CAM ACSF
Midwives for everyone, everywhere
Des sages-femmes pour tous, partout

**REF: TRUST-3200-01235-2509-01**

**TERMS OF REFERENCE**
**Baseline Assessment Consultancy: Technical Support and Operationalization, Malawi**
TRUST: Women's Voices, Midwifery Leadership for Resilient Health

Technical Activity**:** The Canadian Association of Midwives (CAM) seeks to engage **one consultant (1)** to provide focused technical and operational support in the design and implementation of the TRUST baseline assessment in Malawi, with particular emphasis on leading Health Facility Audits and managing all data collection processes and logistics at the facility and community levels.

**Timeframe:** October 2025 – January 2026
**Location:** Malawi: Lilongwe and field locations (Ntcheu, Mwanza and Mzimba South districts)
**Remuneration:** A maximum of $15,000.00 USD

A. Introduction: TRUST Project Summary

The TRUST: Women's Voice, Midwifery Leadership for Resilient Health is a 5-year Global Affairs Canada-funded initiative led by the Canadian Association of Midwives (CAM) that aims to strengthen gender-responsive, resilient health systems in Malawi and South Sudan. The project seeks to improve the ability of women and girls, including adolescents and those facing intersecting forms of marginalization, to exercise their sexual and reproductive health and rights (SRHR) by advancing midwifery leadership, expanding access to inclusive, rights-based care, and engaging communities in participatory, gender-transformative approaches. Through partnerships with midwifery associations, women- and youth-led organizations, and other local and international stakeholders, TRUST supports a range of activities, including health professional training and mentorship, midwifery leadership development, operational and academic research, social accountability initiatives, radio-enabled community engagement campaigns, and participation in transnational learning and advocacy networks focused on advancing collective SRHR priorities such as climate change, Indigenous rights, and SRHR neglected areas. These efforts are designed to address persistent barriers to SRHR and improve access to and quality of essential maternity care services, with an estimated reach of over 1.6 million direct and indirect beneficiaries. By investing in skilled health professionals and promoting inclusive, rights-based care, TRUST will help ensure that health systems can respond flexibly and effectively to both acute crises and ongoing challenges. The project's multipronged approach will foster an enabling environment that upholds the rights and agency of all individuals, specifically women and girls, and marginalized groups, ultimately contributing to improved SRHR outcomes and more equitable health systems in Malawi and South Sudan.

The TRUST project is currently in its pre-launch phase, with implementation activities set to begin shortly following initial planning and coordination efforts. At this stage, it is essential to conduct a baseline assessment to meet donor requirements and to establish a clear evidence-based foundation before activities are rolled out, ensuring that programming is grounded in current realities and tailored to local needs and gaps.

B. TRUST Baseline Background and Design

The overall purpose of the TRUST baseline assessment is to generate context-specific, inclusive, gender-responsive data and insights that will inform evidence-based target setting, refine the project's implementation and Monitoring, Evaluation, Accountability and Learning (MEAL) approach, and establish a foundation for measuring impactful change over the life of the TRUST project.

**The baseline assessment will be designed to achieve three specific objectives:**

1) Establish baseline values and provide additional qualitative insights for selected outcome-level indicators in the project's Performance Measurement Framework (PMF);
2) Provide an evidence basis on which the project team can define targets for selected outcome indicators in the PMF;
3) Provide recommendations for fine-tuning the project's MEAL approach.

Baseline data is intended to inform the establishment of realistic and achievable targets, provide a point of reference against which progress on or towards the achievement of outcomes can be monitored and evaluated, and provide suggestions for the review of indicators if and where necessary.

To establish a robust evidence base, the baseline assessment will be conducted with three main components:

1. **Facility-based data collection** (health facility audits, health provider and client surveys, analysis of facility records/HMIS data);
2. **Community-based data collection** (community mini-surveys);
3. **Organizational data collection** (assessment of midwifery associations' governance, advocacy, and institutional capacities).

C. Scope of Work and Responsibilities of the Consultant

**Scope of Work:** The consultant will play a key role in coordinating and directly supporting facility-based and community-based data collection efforts (*components 1 and 2 above*) for the baseline assessment. This includes leading on the Health Facility Audits, training, supervising and deploying enumerator teams, supporting community-level surveys, and implementing a Knowledge, Attitudes, and Practices (KAP) survey with a qualitative component to inform a needs assessment on midwifery continuous professional development (CPD). *The consultant will not be responsible for advanced data analysis or baseline report write-up.*

**Specific Responsibilities:**

The consultant will:

- Lead the design and implementation of Health Facility Audits in selected facilities across project catchment areas
- Support and advise on the overall design and implementation of the baseline assessment, including tool and template development with translation, piloting/pre-testing and adjustments, in a consultative process with all project partners
- Lead on the obtainment of all necessary ethical and government approvals, with assistance from in-country partners

- Lead on the recruitment, training, and supervision of enumerators for facility- and community-level data collection
- Lead on the incorporation and oversight of the administration of a Knowledge, Attitudes, and Practices (KAP) survey as part of the facility-based data collection
- Lead on providing day-to-day oversight of fieldwork, including logistics planning, scheduling, and problem-solving during data collection
- Lead on implementing in-field quality assurance measures (e.g., spot checks, real-time data verification, daily debriefs with enumerators)
- Support on ensuring ethical and gender-sensitive approaches are integrated throughout the process, including informed consent and confidentiality
- Lead on initial data cleaning and validation, flagging inconsistencies and working with CAM and partners to resolve them
- Lead on carrying out preliminary quantitative and qualitative analysis (e.g., indicator calculations, descriptive statistics)
- Prepare a consolidated dataset and summary of preliminary findings for CAM's review and final analysis
- Provide a short synthesis of field-level reflections and practical lessons learned to feed into the baseline report

D. Methodology / Approach to the Assignment

Baseline data for the facility-based and community-based components of the baseline will be collected using quantitative and qualitative data collection methods, including interviews, surveys, focus groups, community-based mini-surveys, horizontal evaluations, HFAs, and health facility record reviews. Proposed data collection methods, sources, tools and responsibility for the project indicators related to these components (extracted from the TRUST project PMF) are presented in the table below.

| Baseline study indicator | Data collection method & source | Data collection tool(s) |
|---|---|---|
| 1000.2 - Number of maternal deaths in project-targeted health facilities | Health records review (and/or HMIS data review) during health facility site visits | Data extracted from health facility records and HMIS forms, where available |
| 1100.1 - Percentage of women and girls who are satisfied with their last engagement with health professionals (i.e., client satisfaction), disaggregated by age/region/marginalized group | Survey administered to clients during health facility site visits | Client experience & satisfaction questionnaire |
| 1100.2 - Percentage of targeted health facilities offering ANC services, delivery services, and PNC services provided by midwives, disaggregated by region | HFAs conducted during health facility site visits | Standardized HFA tool to capture availability of ANC, delivery and PNC services provided by midwives |
| 1200.1 - Number of active midwives per 10,000 population in project-supported regions | HFAs conducted during health facility site visits; Desk review of available documentation | Facility and district-level staffing verification forms |
| 1110.1 - Percentage of health professionals (working in project-targeted health facilities) who can correctly define the steps of the action plan for essential care during labour and birth, disaggregated by sex/region/cadre | Interviews with health professionals during health facility site visits | Clinical knowledge recall interview questionnaire & guide |

| Baseline study indicator | Data collection method & source | Data collection tool(s) |
|---|---|---|
| 1110.2 - Level of confidence of health professionals in their capacity to provide sexual and reproductive health services to women and girls, disaggregated by sex/region/cadre | Interviews with health professionals during health facility site visits | Confidence interview questionnaire |
| 1100.3 - Number of 1) deliveries with skilled birth personnel, 2) antenatal care visits, and 3) postnatal care visits by women of reproductive age in project-targeted health facilities, disaggregated by age/region/ marginalized group | Health records review (and/or HMIS data review) during health facility site visits | Data extracted from health facility records and HMIS forms, where available |
| 1120.1 - Percentage of women, girls, men and boys in targeted communities able to spontaneously identify three elements of SRHR, disaggregated by sex/age/region/marginalized group/stakeholder type | Mini-survey with women of reproductive age and community members in community spaces | SRHR recall interview questionnaire & guide |
| 1120.2 - Percentage of women, girls, men and boys in targeted communities who agree that women and men should have equal decision-making power over where and with whom to give birth, disaggregated by sex/age/region/ marginalized group | Mini-survey with women of reproductive age and community members in community spaces | Single-item questionnaire on gender-equitable values and attitudes |

In addition to the above PMF-linked indicators, the baseline will also incorporate a KAP survey within facility-based data collection efforts, complemented by qualitative methods (focus group discussions and key informant interviews). This component is designed to generate deeper insights into the enabling environment for SRHR and midwifery practice, including professional development needs and contextual barriers to the provision of high-quality, respectful maternity care. Findings from the KAP survey and qualitative data will be triangulated with quantitative results from the PMF-linked indicators, providing a more holistic understanding of the baseline context and informing both project implementation and future continuous professional development programming.

All baseline data collection tools will be developed collaboratively with project partners to ensure contextual relevance, methodological rigor, and alignment with the TRUST PMF. Tools should be translated to local languages (where relevant and appropriate) and back-translated to English to ensure accuracy and intended meanings of the translations. Data recording forms should include fields to gather information on specific axes of differentiation (such as sex, age, facility, service received, cadre, and disability status, where applicable) in order to allow for data disaggregation. All tools and processes must also incorporate clear protocols for obtaining informed consent, safeguarding confidentiality, and ensuring that permissions are secured from respondents and relevant authorities prior to data collection.

**Study Catchment Area**

The baseline assessment will be conducted in the TRUST target geographies within Malawi: Ntcheu, Mwanza, and Mzimba South districts.

Within these regions, a total of n=67 health facilities in Malawi will form the sampling frame, corresponding to those in which project activities will take place. The final selection of health facilities to be targeted by the project and included in the baseline study will be determined upon completion of the concurrent landscaping exercise, which will assess functionality, presence of midwives, and other relevant criteria as jointly determined by project partners.

Priority localities for client/community level data will be selected purposively, based on criteria such as population density, presence of community structures, guidance from local authorities (the District Executive Committees in Malawi) and relevance to planned interventions.

**Sampling Strategy**

Target sample sizes for each group of respondents will be determined *a priori*. Each data collection method and tool will employ a specific sampling methodology aligned with the data source, indicator, and unit of analysis. Facility-based data collection will entail 1) a time period-based census for recruitment of clients (structured client exit interviews with all eligible women and girls who receive ANC, delivery, or PNC services from midwives during defined data collection windows in project-targeted health facilities) and 2) a census of available providers for recruitment of health professionals (all midwives and relevant health professionals working in project-targeted facilities at the time of data collection). For the KAP survey, a purposive sample of health professionals and stakeholders will be recruited to capture diversity across cadres, levels of experience, and facility types, ensuring a range of perspectives on knowledge, attitudes, and practices related to midwifery and SRHR.

Community-based data collection will utilize venue-based time location sampling (TLS) in project-targeted communities. This systematic approach will involve intercepting respondents in public spaces (e.g., markets, health facilities, transport hubs) according to a structured schedule, providing a resource-feasible and repeatable method for achieving balanced samples disaggregated by sex, age, and marginalized group. Sample sizes for each round of TLS data collection will be calculated using agreed upon parameters.

**Roles, Responsibilities, and Collaboration with Project Partners**

The consultant will report directly to the CAM MEAL Lead and work closely with the in-country midwifery association (AMAMI) and community-based implementing partner (Farm Radio Trust). A co-creation workshop to develop all baseline tools and standard operating procedures will be held (organized and facilitated by CAM) at the outset of the assignment.

The in-country midwifery association, AMAMI, will be the key technical advisors for facility-based data collection (*Component 1*), drawing on their strong relationships with health facilities and technical familiarity with midwifery care.

The community-based implementing partner, FRT, will be the key technical advisors for community-based data collection (*Component 2*), given their extensive network, contextual knowledge, and experience working directly with community members.

The consultant will lead targeted enumerator training sessions to build the technical and ethical capacity of data collectors, with a focus on informed consent, data quality, safeguarding, and respectful engagement with diverse respondent groups. Ongoing quality assurance measures will be implemented throughout the data collection period to ensure data completeness, accuracy, and reliability. The consultant, together with the CAM MEAL Lead, will play a central role in establishing and overseeing these quality assurance processes in the field, including supervision of enumerators, spot-checks, and real-time data verification. The consultant will also contribute to preliminary quantitative and qualitative analysis, including indicator-level calculations and initial descriptive statistics, before handing over consolidated datasets to CAM. CAM will then lead the quantitative and qualitative data analysis (including indicator-level calculations, descriptive statistics, and thematic insights) and will validate preliminary findings internally and with project

partners. *Note that the consultant will not be responsible for the drafting of the final baseline report.*

E. Deliverables

- Work plan and field implementation plan for baseline data collection.
- Adapted and finalized baseline data collection tools (for facility-based and community-based data collection).
- Trained enumerator team (identified, hired and managed by the consultant) with training report and materials. *Note: The team of enumerators should comprise health professionals, including midwives, as advised and directed by the in-country MAs.*
- Completed datasets from facility-based (including Health Facility Audits) and community-based data collection.
- Integrated KAP survey dataset and qualitative notes/transcripts (FGDs, KIIs).
- Short technical note on field-level reflections and practical lessons learned.
- Summary of preliminary findings (quantitative and qualitative).

F. Proposed Timeline and Level of Effort

The consultancy will take place between October 2025 and January 2026. Distribution of time will include design, tool adaptation, training, field supervision, data processing, and reporting inputs.

G. Remuneration

As full compensation for the services rendered for this consultancy, CAM shall pay the consultant a maximum amount of **$15,000 USD**. This amount should include all relevant taxes and expenses incurred in the preparation of milestones and deliverables, including all expenses related to data collection tools, travel, and the recruitment, hiring and deployment of local enumerators.

The consultant will be remunerated for their services based on payable amounts for the activity according to an agreed-upon deliverables schedule. Payment will be dependent on the satisfactory completion of deliverables as assessed by CAM (including proof of payment of local enumerators).

H. Required Skills and Qualifications

The candidate must demonstrate in their application the following educational and professional experience:

- Minimum 7 years of experience in M&E, baseline/midline/endline surveys, or health systems research.
- Proven experience in health facility assessments, SRHR/MNCH research, and survey design.
- Advanced degree in public health, epidemiology, demography, or related field.
- High level of familiarity with the Malawian health care system and context surrounding the provision of nursing and midwifery care.
- Strong background in quantitative and qualitative research methods.
- Demonstrated ability to integrate gender-responsive, inclusive, and equity-focused approaches into research design, data collection, and analysis.
- Experience managing enumerator teams in complex settings.
- Familiarity with SMO- and grassroots-led programming an asset.

- Fluency in English required.
- Located in Lilongwe, or ability to travel to this location to participate in co-creation workshops with partners and manage field-based enumerator teams.

I. Application Instructions

Follow these instructions:

- Send your CV and a cover letter with your availabilities in one PDF document and ensure that your name and the title “TRUST_Baseline-Consultancy_Malawi” are included in the file name.
- Send your PDF by email with the subject “TRUST Baseline Consultancy, Malawi” to admin@canadianmidwives.org.
- Deadline for applications is **Monday October 6 2025.**