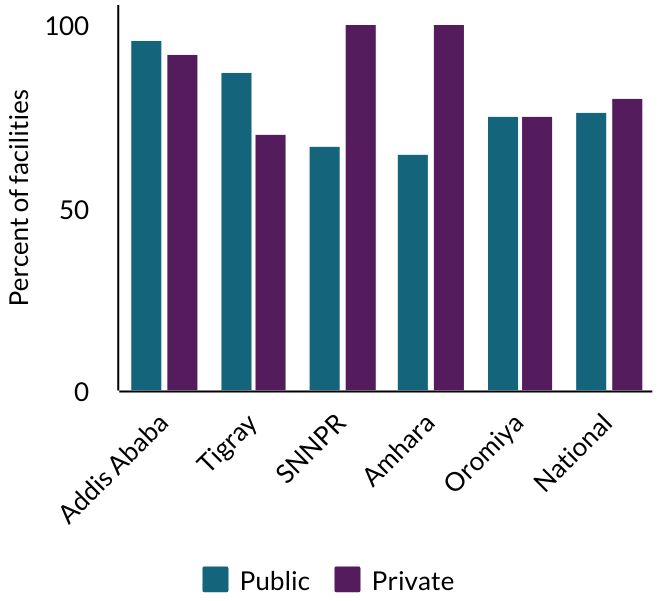


Figure 17. Percent of facilities that provide implants and have a trained staff member for implant removal, by region



KEY FINDINGS ON FACILITY FEES AND READINESS

- Majority of facilities have trained personnel to provide removal services of long-acting contraceptive methods, specifically IUDs and implants

AVAILABILITY OF METHODS AT LOWER LEVEL HEALTH FACILITIES

Figure 18. Percent of health centers providing two long-acting methods (implants and IUDs) and three short-term methods (injectable, male condom and pills), by region

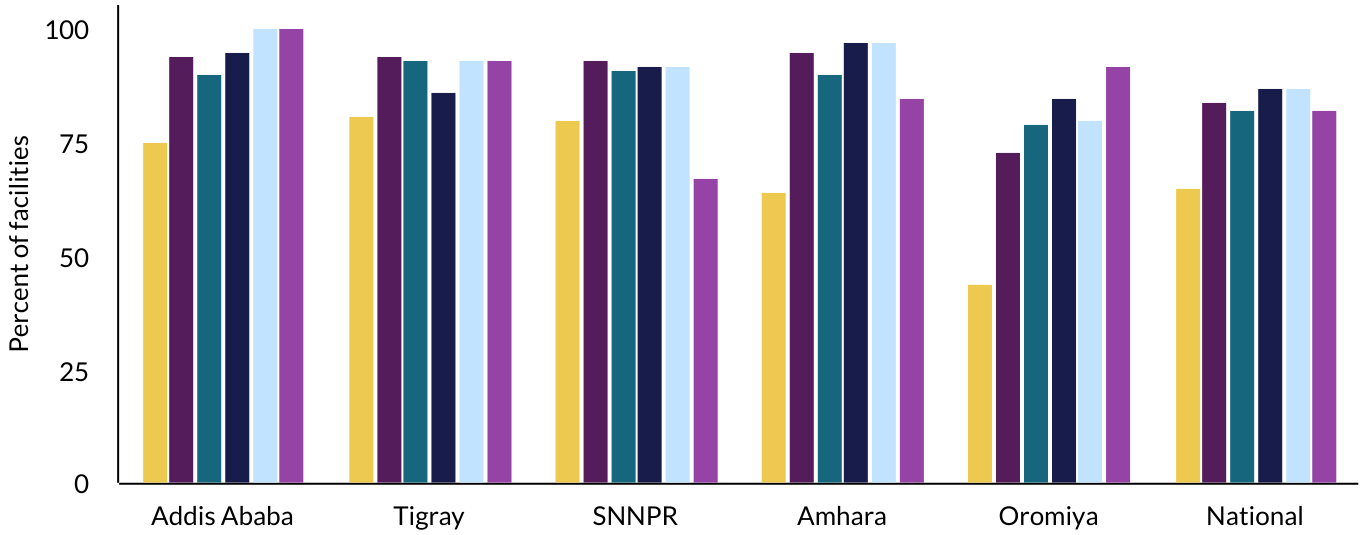
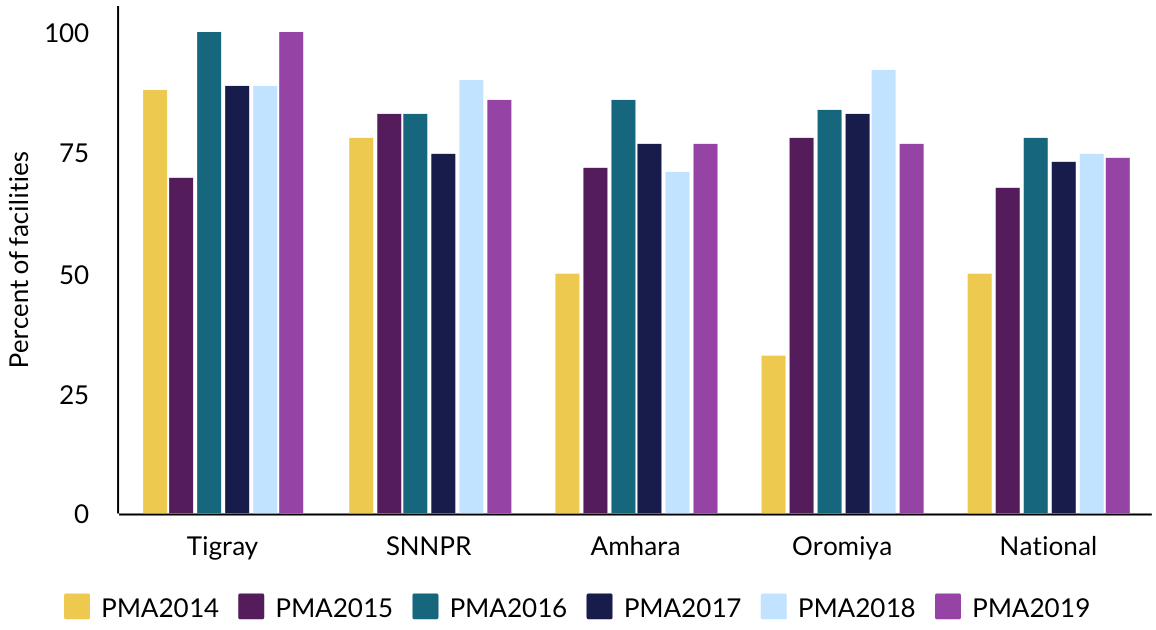


Figure 19. Percent of health posts providing four methods (injectable, implant, male condom and pills), by region



Note: As there are no health posts in Addis Ababa, data for this region are not included in this graph

KEY FINDINGSON METHOD AVAILABILITY AT HEALTH CENTERS AND HEALTH POSTS

- Oromiya and Addis show relatively consistent increase in provision of two long-acting and three short-acting methods between 2014 and 2019
- Some indication that access has decreased in Amhara and SNNPR between 2018 and 2019
- Availability of at least four contraceptive methods at health posts increased between 2014 and 2016 and then plateaued
- There is some regional variation in provision of at least four methods at health posts, but no clear pattern over the years