REQUEST FOR PROPOSAL

Impact Evaluation - Baseline Assessment for Pencerah Nusantara

A. Background

The Center for Indonesia's Strategic Development Initiatives (CISDI) is implementing the **Pencerah Nusantara**, a flagship initiative designed to strengthen **25 Village Health Service Units (VHSUs)** in **Kendal District, Central Java**, and to improve high-quality access, gender-responsive primary healthcare services for women of productive age. The program adopts a comprehensive systems-strengthening approach that focuses on improving service readiness, enhancing the capacity of health workers and community health workers, strengthening data systems and digital integration, and increasing community participation and women's leadership in local health governance.

The program is aligned with Indonesia's national health transformation agenda, including the implementation of ***Integrasi Layanan Primer*** **(ILP)**, the strengthening of the **SATUSEHAT** digital health ecosystem, and the achievement of the Sustainable Development Goals (SDGs), particularly **SDG 3 (Good Health and Well-being)** and **SDG 5 (Gender Equality)**.

To achieve these objectives, the Pencerah Nusantara is built on four strategic pillars:

1. Standardization and Strengthening of Primary Healthcare Services

The program will strengthen primary healthcare service readiness through the development and institutionalization of standardized service guidelines, cross-professional collaboration, and the implementation of task shifting and task sharing. VHSUs will be strengthened as the first point of care, integrated with community health posts (Posyandu) and primary health centers (Puskesmas) through more effective referral pathways.

Continuous quality improvement will be promoted through supportive supervision, peer learning, community feedback mechanisms, quality reviews, and improvements in infrastructure, service systems, and operational readiness.

2. Strengthening Gender-Responsive and Community-Based Health Workforce Capacity

The program will strengthen the competencies of healthcare workers, community health workers (*kader*), and other local actors through competency-based training that emphasizes gender-responsive care, service ethics, and interpersonal communication. Structured mentoring and supportive supervision will be implemented to improve the consistency and quality of service delivery.

At the community level, task shifting and task sharing approaches will be leveraged to expand access to essential health services through home visits, strengthened Posyandu services, and community-based health promotion activities.

3. **Strengthening Data Systems and Digital Integration for Evidence-Based Decision-Making**

   The program will enhance the utilization of digital reporting and monitoring systems, including routine service dashboards and performance monitoring tools, integrated with the primary healthcare information system and the SATUSEHAT ecosystem. Strengthened data governance, reporting standards, and data security will improve data quality and reliability.

   Beyond routine monitoring, the program will use data to support adaptive management, evidence-based decision-making, policy advocacy, and documentation of best practices to facilitate future scale-up and replication.

4. **Enhancing Community Participation and Women's Leadership in Health Governance**

   The program will strengthen the engagement of local stakeholders, including women's groups, community organizations, and village-level institutions, to increase women's participation in local health planning, implementation, and governance processes.

   In parallel, the program will promote positive health-seeking behaviors through participatory health promotion activities and strengthen community-based accountability mechanisms, including community feedback systems and service quality reviews, to ensure that primary healthcare services are increasingly responsive to the needs of women and local communities.

To measure the effectiveness and long-term impact of these interventions, CISDI is seeking proposals from qualified research institutions, organizations, consortiums, or joint ventures to conduct the **Impact Evaluation Baseline Study** for the Pencerah Nusantara. This assignment represents the first phase of a longitudinal impact evaluation and will establish the baseline against which future midline and endline evaluations will be measured.

The baseline study is expected to generate robust evidence on the existing conditions of primary healthcare services, women's health status, healthcare utilization patterns, health-seeking behaviors, digital readiness, community participation, and local governance mechanisms across the intervention areas. The findings will inform program implementation, guide adaptive management, and provide a rigorous foundation for assessing the program's effectiveness throughout its implementation period.

B. Objectives

The principal objectives of this assignment are to:

1. Establish pre-intervention baseline values for the selected impact, outcome, and output indicators of the Pencerah Nusantara, which will serve as reference points for future midline and endline evaluations.
2. Assess the pre-intervention health status, healthcare needs, healthcare utilization patterns, and unmet health needs of women of productive age (15–64 years) in the selected intervention areas, with particular attention to maternal health and non-communicable diseases.
3. Assess pre-intervention knowledge, attitudes, decision-making autonomy, perceived barriers, and health-seeking behaviors related to preventive, promotive, and priority primary healthcare services among women of productive age.
4. Assess the pre-intervention readiness, quality, people-centeredness, gender responsiveness, and compliance of Village Health Service Units (VHSUs/Pustu) with relevant primary healthcare service standards.
5. Examine the level of women's participation and leadership in community health governance, village-level planning, health facility accountability mechanisms, and local health decision-making processes prior to program implementation.
6. Generate evidence-based recommendations to inform program refinement, validate and finalize indicators and targets, and strengthen monitoring, evaluation, research, learning, and knowledge management throughout the 2026–2030 implementation period.

C. Methods

The baseline assessment shall employ a mixed-methods approach, integrating quantitative and qualitative data collection from service users, healthcare providers, community health workers (*kader*), community representatives, and other relevant stakeholders in both the intervention and comparison (control) areas. The selected research institution shall identify and justify appropriate comparison areas based on their similarity to the intervention areas in key baseline characteristics, including demographic profile, socio-economic conditions, and access to primary healthcare services, to establish a credible counterfactual for measuring program impact over time.

In addition to primary data collection, the baseline assessment shall include a review and analysis of relevant secondary data and documents, including program documents, health profiles, policy and regulatory frameworks, routine health information system data, service utilization records, and other available qualitative and quantitative information related to primary healthcare services and women's health in both the intervention and comparison areas. The findings will establish the baseline for subsequent midline and endline evaluations and

provide evidence to support program implementation, monitoring, learning, and adaptive management throughout the Pencerah Nusantara.

D. Expected Evaluation Design and Methodological Requirements

The selected consultant is expected to propose a rigorous, feasible, and contextually appropriate evaluation design for the baseline assessment, including a credible counterfactual strategy—such as the identification of suitable comparison areas—to enable robust assessment of program impact over time. As this assignment constitutes the baseline phase of a longitudinal impact evaluation, the proposed methodology should clearly demonstrate how the baseline findings will serve as the foundation for future midline and endline evaluations (**further details can be found in Annex 1**).

The following section outlines the outcome levels and their corresponding indicators used in this baseline study:

1. Indicator Measurement Matrix

Table 1. PN Indicators Measurement

Code	Result Statement	Measurable Indicators	Means of Verification/ MoV
People Level Outcome			
PLO	By 2030, 80% of productive-age women (15 to 64 years old) with middle- to lower-economic status living in CISDI-supported VHSUs' catchment areas (out of 93,905 women) have maintained and achieved the maximum possible improvement in health outcomes with the investment received.	Proportion of productive-age women (15–64) with improved or maintained composite health score:	Household Survey
		1. % of women aged 15 − 49 years with a live birth in the past 2 years who received antenatal care at least six (6) / four (4) times from any provider	
		2. PNC within 48 hours / % of women aged 15 - 49 years whose health was checked by a trained health care provider within 2 days after delivery of their most recent live birth	
		3. Iron/IFA tablet completion (women of reproductive age) or TTD completion – For women of reproductive age	
		4. Complete female immunisation (as defined in the program context) / Female full immunisation coverage (% of women aged 15-49 years who are vaccinated)	
		5. Controlled NCD status under PRB (% of women with NCDs enrolled in PRB)	

Code	Result Statement	Measurable Indicators	Means of Verification/ MoV
Long-Term Outcomes			
LO	By 2030, CISDI-supported VHSUs' effectively deliver high-quality primary health care services that meets the health needs of user's life course productive-age women (15 to 64 years old) from middle- to lower-economic status	Proportion of VHSUs complying with the 2024 VHSU Technical Guidelines by the Ministry of Health	Health Facility Assessment (including Secondary Data)
		Proportion of VHSUs delivering health services that align with population needs, uphold people-centred care principles, and integrate gender-responsive approaches	Structured Scorecard embedded into Health Facility Assessment (including Secondary Data)
		Proportion of service users reporting satisfaction with the healthcare services received from VHSUs that also complies with GEDSI guideline	Household Survey Patient/Health facility Satisfaction Survey
		Average score of respectful/person-centered on priority conditions experienced by patients (received respectful care) in CISDI-supported VHSUs catchment areas	- Patient satisfaction surveys/Client Exit Interview - Fieldnotes POIC
		Proportion of the population with unmet health needs in VHSU catchment areas.	- Household Survey - Secondary data
Intermediate Outcomes			
IO 1	Increase in the percentage of VHSUs that demonstrate competency and compliance with gender-sensitive and responsive Integrated Primary Care (ILP) policies, ensuring ethical, respectful, and high-quality delivery of healthcare services	Percentage (%) of targeted VHSUs with interprofessional teams (VHSU healthcare workers and CHWs) that meet the minimum standard for gender-sensitive, responsive, and high-quality ILP primary care service delivery.	Health Facility Assessment *(including Secondary data)*
IO 2	Women's priorities are used in village and Puskesmas health planning and follow-up actions.	Percentage of supported villages or Puskesmas that include at least one women's priority in their plan or follow-up action	- Village health plan, Puskesmas workplan, Pustu/ILP action plan,

Code	Result Statement	Measurable Indicators	Means of Verification/ MoV
			MMD/SMD notes, action tracker, priority register. - Desk Review (women's voice) - Village health plan
		Average value of the Women's Autonomy Index	Household Survey
IO 3.1	Productive-age women demonstrate improved appropriate health-seeking behavior and continuity of care for priority services	Percentage of productive-age women (15–64 years) and/or their caregivers who report improved awareness of health needs and available health services	Household Survey
		Sub-indicator 3.1.1: Percentage of productive-age women (15–64 years) who can correctly identify their health needs and relevant service options	Household Survey
		Sub-indicator 3.1.2: Percentage of productive-age women (15–64 years) who have accessed services from VHSU	Household Survey
IO 3.2		Percentage of women who want to maintain their health, seek health-related information, and report having self-autonomy in accessing health services and information.	Household Survey
Short-term Outcomes			
STO 1.1	VHSU human resource competency to deliver people-centred & gender-responsive care increases	Percentage of targeted human resource (program coordinators, nurses, midwives, CHWs) who demonstrate competency in people-centred and gender-responsive service delivery (score ≥ threshold).	- Health Facility Assessment - Observation Checklist
		Percentage of health-care workers with attitudes supportive of gender equality	Healthworkers Survey
STO 1.2	Care pathway is adopted and used in routine practice	Percentage of eligible patients receiving routine services who were managed according to the Gender Care Pathway	Patient satisfaction surveys/ Client Exit Interview
		Percentage of increasing vulnerable (women) groups' satisfaction with healthcare services	Household survey
STO 1.3	VHSU's Staff (CHW) effectively apply supportive	Percentage of CHWs Pustu able implementing standard-supportive supervision to Posyandu's	- Quality assessment

Code	Result Statement	Measurable Indicators	Means of Verification/ MoV
	role to increase delivery practices in Health Integrated Post (Posyandu)	CHW Percentage of targeted VHSU that implement structured supportive supervision for Posyandu meeting minimum service quality and management standards	checklist; service observation forms; supervision scoring sheets; Puskesmas review records - KII
STO 1.4	VHSU demonstrates improved service delivery performance, problem-solving capacity, and adherence to standards through routine supportive supervision by Puskesmas.	Percentage of VHSUs providing standardized and gender-responsive health services Percentage of VHSU have standard service delivery performance, problem-solving capacity, and Adherence	- Supervision scoring/Quality assessment checklist - Health Facility Assessment
STO 1.5	VHSU able implementing basic standard delivery health services	Percentage of VHSU implementing 5 health delivery services model standard	- VHSU Reporting docs - Health Facility Assessment
STO 1.6	VHSU strengthens community-based support and outreach mechanisms that improve women's access to, follow-up of, and continuity in primary health care services.	Percentage of targeted Pustu/VHSUs with functional community-based support and outreach mechanisms that improve women's access, follow-up, and continuity of care	Health Facility Assessment
STO 2.1	More women from the community take part in health planning forums.	Percentage of supported health planning forums attended by women from the community. Number of women from the community who participate in supported health planning forums.	Attendance list, invitation list, participant registration, forum report.
STO 2.2	Women share their health priorities in health planning forums, and these priorities are documented.	Percentage of supported health planning forums where women's health priorities are documented. Number of women's health priorities documented through supported forums.	- Meeting notes, priority list, action tracker, forum report, facilitator notes. - Priority register, forum notes, action tracker
STO	Feedback from women and	Percentage of supported villages or facilities	Feedback log,

Code	Result Statement	Measurable Indicators	Means of Verification/ MoV
2.3	communities is collected, responded to, and communicated back.	with a functioning community feedback and response mechanism.	response tracker, action tracker, meeting notes, communication-back records
		Percentage of feedback items from women that receive a documented response or status update.	
STO 3.1	Productive-age women (15–64) and/or caregivers improved knowledge and Awareness	Percentage of women (15-64) or caregivers achieving minimum knowledge threeshold of priority services	Household survey
		Percentage of women (15-64) or caregivers who meet increased awareness for health information-seeking	Household survey
STO 3.2	Increased utilization and sustainability of priority services in line with the health composite score	Percentage of women (15-64) who used the promoted healthcare services at Village Health Centre (Pustu)	Household survey
STO 3.3	Women report reduced barriers and increased self-autonomy to access health services and information.	Percentage of women (15-64) who meet the "self-autonomy" criteria	Household survey
		Percentage of women report reduced barriers to accessing priority services and health information	Household survey

The selected consultant is expected to review and refine the proposed indicators in consultation with CISDI and develop a detailed indicator measurement matrix as part of the inception phase. Additionally, the consultant is expected to provide technical input and guidance in developing **composite indicators** for **People Level Outcomes (PLO)**. The matrix should ensure that each indicator is clearly defined, measurable, and feasible to assess within the baseline study.

For each indicator, the consultant should specify:

a. Result level and result code;
b. Indicator statement;
c. Operational definition;
d. Numerator and denominator, where applicable;
e. Unit of analysis;
f. Respondent group or data source;
g. Data collection method;
h. Source of verification;
i. Disaggregation variables;
j. Baseline calculation method;

k. Measurement limitations; and
l. Recommendations for future measurement at midline and endline.

The matrix should also clarify whether each indicator will be measured through household survey, health facility assessment, patient or service user satisfaction survey, qualitative inquiry, secondary data review, or a combination of methods. Indicators that are not feasible to measure directly at baseline should be clearly flagged, with justification and recommendations for future measurement.

The consultant should ensure that the indicator measurement matrix is aligned with the Pencerah Nusantara theory of change, result framework, and the broader monitoring, evaluation, research, learning, and knowledge management needs of CISDI.

2. Deliverables

The main deliverables expected from the selected organisation/institution/consortium include:

a. Inception report, including refined methodology, evaluation design, sampling strategy, workplan, risk mitigation plan, and data quality assurance plan;
b. Baseline study protocol, including research permits and ethical clearance submission package for all agreed research locations;
c. Finalized quantitative and qualitative data collection instruments, including household survey, health facility assessment tool, patient or service user satisfaction survey, and qualitative interview or focus group discussion guides;
d. Enumerator and supervisor training materials, including fieldwork manual and data collection protocol;
e. Pilot test narrative report, including documentation of pilot findings, comparability report, instrument revision, and any validity or reliability checks where relevant;
f. Data analysis plan;
g. Raw and cleaned quantitative datasets, data dictionary/codebook, and syntax or formula sheets for indicator calculation;
h. A comprehensive replication package and data governance framework to ensure replicability at midline and endline, including but not limited to:
    i. Analysis syntax or code that fully reproduces every reported figure and table.
    ii. A detailed field manual documenting sampling methodologies and site selection decisions.
    iii. Anonymized datasets in an open format, with all Personally Identifiable Information (PII) secured and held separately.
i. An explicit clause ensuring all instruments, data, code, and outputs are the sole property of CISDI, with an irrevocable license for future adaptation;
j. Qualitative transcripts or field notes, coding framework, and analytical matrix;

k. Indicator baseline value matrix, including operational definitions, numerator, denominator, data source, calculation method, baseline values, limitations, and recommended targets where relevant;
l. Validation workshop or findings discussion with CISDI and relevant stakeholders;
m. Final baseline report, including executive summary, background, methodology, findings, limitations, conclusions, and recommendations; and
n. Presentation deck for internal and/or external dissemination, as required by CISDI.

The selected consultant will conduct the baseline phase of the evaluation cycle. Continuation to the midline and endline phases **may be considered** based on CISDI's assessment of the consultant's performance, methodological quality, timeliness, and overall value for money.

E. Timeline

Activities	Week																							
	Date	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Preparation and Selection																									
Deadline for statement of interest	Aug 2026																								
Pre-bidding meeting (if any)	Mid Aug 2026																								
Deadline for submission of proposals	Late Aug 2026																								
Proposal review and selection process	Sep 2026																								
Contracting and administrative process	Late Sep 2026																								
Work and Report																									
Kick-off and program orientation	Oct 2026																								
Building instrument (Methodology refinement and sampling finalization)	Oct 2026																								
Instrument development and CISDI review	Oct 2026																								
Pilot testing and instrument revision	Oct 2026																								
Enumerator training	Oct 2026																								

Activities	Week																							
	Date	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
Data collection process	Nov 2026																								
Data processing, analysis, and report writing	Nov 2026																								
Report discussion and validation	Nov-Dec 2026																								
Final report and final datasets submission	Dec 2026																								

F. Proposal Submission

The submitted proposals must include the approach, methodology, team composition, and costs required to conduct the work. The research methodology may employ quantitative and qualitative approaches. The proposals must also detail the methods used to achieve the research objectives. The proposal and all supplementary documents must be submitted no later than **August 28, 2026**, via email to procurement@cisdi.org and mel@cisdi.org with the subject **[Institution Name]_RFP_Baseline Assessment Proposal.**

Proposals must include:

1. **Technical Proposal:**
    a. Background, situational analysis, and research objectives;
    b. Proposed methodology, detailing respondent selection/sampling methods, data collection mechanisms, and cross-platform data integration plans;
    c. Data analysis plan, outlining the specific analysis methods to be utilized;
    d. Detailed research timeline and work plan;
    e. Risk register and mitigation matrix, identifying potential fieldwork or data challenges and proposed solutions;
    f. Team composition and Level-of-Effort (LoE) table, mapping out named roles against person-days allocated per project phase; and
    g. Curriculum Vitae (CVs) of key research team members, which must include at minimum: a Principal Investigator, a Statistician/Quantitative expert, a Qualitative expert, a GEDSI/Gender Specialist, and a Field Operations Manager.
2. **Financial Proposal (to be submitted in a separate file):**
    a. Detailed budget proposal (itemized cost breakdown);
    b. Budget narrative

Financial proposal note: Bidders must take into account that the total allocated budget for this baseline assessment is subject to a strict budget ceiling of IDR (565,000,000), inclusive of all applicable taxes, operational costs, and field expenses. Financial proposals exceeding this range/ceiling will be subject to disqualification.

3. **Institutional & Administrative Documents:**
    a. Information on the organization/institution, demonstrating legal entity status and minimum eligibility criteria;
    b. Organization's research portfolio;
    c. Proposal validity period statement;
    d. Signed declaration of conflict interest; and
    e. Copies of institutional policies regarding safeguarding/PSEA (Prevention of Sexual Exploitation and Abuse) and data protection.

Note on Administrative Documents: CISDI does not provide standardized templates for the proposal validity statement, conflict of interest declaration, or institutional policies. Bidders are expected to provide these documents using their own official institutional letterhead/formats, signed by an authorized representative, or attach copies of their existing organizational policy documents.

G. Required Legal Documents

The following legal documents must be submitted once the organisation/institutions **are selected to** commence the work:

1. ID Card (Head of Institution)
2. Institutional Taxpayer Identification Number (NPWP)
3. Institution Portfolio
4. Institution's Bank Account Number
5. Articles of Association and Amendments
6. Certificate of Domicile
7. Business License (SIUP)
8. Company Registration Certificate (TDP)
9. Business Identification Number (NIB, can replace SIUP and TDP)

H. Proposal Assessment

The proposals submitted by all candidates must encompass all objectives outlined. The candidate will be disqualified if a submitted proposal does not cover all the stated objectives. The evaluation of proposals will consider the following indicators:

1. Alignment with the objectives and scope of the RFP
2. Technical capability and previous experience in executing similar projects
3. Methods and approach
4. Timeline and cost

No	Criteria	Weight
1.	Technical approach and Methodology	40%
2.	Relevant institutional and team experience	20%
3.	Operational excellence and risk management	10%
4.	Financial proposal and value for money	30%

The technical proposal should carry greater weight than the financial proposal, given the complexity and strategic importance of the baseline assessment as the foundation for future midline and endline evaluations. CISDI may invite shortlisted candidates for clarification or presentation before final selection.

Annex 1. Expected Evaluation Design and Methodological Requirements

The selected consultant is expected to propose a rigorous, feasible, and contextually appropriate evaluation design for the baseline assessment. As this assignment represents the baseline phase of a broader impact evaluation for the Pencerah Nusantara, the proposed methodology should not only describe data collection methods, but also explain how the baseline will serve as a reference point for future midline and endline assessments.

At minimum, the consultant's proposed methodology should include the following components:

1. **Evaluation design**
   The consultant should clearly describe the proposed evaluation design, including whether the study will use a quasi-experimental, repeated cross-sectional, cohort/panel, mixed-methods, or other suitable design. The proposal should explain how the baseline data will be used to assess changes over time and support future impact or contribution analysis.

   Where feasible, the consultant should propose an appropriate comparison or counterfactual strategy, including the identification of comparison areas or groups, matching criteria, and baseline equivalence assessment. If a comparison group is not feasible, the consultant should provide a clear justification and propose alternative analytical strategies to support credible interpretation of program contribution over time.

2. **Unit of analysis and study population**
   The consultant should clearly define the unit of analysis for each study component. This may include, but is not limited to:
   - productive-age women aged 15–64 years living in the catchment areas of supported VHSUs/Pustu;
   - service users accessing VHSU/Pustu services;
   - VHSU/Pustu facilities;
   - health workers, midwives, nurses, community health workers, and relevant Puskesmas staff;
   - village-level actors, women's groups, local champions, and community representatives involved in health planning and decision-making.

   The consultant should also define eligibility criteria for each respondent group and explain how different sub-populations, such as pregnant women, postpartum women, women of reproductive age, women with NCD risk or diagnosis, and women from middle- to lower-economic status groups, will be identified and included.

3. **Sampling strategy and sample size**
   The consultant should propose a clear sampling strategy for each quantitative and qualitative component. For quantitative data collection, the proposal should include the sampling frame, sampling method, sample size calculation, assumptions used, clustering or stratification approach, and any design effect applied.

For qualitative data collection, the consultant should describe the respondent categories, sampling approach, estimated number of interviews or focus group discussions, site selection criteria, and saturation strategy.

The sampling design should ensure sufficient representation across the 25 supported VHSUs/Pustu and their catchment areas, while also allowing meaningful disaggregation by relevant equity dimensions where feasible.

4. **Quantitative components**

   The baseline assessment is expected to include quantitative data collection through, at minimum:

   a. Household survey with productive-age women in VHSU/Pustu catchment areas to assess health status, service utilization, unmet health needs, knowledge, attitudes, intention, self-autonomy, barriers to care, and health-seeking behavior.
   b. Health facility assessment of targeted VHSUs/Pustu to assess service readiness, availability of priority services, compliance with relevant technical guidelines, referral mechanisms, data systems, infrastructure, human resources, supervision, and gender-responsive service practices.
   c. Patient or service user satisfaction survey to assess perceived quality of care, respectful care, people-centred care, satisfaction, barriers experienced during service use, and compliance with GEDSI-related service standards where relevant.

The consultant may propose additional quantitative components where necessary, such as health worker competency assessment, CHW competency assessment, or routine data quality assessment, if relevant to the baseline indicators.

5. **Qualitative components**

   The baseline assessment should include qualitative inquiry to deepen understanding of service delivery context, gender-related barriers, community participation, women's leadership, health-seeking behavior, and local governance mechanisms.

   Qualitative methods may include key informant interviews, focus group discussions, observation, or other appropriate participatory methods with relevant stakeholders, including productive-age women, service users, community health workers, healthcare providers, Puskesmas representatives, village officials, women's groups, local champions, and other community actors.

   The qualitative component should also explore contextual factors that may influence program implementation and future outcomes, including social norms, household decision-making, trust in health services, perceived quality of care, barriers to access, digital readiness, and community accountability mechanisms.

6. **Secondary data and document review**

The consultant should review and analyze relevant secondary data and documents, including but not limited to program documents, health profiles, Puskesmas and VHSU/Pustu service utilization data, maternal health data, NCD/PRB data, immunization data, local policy and regulatory documents, village planning documents, digital reporting systems, and other available routine data sources.

The consultant should assess the availability, completeness, consistency, and usability of secondary data for baseline measurement and future monitoring. Where routine data are incomplete or inconsistent, the consultant should document limitations and provide recommendations for data strengthening.

7. **Indicator measurement and operational definitions**

   The consultant should review the proposed indicators and develop a detailed indicator measurement matrix in consultation with CISDI. For each indicator, the matrix should include the operational definition, numerator, denominator, unit of analysis, respondent group, data source, data collection method, disaggregation variables, calculation method, and measurement limitations.

   The consultant should clearly identify which indicators can be measured directly at baseline, which indicators require secondary data, which indicators require qualitative assessment, and which indicators need further refinement before future measurement.

8. **Disaggregation and equity analysis**

   The consultant should ensure that baseline findings are disaggregated by relevant equity dimensions where feasible, including age group, socioeconomic status, disability status, geographic area, VHSU/Pustu catchment area, pregnancy or postpartum status, NCD status, and other relevant GEDSI-related characteristics.

   The analysis should identify whether specific groups of women face greater barriers to accessing priority primary healthcare services, have lower service utilization, experience lower satisfaction, or have weaker participation in health planning and decision-making.

9. **Data quality assurance**

   The consultant should propose a data quality assurance plan covering all stages of the study, including instrument development, translation where relevant, pilot testing, enumerator training, field supervision, daily data checks, data cleaning, validation procedures, and documentation of data limitations.

   For digital data collection, the consultant should describe the data collection platform, quality control features, data security measures, and procedures to prevent missing, duplicate, or inconsistent data.

10. **Data analysis and triangulation**

The consultant should provide a clear data analysis plan for both quantitative and qualitative data. Quantitative analysis should include descriptive statistics, baseline indicator calculation, disaggregated analysis, and comparison across relevant groups or areas where feasible.

Qualitative analysis should identify key themes, explanatory factors, implementation context, perceived barriers and enablers, and community perspectives related to women's access to and experience of primary healthcare services.

The consultant should triangulate findings across household survey, health facility assessment, patient satisfaction survey, qualitative data, and secondary data to generate credible baseline conclusions and practical recommendations for program refinement, target setting, and future MERL/KM processes.

11. **Ethics, safeguarding, and data protection**

The consultant should ensure that the study complies with relevant ethical standards, including informed consent, confidentiality, voluntary participation, protection of vulnerable respondents, and safe referral mechanisms if sensitive issues arise during data collection.

The consultant should also describe procedures for data protection, secure data storage, anonymization, and responsible data sharing with CISDI.