UKaid
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ECID Global Baseline

Final Report

June 2020

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1. Introduction

1.1. ECID

a. Overview

The Evidence and Collaboration for Inclusive Development (ECID) programme is a three-year £9m multi-country programme (November 2019[1] - October 2022) working on building civil society effectiveness in Myanmar, Nigeria and Zimbabwe.

The programme is managed by a consortium of 9 organisations: Christian Aid (lead organisation), African Women's Development and Communication Network (FEMNET), Frontline AIDS, The Global Network of Civil Society Organisations for Disaster Reduction (GNDR), Ipsos MORI, On Our Radar, Open University (OU), Social Development Direct (SDDirect) and Womankind.

ECID focuses on increasing access to essential services for marginalised people in Myanmar, Nigeria and Zimbabwe. Going beyond traditional programming, the programme seeks to understand the complexities of how systems exclude people and ways in which data can be used to inform better decision making. By engaging with people directly to identify their service provision needs, such as health, education or water access, ECID will work to empower these individuals to raise their collective voices to engage with decision makers at all levels on these issues. Central to this will be the collection of data related to marginalised people's experiences of services. This will be digitally recorded and shared with decision makers and power holders at different levels to increase accountability. It will also be fed back down to communities to inform action planning and citizen engagement.

By working with civil society, whether local community organisations or larger national networks, and other actors from local to global level, the programme will encourage and facilitate partnerships, collaborations and collective action between civil society, communities and local or national authorities and other stakeholders to address issues prioritised by marginalised people. To sustain these activities, ECID will help to improve the nature of dialogue between decision makers and affected people in communities to ensure greater accountability on commitments made and responsiveness to future demands. It will also ensure more inclusive dialogue within communities to increase participation of marginalised people in decision making.

We use an adaptive approach in the programme, ensuring data and evidence generated is used to inform timely updates to the programme design, adaptation and implementation. At the same time, a focus on learning and in-depth research will provide a depth of insight into individuals' experience of marginalisation.

b. Expected impact and outcomes

The expected impact of the programme is to:

Contribute to the poverty reduction, realisation of rights and improved wellbeing of over 2 million people, with a focus on the most marginalised, including women and girls, LGBT people, ethnic minorities and people living with HIV. The programme will deliver this impact across 3 countries (at least 52% women)

To contribute to achieving this, the programme works toward the 4 key outcomes below:

- Improved access to services for marginalised people in Myanmar, Nigeria and Zimbabwe.

[1] The programme started in August 2018 with a co-creation phase.

- Improved participation in decision-making processes for marginalised people in Myanmar, Nigeria and Zimbabwe at all levels
- Increased effectiveness of civil society and other actors at all levels to address the priorities of marginalised people in Myanmar, Nigeria and Zimbabwe.
- Greater accountability and responsiveness of duty bearers to the priorities of marginalised people in Myanmar, Nigeria and Zimbabwe from local to global levels.

The programme started in August 2018 with a 9-month co-creation phase and a baseline was undertaken between February and June 2020 to ensure that the programme's progress can be measured.

1.2. Objectives of the baseline

The ECID programme will ensure that the Monitoring and Evaluation activities are embedded in the programme's implementation and are not seen as a parallel activity. For this reason, we have defined two overall objectives for the baseline:

1. Measuring impact: presents the status quo in the areas of work to support measurement of programme's results,
2. Informing implementation: generates data and evidence to support quality implementation.

Based on these two overall objectives, the baseline aims to:

- Inform the programme logframe so the programme can measure its progress against intended indicators;
- Identify the prioritised local services that communities wish to focus on in their action planning and within the programme;
- Better understand the context, and system and power dynamics to inform advocacy activities, communication tools, research and learning activities;
- Engage with communities and identify the preferred channels of communication for accountability and safeguarding purposes;
- Start implementing the Gender Equality and Social Inclusion (GESI) and ethical principles when it comes to collection and use of data;
- Learn and adapt.

Finally, the baseline will support the investigation of several assumptions through identification of prioritised local services in communities as well as through developing a better understanding of the context and system dynamics using a GESI transformative approach.

1.3. Assumptions to be tested

The ECID programme assumes that development programming unintentionally leaves people behind. While over the years we have determined that participatory design, enabling for communities to be involved, is the best way to co-design a programme and that the most marginalised people remain invisible and/or not heard in the process.

As part of the programme design, we have developed a Theory of Change (ToC) that includes a number of key assumptions to be tested throughout the life of the programme. The baseline presents the first opportunity to explore these assumptions:

1. Community members (who are not considered part of marginalised groups) understand who the most marginalised people are in their community and why[2],

[2] Within the confines of Do No harm principles, avoiding victimisation and increase the vulnerability of these groups

2. Community members (who are not considered to be part of the most marginalised groups) prioritise the needs of the most marginalised as the key issues in their communities,
3. Civil Society Organisations (CSOs) understand the needs of the most marginalised people in society and represent them,
4. Duty bearers understand the needs of the most marginalised people in society and represent them in decision making processes.

During the co-creation phase, the Gender, Inclusion, Power and Politics (GIPP) Analysis process supported the different country teams to undertake an initial contextual analysis of the areas they are working in, involving key representatives from CSOs, Community-Based Organisations (CBOs) and duty bearers, as well as representatives from communities. This exercise supported the identification of priority marginalised groups to work with within each country at the State and/or district level, and the services to prioritise at national or state level depending on the country. As the baseline process involves more engagement at community level, it will be an opportunity to know if:

- The GIPP methodology and process was effective in identifying the most marginalised groups and their needs and issues in each country,
- The stakeholders involved in the GIPP understand and recognise the needs of the most marginalised.

While the tools for the baseline are building on the GIPP findings, it is also expected that they bring further insights of the perceptions at community level.

1.4. Impact of Covid-19 on the baseline activities

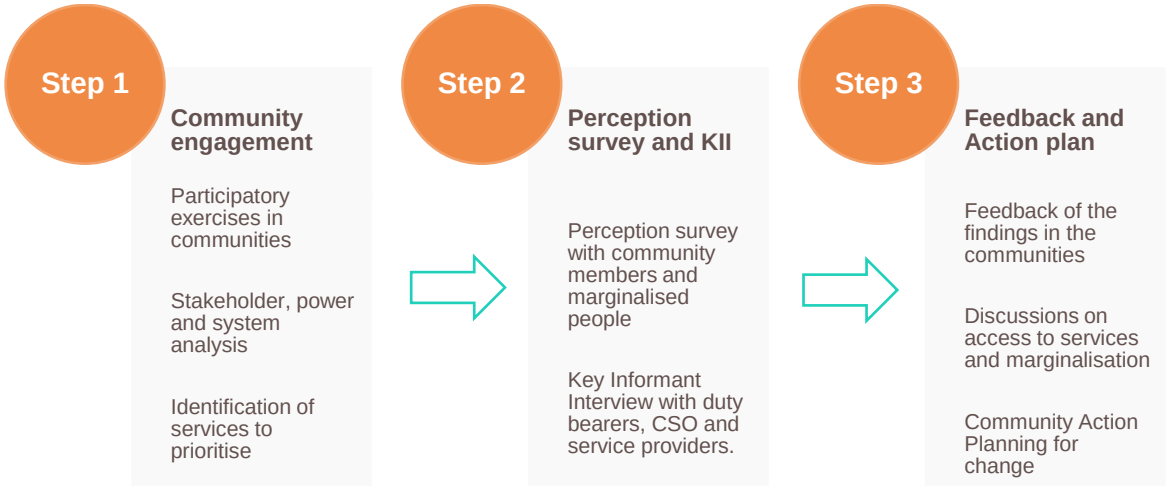
The initial timeline for the baseline activities had planned for the data collection to be conducted between mid-February and end of April, enabling the interim report to be shared on March 31st and the validation activities to happen before this final report was shared at the end of June. However, the Covid-19 pandemic has impacted the baseline activities and required methodologies to be reviewed in all three countries, either in terms of data collection or in terms of data validation. As ECID has not been able to access communities and gather groups of people, the validation activities, bridging with the programme's implementation through action planning at community level, will be conducted in the upcoming months. More detail can be found on the changes made on the baseline activities, due to the pandemic, in the Baseline Methodology Section.

2. Baseline Methodology

2.1. Data collection methodology

a. Baseline methodology: Pre-Covid-19

The initial methodology proposed involved three stages as outlined below. Global guidance had been developed collaboratively, at consortium level, to ensure the process was participatory and not extractive but allowing for country contextualisation and adaptation.



As described in the diagram above, Step 1 was planned to be a series of participatory activities in communities to ensure good community engagement and identify services to prioritise at community level before starting the Perception Survey in Step 2, conducted in the communities with community members, including marginalised people. Step 2 also included Key Informant Interviews (KIIs) with CSOs, CBOs and duty bearers. Finally, Step 3 was designed as a bridge between the baseline and the start of the implementation. It aimed to validate data collected in communities and planning actions for change at community level, in participatory settings. Step 3 is, therefore, not entirely seen as being part of the baseline but it ensures that findings are communicated back, and action planning is based on it. It will, therefore, not be reported against in this report.

b. Impact of Covid-19 on the baseline's methodology

The methodology was reviewed when the Covid-19 pandemic started, and not all three countries were able to follow the 3-step methodology initially proposed.

In Nigeria, the team conducted the training mid-February and started the data collection right after. They proposed a methodology inspired by the global guidance but with small modifications to be coherent within the country context. Data collection was completed before Covid-19 limitations came in. The validation of the findings and action planning (step 3), however, had to be postponed ensuring that programme staff and partners could access communities safely.

In Myanmar, the team only started data collection a week before the Government announced social distancing and restricted travel rules. During these five days of data collection, people from 8 geographical locations participated in Step 1, and the perception survey was conducted with 92 respondents, with a focus on people with disability and internally displaced people. On March 20th, the Myanmar team had to suspend the activities, opening the space for discussions on how to adapt the methodology to continue data collection in the new setting.

Finally, in Zimbabwe, the baseline activities had to be paused the weekend before the training of the enumerators was planned. This forced the ECID team to review the entire baseline plan in Zimbabwe and assess how it could be done during this difficult time. A desktop data review was considered, however, with feedback from the Zimbabwe country team and the Consortium Steering Group, there was a consensus that we should try and work to gather community voices, rather than be drawn into the biases of secondary data sources.

In Myanmar and Zimbabwe, the data collection during Covid-19 took place in May and June 2020.

c. Baseline methodology: During Covid-19

The baseline data collection methodology was reviewed in Myanmar and Zimbabwe based on a risk analysis and alongside with the ECID Ethics Working Group, following the key principles below:

Minimisation of the information to collect

To reduce the length of the data collection tools, keeping them to the 'necessary' information, a full review of the baseline objectives and tools was conducted. As a result, the Perception Survey and Key Informant Interviews were shortened, and the step 1 tools bypassed.

Adapt tools for a risk-free data collection process

Both countries went through several discussions to decide whether to conduct remote data collection through phone calls or to implement face-to-face interviews wearing Personal Protective Equipment (PPE). The team liaised with the ECID Ethics Working Group to adjust the processes to the context and to ensure safety of staff and respondents. Ethical guidance for data collection and research during Covid-19 was also developed and shared with the country offices to support these discussions.

Revise the sample size and methodology

Based on what was possible to achieve in both countries, the sample sizes were reviewed, and the respondents' selection methodology reviewed to incorporate a snowballing methodology and ensuring the most marginalised groups were reached.

2.2. Country level practices

Based on the global guidance and with support from the global team, each country team developed a methodology that was country specific and adapted to the context.

Step	Nigeria	Myanmar	Zimbabwe
Step 1 Community Engagement	31 Focus Group Discussions (FGDs) conducted to cover the Step 1 objectives Semi-structured interviews with leaders at community level	*Before Covid-19:* . Community map, . System map, . Power map, . Service prioritisation *During Covid-19:* No step 1 conducted.	No step 1 conducted.
Step 2 KIIs	Face-to-face Audience: CSOs, CBOs, Duty bearers	Remote (phone) Audience: CSOs, CBOs, Duty bearers	Remote (phone) Audience: CSOs, CBOs, Duty bearers

Step	Nigeria	Myanmar	Zimbabwe
	Sample size: 58	Sample size: 8	Sample size: 157
Step 2 Perception surveys	Face-to-face Audience: service users (community members – including marginalised people) Sample size: 678	*Before Covid-19:* face-to-face Sample size: 92 *During Covid-19:* remote (phone) Sample size: 166 Audience: service users from the most marginalised groups	Face-to-face wearing PPE Audience: service users (community members – including marginalised people) Sample size: 1488

In addition to the changes made on the data collection tools and methodologies, in Myanmar and Zimbabwe the teams adapted to the difficulties of training enumerators remotely. In both countries, enumerators were brought together in our partner's offices close from their home, wearing PPE and following social distancing principles. Due to travel restrictions, the team trained the enumerators remotely, on the data collection tools, on the ethics of collecting data, on marginalisation, safeguarding and power dynamics.

2.3. Gender equality and social inclusion

a. Ensuring inclusive participation in the data collection

The paragraphs below describe what was put in place at country level to ensure inclusive participation in the data collection during the baseline. Annex 5.2 describes the GESI practices in each of the three countries in more details.

In all three countries, partner and Christian Aid staff were encouraged to recruit as many female enumerators (if possible, 50+%) as well as enumerators from the identified marginalised groups. This would support marginalised people to feel safe and comfortable sharing their perception and experiences. In Nigeria, the enumerators were the programme's partners' staff and were all from the programme's remote areas. Female enumerators represented about 40% of the enumerators deployed. In Myanmar 47% of the enumerators were female enumerators, 37% from marginalised groups (people with disability, LGBTQI+[3], female sex workers, people who use drugs) and 44% from ethnic minorities. In Zimbabwe, 85% of the enumerators were women and all from the programme's areas (remote wards, etc.). In addition, 2 enumerators out of 66 were people with disability.

In addition to this, during the participatory exercises or FGDs, the teams created sub-groups of respondents with similar characteristics to help them feel safe to share their experiences. In Nigeria, groups were separated between adult women, adolescent boys, adolescent girls and people with disability. And in Myanmar (pre-Covid-19), three sub-groups were created: women, men and youth[4]. Participation of people with disability was encouraged and followed up in the perception survey.

Finally, during the perception survey, all three countries worked with partners to ensure a purposive sample and a participation of marginalised people of 25 to 50%. In Nigeria, this

[3] Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, +.
[4] While adult women tend to be less vocal when men are around, it appears to be different for younger generations in Myanmar.

proved to be challenging with less than 50% of female respondents and only very limited participation by people with disability and adolescent boys and girls. However, participation of these groups was ensured through the FGDs. In Myanmar, the country team worked with partners who linked with target groups networks to ensure participation from marginalised groups and it proved to be successful. In Zimbabwe, the enumerators received support from the partners, healthcare workers (including District Covid-19 Taskforce from Ministry of Health) and community leaders to identify people with disability, in addition, they used the snowballing methodology to reach a higher number of people with disability. Details on the respondents' demographics can be found in section 3.1.a and annex 5.3.

b. Ethics considerations to protect respondents

ECID recognises the ethical risks related to research and data collection within the programme. In response to this, a systematic, participatory and contextually relevant approach to research ethics has been adopted.

First, the Ethics Working Group developed a comprehensive research ethics and data integrity framework, providing key guidance around six areas (research design, risks and referrals, legal obligations and standards, informed consent, training requirements, and independence of research). The framework sets out the programme's ideal standards for practice relating to all research activity[5]. It is situated within the broader ECID and Christian Aid ethics, safeguarding and data protection policy and procedures and programme GESI strategy. Based on this framework, a conflict-sensitive research ethics and data integrity implementation guide was developed with the three country teams.

As ECID is an adaptive programme, the ethics Programme Lead worked in consultation with the country teams to develop guidelines for carrying out research during Covid-19. These guidelines recognised that research ethics, safeguarding, data integrity and 'Do No Harm' (DNH) principles take on additional importance during such a pandemic. The guidelines produced were used by country teams to review their own ethical process and to consider how best to adapt the research and data collection methods in response to Covid-19. Through this process country teams identified several ethical issues that needed to be explored further, including: (i) How to carry out research interviews over the telephone in a way that is GDPR[6] compliant, maintains ethical rigour and does not exclude groups who may struggle to access and use the required technology, (ii) How to collect participant information from partner organisations in a way that is GDPR compliant and complies with DNH principles, and (iii) How to carry out face-to-face interviews during Covid-19. Protocols for each of these issues were developed in collaboration with the country teams.

To ensure that the standards discussed were implemented during the data collection, each country team developed their own data management plan. For instance, the Myanmar management plan template can be found in annex 5.4, it describes how the data will be managed through the programme's lifespan. In addition, all three teams trained the enumerators on gender, marginalisation, power dynamics, safeguarding and the ethics of data collection.

Finally, before the data collection, in all three countries, the enumerators were trained on how to use relevant referral mechanisms, which would enable respondents to be referred to the right services should they need assistance with anything, including Covid-19 services.

[5] Defined as any purposeful commissioning, collection, analysis, adaptation/representation and communication of data.
[6] General Data Protection Regulation

We also recognised that many of our target marginalised groups will be struggling with primary and secondary impacts of Covid-19, and these sensitivities needed to be considered.

In terms of next steps, we are currently in the process of brokering research partnerships in each country. The purpose of the partnerships is to integrate research expertise into the global consortium and to provide external accountability and critical accompaniment at country level for processes such as ethical review and research design/evaluation.

2.4. Limitations

a. Tool's design and global coherence

As highlighted, all three country offices were at different stages of readiness before the baseline activities started. While the Nigeria country office already had the right staff in place and working relationships with most partners selected for the ECID programme, in Myanmar and Zimbabwe the partner selection and staff recruitment took some time.

This situation, in addition to the need to review the tools during the Covid-19 pandemic, caused some variations in the tools that were developed for the baseline in the 3 countries. However, given the staggered approach to undertaking the baseline, each country developing tools has been able to pass on learning to the next country undertaking this activity which brought a great added value to the findings.

In addition, it is to be raised that in Myanmar, the difference between the tools used pre-Covid-19 and during Covid-19 caused some challenges in the data analysis. Every effort has, however, been made to ensure that the process undertaken in each country ensures the greatest coherence and harmonisation at country and global level.

b. Risks linked to the contexts changing quickly: impact of Covid-19

As part of the baseline, we are assessing the communities' priorities in terms of services and issues to work on. However, we live in a rapidly changing environment which has been demonstrated by the Covid-19 pandemic. We are conscious that there is a risk that this pandemic has had an impact on the data that we have collected. For instance, in Nigeria, the partners have just started piloting the process of validating the findings and while the emphasis was on the lack of good infrastructure during the baseline data collection (in early March), the focus seems to have slightly shifted towards prioritising livelihood services.

Currently, there is no way to evidence the impact that the pandemic has had on the baseline data without deploying a new data collection or having a prior dataset to compare. Although the Myanmar data collection happened before and after the pandemic started, the sample size and sample 'composition' cannot support drawing conclusions regarding the bias that the pandemic might have introduced. However, the programme team is dedicated to ensuring that the data validation process enables a qualitative assessment of that impact before the action planning is conducted at community level.

c. Inclusion of the most marginalised

As mentioned previously, guidance was proposed to encourage the inclusion of the most marginalised. However, it can be difficult to 'target' these groups and individuals as they are often invisible, hard to reach or risk greater vulnerability if they disclose that they are part of these marginalised groups. In the Perception Survey, it was decided not to ask sensitive questions about one's identity (except from people with disability through the Washington Group Questions (WGQ): this was done with consideration of the potential risk that this might pose for people's safety. To tackle this, enumerators would indicate, themselves, if the respondent was selected because they are from a marginalised group.

We are aware that this poses some limitations: people from these groups who do not feel confident enough to contact CBOs or CSOs, who fear disclosing their identity or who do not feel that the CSOs represent them well enough are not being represented in the Perception Survey data (and if they are, we do not know about their complex identity).

Based on the learning from the Nigeria's perception survey exercise, the country teams in Myanmar and Zimbabwe worked in consultation with several consortium members to find more inclusive solutions and approaches. Section 3.1.a. and annex 5.3. show more details of the demographics of the respondents.

d. Adaptive preference

In ECID we believe there are various biases influencing our Perception Surveys' findings. For example, we believe that respondents may have exercised 'adaptive preference' when scoring their satisfaction in services, in participation in decision-making processes or in ability to hold duty bearers to account. This is a phenomenon coined by economist Amartya Sen, which proposes that people living in environments of constrained opportunity will 'adapt their preferences' (or their views) based on those constraints. For example, if you've only ever experienced poor health service provision, you are more likely to be satisfied with that service, than if you had experienced good service provision previously. It is expected that this phenomenon has had an impact on the data collected over the life of the programme.

3. Baseline findings

3.1. Marginalisation

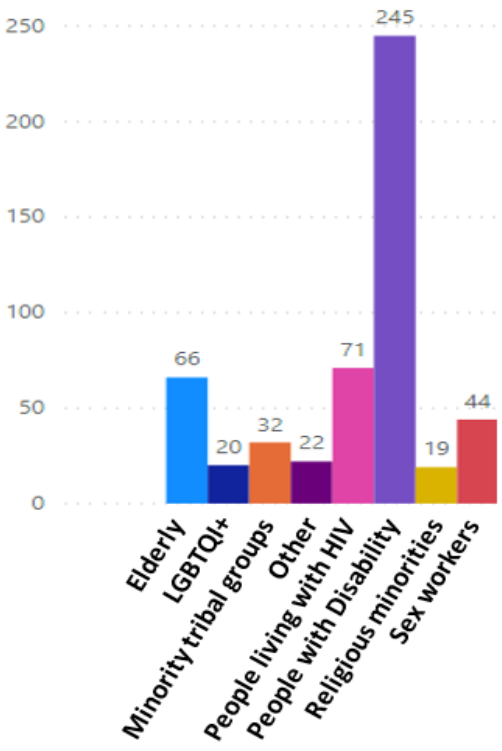
a. Quick overview of respondents' demographics

As indicated in the methodology section, the programme teams worked with partners and other CSOs and CBOs to ensure as much inclusion as possible in the data collection process. The annex 5.3 presents details on the demographics for each of the three countries.

In Nigeria, there were some challenges in ensuring good representation of marginalised people in the perception survey sample because they are invisible and harder to reach (the perception survey exercise reached 27 people with disability (3.4%), 34 were adolescent boys or girls and 46% of women). The involvement of these groups was ensured through the FGDs (7 FGDs were conducted with adolescent boys, 7 with adolescent girls, 6 FGDs with rural women and 9 with people with disability). Although this presents limitations when it comes to quantitatively understanding the specific needs of marginalised people, the perception survey data is triangulated with the FGDs findings in this report. This served as a key learning for the other two countries in which further deliberate efforts were given.

In Zimbabwe, this methodology enabled reaching over 67% of females and in total, over 28% of respondents were selected because they are considered as being marginalised. Although the GIPP analysis resulted in the selection of the people with disability and women as being the groups that the programme would focus on, it was recognised that other invisible groups were also highly marginalised, and the perception survey was a way to capture their voices. The different marginalisation criteria considered are presented in the graph. Given this graph, we can see that 16.4% of the respondents that were selected because they had a disability, and even if other criteria are not as represented, the proposed snowballing methodology enabled the participation and representation of other key marginalised groups.

Criteria of marginalisation of respondents (Zimbabwe)



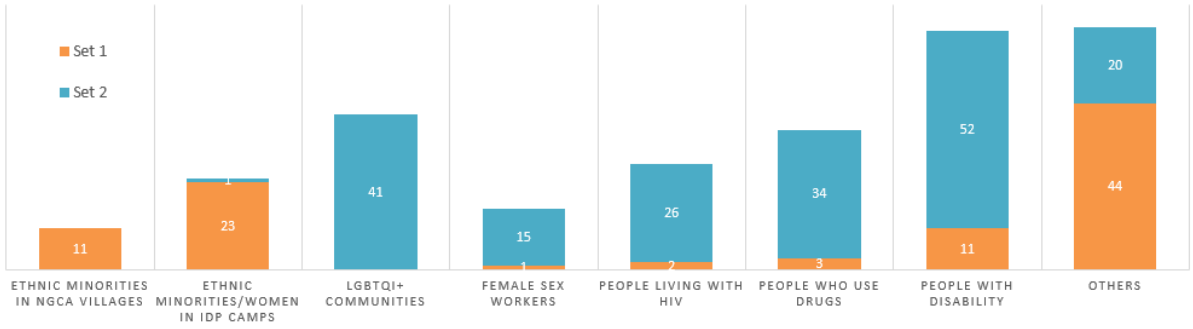
When using the WGQs to assess respondent's disability, we find that through 'Disability 2' lens[7], 36.7% of the respondents are People with disability – versus 31.3% through the 'Disability 3' lens. This demonstrates that the WGQs enable a more granular analysis and understanding of the respondents going further than visible disabilities.

Given the Covid-19 difficulties, the Myanmar team focussed on reaching the most marginalised communities. Before the pandemic, the baseline activities were conducted mainly with people with disability and internally displaced people with the objective to include respondents from other marginalised communities but also respondents that were not considered as being the 'most marginalised' later. However, because of the pandemic, the

[7] See the WGQ analytical guidance: Disability 2 = at least 2 of the questions were responded by 'Some difficulties' or 1 was responded 'A lot of difficulties' or 'Cannot do at all'. Disability 3 = 1 of the questions was responded 'A lot of difficulties' or 'Cannot do at all'

activities had to continue remotely (phone-based surveys) and the team made the decision to continue their focus on the most marginalised groups. Data shows (graph below) that 24.4% of the respondents are people with disability and 15.9% are from the LGBTQI+ community. In addition, the team reached 44% of female respondents.

Criteria of marginalisation of respondents (Myanmar)



The 'Others' criteria refers mainly to people who are not considered marginalised. Some respondents used this category to refer to the elderly as well but in a smaller proportion.

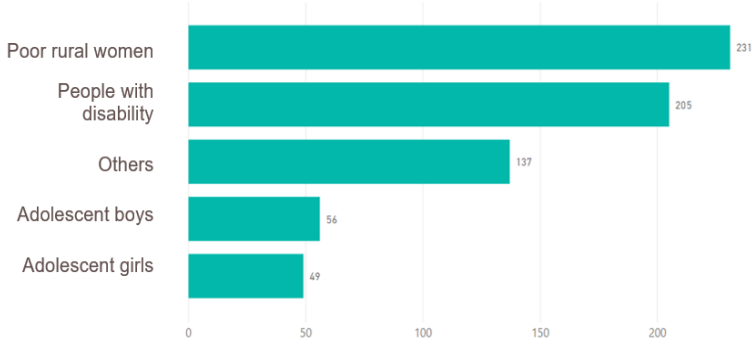
Based on the WGQs, applying the 'disability 3' analytical framework, it appears that 28% of the total of respondents are considered being People with disability versus over 49% using the 'disability 2' analytical framework. It will be interesting to explore this further.

b. Perception of marginalisation by respondents

As part of the programme's objectives, it is key to ensure that communities in which we work recognise who are the most marginalised amongst themselves and why. This is key for ensuring that the needs and priorities of the most marginalised are considered when conducting the action planning activities. In each country, the tools were adapted based on the key marginalised groups identified in the GIPP analysis to assess the perception of marginalisation at the community level.

In Nigeria, the GIPP analysis supported the project team in identifying women living in rural areas, people with disability, adolescent boys and adolescent girls to be amongst the most marginalised. It should be noted that LGBTQI+ people and groups continue to be highly marginalised in Nigeria, in a context of pervasive stigma, discrimination and criminalisation linked to sexual orientation, gender identity and expression (SOGIE). SOGIE presents a highly polarising and divisive set of issues in Nigeria (in society at large and within the development community). Further dialogue will be convened with stakeholders to foster application of an inclusive, intersectional, and (at minimum) 'do no harm' approach across project activities.

People considered as being the most marginalised in the communities (Nigeria)

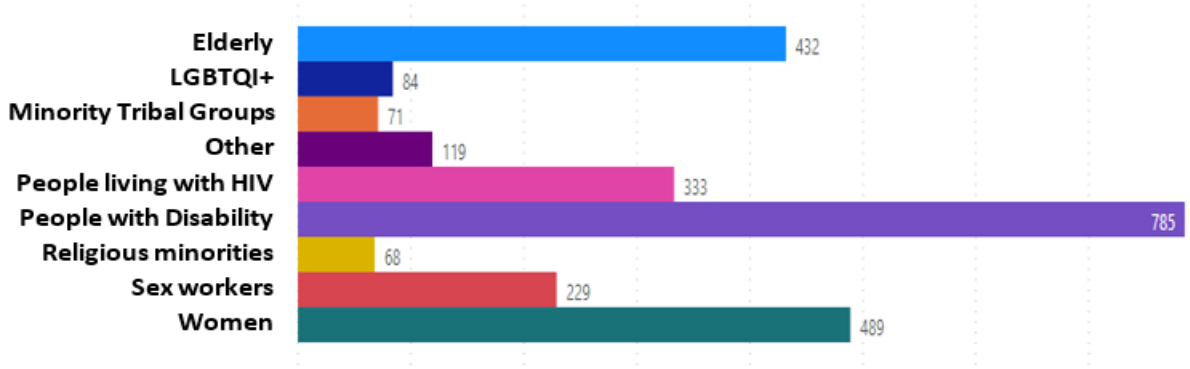


During the baseline data collection, many of the respondents agreed that poor rural women and people with disability are the most marginalised groups with 34% selecting poor rural women and 30% selecting people with disability. The proportion of respondents who selected adolescent boys or girls is much lower.

A large proportion of people suggested that other key groups should be considered as marginalised. Several of them indicated that widows and orphans were also part of the most marginalised. Other respondents mentioned girls forced into marriage, men or even 'everyone'.

In Zimbabwe, most respondents indicated that people with disability were the most marginalised group (52.7%). The graph below shows in detail who the most marginalised people are considered to be in the communities.

People considered as being the most marginalised in the communities (Zimbabwe)

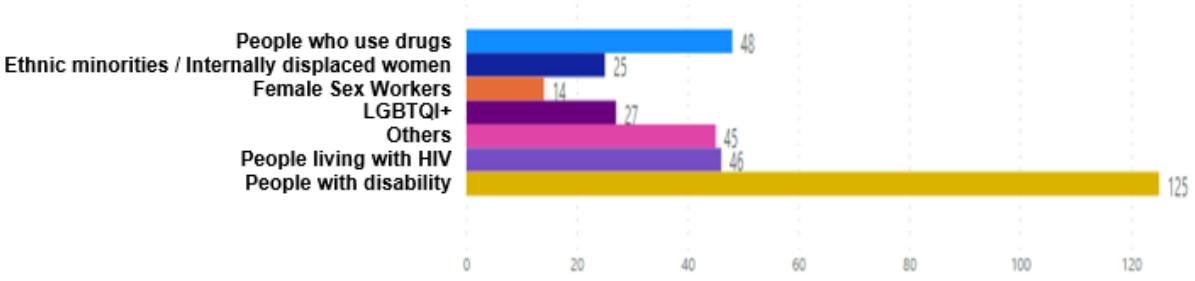


The findings in the communities are consistent with the findings from the GIPP, highlighting that People with disability and women are the most marginalised. However, they also highlight the elderly, people living with HIV and sex workers as key marginalised groups.

The KIIs show a very similar picture, to the one presented in the GIPP analysis, with most respondents indicating that the most marginalised are people with disability, followed by women. Many respondents also discussed the challenges faced by children and orphans but only few referred to people living with HIV, the elderly or sex workers.

Furthermore, in Myanmar, the GIPP analysis had supported the identification of ethnic minorities living in Internally Displaced People (IDP) camps (and conflict affected areas), people who use drugs, female sex workers, people living with HIV/ AIDS, LGBTQI+ communities as well as people with disability (especially women and elderly), as being the most marginalised. The GIPP analysis enabled an intersectional analysis of marginalisation. The graph below shows who people who were involved in the perception survey perceive as being the most marginalised.

People considered as being the most marginalised in the communities (Myanmar)



This shows a similar trend to Zimbabwe, with 48% of the respondents considering People with disability as being part of the most marginalised people. However, in Myanmar, this is followed by people who use drugs and people living with disability (with 18% of the respondents for each). 'Other' marginalised people mentioned are the elderly and the youth.

3.2. Impact: Greater power and strategic needs

Annex 1.1 presents the programme's logframe informed by the baseline values.

ECID Impact is to *contribute to the poverty reduction, realisation of rights and improved wellbeing of over 2 million people, with a focus on the most marginalised, including women and girls, LGBT people, ethnic minorities and people living with HIV. The programme will deliver this impact across 3 countries (at least 52% women)*.

Indicator 1: Increased percentage of target population (including marginalised people) who have greater social, political and economic power

Nigeria: **33.5%**	Myanmar: **10.1%**	Zimbabwe: **9.3%**

In Nigeria, in the two States where the programme is being implemented (Kaduna and Anambra), 33.5% of the respondents consider that they have social, political and economic power, which means that they can influence people and can meet their basic needs.

Amongst the female respondents, only 26.5% are satisfied with their social, political and economic power (versus 39.4% of the male respondents), a similar disparity can be observed between the States with 26.5% of the respondents from Anambra being satisfied with their social, political and economic power (42.7% in Kaduna).

In Zimbabwe, the value is much lower: only 9.3% of the respondents consider having a satisfactory social, political and economic power. This is partly due to the learning from the Nigeria data analysis and a slight adjustment of the questions asked (indeed, a more detailed engagement scale was introduced to measure the influence in decision-making processes, see in annex 5.5). This percentage is cross-cutting respondent's capacity to meet households needs (29% of the respondents) and their decision-making power, looking at the involvement in decision-making processes, with, at least, the possibility to ask questions and be considered (22%).

The factor that seems to have the higher impact on this indicator is the sex of the respondent with only 8% of females feeling like they have a satisfactory social, political and economic power, versus 12% of males. Other factors such as disability, literacy or province did not appear to impact the results.

Finally, in Myanmar, the value is similar to the value in Zimbabwe: only 10.1% of the respondents consider having a satisfactory social, political and economic power. Overall, 22.5% of the respondents consider having the ability to influence people and decisions in their community and 24.4% consider that they can meet their household's needs.

The sex of the respondents seems to have an impact on this indicator. While in Zimbabwe a lower percentage of female respondents considered having good social, political and economic power, in Myanmar 15.8% of the female respondents do so versus only 4.7% of the male respondents.

Disability also appears to be a factor to consider when it comes to social, political and economic power. Amongst the respondents, only 2.7% of the people with disability ('disability 3') who were surveyed feel like they have good social, political and economic power (versus 12.7% of people without disability); 15% feel like they can influence people or decisions in their community and only 6.8% consider that they can meet their HH needs.

These findings are interesting, and the teams will continue investigating the data to better understand the intersectionality of different factors and how they impact people's experiences.

Indicator 2: Increased percentage of target population (including key marginalised people) of all ages that have their strategic needs met

Nigeria: **42.3%**	Myanmar: **49.1%**	Zimbabwe: **31.1%**

In the ECID programme, we define strategic needs as being the needs that women and marginalised groups identify due to their subordinate position in society. It is different from meeting 'basic needs'. The programme recognises that these vary according to the context. Being able to meet your strategic needs therefore refers to a person feeling that they have some power to address issues keeping them in a position of inequality.

In Kaduna and Anambra (Nigeria), 42.3% of the respondents consider that they have their strategic needs met (respectively 37.5% and 48.5%). However, only 33% of women consider that they can meet their strategic needs compared to 52% of men.

This value seems high – which is positive – but could be due to several factors:

- Lack of inclusion of marginalised groups in the quantitative data collection;
- The nature of the questions in the survey did not enable extraction of the information required [8].

Based on these findings, the global programme's team worked with the Zimbabwe and Myanmar country teams to review the questions that were asked and assess people's capacity to meet their strategic needs differently.

In Zimbabwe, 31.1% of the respondents consider that they have their strategic needs met. Based on the review of the questions in the perception survey, this means that they consider that they have equal access to services more than other people in their community. It also suggests they are satisfied with their capacity to influence decisions impacting their lives, or that if they do not feel equal to other people in their community. They are also confident in their ability to change that situation.

Indeed, in Manicaland and Matabeleland (provinces of implementation of the programme in Zimbabwe), 36% believe that they have equal access to services as others in their community, but only 21.8% are satisfied about it (the remaining considering that their access to services and their ability to influence their own lives is insufficient). In addition, out of the respondents who believe they don't have equal access to services, only 9.3% consider having the ability to influence this.

In Myanmar, out of the perception survey respondents, we consider that 49.1% have their strategic needs met. This means that they reported equal access to services as other people in their communities (or other surrounding communities) (this represents 39% of the respondents) or that if they didn't they consider having the capacity to influence this in their lives (10.1%). While people have equal access to services, they might not be satisfied by it (see analysis in Zimbabwe). Unfortunately, the data from Myanmar doesn't enable us to clarify this and we will explore this further when the activities start.

Sex doesn't appear to be a factor that impacts the value of this indicator much, however, disability does with only 35.5% of respondents with disability considered having their strategic needs met versus 54.4% of respondents without disability.

[8] Note that after the data collection process started in Nigeria, the questions to inform the Impact indicator 2 were modified to enable to better capture this indicator in the other two countries.

3.3. Outcome 1: Access to services

As outcome 1 is about access to services, we will first dive into the services prioritised at community level in all three countries.

a. Prioritised services

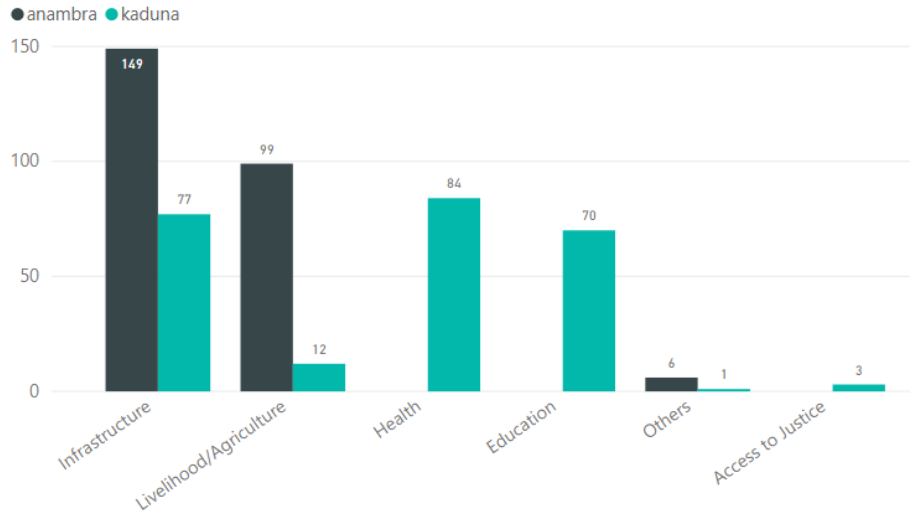
Findings in Nigeria show that out of the services prioritised in different communities, over 50% of the respondents (52%) have prioritised **infrastructure** as a key issue in their community. In descending order of priority, **livelihoods and agriculture**, **health** and **education** have also been identified as main issues and services to prioritise in their community.

In a traditional sense, infrastructure would not necessarily be seen as a service, rather a barrier to service delivery. For example, the lack of a road to a health service or no water pump reducing access to water and sanitation services. Indeed, the data highlights various infrastructure challenges which act as a barrier to service delivery.

The four areas that were prioritised by the respondents were the same areas as the ones prioritised by the GIPP analysis and formed the basis of the ECID Nigeria Programme description. However, in Kaduna, the programme had intended to prioritise education mainly and in Anambra the programme would span across the four social sectors discussed above.

Looking at the perception survey responses, it seems that the evidence shows a distribution per State that is slightly different.

Prioritised services per State - Nigeria

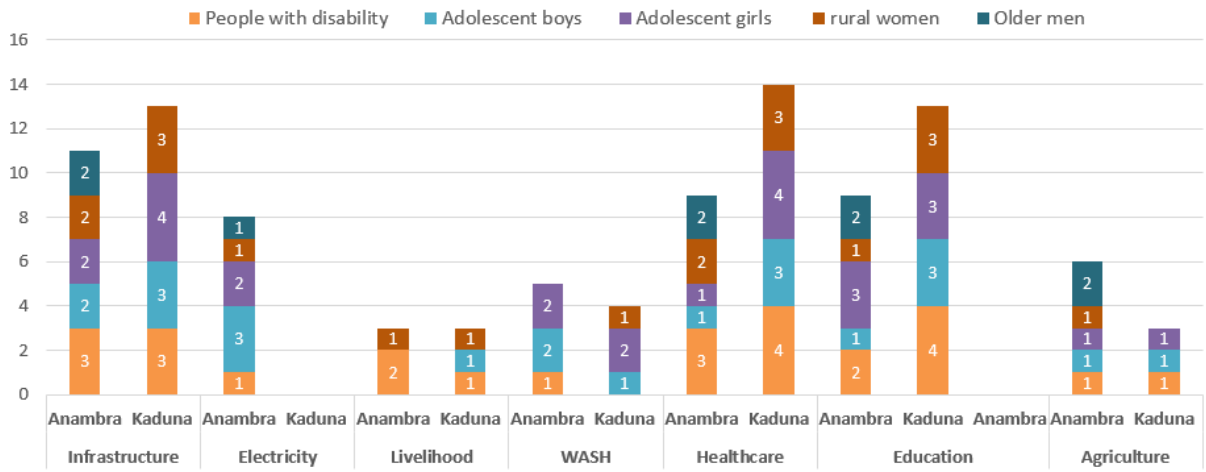


Indeed, it appears that in Anambra, most respondents (and therefore most communities) have prioritised Infrastructure and Livelihood/Agriculture while in Kaduna, the priority appears to be different. In Kaduna, most respondents have prioritised Health, Education and Infrastructure. This can be explained as it appears that across the 4 Local Government Areas targeted in Kaduna stated, many of the communities do not have a functional health centre. In addition, these findings are consistent with the findings from the FGDs that showed a specific focus on education in Kaduna, raised by adolescent boys and girls (confirming the cross-cutting nature of healthcare and infrastructure).

One key limitation to the perception survey is the lack of representation of marginalised groups, therefore, the perception survey data was triangulated with the FGDs. People with disability who have participated in the FGDs have indicated in majority that they would like to see healthcare services, education and infrastructure prioritise. They have indicated that education is difficult to access for them and there are no adult classes available for people

with disability to gain skills. Rural women have highlighted a similar challenge. The graph below gives more details on services that were prioritised through the focus group discussions with adolescent boys, adolescent girls, rural women, older men and people with disability in both states.

FGDs[9] - Prioritised services per State – Nigeria

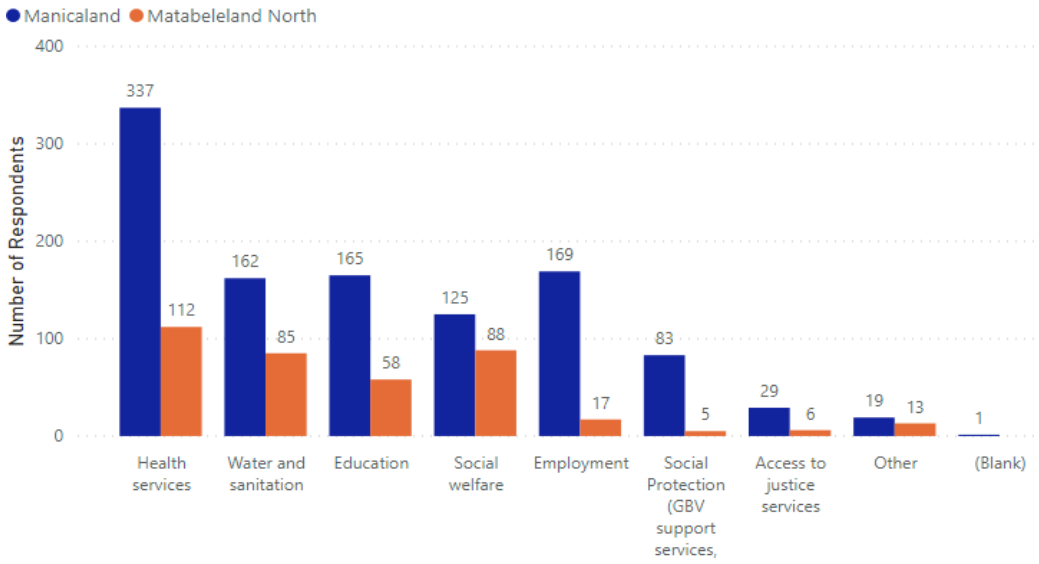


Based on the Perception Survey, in Zimbabwe, it appears that over 30% of the respondents have prioritised **health services**. Amongst the other services discussed during the data collection, it is more difficult to make the cut with between 12.6% and 17% of respondents prioritising either **WASH**, **Education**, **Social Welfare** or **Employment**. Followed then by social protection services, access to justice services, and other services. Employment, like infrastructure, is not traditionally considered a service, however it can be a hindrance to accessing other services such as health, education and WASH support.

The graph below shows the differences in trends between both Provinces. The 4 key services prioritised in Manicaland are health (30%), employment (15.5%), education (15%) and water and sanitation (14.8%), while in Matabeleland North, they are Health (29.1%), Social Welfare (23%), Water and Sanitation (22%) and Education (15%).

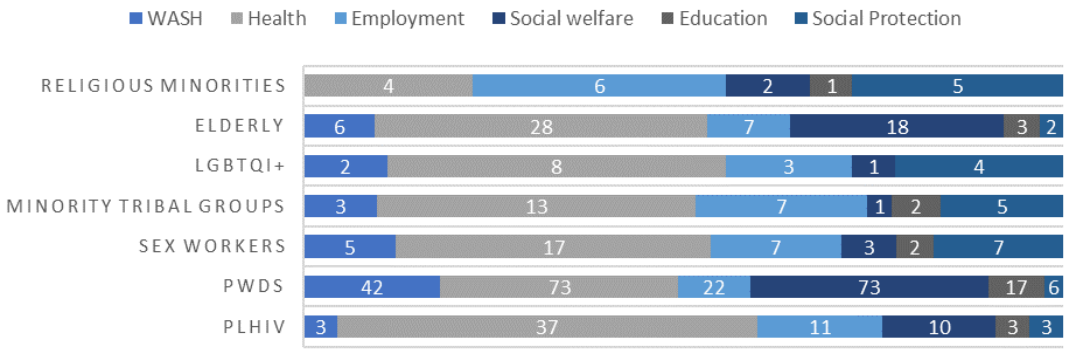
Prioritised services per Province - Zimbabwe

[9] Note that the numbers represent Focus Groups, therefore, when the graph shows 2 it represents 2 focus groups composed of 8 to 15 participants.



Looking at the demographics, it appears that male respondents are more likely to prioritise employment services (20% versus 9% of female respondents). In addition, social welfare seems to be the second priority (19%) for respondents who were selected because they are part of a marginalised group. More detail is presented in the graph below:

Services prioritised by respondents purposively selected – Zimbabwe

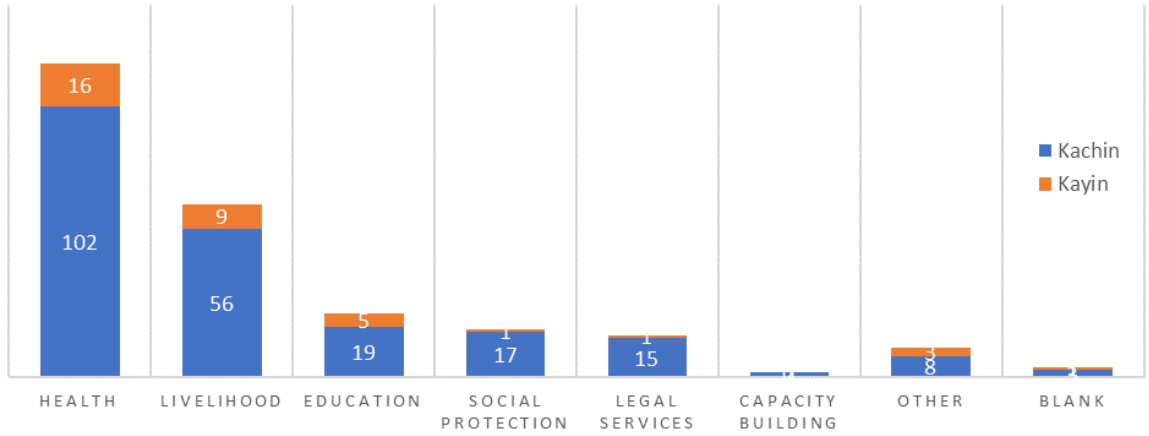


In Zimbabwe, based on the GIPP analysis, the priority was to focus on health and education in terms of services, but also social welfare, social protection and economic and finance policies and accountability. Based on the perception survey, it appears that this focus is confirmed, although more importance was given to WASH services and employment by the perception survey's respondents.

In Myanmar, the GIPP analysis highlighted health-related services as highly likely to be the focus of ECID in the country. The perception survey data, along with the few participatory activities that were conducted pre-Covid-19 confirms that **Health** is the priority for a large majority of the respondents (45%), followed by **livelihood support** (25%) and then **education** (9%) and **social protection**.

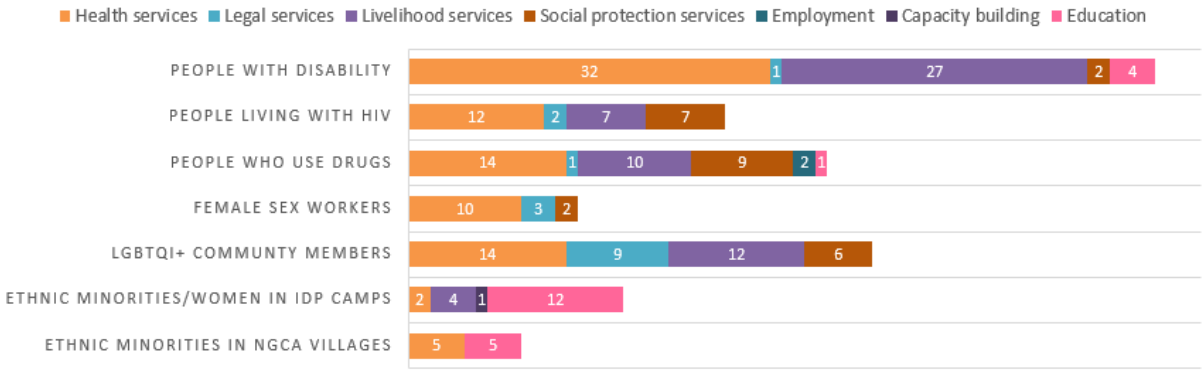
In terms of services prioritised per State, it appears that while overall the trends are similar, the sample size in Kayin doesn't enable drawing meaningful conclusions. This is due to the challenges caused by Covid-19 forcing data collection to be conducted remotely in Myanmar while the partnership agreements in Kayin State were not yet to be final. The graph below shows the prioritisation of services per State.

Services prioritised (Myanmar)



Looking at the demographics, it appears that a large proportion of respondents with disability, male respondents and female respondents have prioritised health services (respectively 43.8%, 46.4% and 50.8% have prioritised it). In addition, the perception survey data shows that male respondents and people with disability who participated in the survey are more likely to prioritise livelihood. Indeed, 28% of the male respondents and 31.5% of the respondents with disability have prioritised livelihood services versus only 18.4% of the female respondents who are more likely to prioritise education then their male counterpart (14.9% of the female respondents have versus only 5.5% of the male respondents). In addition, the graph below presents the priorities for respondents who were selected because they are part of a marginalised group.

Services prioritised by marginalised respondents (Myanmar)



Although the sample is not big enough to draw conclusions for all people who are part of these marginalised groups, the data gives us an indication of key trends. It appears that most people in the marginalised groups represented above have selected health services as their top priority, followed by livelihood services. However, some groups such as the ethnic minorities and women in IDP camps have chosen education as their priority and LGBTQI+ community members seem to consider that in addition to health and livelihood services, the improvement of legal services is very important as well.

b. Access to services and satisfaction

As per the programme's logframe (annex 5.5), outcome 1 is about *'Improved access to services for marginalised people in Myanmar, Nigeria and Zimbabwe*'. It is measured through the indicators below:

Outcome 1 Indicators -	**Nigeria**	**Myanmar**	**Zimbabwe**

1. Proportion of the target population (including marginalised people) reporting improved access to prioritised local service(s)	**16.6%**	**3.9%**	**25.6%**
2. Proportion of the target population (including marginalised people) that are satisfied with their last experience of using prioritised local services	**15%**	**35.6%**	**32%**
3. Percentage increase in uptake of prioritised local service(s)[10]	-	-	-

In Nigeria, looking at livelihood and agriculture, the overall access is low at 15.3%. People have mainly highlighted that there is no service available around this issue and therefore, the satisfaction is even lower (4.5%). Most of the rural women are subsistent farmers and adolescent boys and girls often have to help their families on the farm, and they need to sell some of their agricultural products in order to meet their other needs. However, they do not access any form of support in terms of agricultural inputs (improved seedlings, fertilizers, and implements) or micro-loans and they do not have information about the availability of such support. A major challenge to their livelihood is the environment in which they live, a by-product of marginalisation, flooding is a risk faced by communities, particularly in riverine areas. These seasonal floods destroy their crops and render all their efforts useless.

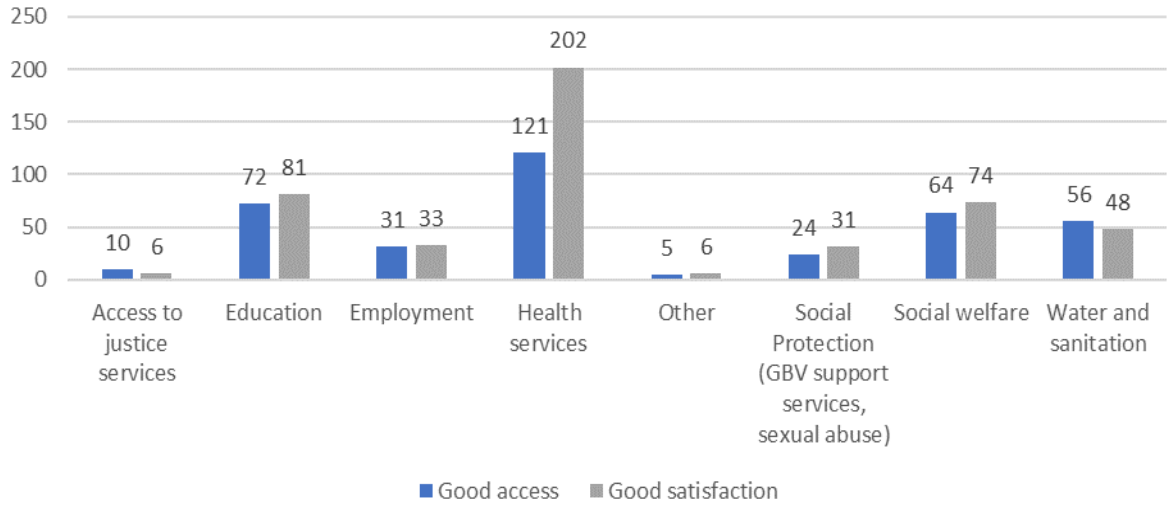
Health services seem to be mostly available and the service seems to be more satisfactory than other services. With an overall perception of the access of about 39.9%, amongst people who have prioritised health, 58% have indicated that there is physical access, 57% have indicated that there is acceptance but only 37% find the service reliable. In terms of satisfaction of their experience, 27.9% of the respondents are satisfied with their last experience and what seems to be the most problematic is the timeliness. The qualitative data collected in Nigeria during the baseline shows that infrastructure and equipment are a big issue related to health (for instance, in one of the communities, a health centre was converted into a classroom because of the lack of material and equipment). This leads to an increase in distances to accessing healthcare services causing inequalities in access. In addition, it was flagged that some medical personnel in the health centres are not youth-friendly, discouraging adolescent boys and girls. In addition, FGDs with People with disability raised that People with disability were often looked down upon and are made to wait for longer periods before being attended to.

Finally, looking into education, only 25% of the respondents who prioritised education find it accessible (physical access, acceptance and reliability all being an issue) but 41% of these respondents are satisfied with their last experience of this service, capacity and attitude being the most satisfactory aspects of it. In Nigeria, the Universal Basic Education (UBE) programme was launched in 1999, with the goal of providing 'free, universal and compulsory' basic education for every Nigerian child aged 6 to 15 years old. Although this scheme exists, many service providers and FGDs respondents have indicated that they couldn't pay for their education and that education couldn't be free because of a lack of equipment and material for pupils.

In Zimbabwe, with regards to health services, although it was the service that was prioritised by the respondents, it is also the service that show the best access and satisfaction. The graph below provides detail on the access and satisfaction for the different services prioritised.

Access and Satisfaction per service – Zimbabwe

[10] This indicator is currently being discussed. See the annex 5.5. for more details.



Regarding, healthcare services, only 26.7% of people who have selected health services find it accessible and 44.6% are satisfied with their last experience. The lack of satisfaction is based on the lack of timeliness (people made to wait) and the lack of materials but also the poor behaviour of the staff towards the patients. Although the sex of the respondents doesn't seem to be a factor regarding the satisfaction of the healthcare services, sex workers, people living with HIV and people from the LGBTQI+ community who participated in the survey seem to have a lower satisfaction of their last experience of services than people with disability. Several of them indicated that although the medicine they were waiting for wasn't available, they were made to wait for a long time and a few respondents expressed their concerns regarding the lack of confidentiality of the staff.

Water, Sanitation and Hygiene was prioritised as a service by 17% of the respondents. Indeed, out of these respondents, up to 67% consider their physical access to the service to be either 'bad' or 'really bad'. 58% respondents raised concerns about its reliability with one respondent flagging that, '3 hours of water supply over 48 hours wasn't enough' and several criticised the queues to access water supply.

Regarding the education services, several respondents mentioned their frustration towards having to provide their own stationary, causing discrimination towards the poorest pupils.

> *"I was not satisfied with the service because if you don't have stationery and have not paid up your school fees, the staff tend to discriminate you from others (sic)."*
>
> *Respondent - Zimbabwe*

Finally, looking at social welfare and employment, respondents flagged that they were unable to access such services. Some flagged the inaction when they shared their issues and other the lack of transparency by the service providers at local level.

It is to be noted that, in Zimbabwe, during the pandemic, the access to electricity increased considerably in the communities and in the programme areas. It appears that electricity that couldn't be used in industries or closed businesses was redirected to these areas. This will have had an impact on the data and services prioritised during the baseline and the team will ensure that the data validation enables any required adaptation.

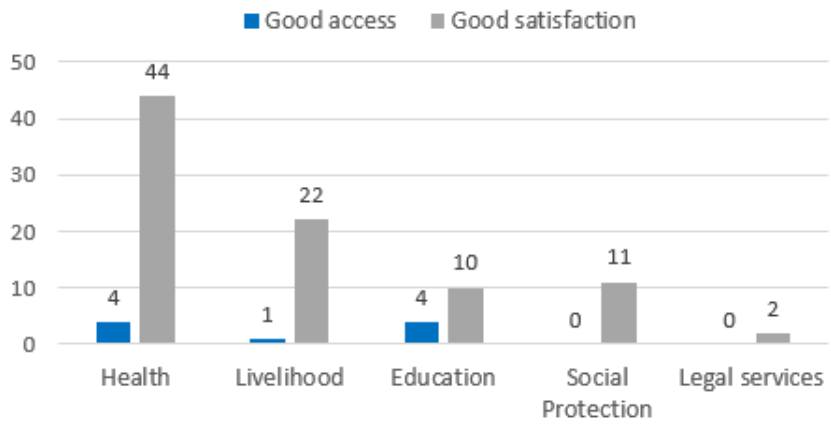
In Myanmar, the level of access to services is very low. Only 3.9% of the respondents consider that they have a good level of access to the service they have prioritised, however, 35.6% of are satisfied with their last experience of the service. Amongst the respondents, 34.9% have indicated that there is no service available in their community when the services

that they have prioritise are available, only 7.3% of the respondents are reporting a good level of access (physical access, reliability and acceptance).

Female respondents seem to have rated their level of access to the services that they have prioritised higher than the male respondents or the respondents with disability. Indeed, 6.1% of the female respondents find that they have a good level of access to the service prioritised versus only 2.4% and 2.7% respectively for male respondents and respondents with disability.

The graph below shows the number of respondents who have reported good access and good level of satisfaction per service prioritised.

Access and Satisfaction per service – Myanmar



Although the level of access is very low for all services, it appears that 37% of people who have selected health services as their priority are satisfied with the quality of the service they have last received. Respondents with disability seem to be less satisfied of their last experience of using health services than female or male respondents (only 31.2% of people with disability are satisfied versus 34.5% of female respondents and 40.7% of male respondents). Members of the LGBTQI+ communities have raised that in some cases, lack of acceptance has impacted their experience:

> *"They always put me the bottom of the waiting list for the medical check because I am from the LGBTQI+ community."*
>
> *Male respondent - Myanmar*

Livelihood support was prioritised by 25.2% of the responds, amongst which only 1 respondent considers its access to be satisfactory but 33.8% are satisfied with their last experience of the service. 42.8% of the female respondents have indicated that they were satisfied with the service the last time they have used it versus only 33.3% of the male respondents and 26.1% of the respondents with disability.

3.4. Outcome 2: Improved decision-making voice/power

The second outcome of the ECID programme is *'Improved participation in decision-making processes for marginalised people in Myanmar, Nigeria and Zimbabwe at all levels'.*

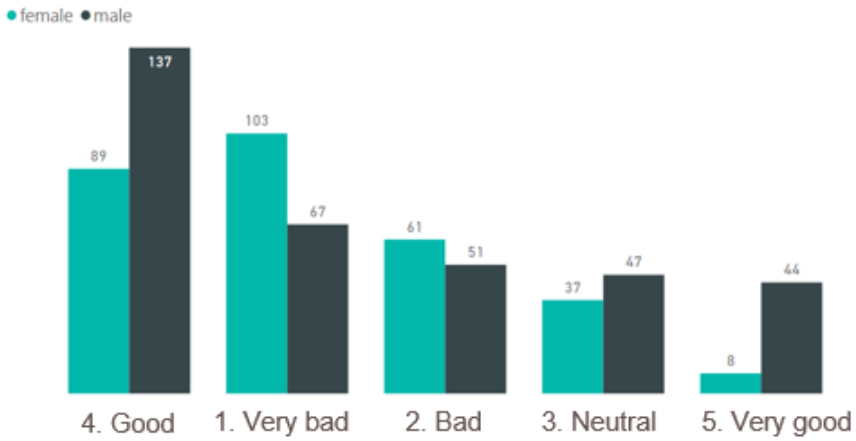
This outcome is measured through three indicators of which two are measured in the baseline, as described below:

Outcome 2 Indicators -	Nigeria	Myanmar	Zimbabwe
1. Number of instances demonstrating that marginalised people have meaningful participation in and/or are leading decision-making processes at all levels[11]	-	-	-
2. Proportion of the target population (including marginalised people) satisfied with their confidence and capabilities in decision making that affects their lives	**43.5%**	**15.1%**	**24%**
3. Proportion of the target population (including marginalised people) that recognise and value the input of marginalised people in decision making	**93.5%**	**89.5%**	**42%**

Based on the data collected in Kaduna and Anambra (Nigeria), it shows that 43.5% of the respondents are satisfied with their confidence and capabilities in making decisions that affect their lives. However, the numbers are quite different for male and female respondents: only 36.4% of female respondents are satisfied with their confidence and capabilities in decision making compared to 49.6% of male respondents.

When these percentages are triangulated with respondents' actual involvement in decision-making, it can be pointed out that satisfaction in confidence and capability can relate to self-confidence and self-capacity rather than actual involvement. However, as demonstrated in the graph below, 43.1% of the respondents indicated that their level of engagement in decision-making that affects their lives is good or very good (although only less than 30% of female respondents).

Level of engagement of respondents in decision-making that affects their lives (Nigeria)

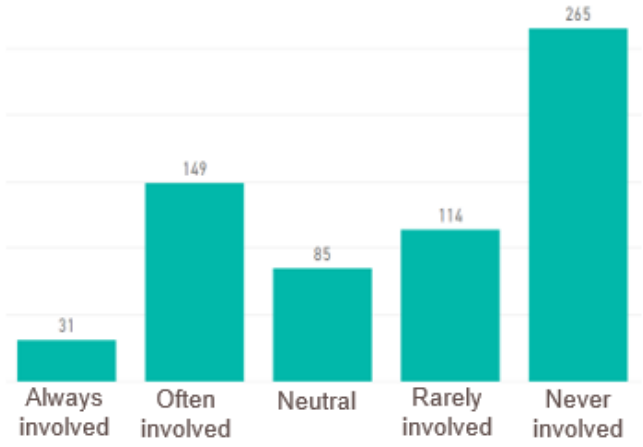


[11] This indicator will be monitored throughout the programme's lifespan. The initial situation will be informed by qualitative data collected during the baseline

It is to be noted that the adaptive preference is particularly relevant here. When the programme starts, a change in satisfaction of engagement might decrease at first. Due to a higher knowledge of one's rights, the satisfaction and recognition of their level of engagement will likely be impacted. Based on this data, the scale of level of engagement (and involvement) in decision making was reviewed to set up a harmonised and coherent scale for the programme that can be found in annex 0.

In addition, the proportion of the population that recognises and values the input of marginalised people in decision making is surprisingly high. Based on the data collected in Kaduna and Anambra, 93.5% of the respondents (94% of the female respondents and 93% of the male respondents) consider that it is important for marginalised people to be involved in decisions that affect their lives.

In practice, data shows a lack of inclusion of marginalised people in decision making. Indeed, 58% of the respondents indicated that the most marginalised people were either never or rarely involved and only 28% indicated that they were often or always involved. Qualitative data confirms that, in Kaduna State, in most cases adolescent boys and girls and People with disability have very little opportunities to engage in decision making while poor rural women are, sometimes, invited to community meetings. In Anambra State, however, there seems to be more space for participation of marginalised groups. Poor and rural women have considerable decision-making power through organisations that they lead, People with disability are members of the Union Town executives or are organised in associations. However, adolescent boys and girls are still under-represented in decision-making processes.



Involvement of marginalised people in decision making (Nigeria)

The data for this indicator needs to be considered carefully:

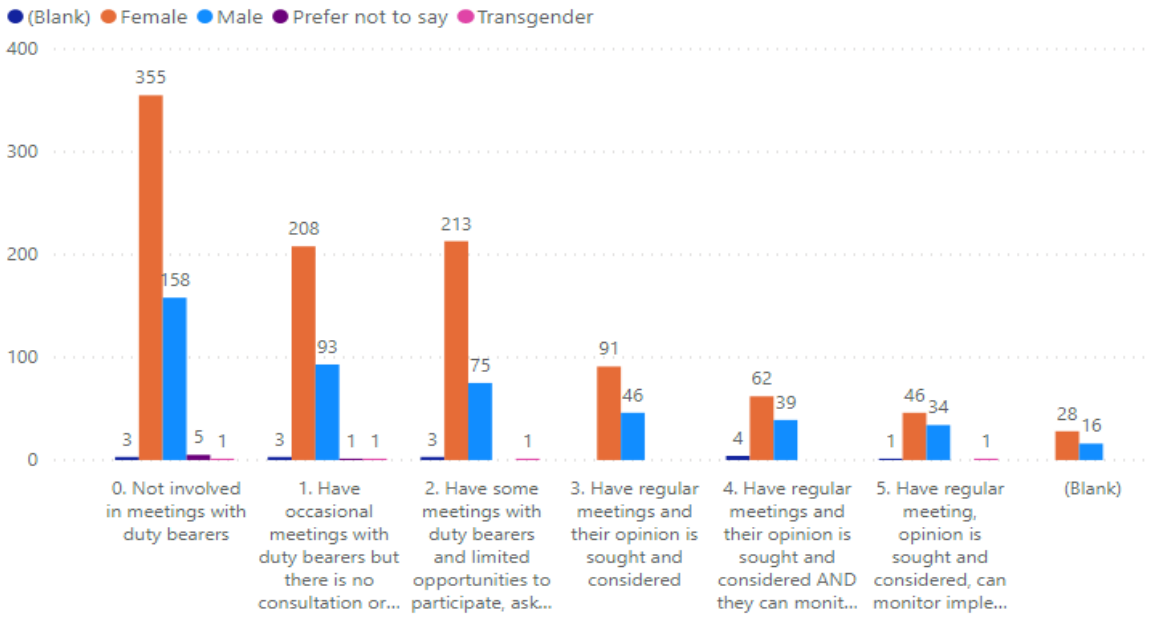
- People's responses are highly dependent on who they consider to be the most marginalised;
- Most respondents consider themselves as being part of the most marginalised people and have responded to this question for themselves;
- The question was considered leading, and respondents could have looked bad if saying that marginalised people's involvement wasn't important.

For these reasons, the global ECID team and different country teams have changed the questions for this outcome, ensuring that the learning from Nigeria could applied in Zimbabwe and Myanmar.

Based on the learning from Nigeria, in Zimbabwe, outcome indicator 2.2. looked at the satisfaction of the engagement in decision making as well as the perception of the value of ones' input. Out of the respondents in Zimbabwe, 359 people (24.1%) have answered that they are satisfied or very satisfied with their engagement in decision making and think that they always (or depending on the subject) have something valuable to share in meeting with duty bearers. Although the percentage for this indicator is low, it appears, that a high percentage of people are confident with the value of their inputs. Indeed, 74.7% of the respondents think that they have something valuable to share in meetings with duty bearers. This percentage is much lower for respondents who were selected because they have a disability with only 56.7% of them trusting that they have something valuable to say (amongst which, only 52.1% of the female respondents do versus 62.6% of the male respondents). Unfortunately, the platform to do so seems to be missing.

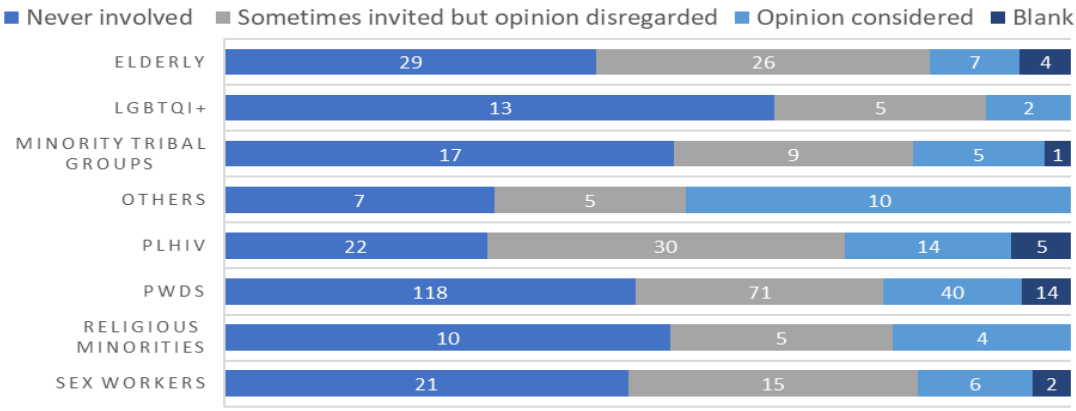
If we look at the involvement in decision making processes, only 21.7% of the respondents have indicated their opinion is considered in decision-making processes (3, 4, and 5 in the scale presented below), 35% of the respondents indicated never being involved or even invited to meetings with duty bearers and over 40% are sometimes involved but their opinion is neither sought nor considered (see graph below).

Involvement in decision-making (Zimbabwe)



When it comes to the involvement of the most marginalised in decision making, when asked who should be involved in decision-making processes, 42% of the respondents have mentioned at least two of the marginalised groups identified. While this value is encouraging, it reflects people's opinion rather than meaningful engagement and the graph below shows the involvement in decision-making processes of the respondents that were selected because they are considered marginalised. The same scale above was used but simplified for easier reading of the data (Never involved = 0, Sometimes invited but opinion disregarded = 1 and 2, Opinion considered = 3, 4 and 5).

Involvement of marginalised people in decision-making (Zimbabwe)



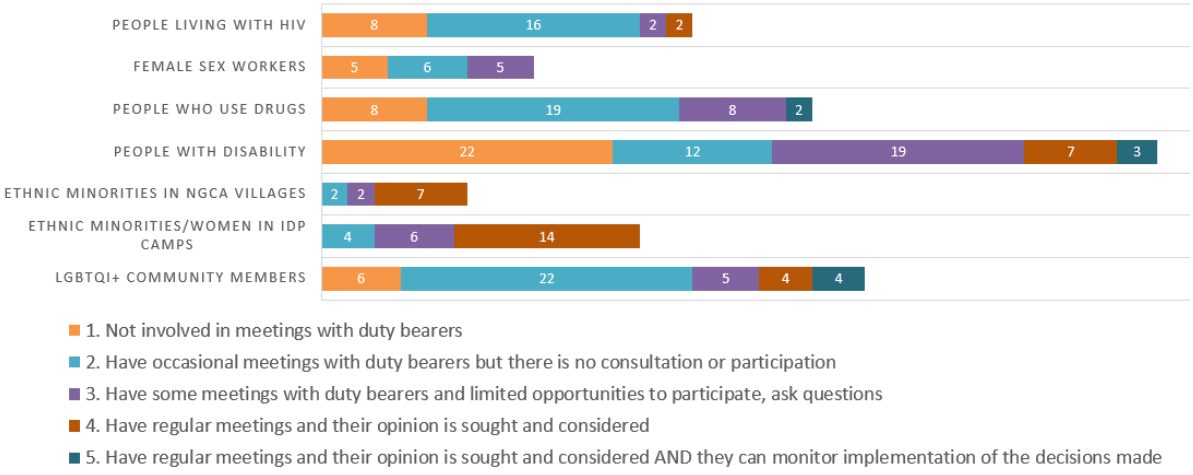
This shows that besides from the category 'Other'[12] a very small percentage of people who are considered marginalised have their opinion considered, while 57% of them, however, believe that they have something valuable to share.

In Myanmar, only 15.1% of the respondents have reported being satisfied with their engagement in decision making processes in their communities. This percentage is much lower than in Nigeria and Zimbabwe, however, we note that a lot of people left this question blank in Myanmar, raising concerns regarding the representativeness of this value.

The data, however, shows more consistently that 26.7% of respondents in Myanmar are involved in decision making (they – at least - participate in meetings, their opinion is sought and considered), the sex of the respondents makes a slight difference in the involvement in decision making with 25.4% of the female respondents involved in decision making processes versus 29.1% of the male respondents.

Looking at the involvement of people who were selected because they are part of marginalised groups, we can see that apart from ethnic minorities in NGCA villages and ethnic minorities/women in IDP camps, a large majority of respondents have reported not being involved in decision making processes (or that their participation is not sought). The graph below shows more details about this.

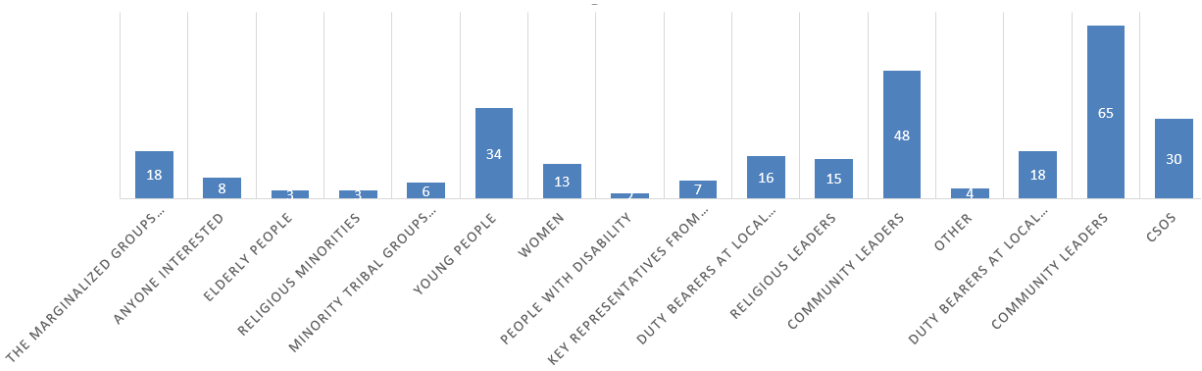
Involvement of marginalised groups in decision-making processes (Myanmar)



The last indicator of this outcome is about the perception that people in the community have about the most marginalised people being involved in decision making processes. Data shows that 89.5% of the people surveyed find it important for the most marginalised to be involved in decision making processes. This is very encouraging for the project, however, when the activities were stopped and re-planned because of the Covid-19 pandemic, we decided to add a question and directly ask the respondents who they believe should be involved in decision-making (questions used in Zimbabwe to measure this indicator). Out of 166 respondents, 10% have indicated that they believe that 'marginalised people' (in general) should be involved, and only 7.9% have specified at least 2 groups of marginalised people (see graph below).

Perception of who should be engaged in decision-making processes (Myanmar)

[12] Unfortunately, the data does not explain who is included in this category 'other'.



3.5. Outcome 3: Effectiveness of civil society and other stakeholders

The third outcome aims for an *'Increased effectiveness of civil society and other actors at all levels to address the priorities of marginalised people in Myanmar, Nigeria and Zimbabwe'*.

It is measured through the three indicators below, however only one of these has currently been measured at baseline[13].

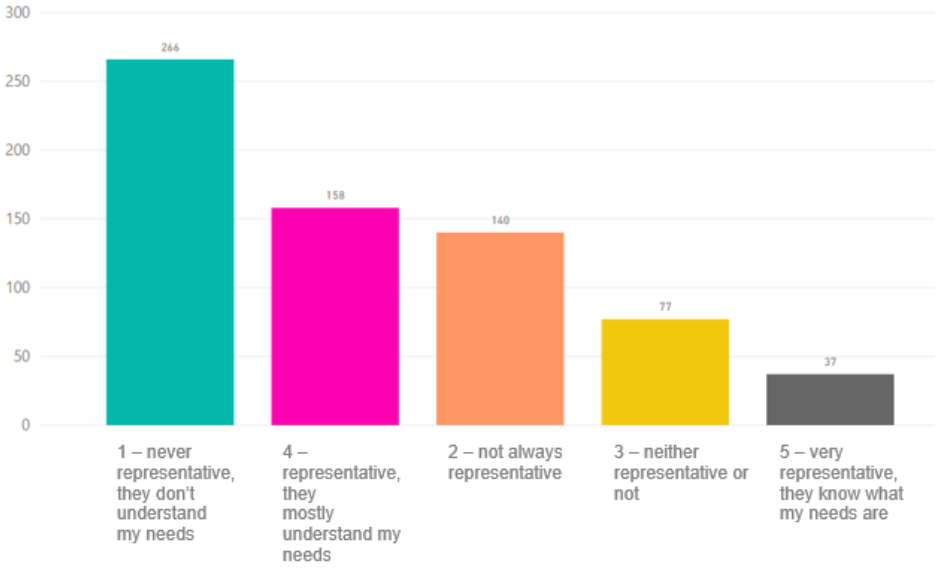
Outcome 3 Indicators -	**Nigeria**	**Myanmar**	**Zimbabwe**
1. Number of sustained initiatives by civil society and communities that have facilitated engagement with duty bearers to influence/ participate in decision-making on issues prioritised by marginalised people	-	-	-
2. Number of new functioning and rewarding partnerships, collaborations and collective actions between civil society, communities and local or national authorities and other stakeholders to address issues prioritised by marginalised people	-	-	-
3. Percentage of the target populations including marginalised people who find CSOs effective when it comes to representing them and their needs	**28.7%**	**43%**	**56.7%**

Development programmes in general, assume that CSOs should be consulted as a way of better understanding the needs of the most marginalised groups they aim to represent. Within the ECID programme, we want to test this assumption that CSOs are effective at representing marginalised people.

The baseline data for Nigeria indicates that this isn't the case, with only 28.7% of the respondents considering that the CSOs are representative of their needs.

Effectiveness of CSOs in representing people's needs (Nigeria)

[13] The other two indicators don't need baseline values but are informed by qualitative data to understand the initial context of the programme.



While it doesn't appear that the sex of the respondent is a factor that makes a difference in the perception of the representativeness of CSOs, the State in which people live in might. In Kaduna, 35.7% of respondents seem to find the CSOs representative versus only 23.3% in Anambra state. KIIs have shown that in Anambra only 21% of the CSOs interviewed seem to 'understand and recognise' the needs of the most marginalised[14] versus 31% in Kaduna. Evidence from the FGDs supports different trends:

- In Kaduna, majority of the CSOs do not work in the hard-to-reach communities, as most of the target groups in these communities claim they are not aware of their existence. In addition, while People with disability feel like CSOs have been supporting them, poor rural women and adolescent boys and girls have not felt any impact of the CSOs in their lives.
- In Anambra State, CSOs engage more with the target groups at the rural communities more than they do in Kaduna State and their community engagement has been increased due to several previous interventions (such as Christian Aid V2P[15] project).

This shows the difference between the perception of marginalised groups, involved in the qualitative data collection processes and community members who are not specifically part of these groups, involved in the perception survey.

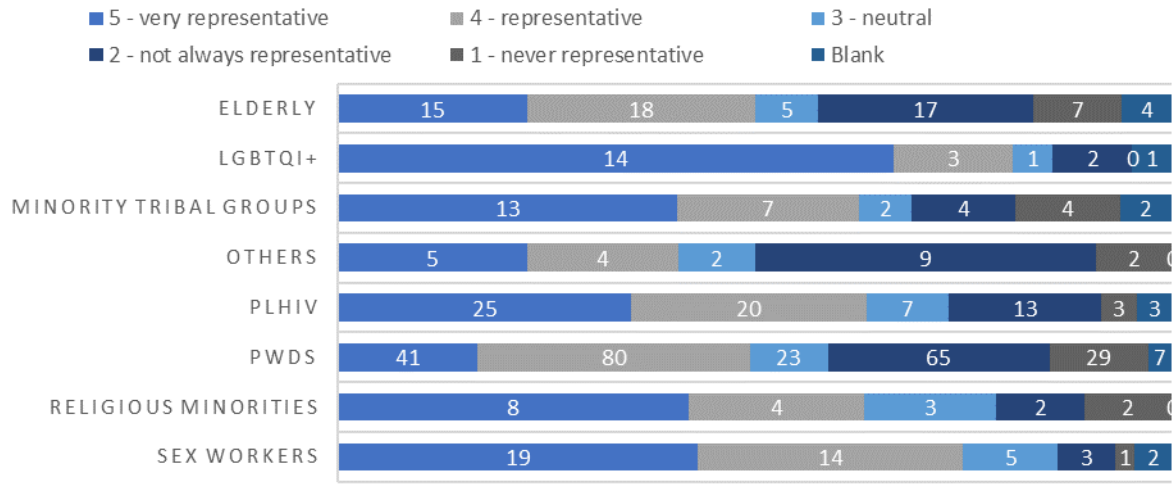
In addition, a question was also asked to understand whether people considered these CSOs to be representative of marginalised people's needs. Most respondents (40%) indicated that they don't know. This might be for different reasons, either they do not consider themselves to be marginalised and do not wish to speak on behalf of other people, or they do not have much interest in supporting marginalised people accessing they rights. Out of the 59% remaining, only about 42.3% (25.5% of the total) considered that the CSOs are representative (up to very representative) of the most marginalised needs.

In Zimbabwe, 56.7% of the respondents find that CSOs are representative of their needs and amongst respondents that were selected for being part of a marginalised group, 52% believe so. This shows a much higher satisfaction than in Nigeria. The graph below, disaggregating this value for the people who were selected because part of a marginalised

[14] This was measured through the way key informant collect and use data about the most marginalised.
[15] The V2P - Voice to People – project is a Christian Aid project that was implemented in the State of Anambra and which recently showed positive results.

group, shows that aside from Elderly and People with disability – whose satisfaction is slightly below the satisfaction of other respondents – marginalised people broadly find CSOs to be representative of their needs.

Representativeness of CSOs for the most marginalised people (Zimbabwe)



In Zimbabwe, ECID has chosen to work in some remote areas with very limited access. Respondents from these areas have highlighted that CSOs were not representative of their needs. Indeed, they mentioned that they 'don't see them', 'don't know them', 'haven't heard of them' or simply, don't have CSOs and NGOs representing their needs.

When it comes to respondents who find CSOs very representative, one respondent indicated:

> *"They always represent the people and take our complaints to the next and relevant stakeholders."*
> *– Perception Survey's respondent, Zimbabwe*

In addition, several respondents indicated that CSOs and NGOs care and that they appreciate the value that they give to their opinions, feedback and issues.

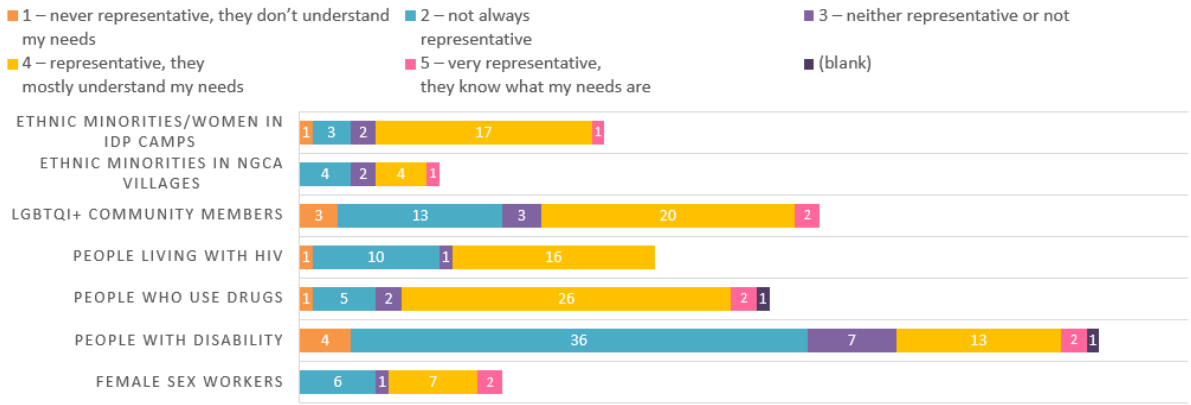
In Zimbabwe, KIIs were conducted with CSOs and Duty bearers and from the KIIs conducted with CSOs, it appears that 60% of the 32 respondents collect disaggregated data about the most marginalised groups and use that data for a better understanding, planning of their activities and/ or budget allocation. Respondents who do not collect sex, age and disability data sometimes consider that being close to the communities and engaging with their direct programme's participants, means they have the information required for activity planning. In addition, up to 44% of the CSO's respondents consider CSOs to be very effective. The main limitations flagged are the timeframe of the programmes, limiting their impact, as well as the need for funding.

> *"CSOs and CBOs are becoming highly active in influencing policymaking, change and implementation for/by the duty bearers."*
> *CSO representative, Zimbabwe*
>
> *"Effectiveness is minimum as most organizations depend on funding hence their terms of operation are short-lived."*
> *CSO representative, Zimbabwe*

Most of the CSO key informants showed a high interest in the interview and the work that ECID will be doing with them in the areas. This demonstrates a motivation to represent the most marginalised people and to improve the work done in the two provinces.

In Myanmar, 43% of respondents find CSOs representative of their needs. Male and female respondents seem to agree on this, however, people with disabilty who have participated in the survey do not. Amongst the respondents with disability, only 30% find CSOs representative of their needs. This perception seems to be stronger amongst people with disability than amongst other marginalised groups involved, as shown in the graph below.

Representativeness of CSOs for the most marginalised people (Myanmar)



Like in Zimbabwe and Nigeria, some of the project's implementation areas are 'hard to reach' and data shows that the main reason for the lack of satisfaction regarding the representativeness of CSOs is their absence. Indeed, several respondents have raised that they haven't seen CSOs in their village before.

> *"Due to transportation difficulty, no CSOs/ NGOs can arrive to our village. Hence, they will not know what we really need."*
>
> *Respondent in Myanmar*

In addition, several respondents who are female sex workers have raised that CSOs are representative during the duration of their projects but then don't represent them anymore as soon as the project ends.

In Myanmar, KIIs were conducted with five CSO representatives and although they do not all collect SAD disaggregated data, they seem to be aware of the challenges of marginalised groups. When asked who the most marginalised people are and what challenge they face, one of the respondent indicated:

> *"It depends on situation... Generally, women, children and elders can be most marginalised. But in conflicted-affected situations, men can also be included in marginalised groups. For men in conflict-affected area, abduction and abuse by soldiers from one armed group are some risks/challenges.*
>
> *Other marginalised groups that come to my mind are the internally displaced people who face challenges regarding livelihood and freedom of movement, people with disability who face infrastructure barriers (transportation, buildings no adapted (sic), etc. there is a lack of consideration for them) and LGBTQI+ communities who are victims of Cyber bullying and face challenges due to social norms."*
>
> *CSO representative - Myanmar*

The same respondent highlighted that they would like to have more information about how to best support people with disability psychologically and physically to be equal to people who do not have a disability. They also raised that they would like to have the relevant information to find ways to negotiate and mediate for people from the LGBTQI+ community to live in 'harmony' with their community.

Although some respondents in the KIIs have shared that they work in partnership and collaboration with other stakeholders (for instance to support people with disability access legal services and be provided with wheelchairs), a respondent has raised that in Bamaw district people with disability and LGBTQI+ community members have to advocate for their rights themselves and receive no support from CSOs to do so.

All participants in the KIIs were at ease with the questions and engaged in discussing the support that they can provide to the most marginalised which is encouraging for the project and future work that will be conducted with these organisations.

3.6. Outcome 4: Accountability of stakeholders

The last outcome that the programme reports against is about *'Greater accountability and responsiveness of duty bearers to the priorities of marginalised people in Myanmar, Nigeria and Zimbabwe from local to global levels'*. It is measured through three indicators of which only one has been measured through the baseline.

Outcome 4 Indicators -	Nigeria	Myanmar	Zimbabwe
1. Proportion of target population who are satisfied with and confident in their ability to hold duty bearers to account	**35%**	**43.4%**	**40.3%**
2. Evidence that government / duty-bearer have an increased level of respect for and buy-in to evidence and data on service delivery, justice and rights	-	-	-
3. Evidence of accountable relationships, actions taken by duty bearers/states/ governments, in response to community action plans	-	-	-

Out of the 678 respondents in the Perception Survey in Nigeria, only 35% feel confident and satisfied with their ability to hold duty bearers to account (35.5% of women and 34.5% of men). While the sex of the respondent does not appear to be a significant determinant in this indicator (and other factors such as disability are not representative enough in the perception survey's sample size to draw conclusions), the State of the respondents does: in Kaduna only 26.9% of the respondent are satisfied with and confident in their ability to hold duty bearers to account whereas, 41.2% in Anambra. Christian Aid worked in Anambra on the V2P project before and positive results could be contributing to the higher satisfaction of the respondents in this State.

Overall, respondents who are satisfied mainly indicated that they 'know their rights and can fight for them', and they are confident that they can speak up when they need to.

> *"When my mind is trampled, I speak out on it and any other wrong in the community."*
> *– Male respondent from the State of Kaduna.*
>
> *"Though I don't do that, I am confident that I can hold duty bearers to account."*
> *– Female respondent from the State of Anambra.*

Only a few respondents added that when they do speak up, they feel heard. A respondent even gave an example of actions being taken upon engagement of communities:

> *"Our councillors are beginning to take action as a result of our engagement: our past chairman took action to pay school fees for some of our youths as a result of our engagement."*
> *– Male respondent from the State of Kaduna*

Age seems to be a factor in people's perception in one's ability to hold duty bearers to account. While there is not a clear difference from the numbers, several respondents indicated that young people are not listened to. One of the respondents from the State of Anambra, indicated that they have, 'confidence but people are not given the space to do anything until the age of 40 and above'.

While, 67% of respondents are not satisfied with their capacity and ability to hold duty bearers to account. Most people talked about being afraid, not being confident or bold

enough to speak up. Many respondents indicated that duty bearers 'don't care', 'they don't listen' and 'they don't respond'. The few quotes below highlight some key perceptions from these respondents.

> *"I am scared oh, I don't want to put myself in danger."*
> *– Female respondent from the State of Kaduna.*
>
> *"A poor person has no opinion. If you talk they will try to silence you."*
> *– Female respondent from the State of Anambra*
>
> *"We are in a lawless country where justice is for the highest bidder."*
> *– Male respondent in the State of Anambra*

Another issue highlighted which is of great relevance for the specific aims of the ECID programme is that several people mentioned not having the right platform/space to be able to hold duty bearers to account:

> *"I don't have access to them but if I do, I will surely tell them my mind."*
> *– Male respondent in the State of Anambra*
>
> *"I know I ought to hold them accountable, but I can't even meet them to ask questions."*
> *– Male respondent in the State of Anambra*

In addition, data collected through KIIs shows that in Kaduna, policy making is more often based on evidence, as duty bearers (especially Government Ministries, Departments, Agencies(MDAs)) in the State rely heavily on data for planning. Before the establishment of the Kaduna State Bureau of Statistics (KSBS) (which is the recognised agency for data management in the state), the Ministries meet their data needs through a unit called Planning, Research and Statistics (PRS). For instance, the 'Education for all' was extended to support not only adolescent girls but also adolescent boys. The decision was based on evidence collected in the State. Through the KSBS, anyone can access basic data collected and request other specific data that is available at State level. In Anambra State, reports from the field exercise show that duty bearers are not as responsive and accountable to the priorities of the marginalised groups as they are in Kaduna State, partly because of the limited use of data for planning, though MDAs claim the data they generate is used for planning and budgeting. Nevertheless, in relation to prioritised issues of the target groups, government has been making budgetary provisions for the elderly, the poor and the women, training women and mobilising them for move engagement in politics, working for the 35% Affirmative Action (a policy that demands 35% involvement of women in all governance processes) as well as providing them (the women) with equipment such as grinding machines. More details on State level initiatives can be found in annex 5.7.

Although qualitative data seems encouraging, only 30.3% of duty bearers who responded to the KIIs seem to really recognise and understand the issues of the most marginalised. In addition, service providers (in schools and health centres for instance) have indicated that they are asked to collect data about their service users (for instance school attendance) but hardly know what the data is used for. As a result, responses related to the use of data were often based on assumptions.

> *"I don't really know how that [data use] works. My own part is to ensure that the data gets to the LGA within the stipulated time."*
> *-Service Provider (school) - Nigeria*

This speaks to ECID's intention to support key stakeholders (duty bearers, service providers, CSOs and community members) to use data via an appropriate platform for decision making.

In Zimbabwe, they found a slightly higher percentage, with 40.3% of respondents satisfied with their ability to hold duty bearers into account. Given the context, the value seems high and there is a possibility that adaptive preference has an impact on the evolution of the satisfaction of the respondents.

Respondents who find that they can hold duty bearers to account mainly mentioned their rights to do so and their feeling of power in that regard. In addition, satisfied respondents indicated that they find duty bearers understanding and representative.

> *"Because we voted for them, they should understand our grievances."*
> *-Male respondent from Manicaland*
>
> *"They treat everyone equally and they consider our opinions in society."*
> *-Male respondent from Matabeleland North*
>
> *"They solve our problem as our representatives."*
> *-Female respondent from Matabeleland North*

Respondents who are not satisfied (to not satisfied at all) represent 37% of the respondents. The main reasons shared are the risk of being discriminated against, or the feeling of being invisible in their communities. Some respondents also flagged that they would not know how to hold duty bearers to account or that duty bearers are not interested in their opinions and needs.

> *"I am afraid of being victimised." - "I am afraid of being scolded by those in power."*
> *-Two female respondents in Manicaland.*
>
> *"They never care what anyone thinks, they do what suits their wants and needs."*
> *-Male respondent in Manicaland.*

Marginalisation does make a difference on the satisfaction of respondents on their ability to hold duty bearers to account. Only 36.4% of the respondents who were selected because they are part of a marginalised group are satisfied. This value is lower for people with disability with only 30% of them satisfied. Several respondents with disability have raised the lack of arrangements for them to participate in discussions with duty bearers. Other have raised that they have no idea on the approach that they should take to do so or don't think they sufficiently know their rights and that duty bearers are not interested in their situation.

Looking at the KIIs however, duty bearers seem very aware of the challenges faced by marginalised people with 82.4% of the duty bearers interviewed (out of a sample of 125) indicating that they collect data that is disaggregated by sex, age and disability and that this data supports their understanding, planning and/ or budget allocation[16]. Only up to 33% of them perceive themselves as very effective at representing the most marginalised. In addition, data from the KIIs with CSOs shows that CSOs are very satisfied with their relationship with duty bearers but it also shows that they don't find duty bearers effective (less than 10% of the CSOs interviewed perceive the duty bearers as effective).

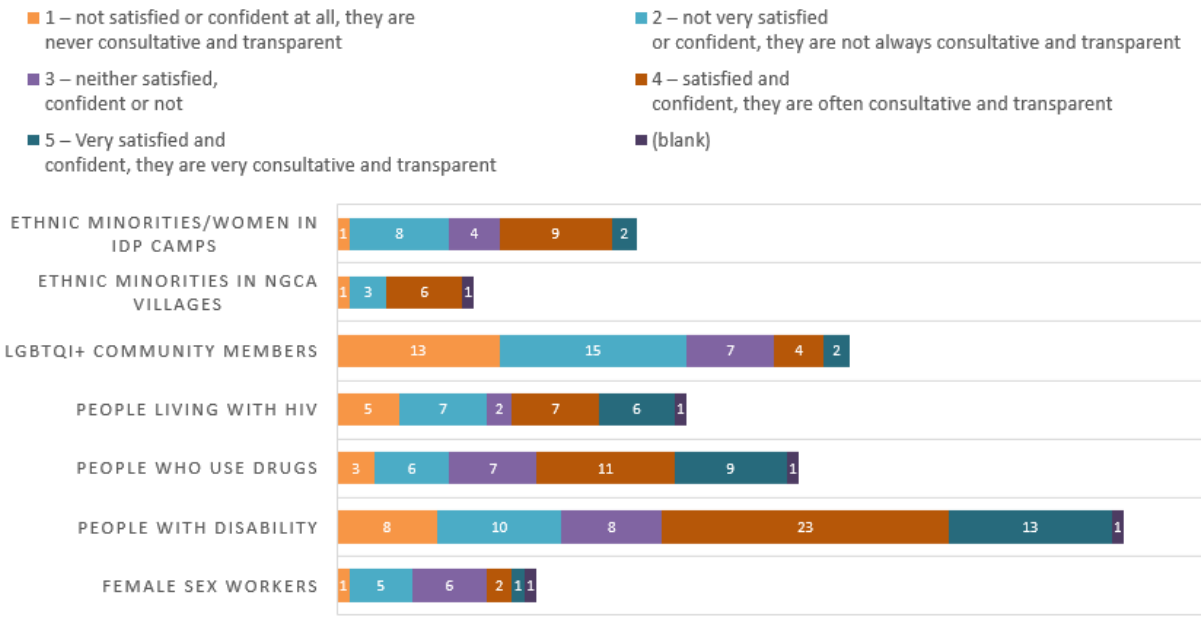
This will be important to continue exploring during the programme's lifetime to ensure that the interventions enable successful partnerships and collaboration and to ensure that the most marginalised are well represented.

[16] This value around disaggregation of data is surprising for the Zimbabwe country team and although efforts were made to ensure that the questions were not leading, there is a risk that follow up questions were and therefore, may have biased the findings. This will be further discussed and assessed with CSOs and Duty Bearers during project activities.

In Myanmar, 43.4% of respondents in the perception survey find that they can hold duty bearers to account. This is slighter higher than the value for Zimbabwe and much higher than the value found in Nigeria. Whether the respondents have a disability does not impact this value as 45.2% of people with disability involved in the survey are satisfied with their ability to hold duty bearers to account. The sex of the respondents does not influence this value either. As indicated in the limitations section of this report (and as flagged in the previous paragraph about Zimbabwe), there is a probability that the 'adaptive preference' phenomenon is having an impact on this indicator. Indeed, it is expected that when the project's activities start, and people are more aware of their rights for transparency and accountability, this value will go down.

The graph below presents respondents' satisfaction when it comes to holding the duty bearers to account. It focuses on respondents who were selected because they are part of one or several marginalised group.

Representativeness of CSOs for the most marginalised people (Zimbabwe)



The data shows that respondents from the LGBTQI+ community are the least satisfied when it comes to their ability to hold duty bearers to account. Indeed, 58% of them have selected that they are either not satisfied or confident at all or not very satisfied or confident. Based on the data, the reason for this lack of satisfaction is mainly the poor consultation and transparency. Respondents from the LGBTQI+ community have raised that they 'never know what duty bearers do' and they are not invited in discussions. Only a few respondents have raised issues around discrimination.

In Myanmar, during the baseline, the team conducted three KIIs with duty bearers to better understand their perception of the situation. All three respondents appeared very engaged in the discussions and to want to support the improvement of the situation of the most marginalised (whom they mainly consider to be the people with disability, drug users, children and elders). However, data showed that the duty bearers do not collect the necessary data to understand the most marginalised groups (at least SAD disaggregated data) and when they do, they do not seem to use it for decision making and budget allocation. Although this presents some challenges, all respondents have indicated that they

work in collaboration with NGOs, CSOs, CBOs and other duty bearers. In addition, one of the respondent mentioned several joint initiatives in the Myikyina Township[17].

[17] Child Protection WG for children, Women Legal Aid, ICRC and MRC collaboration for PWDs, PYOE (local CSO) project for blind people, British Council and USAID and Ambassadors from Japan, US, China, Korea support marginalised groups as well.

4. Conclusions

4.1. Conclusions

a. Access and quality of services

Based on the findings from this baseline, it appears that services and sectors prioritised by the communities are not always in line with what was prioritised by the GIPP analysis undertaken during the co-creation phase. Although the overall findings show the same trends in all three countries, we can observe that in Nigeria the services prioritised at community level, if looked at by State, they are very different from the State level services initially identified.

Overall, in Nigeria, most participants in the perception survey and FGDs would like to see 'Infrastructure' improving as they recognise that it is the underlying issue when it comes to accessing services. While this is true, data shows that the satisfaction of the quality of the existing service is very low as well and other aspects of the health and education services will have to be improved too.

In Zimbabwe, 30% of the respondents in the Perception Survey have prioritised health followed by WASH, Education, Social Welfare and Employment (all between 12.6 and 17%). This is aligned with the most marginalised people who participated in the survey who all also mainly prioritised Healthcare services (except the religious minorities who would like to prioritise employment and social protection). People with disability have prioritised Social Welfare to the same extent as Healthcare services. Although the access to the service as well as the satisfaction of its quality, is low, it is better than for Nigeria with 25.6% of respondents indicating having access to the service and 32% being satisfied with their last use of the service.

In Myanmar, the perception survey data, along with the few participatory activities that were conducted pre-Covid-19 confirms that Health is the priority for a large majority of the respondents (45%), followed by livelihood support (25%) and then education (9%) and social protection. Some groups such as the ethnic minorities and women in IDP camps have chosen education as their priority and LGBTQI+ community members seem to consider that in addition to health and livelihood services, the improvement of legal services is very important as well. While all services present a very low level of access (3.9%), the level of satisfaction is much higher with 35.6% of the respondents satisfied with their last experience using the service that they have prioritised.

b. Decision making power

The indicators informing outcome 2 have been the most surprising in terms of findings for the Nigeria country team. Based on the perception survey data 43.5% of the respondents are satisfied in their ability to make decisions affecting their life and 93.5% find it important for marginalised people to be direct actors when it comes to making decisions for themselves. While this might be due to several limitations (people's understanding of marginalisation, not taking some groups into account, questions in the survey not enabling enough granularity), this is very positive and encouraging for the ECID programme.

Based on this learning, the perception survey tool was revised for the remaining baseline activities and the greater granularity showed that in Zimbabwe, 24% of the respondents are satisfied with their confidence and capabilities in decision-making that affects their lives and 42% think that marginalised people should be involved in decision-making. This is very encouraging, however, changing behaviours takes time and for now the marginalised people involved in the baseline seem to not be involved in decision-making.

In Myanmar, only 26.7% of respondents are involved in decision making (they – at least - participate in meetings, their opinion is sought and considered). Findings show that apart

from ethnic minorities in NGCA villages and ethnic minorities/women in IDP camps, a large majority of respondents who were selected because they are part of one (or several) marginalised groups have reported not being involved in decision making processes.

c. Stakeholder's effectiveness

Finally, outcomes 3 and 4 highlight the perception of citizens when it comes to the effectiveness of different stakeholders (CSOs and duty bearers). Based on the baseline findings for this report, only 28.7% of the respondents in Nigeria felt that CSOs were representative of their needs and only 34% of the respondents were confident in their ability to hold duty bearers to account. One main reason for the latter is the lack of confidence and fear of repercussions, but also the lack of a platform and fora to discuss their issues with Duty Bearers.

In Zimbabwe, the situation seems slightly better with 56.7% of the respondents finding CSOs representative of their needs and 40.3% of the respondents confident in their ability to hold duty bearers to account. Respondents have indicated that CSOs represent the people and always follow up on their complaints with the relevant stakeholders and they have indicated that because they voted for their duty bearers, they should represent them, but some people are afraid of being victimised and prefer not to share their grievances.

In Myanmar, 43% of respondents find CSOs representative of their needs (but only 30% of the respondents with disability). The main reason for the lack of satisfaction regarding the representativeness of CSOs is their absence in some remote areas. Regarding the duty bearers, 43.4% of respondents find that they can hold duty bearers to account. The data shows that respondents from the LGBTQI+ community are the least satisfied when it comes to their ability to hold duty bearers to account.

d. Reaching the most marginalised

Finally, this baseline process has reinforced the benefits of working with local partners to reach the most marginalised. Indeed, especially in Myanmar and Zimbabwe, working with local partners enabled reaching some of the most marginalised people, often invisible and therefore, hard to include in programme planning. Also, in all three countries, it has supported gaining access to the geographically hard to reach communities and managing the communication gap arising from the multi-dialect nature of the programme focal states.

Reaching the most marginalised has been a challenge in Nigeria and this learning enabled the programme's team to reach a higher proportion of marginalised people in Myanmar and Zimbabwe. In addition to demonstrating the added value of working with local partners, this demonstrates the added value of a multi-country programme for cross-country learning.

4.2. Recommendations and next steps

The main recommendations and next steps based on this baseline activities are:

- A learning meeting with country offices and consortium members involved in M&E work to understand how the learning from the baseline impacts the ECID programme logframe and review it, as see needed,
- A global level learning event on findings but also on processes (including a review of GESI, ethics and safeguarding processes)
- Country level workshops based on the data – resulting in strategy review of the programme at country level, country level recommendations shall be made at this stage to ensure that they are integrated in the programme implementation,
- A full learning review of the baseline activities and findings, resulting in a report that ensures that the programme can integrate the baseline learning,
- When possible, validate data at the community level in participatory settings enabling the action planning with the communities.

5. Annexes

5.1. Description of the three steps initially planned

Step 1 represents the community engagement. During this step, enumerators spent about 2 days in the community, engaging with community groups through a series of participatory activities (including community mapping, system mapping, services and barriers prioritisation, etc.). The series of activities is adapted at country level to ensure contextualisation but respond to the same overall objectives in each country:

- To ensure good community engagement in the programme;
- To identify services or issues that the community would like to see addressed to improve their lives;
- To start discussing marginalisation and the difference in experiences of services of different individuals.

The baseline findings about services to prioritise in a community will serve as a basis for the perception surveys and key informant interviews. In addition, all data collected through the Step 1 will be used to triangulate the perception survey data and Key Informant Interviews (KII).

Step 2 represents the one-to-one discussions. During this step, enumerators conduct perception surveys with community members (including marginalised people) as well as Key Informant Interviews with key stakeholders related to service access and quality (duty bearers, Service providers and CSOs). Step 2 builds on the findings from Step 1 at community level and is conducted just after Step 1 is finalised so the community engagement is not scattered over time. As for Step 2, tools are harmonised at global level but contextualised for each country to serve the below objectives:

- Collect information on experience of prioritised services with individuals (including people considered the most marginalised[18]),
- Collect information on effectiveness and ways of working of CSOs, duty bearers and service providers.

After step 2 is completed, all data is gathered and analysed in a unique dashboard supporting global level interpretation but also country level interpretation and data sharing (with all different stakeholders, including communities).

Step 3 represents data validation and action planning. Step 3 is seen as the bridge between the baseline and the start of the implementation. During this step, a series of activities are proposed to share the data collected back with communities and have discussions about any differences in experiences of services by different groups within the communities. As mentioned, step 3 has three main objectives:

- Validate the baseline data collected and interpret it together with the community (closing the data collection loop),
- Discuss changes in context that might have impacted people's priorities in the communities,
- Discuss any differences between findings from the GIPP and findings from their communities,
- Discuss difference in experience of services based on people's marginalisation,
- Conduct the community action planning to address the issues identified.

[18] Marginalised people identified as part of the GIPP and though Step 1.

5.2. GESI practices in country

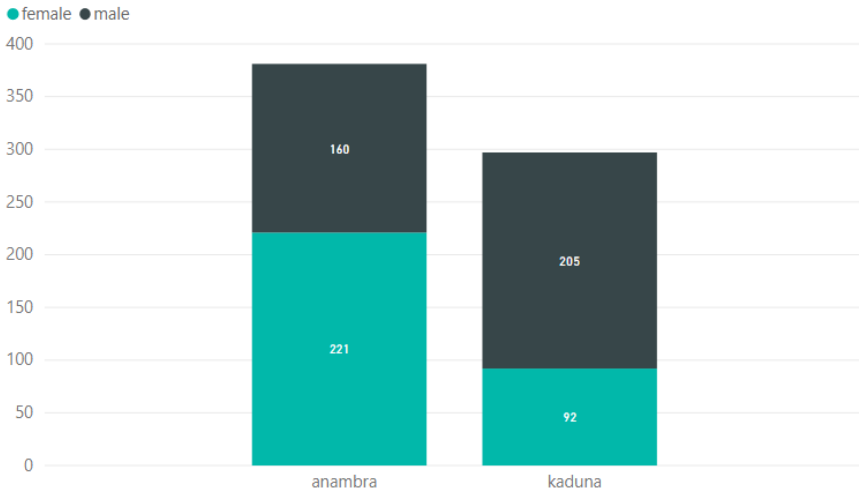
Global guidance	Nigeria	Myanmar	Zimbabwe
Ensure that at least 50% of the enumerators are female	Amongst the two states, only 39% of enumerators were female because enumerators were the programme's partner staff who had the right expertise and knowledge.	Out of a total 32 data enumerators, 15 of them are female enumerators (47%). However, for data collection in communities, 3 of CA female staff were supporting.	Out of 66 enumerators, 56 were female which represents up to 85%.
Ensure that some of the enumerators are from the same marginalised groups as the respondents	Partners are from remote areas and the staff is close to the marginalised groups in the areas.	Out of the 32 enumerators: 7 People with disability, 1 person from the LGBTQI+ community, 2 Female Sex Workers, 2 People who use drugs, and 14 enumerators from ethnic minorities.	All 66 enumerators are from the programme's areas (wards) and some are from very remote areas. In addition, 2 enumerators were People with disability.
Break the participatory activities into sub-groups that are bringing together people with similar characteristics to ensure that people feel comfortable sharing their experience.	Three groups: Adult women, Adolescents (boys and girls) and People with disability.	Three groups: women, men and youth[19]. Participation of other People with disability was encouraged and follow up in the Perception Survey.	N/A
Work with local CSOs working with specific marginalised groups to identify 25 to 50% of respondents from these marginalised groups	CAN used a purposive sampling approach to select respondents for the perception survey, however, also based on availability and consent to participate in the survey.	Working with partners who linked with target groups networks, CAM team ensured that LGBTQI+, people with disability, female sex workers, People who use drugs and internally displaced people and Non-Governmental Controlled-Areas (NGCA) ethnic communities were reached.	CAZ ensured inclusion of People with disability through purposive sampling: support by healthcare workers, community mobilisers and local leader, snowballing (in Binga), identification by local Focal Persons (in Mutasa), identification by the enumerators (Mutare urban).

[19] While adult women tend to be less vocal when men are around, it is different for younger generations in Myanmar.

5.3. Demographics

a. Nigeria

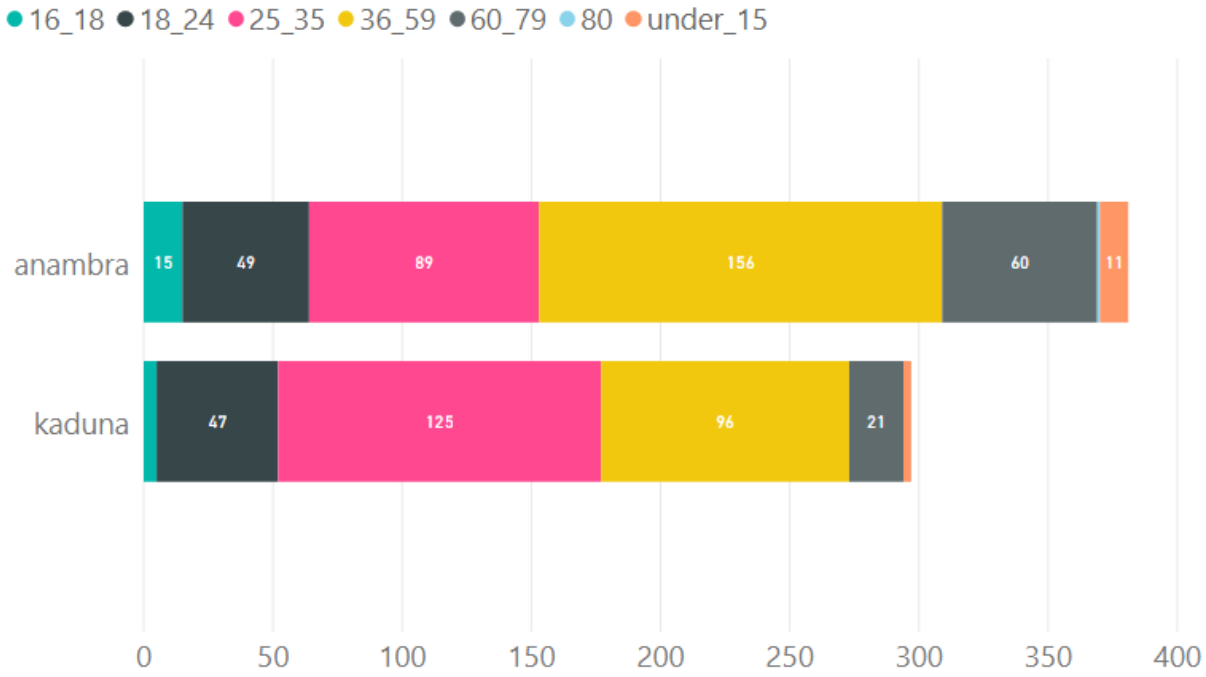
Sex of the respondents per State



Disability of the respondents per State

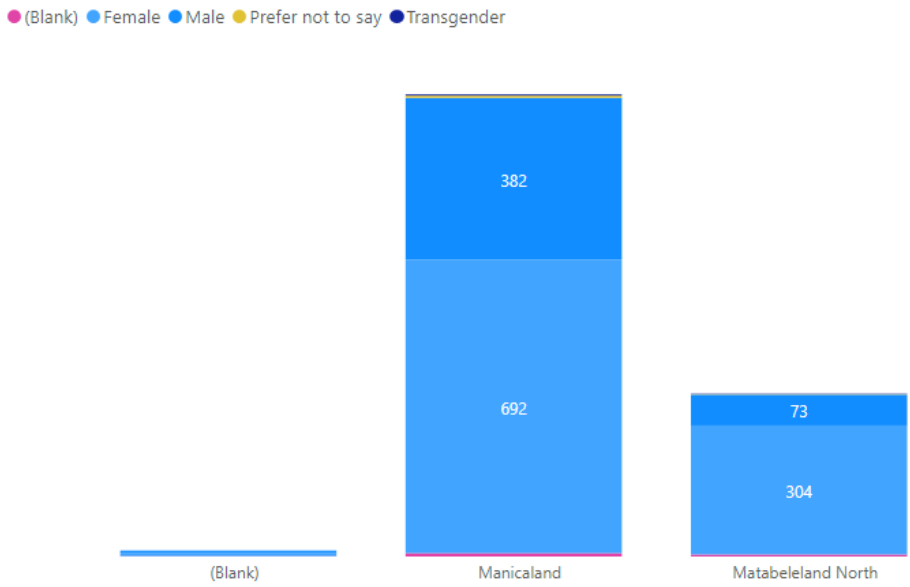
	Anambra	Kaduna	Total
People with disability	11	16	27
People without disability	370	281	651
Total	381	297	678

Age of the respondents involved in the perception survey per State



b. Zimbabwe

Sex of the respondents per Province

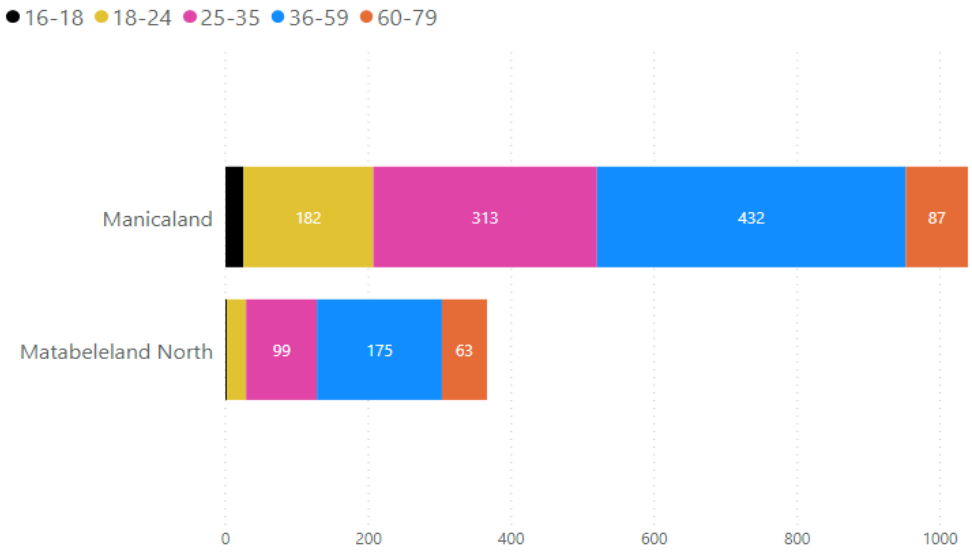


Number of People with disability per Province

This is based on the WGQs and calculated through the 'disability 2' analytical framework.

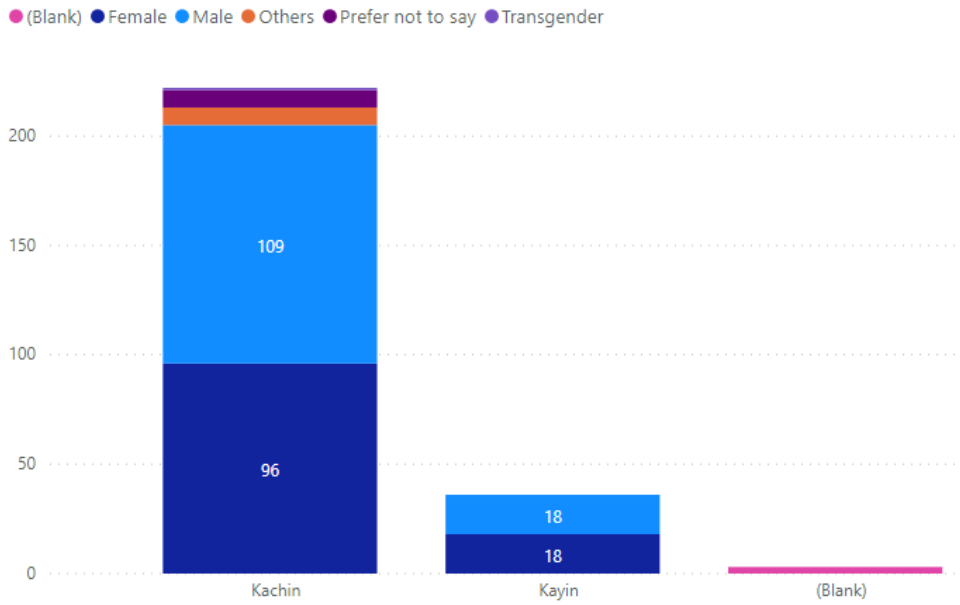
People with disability (Disability 2)	Manicaland	Matabeleland North	(blank)	Grand Total
No	711	230	7	948
Yes	387 (35%)	157 (40.6%)	4	548 (36.6%)
Grand Total	**1098**	**387**	11	**1496**

Age of the respondents per Province



c. Myanmar

Sex of the respondents per State

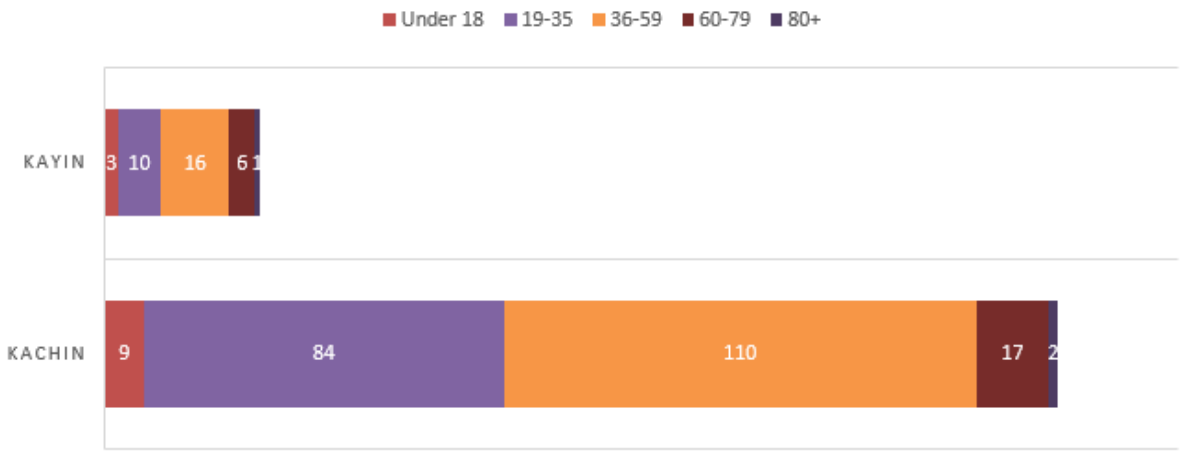


Number of People with disability per State

Disability 2	Kachin	Kayin	Total
No	105	25	130
Yes	117 (53%)	11 (30%)	128 (49.6%)
Total	**222**	**36**	**258**

Disability 3	Kachin	Kayin	Total
No	155	30	185
Yes	67 (30%)	6 (17%)	73 (28%)
Total	**222**	**36**	**258**

Age of the respondents per Province



5.4. Template used for the Responsible Data Plan in Myanmar

Responsible data Plan

<table>
<tr><th colspan="4">MATRIX</th></tr>
<tr><td colspan="2">What is your purpose? What are you going to do with the data?</td><td colspan="2">What methods/tools will you use to collect the data?</td></tr>
<tr><td colspan="2">How will you get informed consent?</td><td rowspan="2">SCENARIO
ECID Baseline Data</td><td colspan="2">Who will you collaborate with?</td></tr>
<tr><td colspan="2">How will you train your team? How will you involve the community?</td><td colspan="2">What are the risks to individuals?
People who may cause harm if they have access to the data
Ways they could be harmed</td></tr>
<tr><th colspan="4">What measures will you take when you do the following with the data?</th></tr>
<tr><td>Transfer</td><td>Access</td><td>Store</td><td>Share</td></tr>
<tr><td colspan="2">How will you feed back to communities?</td><td colspan="2">How will you retain/archive/dispose of the data?</td></tr>
</table>

5.5. Logframe

Accessing the logframe:

For ECID consortium members, please find the ECID logframe up to date[20].

For audience who does not have access to the extranet, the logframe will be sent separately.

Note of the logframe:

Based on the learning from the baseline, the ECID team (including country offices and several consortium members) is currently having discussions around a couple of indicators. As indicated in the next steps, the ECID team plans to hold a review of the logframe. This might result on:

- A review of a couple of indicators,
- The adjustment of some of the targets that appear to be difficult to set with the current baseline values.

One of the indicator under discussions in the 'Percentage increase in uptake in prioritised services'. The concerns that were raised by country offices and consortium members on this indicators are:

- The programme will be prioritising different services in different areas in all three countries, some of which might be health or educated (and to some extent, 'easy' to monitor), but some might be livelihood services, social welfare services, or infrastructure related services. Finding reliable data for these will be challenging,
- In addition, in Myanmar, the country team raised that the data currently available might not be valuable and it would be a bad idea to use it as a basis of an indicator.
- Finally, for health services, for instance, in some areas, people might want to work on maternal and new-born health, in some other areas on sexual and reproductive health, etc. This will cause discrepancies in the type of data collected and difficulties to measure this indicator.

The team will therefore work on proposing some key changes based on the baseline learning. These changes will be proposed to the donor at the next reporting period, submitted on the 4th of August.

20 https://christianaid.sharepoint.com/:x:/r/teams/UKAC/Shared%20Documents/MEL/Reporting/ECID_Logframe_CA_baseline%20June%202020.xlsx?d=w17542e37bad44751bcad5f0b6b3282bf&csf=1&web=1&e=6qFH6r

5.6. Scale of engagement and influence in decision-making process

Below is the scale of engagement that was used in the perception surveys in Zimbabwe and Myanmar (During -Covid-19):

0. Not involved in meetings with duty bearers
1. Have occasional meetings with duty bearers but there is no consultation or participation
2. Have some meetings with duty bearers and limited opportunities to participate, ask questions
3. Have regular meetings and their opinion is sought and considered
4. Have regular meetings and their opinion is sought and considered **AND** they can monitor implementation of the decisions made
5. Have regular meeting, opinion is sought and considered, can monitor implementation of decisions made **AND** there is evidence that their opinion has influenced the plan

5.7. Nigeria – state level initiatives

This paragraph is from the ECID Nigeria qualitative baseline report.

More Accountable and Responsive Power Holders (Duty Bearers) to the Priorities of Key Target Groups

Evidence from the field indicates that Kaduna State government has put in place sustainable systems and structures that are open to be utilized for more responsiveness to the needs and priorities of the target groups than what is obtainable in Anambra State. There is more of evidence-based policy making in Kaduna as duty bearers (especially MDAs) in the State rely much on data for planning. Before the establishment of the Kaduna State Bureau of Statistics (KSBS) (which is the recognized agency for data management in the state), the Ministries meet their data needs through a unit called Planning, Research and Statistics (PRS). There are two major surveys through which the State government collects data on the target groups. These are the General Household Survey and the Annual School Census (ASC). The school census covers for Persons with Disabilities and adolescent boys and girls while the general household survey captures the poor and rural women. There is also the Rehabilitation Board that has a comprehensive data on Persons with Disabilities in the State. MDAs do collaborate with these agencies for their data needs, beyond the ones they collect by themselves.

Though it is the responsibility of the Kaduna Bureau of Statistics to manage state-level data, some MDAs do manage some level of data. The KSBS has a functional website which is open for all to access at any given time. Also, members of the public and CSOs can also write to them to request for information that is not on the website. For the Ministries, there is an Electronic Management Information System (EMIS) which also stores and manages data at Ministry levels. In addition to this, the Ministry of Health also uses a cloud service called District Health Information Service (DHIS) to store data on health-related issues. Data collected by many of MDAs are disaggregated in form of SAD.

As noted above, the government of Kaduna State relies heavily on data to inform planning and programming. For example, the survey and census mentioned earlier are used to inform planning in the State. They also influence budget allocations to issues that are of interest to the target groups. The extension of the **Education for All Program** to adolescent boys was informed by data. This decision was supported by budgetary allocation as well. It also helps in programme intervention, especially in avoidance of duplication of programmes. Apart from the **Education for All program** mentioned above, there are some other programs government is implementing primarily targeted at the marginalized groups, and which were informed by data as well. Some of these include: **The Kink Program; Global Partnership for Education; Girls 4 Health; The Conditional Cash Transfer Program (The Poorest of**

the Poor Program); and **Second Chance Education**. These programs are some of the evidence which shows the actions the government is taking to address the issues around the target groups. For example, the Poorest of the Poor Program is targeted at the poor rural women and Persons with Disabilities while the Education for All Program and the Kink Program is targeted at adolescent boys and girls. The same goes for the Global Partnership for Education, Girls 4 Health, and Second Chance Education. They are all examples of government actions aimed at addressing the prioritized issues of the target groups.

There are some other interventions by duty bearers aimed at addressing the priorities of the key target groups. In the area of health, there are free healthcare services for children below five years. This is a big relief for poor rural women who do not have to pay for health services for their children within that age range. There are also interventions around HIV and Acquired Immune Deficiency Syndrome (AIDS) (for members of the target groups who have it), Prevention of Mother to Child Transmission (PMTCT) initiative, renovation of 255 PHCs in the respective wards of the state. The Rehabilitation Board takes care of interventions around HIV and AIDS, PMTCT, and Persons with Disabilities. They provide health services to them in collaboration with the Ministry of Human Services and Social Development. They also have other support organizations created to sensitize and support adolescents living with HIV in seven LGAs of Birnin-gwari, Lere, Kagarko, Jaba, Chikun, Igabi and Jema'a. Their major activities of actions are empowerment activities, upgrading of their centres, skills acquisition, and starter packs at the end of the program, supporting with food items and establishment of adult and mass education centres. Spaces or fora also exist for stakeholders to discuss access to services of the marginalized groups. There are **town hall meetings; State development plan; Medium term expenditure framework** and the recent **public budget hearing.** These are spaces where stakeholders discuss the priorities of the target groups. **Dialogue Forums** by the Ministry of Human Services and Social Development are also spaces where stakeholders discuss the priorities of the target groups.

In Anambra State, reports from the field exercise show that duty bearers are not as responsive and accountable to the priorities of the marginalized groups as they are in Kaduna State, partly because of the limited use of data for planning, though MDAs claim the data they generate are used for planning and budgeting. Nevertheless, in relation to prioritized issues of the target groups, government has been making budgetary provisions for the elderly and the poor, training women on soft skills, working for the 35% affirmative action as well as empowering them with equipment such as grinding machines etc. There is also the **One Youth One Skill Program** that is still at the planning stage, the **Three I's of Initiative, Invention and Investor Support Program**; as well as training youths in agriculture and start up parks given to those trained. The State is also working with communities on the **Community Choose Your Project Initiative** whereby they are given 20 million naira each to undertake programmes of their choice. However, it is not clear how all these programs benefit any of the target groups.

Evidence from the narratives of duty bearers at the MDAs in Anambra State suggest that the state government promotes girl-child education, offers scholarships and free education, and donates learning materials such as books etc. Evidence from many of the rural communities shows that children still pay school fees and other levies in schools. In fact, teachers interviewed in some of these schools insisted that government is paying lip service to free education as they do not provide the necessary resources required for full implementation of free education in the State. Community leaders also maintained that Government's claim of running free medical care for children and old people above 60 years is false as they pay money to access healthcare.

On data management, the State has a Bureau of Statistics which manages state-level data as well as serves as the central data melting point. State-level data is generated from field surveys and from MDAs, and every Ministry also generates its own data which they use for their own planning. Only authorized persons from the MDAs can input data. For state level

data, only the Bureau can input data into the database. Apart from the Bureau of Statistics, Ministry of Economic Planning, Ministry of Youths and Sports, and the Women Development Centre are the MDAs that manage data on the target groups. Access to data in Anambra State is difficult as the public cannot access data online because data is not stored on the website. The Bureau of Statistics only disseminates state data by launching its publications, which it distributes to the MDAs. The implication is that if the CSOs or the public have need for data, they either apply to the Bureau or any other relevant MDA for such data. The process of this application and how long it takes was not stated.