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Women and Girls Well-being in Niger: A Systems-Level Review of MMD Groups

REPORT

MARCH 2024

care

EXECUTIVE SUMMARY

Few development programs have a decades-long lifespan and impact. CARE's Mata Masu Dubara model (MMD), has been rolled out since 1991 championing women's leadership and economic empowerment in Niger. Originally conceived as savings and credit groups, the model has evolved over the years to address women's groups demands to have better access to public health services, improve nutrition, receive technical training and participate in civic and electoral processes, among others. Multiple studies have been conducted to document the impact of the model on member and non-member women, their spouses, households and communities. To build on those evaluations, CARE underwrote the current study, using an innovative systemic framework designed to understand and measure changes in gender norms and explore ways of scaling up MMD nationally and globally. The study illustrates the systemic impacts of MMD on improving the living conditions of women and girls, in particular their maternal health, education, nutrition and the prevention of early and forced child marriage.

Four main research questions are central to the study:

- What impact has MMD had on regional and local policies, programs and budgets
- How have MMD's activities and advocacy changed discriminatory gender norms concerning maternal health, child marriage, nutrition and education?
- How did MMD participants encourage and strengthen collective action throughout the program?
- How has MMD increased the capacity and responsibility of institutions and services to address maternal health, child marriage, nutrition and education?

This evaluation used a mixed methodology - qualitative and quantitative - to address the shortcomings identified in previous evaluations. This methodology is based firstly on a stratified sampling plan from regional to communal level, considering the diversity of experience in implementing the model since 1991. The evaluation team strategically chose the four regions of Dosso, Maradi, Tahoua and Zinder. Together these four regions account for 72% of the population in Niger. CARE has been implementing MMD groups there since 1991. Quantitative and qualitative data collection tools were developed using CARE's pathways to sustainable impact at scale, notably advocacy for influencing policies and programs, changing social norms, supporting social movements, and service system strengthening and social accountability. These tools were administered to different groups such as MMD and non-MMD women members, adult and young men (including women MMD's members' husbands), young girls, development agents, administrative, religious, education and customary authorities, and CARE staff.

Key Findings

We found that MMD groups in Niger contributed to meeting Sustainable Development Goals (SDGs) 1: No Poverty, 2: Zero Hunger, 3: Good Health and Well-being, and 5: Gender Equality. We found evidence of systems-level change in several domains.

Systemic changes in maternal health: changes are summarized by a quote from a representative of local authority in Zinder who noticed "an abandonment of bad practices and bad behaviors on the part of men and women with regard to family management and maternal health." Among the changes we note:

- Using "en masse" health centers by women: for children's vaccination, pre- and post-natal care
- Successfully lobbying local authorities to obtain better health care services (hiring midwives/doulas), providing better equipment in the maternity ward (mattresses)
- Supporting a fine of 5,000 FCFA imposed on women who continue to give birth at home
- Leveraging MMD networks to share their knowledge with other women
- Women members of MMD have a slightly higher rate of per-natal visits (98%) during their last pregnancy, compared to 92% of non-MMD members.

...but, use of contraception is still split among women with no clear explanation.

Women members of MMD increase their usage of reproductive health services and men tend to participate more in pre-natal care than they used to. Their social status has changed: they are recognized as effective advocates to keep girls in school longer, to lobby and obtain better healthcare services and change attitudes towards pregnant and breast-feeding women's nutrition needs. The steady flow of MMD women elected to parliament underscores how much communities value their representation and the policy work they do on behalf of their constituencies.

Systemic changes in early and forced marriages: while Niger continues to have the highest rate of early girl marriage in the world (77%), there is encouraging evidence that mentalities are starting to change.

- Over 90% of women interviewed acknowledge that marrying a girl younger than 15 years old is not normal
- Parents do wait longer to marry their daughter
- All respondents have a deep knowledge and understanding of the risk early marriages pose to the physical and mental health of their daughters, as well as the impact on ther economic prospects.
- There is no evidence of the old celebrations that took place when parents removed a girl from school. In fact, most respondents share a sense that the "mentalities have changed".

...but, quantitative data still shows a high number of girls under the age of 18 being married, as large families face hard economic choices.

Girls continue to face stigma: when they go to school, parents believe that they are not as attentive to their studies as boys; and that they may have sexual relationships before marriage, which remains taboo. Early marriages for girls can be perceived as strategies to avoid early/out of wedlock pregnancies, which could in turn lead to juvenile delinquency (pregnant girls thrown out or leaving the house on their own, ending up being homeless)

The tradeoffs made by parents are clear: it is better to marry a girl early than having an unwed pregnant girl at home with little economic prospects now that she is out of school. However, the weight of religious institutions and social norms slows the progress MMD groups were able to achieve reducing early child marriage, despite a clear understanding of the consequences of those unions on girls' physical and mental health, and their education and economic prospects. Indeed, 86% of men and 84% of women cite health risk as the most important consequence of early marriage for a girl.

Systemic changes in girls' education: "Nowadays, boys only like educated girls". While women's literacy rate still lags men's, when it comes to education, mentalities are also starting to change:

- The same education opportunities are afforded to boys and girls
- Girls and boys tend to start school at the same age, 7 year old
- Girls should get a secondary education and beyond

...but girls are perceived as being less attentive to their studies and more likely to get sexually active if they go and stay in school.

When it comes to girl's education, it seems that the changes in behaviors and mentality are irreversible, with participants alluding that it would no longer be acceptable not to send girls to school

Systemic changes in nutrition: Access to land, especially fertile land remains challenging for women. However, women members of MMD seem to have better access to land ownership than non-MMD members.

- Women and youth have a better understanding of the importance of providing pregnant and breastfeeding women nutritious foods
- Women and youth are more likely to sacrifice some of their nutritious foods and give it to pregnant or breastfeeding women
- A majority of women know the benefits of exclusive breastfeeding, however most of them make the decision to adopt it with the health agent.

Are girls and women better off now than they were in 1991? Yes.

The majority of MMD members (75% to 97% depending on cohorts) have received training on income generation. This training is critical in giving women financial independence and increasing their ability to lead social change on community issues. 90% of women MMD members have gone to the health center during their last pregnancy. In terms of education, men and women expect girls and boys to have the same opportunities to go to school, and communities to support girls' education. Overall, progress translates into a higher number of women using contraception; a rapidly decreasing acceptance of organizing celebrations when a girl is removed from school and increased attention to pregnant and breast-feeding women's nutrition needs. It is still complicated for young people to talk about sex with their parents or religious leaders.

Through MMD, women members have improved their economic status and are socially perceived as strong community leaders, alongside school teachers and principals.

The social organization of Niger focuses on the commune/village. Within the confine of those communities, it is clear that the systems, traditions, authority distribution have been influenced by MMD women. However, we could not make any linkage between those super local bubbles of change to the national policy level, or even the regional one. Women MMD seem to be leapfrogging their leadership status from the local administrative level (as mayors and vice-mayors) all the way to the Parliament.

The most common cause cited for increased women's leadership is the training MMD members receive on income generation. More than one respondent has made the connection between that specific training and women's capacity to advocate on key issues like child early marriage, use of contraception, improving health care services and equipment, etc.

This study provides evidence to formulate effective actions and recommendations to CARE programs, policymakers and other development partners for scaling up good practices to improve health/nutrition and education outcomes as well as reducing forced and early marriage by leveraging system-level change pathways.

Team

Care Coordination Team

Idriss Leko, Deputy Country Director, CARE International in Niger

Idi Moutari, Monitoring & Evaluation Manager, CARE International in Niger

Dawalak Ahmet, Monitoring & Evaluation Focal Point, CARE

Dr. Brittany Dernberger, Senior Manager of Systems-Level Impact, CARE

Dr. Bhumika Piya, Gender Justice MEAL Technical Advisor, CARE

Hilawit Gebrehanna, Senior Technical Advisor – Social and Gender Norms

Consultants & Experts

Sophie Romana,
Team lead, Althaë Strategy

Julia Arnold,
Evaluation Advisor & Designer, Althaë Strategy

Vivienne Balicki, Research Assistant, Althaë Strategy

Dr. Massaoudou Moussa,
Quantitative Expert

Ms. Mariam Diakité, Qualitative Expert

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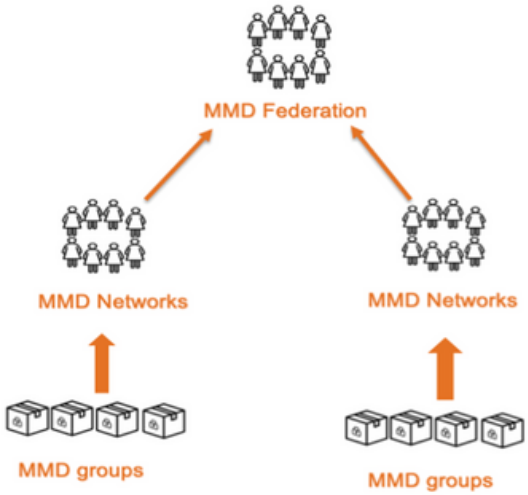
Abbreviations

IGA	Income Generating Activity
INGO	International Non-Governmental
MMD	Organization Mata Masu Dubara
RCT	Randomized Controlled Trial

Introduction

Background and rationale

In 1991, CARE International restructured its programs in Niger, to increase the level of women's empowerment by forming Village Savings and Loans Associations (VSLAs), based on the known practice of tontines. VSLAS groups formed the first level of the Mata Masu Dubara structure (MMD: "Femmes Ingénieuses" in Hausa, which translates to "women on the move"), see Figure 1. The 1991 pilot project was designed to help women in the Maradi region meet their many responsibilities by facilitating access to financial and technical resources through savings and microcredit.



The MMD approach, born of this particularly successful experience, has been modified over the years in line with the evolution of CARE Niger's programs, and even more importantly, the evolution of CARE International and CARE Niger's systemic approach to poverty.

Several studies and evaluations carried out on the MMD approach show that the model has contributed to strengthening the economic, social and political empowerment of Nigerien women, as well as reducing their poverty. In addition to the MMD groups supervised and used by CARE Niger in various fields as an entry point, many others have sprung up, either because of the ripple effect, or as a result of partner organizations adopting the MMD approach in their programing. From then on, the "MMD label" has become a distinctive sign that CARE, partners and even groups associated or combined with other activities or actions draw dividends linked to the potential for visibility or impact intrinsic to MMD groups. In this way, MMD has become a programmatic basis for CARE to leverage and expand combining MMD with other activities such economic empowerment, nutrition, financial inclusion, education and access to sexual and reproductive health, girls' education, women's political participation, entrepreneurship and humanitarian relief.

In other words, the **MMD** model **acts on all systems** (social, economic and political) and **at all levels** (village, commune, department, region and national).

1. Evaluation purpose & objectives

This systems-level impact evaluation has been designed to illustrate the systemic impacts of CARE's MMD model on improving the living conditions of women and girls' maternal health, education, nutrition and child marriage, so that they can be taken to sustainable impact at scale.

In June 2022, CARE Niger conducted a meta-evaluation demonstrating how the MMD model has improved the living conditions of women, girls and households in general. Four major themes were explored in this study: 1) women's voice and leadership; 2) men's engagement; 3) social and economic justice; and 4) climate justice for women. The results clearly show that the MMD approach has produced many impacts in several areas of women's lives in Niger, with an extension to communities. Some of these impacts are clear and quantifiable. However, the study identified areas that needed further investigation, to better understand the system's-level changes and subsequent impact of MMD women's voice and leadership, the scope of the social movements, and changes in maternal health practices, early and forced child marriage, and girls' education.

1.1 General objective

The overall objective is to document changes in the quality of life of women and girls because of the interaction between the MMD model and the various actors involved in implementing policies and programs at regional, district and commune level in the fields of maternal health,girls' education, child marriage and nutrition. This study will enable us to understand how actors, relational factors and social structures influence social and gender norms in the context of the Mata Masu Dubara (MMD) model in Niger.

1.2 Specific objectives

Specifically, the study aims to:

- Understand and document the influence of MMD at local/communal and regional levels and on maternal health, early child marriage, girls' education and nutrition.
- Identify the key actors and factors that promote (and challenge) positive norm change and map the pathways (and barriers) to change at the system level.
- Propose effective actions and recommendations to government and partners to scale up good practices to improve health/nutrition, education and marriage outcomes by leveraging system-level change agents and pathways.

1.3 Research questions

The following research questions were posed and deployed on the four areas of maternal health, girls' education, child marriage and nutrition in a logical framework combining the pathways to change identified by CARE, and the areas in which results were expected (see tables below)

- What impact has MMD had on regional and local policies, programs and budgets?
- How have MMD's activities and advocacy changed discriminatory gender norms concerning maternal health, child marriage, nutrition and education?
- How did MMD participants encourage and strengthen collective action throughout the program?
- How has MMD increased the capacity and responsibility of institutions and services to address maternal health, child marriage, nutrition and education?

1.4 Expected results

The following results are expected from this study:

- The operation of MMD at local/communal, regional and national levels to have a direct impact on education, health/nutrition and child marriage outcomes is understood and documented.
- The key actors and factors that promote (and challenge) positive norm change are identified, and the pathways (and barriers) to system-level change are mapped.
- Actions and recommendations to be shared with government and partners to scale up good practice to improve health/nutrition, education and marriage outcomes by leveraging system-level change agents and pathways are proposed.

2. Methodological approach

2.1 Internal Review Board

The study has been sanctioned by the Government of Niger's Ministry of Women's Affairs who has reviewed the methodology proposed in July 2023.

The original framework of the study provides an understanding of how actors, relational factors and social structures influence gender norms, social movements, advocacy and systems strengthening in the context of the MMD model in Niger through quantitative and qualitative data collected in a sample of MMD and non-MMD areas. The study is not designed to look at household or individual levels of impact. The full methodology, sampling model, demographic data of respondents, village selection criteria, for both the qualitative and quantitative studies can be found in the Annexes to this report.

The framework adopted uses CARE's pathways for sustainable impact at scale: 1) Advocacy to influence policies and programs; 2) Social norms changes; 3) Social movements; and 4) Service system strengthening and social accountability. The pathways are applied across the four domains of the review to document the changes that have occurred in a) maternal health; b) early and forced child marriage; c) girls' education and d) nutrition. Applying this framework the team identified expected outcomes and designed qualitative and quantitative indicators used to develop the quantitative questionnaires, focus group discussions and interview guides for the qualitative study.

Details of the expected results are presented in outcomes Tables for each of the four domains (maternal health, girls' education, nutrition and early child marriage), with additional analyses available in the Methodological Annex. These tables are based on indicators associated with the relevant systems-level change pathways as outlined in CARE's theory of change. For each area, indicators are to be achieved in the following ways: advocacy and influencing of policies and programs, changes in social norms, social movements undertaken to bring about change, and service system strengthening and social accountability.

2.2 Study areas

Study areas were selected according to the following criteria: longevity of MMD practice, accessibility of MMD and non-MMD areas, and model penetration. Based on the results of the meta-evaluation, four of the eight regions where CARE is active in Niger were selected. These are Dosso, Maradi, Tahoua and Zinder (figure 2). Using CARE Niger's database, a shortlist of villages with MMD program interventions in varying years was selected (see Methods appendix).

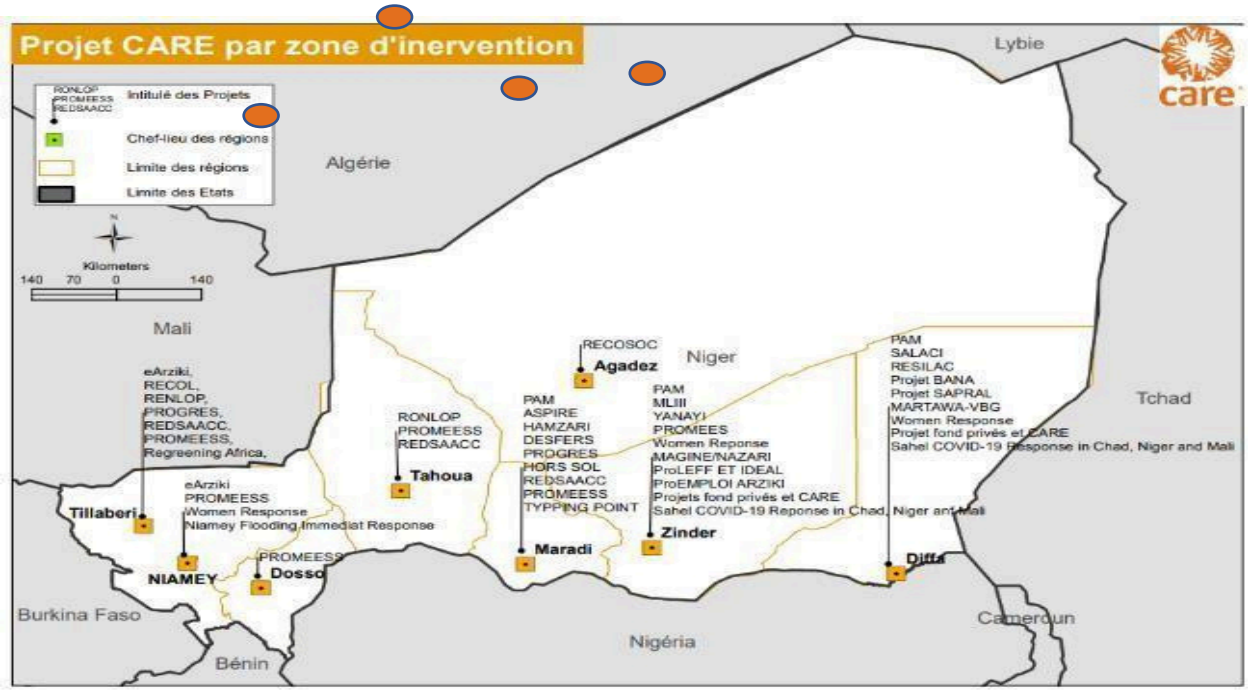


Figure 2 Location of intervention projects by study area

2.3 Quantitative Sampling

In the absence of a baseline, we used mixed methods to understand the views of MMD and non-MMD members along with key community members on the changes that have taken place in their lives, focusing on four domains. Quantitative sampling was random and used a recognized statistical methodology to reach a significant number of respondents. Overall, 1,378 women and men were interviewed by a trained enumerator using tablets and Kobo (see details in Annex 1).

2.4 Qualitative Sampling

This study is not an impact evaluation – no baseline exists from the start of MMD in Niger for a comparison study. To assess the changes that have taken place over the past 30 years within communities with MMD groups, the quantitative portion of the study looks at present day attitudes and practices and then asks respondents to compare their experience in the past. A systems impact lens was layered onto this approach which asked respondents to speak from a community perspective, rather than an individual perspective. For the study, the term "impact" refers to the cumulative impact of MMD's programming, curriculum, training and technical capacity building on members, their families and their communities.

Table 1 - Quantitative study sampling

Qualitative Study Newsgroups Target	MMD member	non MMD member
Women 15 to 24 y/o	✓	
Women 25 to 39 y/o	✓	
Women 40 y/o and over	✓	
Husbands of MMD members		✓
Non-members, women		✓
Husbands of non-MMD members		✓
School principals & teachers	Membership irrelevant	
Maternal health and nutritution agents		
Qualitative Study In-depth interviews	**MMD member**	**non MMD member**
Female MMD group leader	✓	
Traditionl male leaders	Membership irrelevant	
Female customary leaders		
Male religious leaders		
Male community leaders		
Local authority (town hall official and ex		

Respondents participated in either the qualitative or quantitative study, with none participating in both. Demographic data on participants can be found in the Methodology Note.

2.5 Data analysis

2.5.1 Quantitative analysis

Quantitative data was collected on tablets using Kobo tool and stored on the CARE server. They have been analyzed step by step using Excel spreadsheets, SPSS and Minitib 16 software to generate descriptive statistics (e.g., frequency, mean, standard deviation, etc.). A multivariate analysis using Stata was also done.

2.5.2 Qualitative analysis

All responses collected during individual interviews and newsgroup discussions have been analyzed to identify themes, commonly used terms and phrases, and key similarities and differences across sex and age demographics. Analysis framework included identifying themes around the four research areas and individual changes, changes to the community linked to MMD, and changes to gender roles and norms stemming from MMD activities. All responses from individual interviews and group discussions were analyzed using thematic qualitative methods. Data processing was carried out manually, using an Excel spreadsheet.

3. CARE's Programs and Niger Context

3.1. Niger Context and Progress

While the absence of a baseline makes it difficult to directly assess the impact of MMD since its inception, the fact that 14% of 15 to 64 year old Nigerien women are members of an MMD group is a clear indication not only of the value the groups bring to women themselves, as a resource, but also the contribution groups supported by CARE and other INGOs have provided to progress, measured by regular DHS surveys and data collected by the World Bank. This section is design to provide the context in which MMD groups operate in Niger and their potential contribution to eliminating some of the most pressing social issues women and girls face regarding their health, education and civic participation. Today close to 14% of adult women are members or an MMD group in Niger (15 to 64 years old). They have accumulated over $265M in savings.[2]

Women in Niger face structural hurdles to engaging in the private sector. Niger scores 53.8 out of 100 on the *Women, Business, and the Law* 2024 index covering 190 national economics. Niger is lower than the Sub-Saharan Africa regional average of 74.0 average and has particularly low scores for gender differences in property and inheritance.[3]

3.1.1. Women's participation has increased.

The number of women members of MMD has grown enormously between 1991 and 2023 to a total of 865,000 registered members. Women now represent 25% of Members of Parliament (MPs) in the National Parliament as of the end of 2022. At a local level, thanks to MMD networks, women are now more involved in political activities and stand for election than they were ten years ago. Women members are better informed about community life; they advocate at community councils and demand rights for women and girls. In Zinder, the town councilor is a woman. In Dosso, the influence of women can also be seen through awareness-raising and training initiatives.

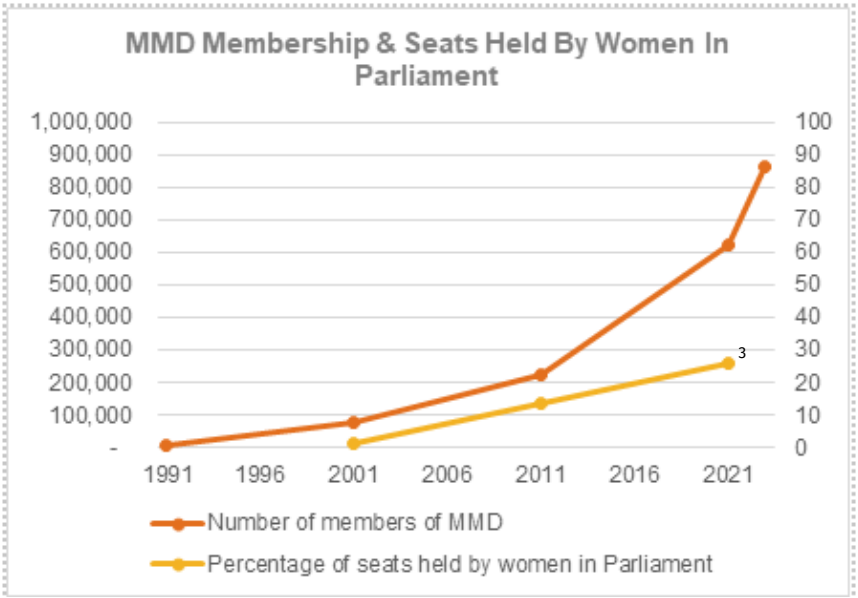


Figure 2 - Evolution of MMD membership and women in Parliament.

In 2016, 25 women were elected to Parliament out of the 171 seats. In 2021, they represented over 30% of the seats. Women MMD are more successful in their election bids because of their participation in the MMD groups, where they learn how to speak in public among other skills. Women MMD members have increased their participation in local elections: in 2011, 279 ran for municipal elections with 140 of them successful.[6]

CARE PROGRAM SPOTLIGHT: MMD Groups

3.1.2. Nutrition & Stunting

We don't have sufficient data to directly attribute declining rates of stunting among children to MMD. However, we know that CARE has invested resources in designing programs that have raised the awareness on children's malnutrition and elicited the participation of the Government of Niger who has adopted CARE's nutrition platform as its policy to fight malnutrition in the country. The multiple programs designed to increase women's economic empowerment and financial independence may be linked to those improvements. In randomized controlled trials in Mali, members of savings groups were 10 percent less likely to be food insecure than in control villages.[7] The study (and other evaluations of MMD by CARE) also show that those groups tend to be more resilient to shocks.

However, the 2022 Global Nutrition Report[8] shows slow progress in childhood wasting and exclusive breastfeeding. Stunting is slowly decreasing, so is the prevalence of underweight in women.

[6] "Meta-Evaluation on Social Norms, Performance and Prediction of MMD/VSLA Achievements", M. Moussa, 2023

[7] "Evaluating Saving for Change Program in Mali", 2011, Innovations for Poverty Action

[8] "Global Nutrition Report, 2022", Accessed December 2023

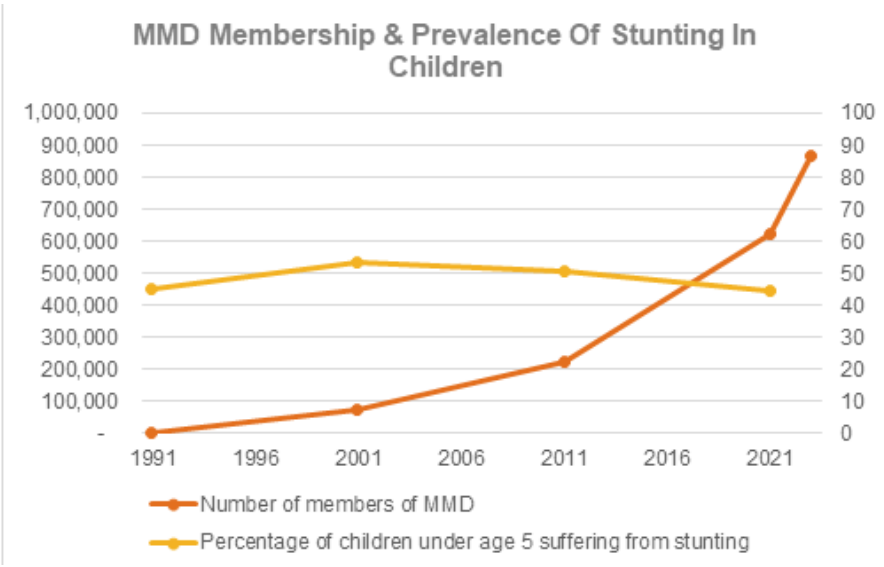


Figure 3 - Evolution of stunting and MMD membership.

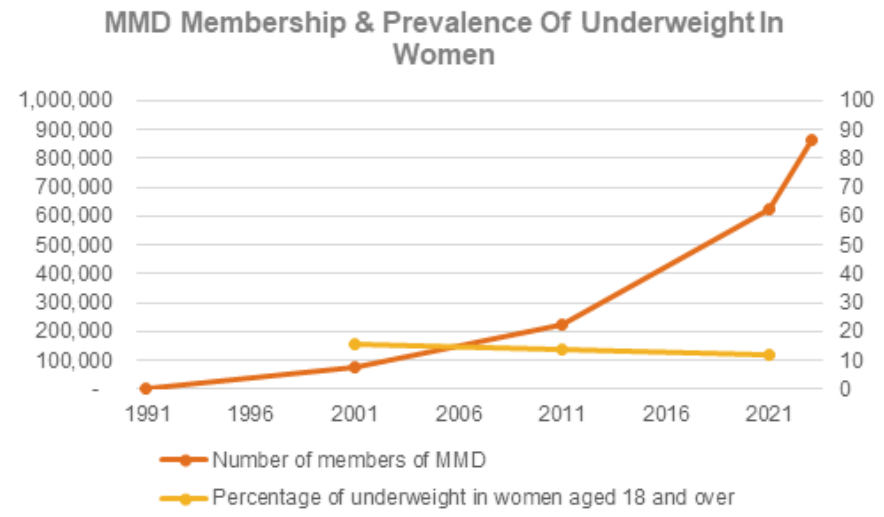


Figure 4 - Evolution of women's underweight and MMD membership.

Although MMD does not include a nutrition and food security component, the conclusions of the mid-term evaluation report for the Zinder and Diffa regions in May 2006 show that this project indirectly improves household well-being. Women's and children's nutrition is thus evolving positively.

According to CARE Niger's 2014 Annual Report, pleas made by women members of MMDs to the authorities and elected representatives have been recorded on the theme of nutrition, for example concerning the right to a plot of land, access to land titles, and the provision of phytosanitary products for women[9]. Among the initiatives of the Dosso Regional Council, 43% of the 521 agricultural projects launched in 2021-2022 were projects led by women[10].

[9] CARE International, Annual Report Niger, 2014

[10] Le Sahel, "Mr Mamane Tourba, President of the Dosso Regional Council", 2023

With the Mainstreaming Nutrition MMD project, several groups have integrated nutrition. Unfortunately, we don't have statistics on the prevalence of undernutrition and other health indicators for groups that are already autonomous, groups that are still supervised and groups that have integrated nutrition (MMD plus).

According to the report on Progress towards achieving the Millennium Development Goals, in Maradi, there is still a need for an intensive program to raise awareness and inform the population in general, and young women in particular, with a view to reinforcing changes in nutrition-related behavior.[11]

CARE PROGRAMS SPOTLIGHT: RECOLG, HAMZARI, MAMAN LUMIÈRE, REDSAACC, PRO-ARIDES, RECOSOC

3.1.3 MMD membership and Education

In parallel with the rise in the number of women members of MMD networks, parity indexes for primary and secondary school enrolment have been rising steadily over the period.[12]

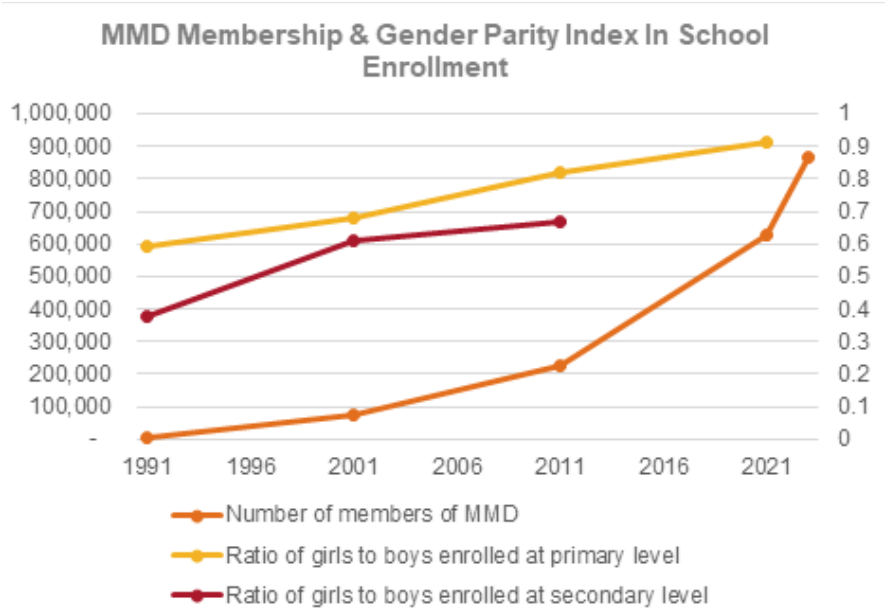


Figure 5 - School enrollment and MMD membership.

MMD networks indirectly contribute to making girls' education a priority issue. According to CARE Niger's 2014 Annual Report, advocacy carried out by women members of MMDs with authorities and elected representatives has been recorded on the theme of girls' education: length of schooling, decision-making on children's education within the household.[13]

The various local women's initiatives in the Tahoua region have thus led to a drop in the rate of exclusion of girls from school in several communes including Tama from 86.46% in 2012 to 33% in 2014, or Guidan Idder from 49% in 2012 to 30% in 2014.[14]

[11] «Rapport Régional sur les Progrès vers l'Atteinte des Objectifs du Millénaire pour le Développement à Maradi », 2009, Institut
National de la Statistique du Niger et Système des Nations Unies, 2009

[12] Girls/boys primary enrollment ratios, Girls/boys secondary enrollment ratios, World Bank Data

[13] CARE International, Annual Report Niger, 2014

[14] Ibid

According to national statistics on the participation of the Comités de Gestion Décentralisée des Établissements Scolaires (CGDES) in the primary school enrolment effort in 2011-2012, 84.9% of CGDESs built or improved straw hut classrooms in Dosso, 80.8% in Tahoua, 72.3% in Zinder and 47.2% in Maradi.[15] Actions have also been carried out at regional level, such as the construction of classrooms and boarding schools for young girls by the Maradi Regional Council.[16]

CARE PROGRAM SPOTLIGHT: MMD

3.1.4 MMD membership and sexual and reproductive health

The adolescent fertility rate, measured by the number of girls per 1,000 women aged 15 to 19,who give birth, has been falling since 2010, reaching 170 in 2021, while the rate for sub-Saharan Africa was 100 for the same year.[17] Recent efforts by the Government of Niger, supported by international donors, have also led to a clear reduction in maternal mortality over the period,[18] as well as in infant mortality.[19]

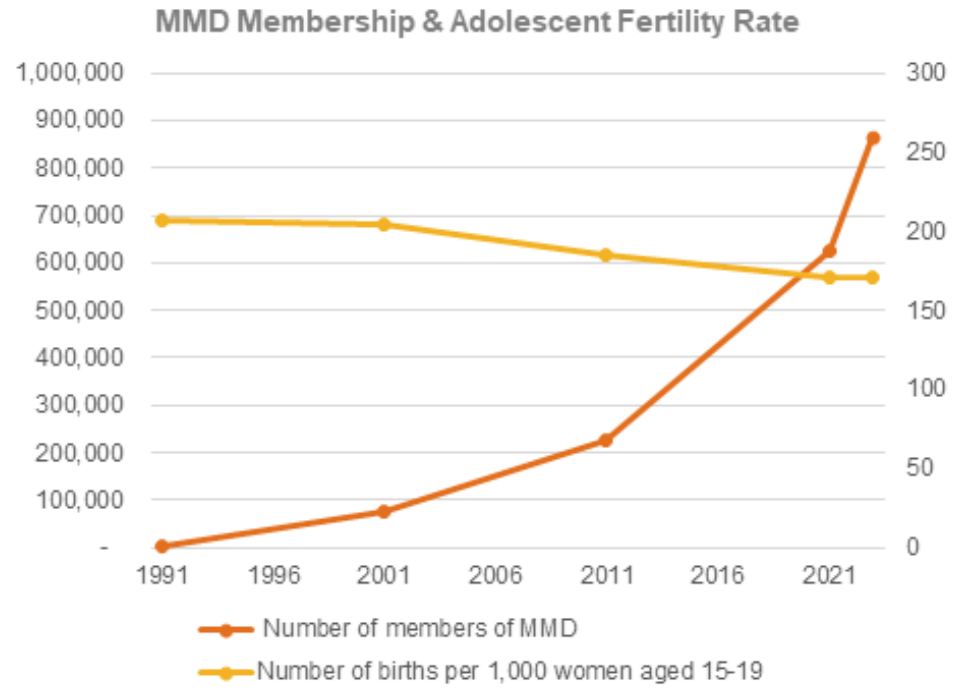


Figure 6 - MMD Membership and adolescent fertility rate (World Bank Data)

[15] Statistiques de l'éducation de base, Direction des Statistiques du ministère de l'Éducation nationale, 2012
[16] "Minister of Education ends working mission in Maradi", Le Sahel, 2023
[17] World Bank, Gender Data Portal
[18] Ibid
[19] World, Bank, World Bank Data, Niger

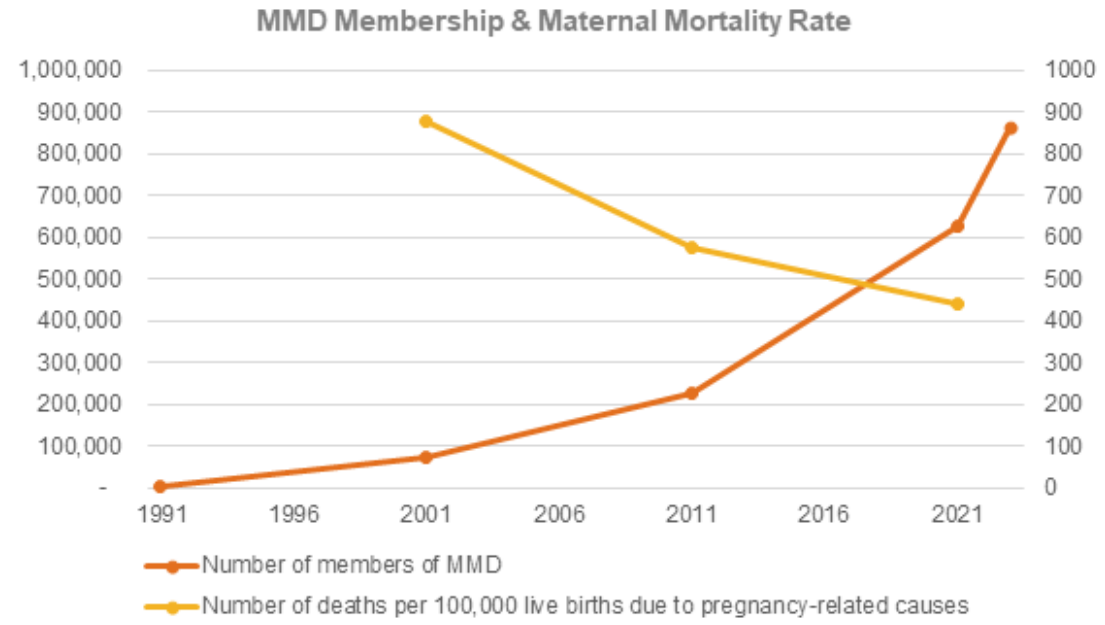


Figure 7 - MMD Membership & Maternal Mortality Rate (World Bank Data)

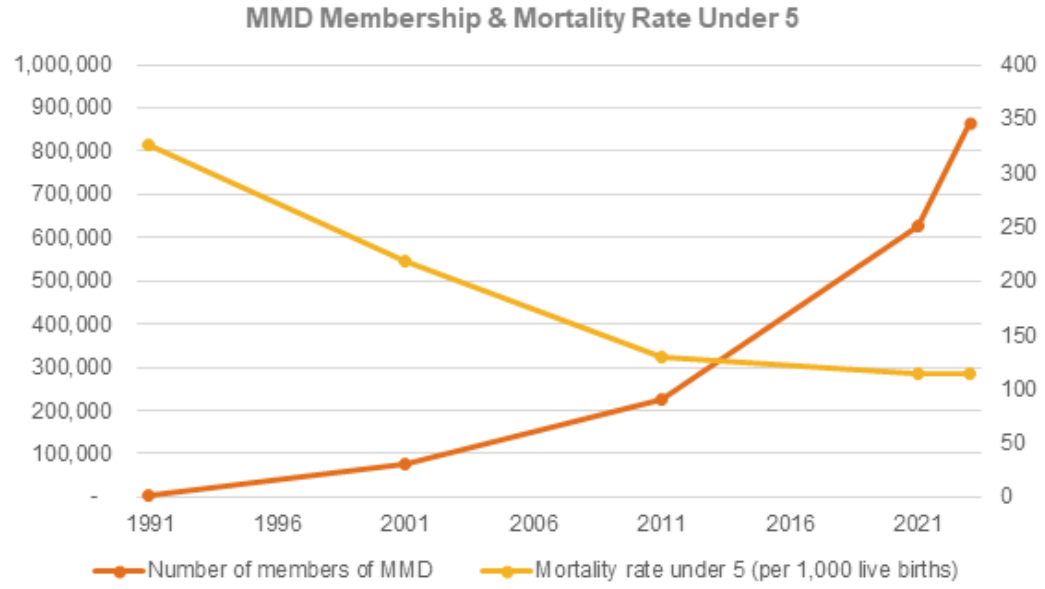


Figure 8 - MMD Membership and Under-Five Mortality Rate (World Bank Data).

The reduction in maternal and child malnutrition rates in certain regions (Zinder and Maradi) has been made possible by the introduction of innovative, participative and integrated strategies for the prevention and management of community-based maternal and child malnutrition in Maman Lumière zone communities.[20]

In focus group discussions, MMD groups report that they have also successfully lobbied local authorities in Tahoua, enabling new labor and delivery rooms to be built. Husbands of women MMD members report that their wives have successfully lobbied INGOs such as CARE and CRS for mattresses and mats for health centers in Dosso, and community leaders report that women have also requested similar support from the mayor's office (Dosso). In Zinder, women MMD members note that MMD groups play anessential role in women's education. Once members have been trained by CARE, they continue to raise awareness through their groups. In Maradi, MMD groups have gone a step further by lobbying the village chief to hire matrons (Doulas) to support the local health center and provide sustainable prenatal care.

[20] CARE International, Annual Report Niger, 2014

In addition, the women observed that awareness-raising campaigns and capacity-building have shifted community perceptions towards a more positive attitude towards maternal health. In Dosso, MMD women leaders have successfully lobbied local authorities in favor of maternal and child health.

CARE PROGRAMS SPOTLIGHT: IMAGINE, MAMAN LUMIERE II

3.2 CARE's Programs in Niger

CARE has been working in Niger since 1974. In 1991, the first VSLA group was piloted laying the foundation for MMD. Key long-term projects implemented by CARE (and its partners) which have influenced VSLAs and MMDs by providing members with technical training in agriculture, business management, financial education, literacy, gender, women's economic empowerment, access to financial services, adaptation to climate change.

Table 2 - CARE's main programs in Niger working with MMD

Program	Objective	MMD members enrolled
Imagine	Delaying timing of first birth among married adolescents (ages 15-19)	1,573
Martawa	Support legislative action to prevent gender based violence	8,750
Bana		21,152
RecolG	Climate change resilience & Adaptation	5,384
Progres II	Equitable management of natural resources and strengthening of civil society	1,025
Hamzari	Food insecurity	30,654
Resilac	Inclusive economic and social recovery around Lake Chad	4,975
Maman Lumière II (mother of light)	Prevent malnutrition	6,988
Pro Arides	Resilience, food security and income generation for farmers	4,602
REDSAACC	Research and development for food security and climate change adaptation of production systems in Niger.	11,853
Support project for strengthening community resilience to climate shocks in the Maradi region (above ground)		3,879
RECOSOC	Food security	3,320
GEWEP I and II	Gender Equality and Women's Empowerment	

4. Demographic Data

The data used for graphs and tables is extracted from the quantitative surveys, unless otherwise specified. The responses from the qualitative interviews are identifiable by the region from where they were collected cited in parenthesis. Additional data analysis has been included in the Methodology Note.

4.1 Quantitative Survey Respondents Demographic Data

The quantitative sampling methodology resulted in 1,378 respondents (187 men, 803 women and 393 youth) between the ages of 14 to over 80 years old. In the study, we stratified age and marital status. Female youth are unmarried girls between the ages of 14 and 18 years old. Male youth are boys under 18 years old.

A vast majority (81%) of women respondents were married and only 15% were widowed. Nearly all men (98%) are married and only one was a widower.

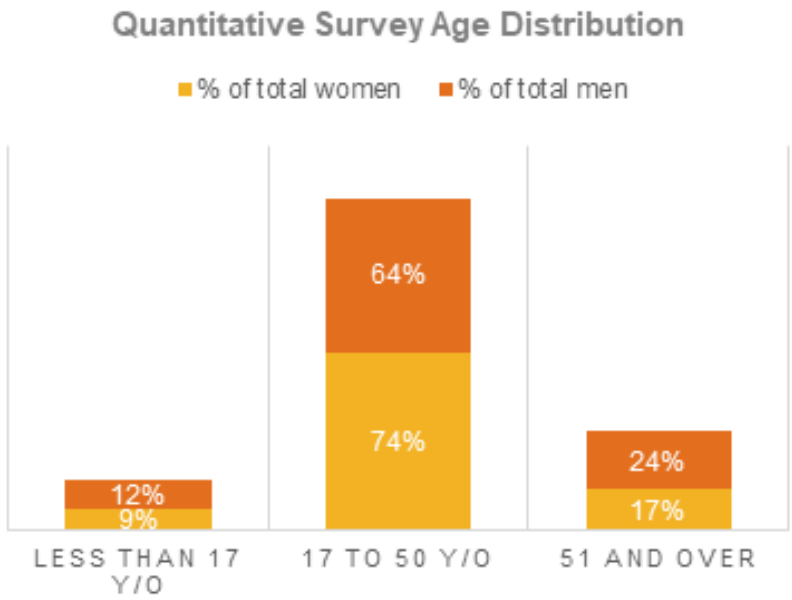


Figure 9 - Age distribution of quantitative respondents (n=1,378)

Livelihoods among men and women respondents varied between agriculture, trade, animal breeding, and housekeeping. Many reported more than one livelihood activity, as is common in sub-Saharan Africa. Women are also asked if they grow vegetables which may be their secondary activity. The survey asked whether respondents had to migrate to other regions to find work, only one man living in Tahoua did so. It is quite rare in Niger to find women who need to migrate to work.

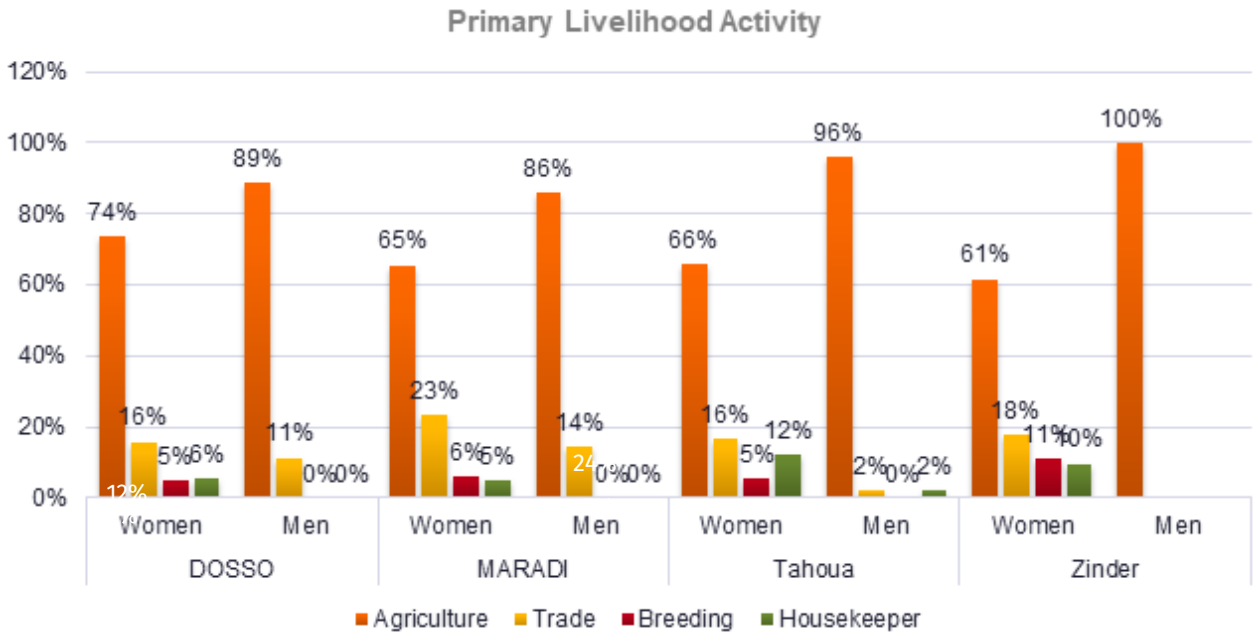


Figure 10 - Primary livelihood (n=1,378)

Figure 10 shows the range of livelihood activities across adult men and women. Nearly all respondents were involved in agriculture, with more men reporting farming as their primary livelihood than women. Nearly a quarter of women in Maradi reported trade as an income-generating activity, with women in Zinder (18%), Tahoua (16%), and Dosso (16%) close behind. Interestingly, 12% of women in Tahoua reporting being housekeepers, the highest among the four regions. The questionnaire included an option to cite "migration" as livelihood activity—either internal migration from village to village or international. Only one adult male responded that he had migrated to find work.

The CARE team offered context on women's land ownership in Niger. Religiously, women have the right to own land, but culturally this right has been ignored for decades. They only have access to land, not control over it. If need be, men offer them plots of land they can work on during the rainy season. With the advent of MMD in CARE's Gender Equality and Women's Empowerment Program (GEWEP) intervention zones[21], capacity-building in law and leadership has enabled women to regain their right to possess land through their structures (gender platform), set up by the MMD program in its intervention zone and made up of duty-bearers such as village chiefs and commune mayors to influence men who refuse to recognize women's right to land.

[21] GEWEP: "Gender Equality and Women's Empowerment Program"

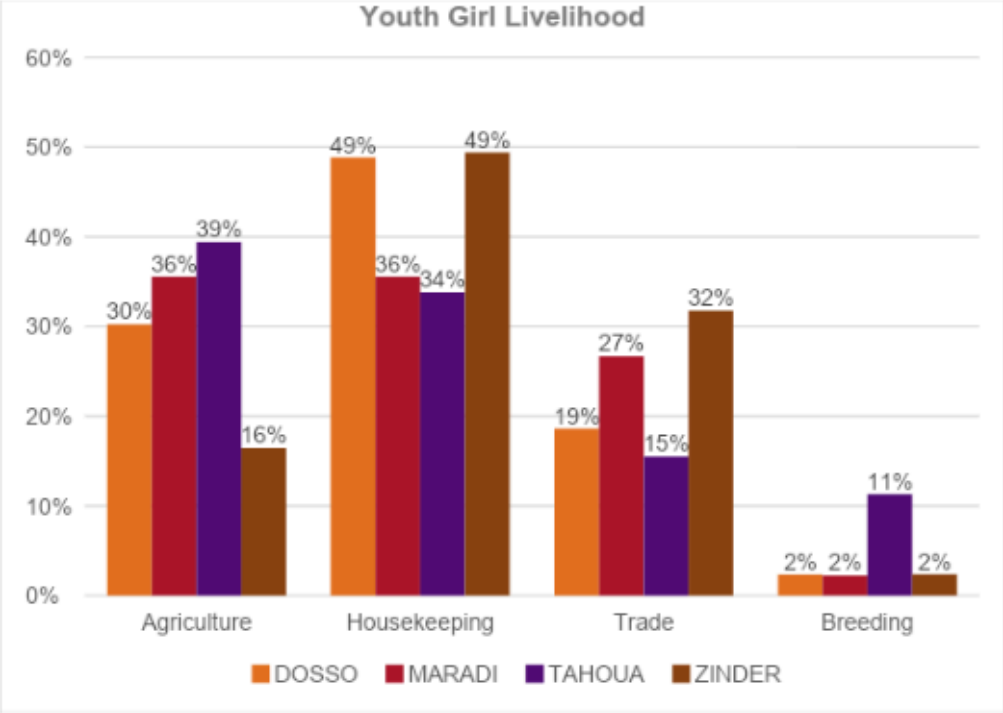


Figure 11 - Youth girls livelihood (n=264)

Among youth, girls and boys reported very different livelihood activities – which may speak to gendered expectations in their households and communities. Female youth report mainly housekeeping activities, with nearly half of girls in Dosso and Zinder. For girls in Tahoua, 39% report agriculture as their primary livelihood and only 34% report housekeeping. One outlier is 11% of girls in Tahoua report animal breeding as a livelihood while only 2% of girls from any other region report the same. Similarly, 32% of girls from Zinder report trade as a primary activity and only 16% report agriculture. These differences likely speak to the variations in region and urban/rural livelihoods.

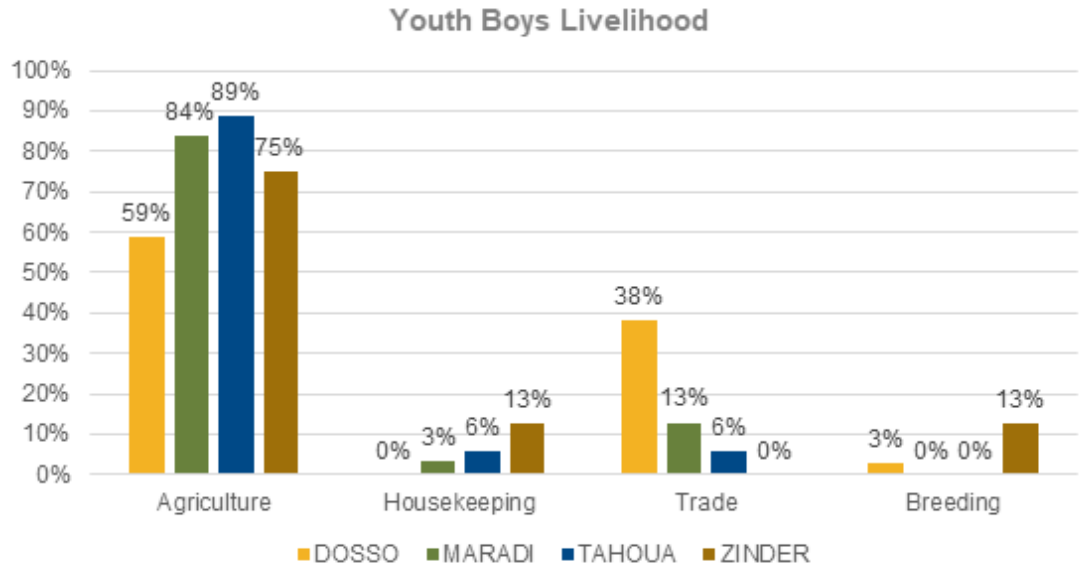


Figure 12 - Youth boys livelihood (n=126)

Figure 12 shows nearly all young men work in agriculture and in trade. An interesting regional difference here is that boys from Dosso report trade (38%) or agriculture (59%) as their livelihood, while most boys from other regions report only agriculture.

4.2 Qualitative Survey Respondents Demographic Data

314 men and women participated in either a focus groups discussion or an individual interview. No demographic data was collected on this sample.

Graphs and statistics are extracted from the quantitative survey, unless otherwise specified. The qualitative data is identifiable by the region it is linked with in parentheses.

5. MMD Membership, capacity building and advocacy

Membership in MMD groups has grown with the population and since 1991 has been expanding by CARE and its partners to cover the whole country with no exception. Using data from SAVIX and the World Bank, an estimated 14% of all Nigerien women aged 14 to 64 years old are members of an MMD group. The expansion of MMD throughout Niger is remarkably fast.[22]

As MMD groups grew, so did the capacity of women MMD members to increase their representation in the highest institutions.

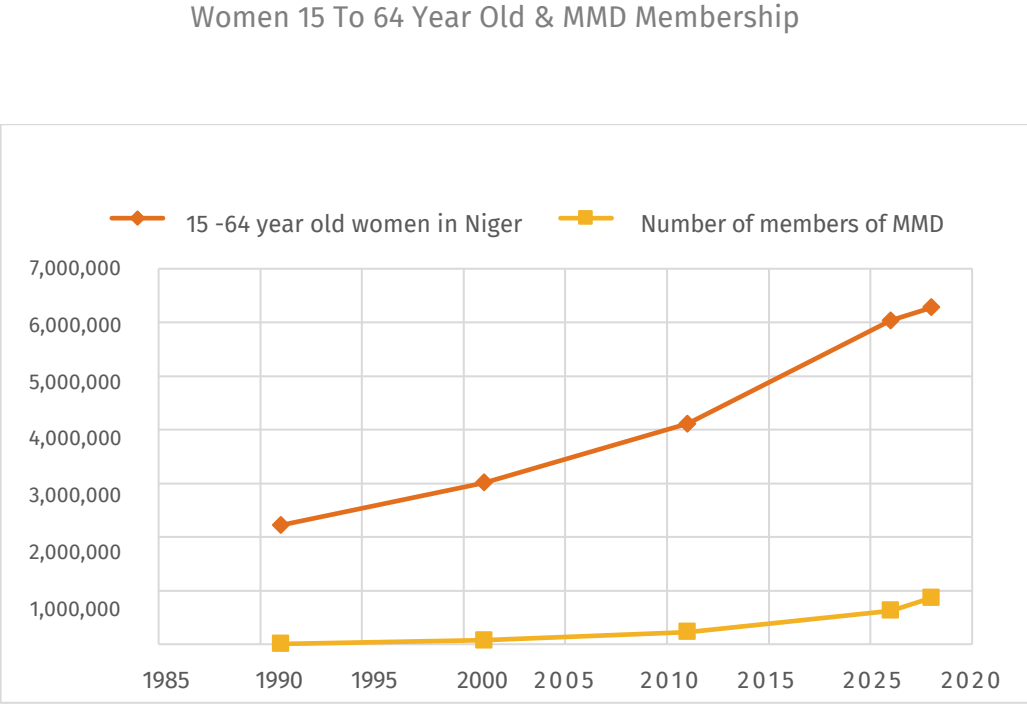


Figure 13 - Women aged 15 - 64 and MMD membership (1991-2023)

5.1 Membership tenure

While most of the MMD groups were facilitated by CARE, other development organizations have promoted and created new MMD groups. All adult women interviewed belong to one structure either MMD, religious, political or "other" (See Figure 15 below). Of the married women respondents, about 77% are members of an MMD group. According to the quantitative survey, 47 men were MMD members (15% of the sample). Membership is relatively high among the sample of 799 adult women, with 68% of them belonging to an MMD group in Tahoua and up to 100% in Zinder.

[22] In 2011, Oxfam's Saving for Change had 500,000 members in Mali, representing approximately 6% of the female population.

We surveyed 393 youth in all four regions. In our sample, female youth are less likely to be affiliated with any organizations or formal community groups compared to their older, married counterparts. Out of the 209 female youth who responded with an affiliation with a local association, 30% are affiliated with MMD and 50% say they have no affiliation with significant regional differences from 6% in Dosso to a high of 33% in Maradi. Only 15% of male youth belong to an MMD structure, and 39% are unaffiliated.

According to CARE's team, in Maradi, where young people's commercial activities are culturally rooted, there is a high take-up rate, as the MMD framework is a great economic opportunity for these young people to get involved. Also, in its early days, the MMD space was more frequented by adult women, who are not much in demand for daily housework. Towards 2018, the GEWEP Niger program had sensed this low level of youth participation in decision-making bodies at both community and communal level and commissioned a study on intergenerational MMD in order to open up more space for youth participation in VSLAs.

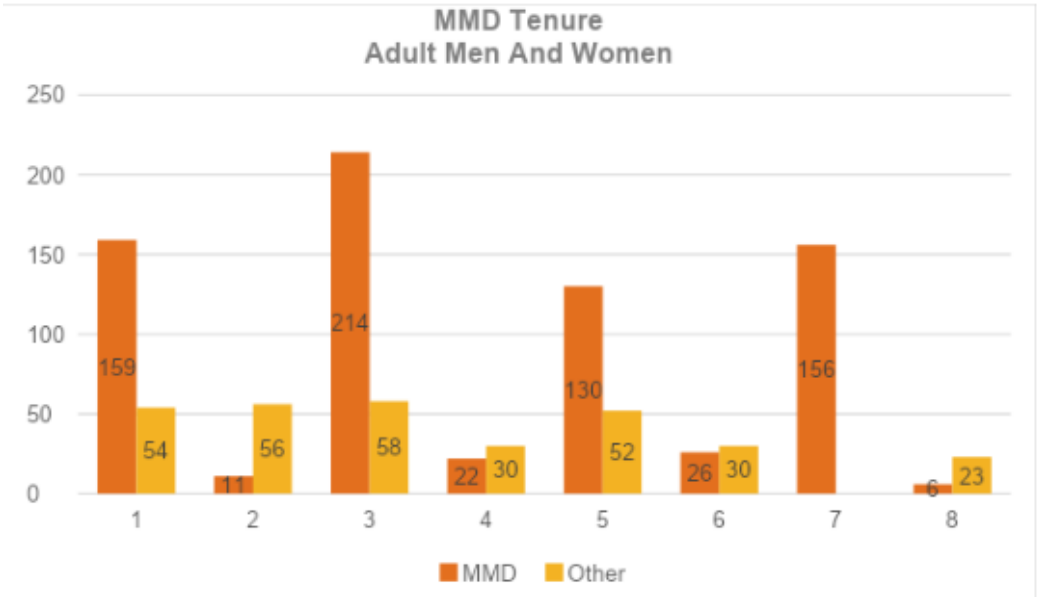
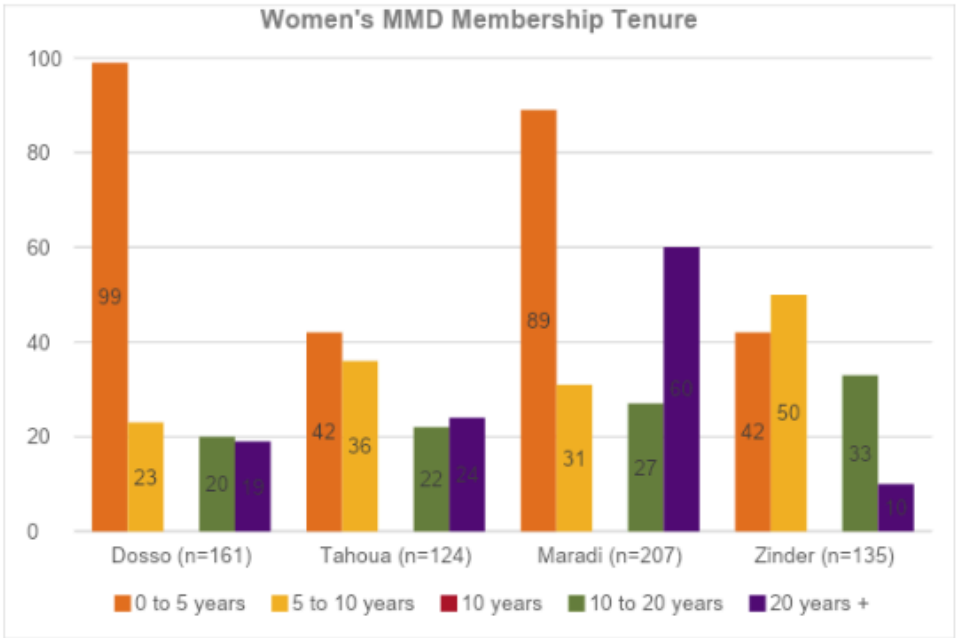


Figure 14 - Distribution of MMD membership by gender and adult categories.

Women were asked about how long they were members of MMD. Study timeline and resource limitations did not allow for independent verification in MMD records. Given our reliance on recall information, it is not surprising that the largest cohort would remember having joined within the last 5 years (see Figure 16).



5.1 Advocacy Training for Members

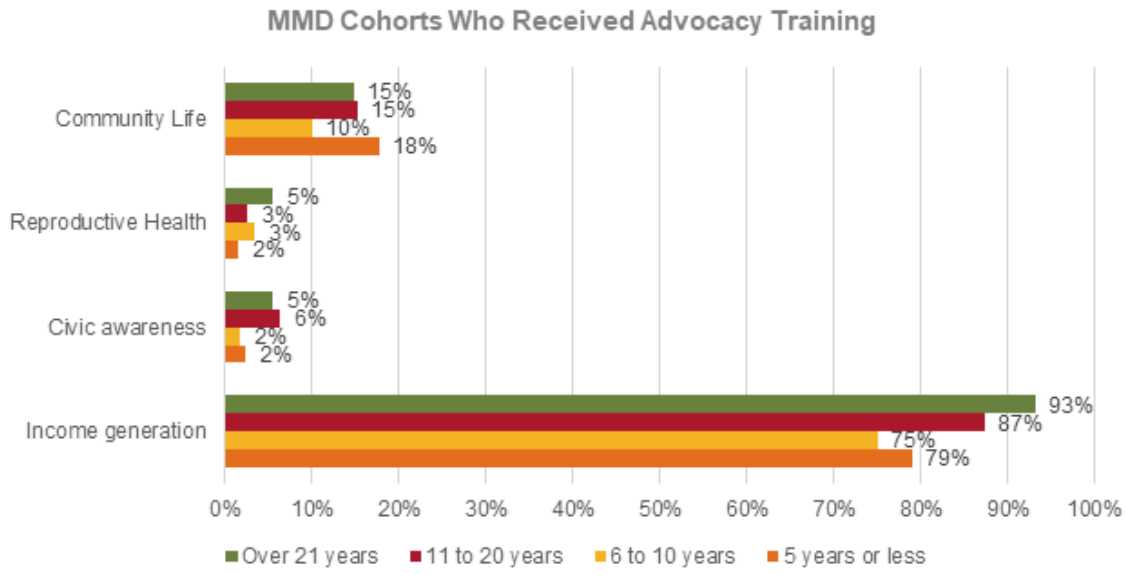
Since the inception of MMD, CARE has provided groups with multiple programs and opportunities of capacity building, offering training on a range of topics from empowerment, political activity, literacy and income generating activities.

Across all MMD membership tenures, a large majority of women have received training on income generation. In fact, income generating activities were one of the most cited reasons for men and women to use as an example of value MMD has brought to their lives. This result is aligned with CARE's original approach through the creation of Village Savings and Loans Associations (VSLAs) designed to increase women's informal financial inclusion by promoting regular savings. Pooling their resources together, women accumulate a small fund they can borrow from to finance their income generating activity and important social activities.

Those opportunities have translated into, for example, a steady increase in women's representation in Parliament: in 2001, only 1% of MPs were women. In 2022, they had conquered over 25% of the seats. Women are running at every level of participation: in 2014, 67% of women elected to local mandates are MME members. In regional councils, MMD women are estimated to be 20% of all elected representatives. At the national level, in 2021, one woman had been elected to Parliament.

Further developments of VSLAs included specific trainings on income generation, business, and linkages with financial institutions.

In focus group discussions, men also attribute the increased leadership of women to the income generating training. In fact, women's leadership is recognized as they share household expenses with their husband, become financially independent and take part in village activities. Their membership of MMD has led to a positive change in their power relationship with their husbands and has increased their role in household and community decision-making. Income generating activities are strongly associated with an increase in participating in household decisions by women. In 2011, seven Randomized Controlled Trials (RCTs) on how savings groups expand was conducted by CARE, Oxfam and CRS in sub-Saharan Africa. The RCTs show that women's decision-making power increases with membership, first at home and then in the community as they build confidence to speak in public.[23]



[23] "The Evidence-based Story of Savings Groups: A Synthesis of Seven Randomized Control Trials", M. Gash, K. Odell. September 2013

Women were asked about the type of training they received from their MMD groups: training on community life, reproductive health, civic awareness, and income generating activities. Figure 17 shows that a vast majority of respondents received training on income generating activities followed by community life. Other types of training mentioned were around how VSLA's function, training on the use of fertilizer, and soap making.

In more recent years, CARE and other partners have turned their attention to the capacity of Savings Groups and MMDs to advocate and influence decision-makers from local authorities (mayors) to regional and national ones. Trainings focus on identifying an issue that is important to the members, building a strategy to effect change (creating a coalition, organizing information sessions to build a grassroot base, engaging in a dialogue and negotiations with decision-makers, and reporting back to their constituencies). There are dozens of success stories: from savings groups members convincing husbands to sign their daughters' birth certificate confirming her birth date therefore preventing underage marriage (Mali)[24] and cohorts of women running and winning local and national election in Niger in particular.

In addition to training women and men within their VSLA groups, NGOs have used the radio to further their awareness campaigns. In fact, qualitative interviews revealed that this is a key means for community members to hear messages on a range of topics, including maternal health information aired on community radio stations encouraging women to visit health centers.

More broadly, MMD groups have become an influencing force in the country's political life: candidates seek the endorsements of MMD groups who in turn have produced a high number of women elected to Parliament and in local institutions.

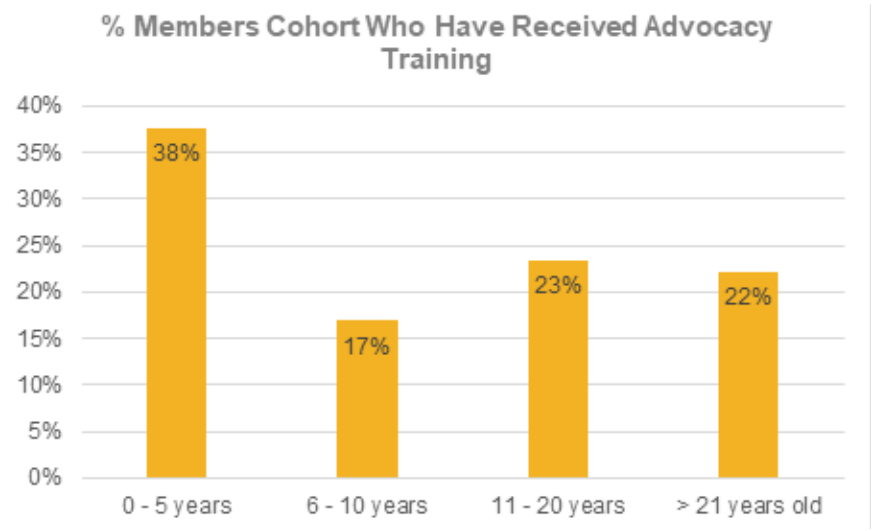


Figure 17 - MMD Cohorts who received advocacy training since they joined MMD

5.3 Social movements landscape in Niger

The study is unable to yield significant information on whether MMD groups and federations are able to influence policies and programs beyond the communal level. A 2017 study provides insights on national women's organizations which have been created after Niger gained its independence: Union des Femmes du Niger created in 1959 (Union of Niger Women) by a political party and disbanded with the 1974 coup. Association des Femmes du Niger in 1975 (Association of Niger Women). [25]

[24] Oxfam Saving for Change program in Mali – Unpublished interviews with groups in 2015 (Sophie Romana)

[25] Wikipedia note on Union des Femmes du Niger and « Conscience Politique et Action Collective des Structures Mata Masu Dubara au Niger », M. Diarra & M. Monimart, 2017

It seems that MMD groups find are the most powerful at the community base level, where they can influence the direction of certain investments in education or health. We could not get information on the involvement of MMD groups at the district and regional levels. A 2014 survey shows that 67% of women elected in rural zones are members of MMD, as mayors and vice-mayors.[26] There are no "grassroots" models or organizations in Niger that would create advocacy and influencing models linking local advocates to national movements. That being said, MMD may be the only system with is local groups, associations and federations that has been able in the past to offer a pathway to being elected in Parliament, to women members.

6. Maternal Health

Niger Context

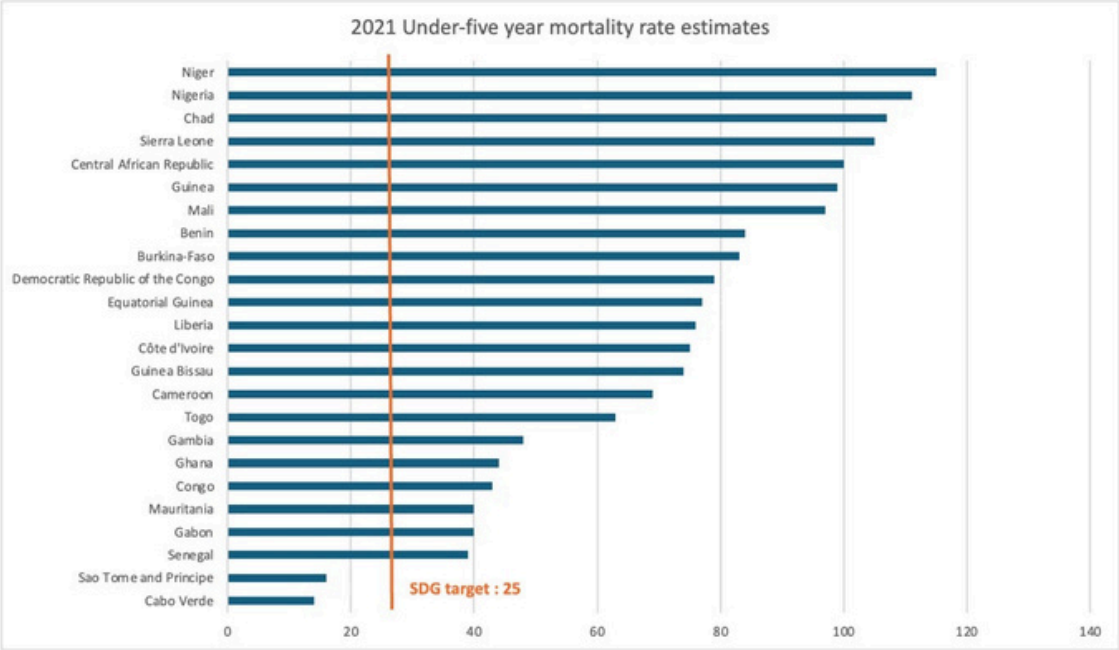


Figure18, under give years mortality in West Africa

Maternal and child mortality rates in Niger is higher than averages for sub-Saharan Africa (Figure 18). Maternal mortality rates in Niger fell from 867 per 100,000 in 2000 to 441 per 100,000 in 2020.[27] Recent efforts implemented by the Government of Niger with support from international donors has seen a reduction of mortality rates of children under 5-year-old from 326 per 1,000 in 1990 to 85 per 1,000 in 2017.[28] UNICEF further estimates that less than half the mothers and children in Niger live near a health care facility, leaving most women with little access to information or medical support during birth. Only 44% of births are attended by a trained medical provider and just over a third of women receive postnatal care.[29] One quarter of children are breastfed between 0-5 months post birth.[30]

Using CARE's impact framework, the following expected results table was designed and served as the basis for the development of the qualitative and quantitative questionnaires on maternal health. The most significant changes are documented in advocacy to influence policies and programs and changing social norms. There is some indication of systems-level changes in outcomes related to social movements and service systems strengthening and social accountability.

[26] Meta-Evaluation on Social Norms, Performance and Prediction of MMD/VSLA Achievements », M. Moussa, 2023

[27] World Bank Gender Data. Accessed Nov 2023.

[28] UNICEF: Niger, Child and Maternal Health page, accessed November 2023

[29] https://data.unicef.org/country/ner/

[30] https://data.unicef.org/country/ner/

Qualitative and quantitative do not provide sufficient evidence of successful influencing at the regional or district levels.

Pathway	Expected outcome	Quantitative & Qualitative synthesis
Advocacy to influence policies and programs	Policies to support maternal health implemented at regional and district level	Mixed[31]
	Budgets increased and strengthened to further policy changes at municipal level to support women's maternal health	Yes
	Women in elected positions to create and further the formulation of local public policies on women's maternal health	Yes
	Elected/unelected positions that oversee and further the formulation of local public policies focused on women's health	Yes
Changes in social norms	Women go clinic/health center for antenatal care (maternal health screenings/visits) at least 8 times during their pregnancy	Yes
	Women seek and receive contraception	Yes
	Women determine the timing and spacing of births	Yes
	Men are expected to be actively and equally participants in all ante and post-natal care	Yes
	Health workers provide any SRH service with quality, confidentiality, and dignity to unmarried girls and women	Yes
	Young couples are making own/sole decision on first pregnancy after marriage	No
Social movements	Coalitions are formed or strengthened to support women's maternal health	Yes
	Improved stakeholder capability to serve women's maternal health	Yes
	Improved responses to communities' needs for maternal health	Yes
Service system strengthening and social responsibility	Communities have greater access to maternal health information, resources, services	Yes
	Healthcare structures' cultural shift to support women's maternal health	Some
	Women are able to access healthcare centers when needed, close by.	Some

6.1 Maternal Health: Advocacy to influence policies and programs

Among adult women, 614 (76%) said they were MMD members. Of those, nearly 50% reported they received training on income generating activities as part of their groups. Other types of training reported were courses on sanitation (32%), reproductive health (26%), raising civic engagement (26%), community life (26%), and advocacy (26%). According to our discussions with them, this relatively low number (fewer than half of MMD member respondents) may be linked to the length of time the MMD groups have been in existence. The younger the group are, the less experience women members have in the various training themes. Furthermore, we found that the projects offered mostly Income Generating Activities (IGA) training. Nevertheless, we note that even if these women have been trained in advocacy, few of them favor it. Investing in influencing or advocacy is an individual and opportunistic choice. For instance, women leaders do work on influencing policies, but large groups of members tend to remain less interested in this type of advocacy.

Women in MMD and outside MMD and their husbands all discussed the wide range of ways MMD groups' advocacy influenced women's maternal health. In fact, women's advocacy has grown over the lifetime of MMD. Women in Zinder reported that over a decade ago, they were "forbidden" from standing for election because of bias against women and "custom." With changes attributed to MMD, women reported that they are now involved in political activities and run for election; the town hall councilor is a woman. Local community leaders reported that MMD women "learned to speak in public, and have been integrated into political parties, resulting in vice-mayor and councilor positions." In addition to holding political positions, women in Dosso hold influence within the communities through awareness-raising and trainings. Due to their ability to mobilize, non-MMD members have observed that politicians listen to MMD leaders.

31 Qualitative and quantitative do not provide sufficient evidence of successful influencing at the regional or district levels.

To better understand attitudes and behaviors around women's maternal health practices, qualitative focus group discussions were asked to react to a vignette with the story of a couple making decisions on maternal health issues (see Methodology Appendix).

MMD groups have successfully lobbied local authorities (in Tahoua) to build new labor and delivery rooms. MMD husbands report that their wives have successfully lobbied INGOs such as CARE and Catholic Relief Services (CRS) to obtain mattresses and mats for the health care centers (in Dosso) and community leaders report that women have also asked city hall for similar support (in Dosso). In Zinder, women members of MMD note that MMD groups are critical in educating women. Once members have been trained by CARE,

They continue raising awareness through their groups. In Maradi, MMD groups went further, lobbying the village chief to hire matrons (Doulas) to support the local health center and sustainably provide prenatal care.

In Tahoua, women members of MMD groups noted that "multiple community actions took place such as building new labor and delivery rooms; electrification of the local health center" with support from INGOS like CARE and Concern International. Furthermore, women observed that awareness campaigns and capacity building community perceptions have shifted towards a more positive attitude in support of maternal health. The new perception is that women massively use health centers for pre- and post- natal consultations, to deliver babies, vaccinate children and family planning. They are also committed to training and raising awareness among pregnant and breastfeeding women on how to prepare nutritious food and care for malnourished children. Women respondents also noticed that more women tend to breastfeed newborns exclusively which, in their opinions "is well practiced leading to remove children from the threat of malnutrition and other diseases." These observations are shared by non-MMD members[32] who offered the example of the creation of a health post in the village ("case de santé") and awareness campaigns led by health agents to increase usage of maternal health services. Notably, MMD women trained on this topic share their knowledge with other women, demonstrating the network power of MMD groups. Another initiative promoted and enforced by MMD groups is the assessment of a 5,000 FCFA ($US 8.30) fine on women who give birth at home instead of at the health center (Tahoua, Maradi).

In Dosso, MMD members and nonmembers equally observed that women MMD leaders successfully lobbied local authorities for maternal and child health "during the rainy season to obtain medicine and mosquito nets." Contribution to the shift in attitudes and mentality is attributed to "all economic levels." In Zinder, this change is characterized by "an abandonment of bad practices and bad behavior of men and women on family planning and maternal health." The role of women MMD members continues to be highlighted not only as key communicators in their community but as keen supporters of the health centers. Respondents establish a clear link between awareness, capacity building and change in attitudes and mentality. In Maradi, respondents also noted a higher compliance with maternal health guidance and visit schedule. Local lobbying by women MMD led to building housing for health agents (respondents say this project took five years). Non-MMD members have observed that local authorities and politicians do listen to MMD women, as women are involved in the community life decisions. (MARIAM)

6.2 Maternal Health: Changes in social norms

32 This group includes Husbands of MMD members; Women non MMD members, husbands of non MMD women, school principals and teachers, maternal health & nutrition agents, community leaders, local government administrators, local authorities, women leaders, and CARE Staff.

Respondents were asked about attitudes and behaviors in their communities around maternal health – and men's role – in contraception and family planning. Responses in Table 3 show the range of attitudes and beliefs held by adults and youth across the four study areas. These questions were designed to capture systemic shifts in norms that disproportionately impact women's economic and social inclusion.

Table 3 - Contraception and maternal health social norms change

		Women	Men	Youth
Most people in my village/ community expect women to use contraception.	Agree	60%	43%	32%
	Somewhat Agree	32%	39%	37%
	Do not Agree	3%	9%	6%
	Don't know	5%	9%	25%
Most people in my village/ community expect women to make their own decisions about when and which contraceptive method to use.	Agree	46%	34%	25%
	Somewhat Agree	38%	35%	35%
	Do not Agree	11%	19%	14%
	Don't know	5%	12%	26%
Most women in my village/ community visit health clinics at least eight times during their pregnancy.	Agree	59%	59%	46%
	Somewhat Agree	23%	23%	14%
	Do not Agree	13%	13%	17%
	Don't know	5%	5%	22%
When women go for antenatal care, most members of my community expect their husbands to accompany them.	Agree	37%	35%	18%
	Somewhat Agree	38%	37%	45%
	Do not Agree	25%	29%	37%
	Don't know	0%	0%	0%
Most husbands in my village respect and support their wives' decisions regarding child spacing.	Agree	58%	50%	30%
	Somewhat Agree	38%	41%	54%
	Do not Agree	5%	9%	16%
	Don't know	0%	0%	0%
Most unmarried girls in my village use contraception.	Agree	20%	24%	16%
	Somewhat Agree	25%	29%	28%
	Do not Agree	55%	46%	56%
	Don't know	0%	0%	0%
Health workers in my community ensure the confidentiality and quality of sexual and reproductive health information and services.	Agree	84%	88%	73%
	Somewhat Agree	9%	10%	7%
	Do not Agree	1%	2%	1%
	Don't know	6%	0%	19%
In my village, most people approve of young married couples deciding to delay their first pregnancy.	Agree	29%	25%	20%
	Somewhat Agree	36%	28%	40%
	Do not Agree	26%	47%	41%
	Don't know	10%	0%	0%
Most people in my village/community expect young married couples to make the decision of when to get pregnant for the first time independently.	Agree	32%	30%	28%
	Somewhat Agree	38%	29%	39%
	Do not Agree	19%	41%	34%
	Don't know	10%	0%	0%

Interesting contrasts and trends surface across these domains. Most women agree they are expected to use contraception but less than half agree they are able to make their own decisions about when and which contraception they are able to use, suggesting that half of women do not have full autonomy over their bodies when it comes to family planning. However, nearly 60% of women agreed that most husbands support women's decisions on birth spacing showing that women may have more to say about some parts of family planning than others. Men, on the other hand, are about evenly split between agree and somewhat agree on whether women are expected to use contraception in their community and whether most people expect women to make their own decisions about when and which contraceptive method to use. This contrasts to women's responses in the first question which may indicate men seeing a larger role for themselves in women's contraceptive choices or that there are some women in their communities for whom the choice is not their own.

Youth responses reflect an interesting generational mirror. A majority of youth somewhat agree that women are expected to use contraception. Nearly a quarter of youth across age ranges say they don't know. Most youth also report that they somewhat agree that most people expect women to make their own contraceptive decisions with, again, a quarter of respondents saying they don't know and a quarter saying they agree.

Another generational contrast is around whether men are expected to accompany their wives to their antenatal appointments. Men and women for the most part agree (W 37%, M 35%) and somewhat agree (W 38%, M 37%). Youth, on the other hand, mostly somewhat agree (45%) or disagree (37%). This could reflect a lack of experience or an interesting reflection on the dynamic they see in their own homes.

6.2.1 Pregnancy consultations

Amongst all age groups and regions, 89% of women interviewed had visited a health center during their last pregnancies. Women members of MMD lead the way in terms of visits, in all four regions with Zinder (98%), followed by Tahoua (93%), Dosso (89%) and Maradi (72%), closely aligned with rates of MMD membership rates in those regions (Figure 15). 92% of women who are not members of MMD visited a health center during their last pregnancies.

Women in their peak childbearing years—those between 20 and 30 years old (28%) and those between 31 and 40 years old (32%)—report having visited a health clinic during their last pregnancy. Women over 51 represent a smaller proportion (18%) which makes sense.

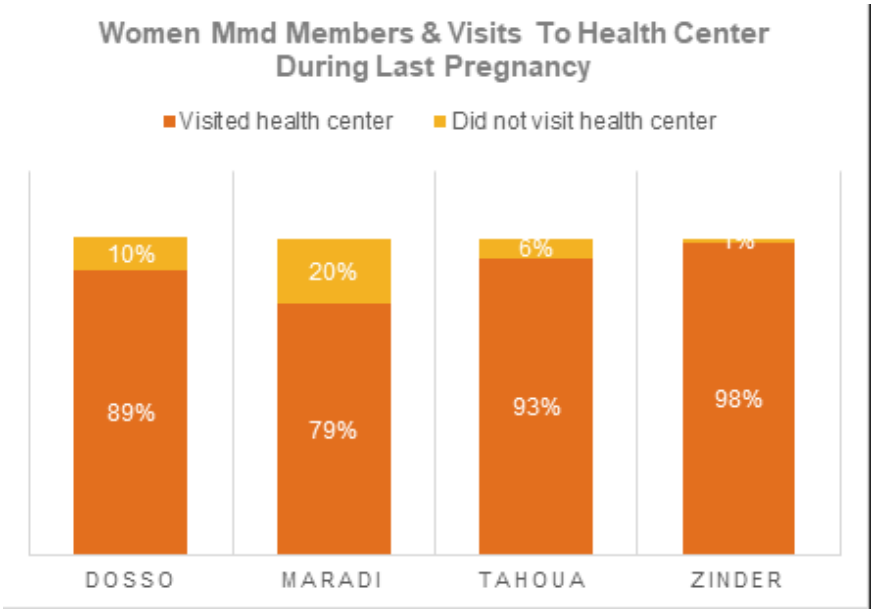


Figure 19 – Percentage of MMD women who visited a health center during their last pregnancy

Given that women over 50 likely had their last child about a decade ago, this demonstrates a positive change in attitudes toward health center visits over time. A majority of MMD members (89%) and non-MMD (91%) members report visiting a health center during their last pregnancy. Education levels do not seem to have affected whether women attend a health center during their last pregnancy. Of those who visited a health center during their last pregnancy, 36% have followed koranic studies, and of those who have not, 37% have also followed koranic studies, indicating that health center visits may not be impacted by type of education. From the interviews, health agents report that women visit health centers and those who do have a deeper understanding of the number of visits required. In fact, across the interviews, men and women reported that women are expected to visit a health center during their pregnancies and are shunned if they do not.

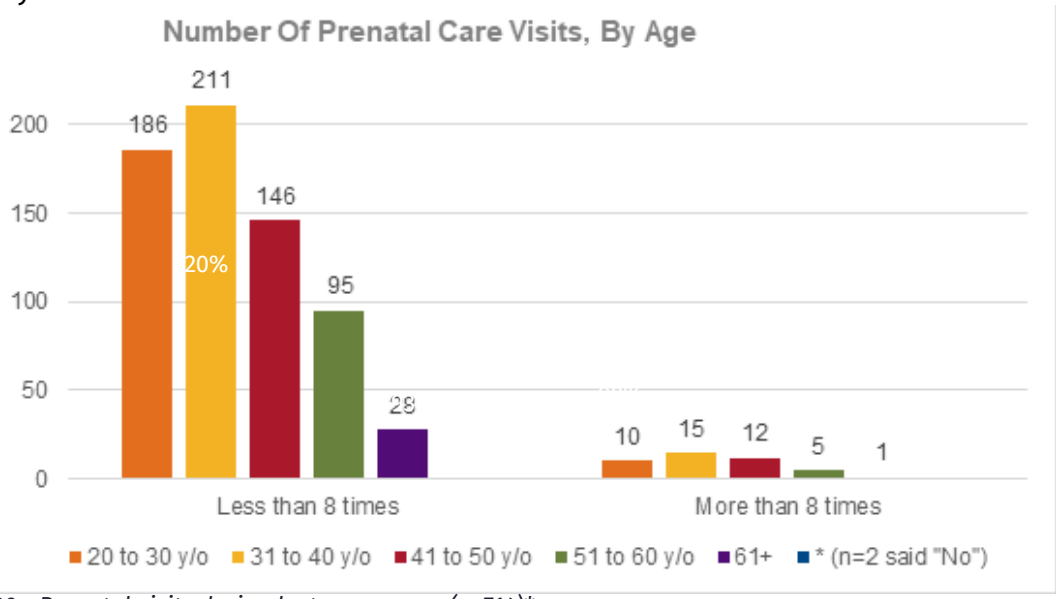


*Figure 20 - Prenatal visits during last pregnancy. (n=714)**

In focus group discussions in Tahoua, health agents reported an increase (as high as 84%) in number of women's visits to health centers. Women have changed their habits, coming while pregnant and breastfeeding and no longer relying on traditional medicine like their elders.

6.2.2 Contraception

6.2.2.1 Women's use of contraception

Most adult women respondents (56%) use contraception. Across the study regions, a majority of MMD women in Tahoua (61%) and Zinder (65%) reported using contraception at some point, while about half of women in Maradi (50%) and Dosso (59%) report they have not (Figure 21). It's not clear what accounts for this difference, as the women respondents in this study have very similar demographics.

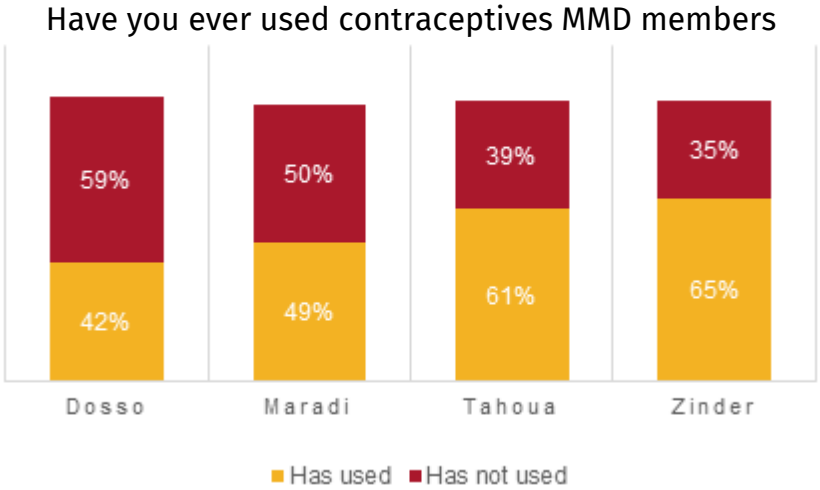


Figure 21 - Women MMD Members' usage of contraception.

Looking at MMD membership across women respondents, MMD and non-MMD women use contraception at about the same rate, with women not part of the MMD structure reporting a slightly higher rate than women in MMD (Figure 22). Figure 23 shows a clear change in contraceptive use after the age of 40 years old, which makes sense as women move away from peak fertility.

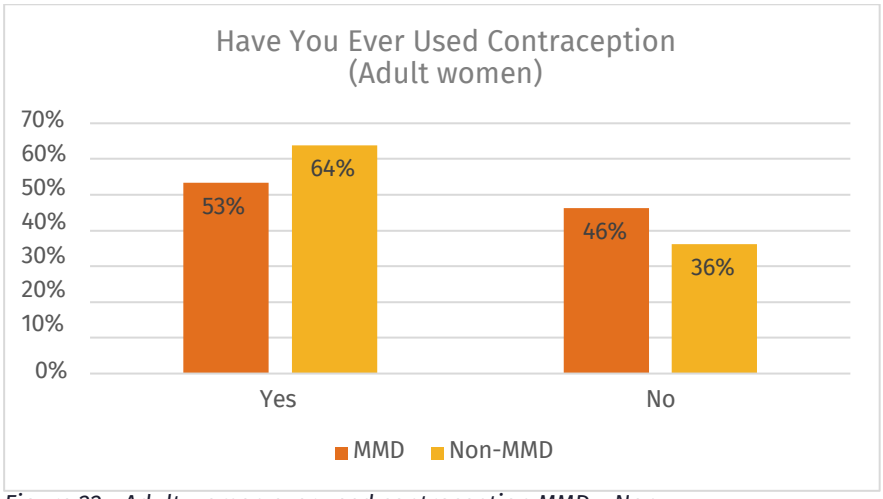


Figure 22 - Adult women ever used contraception MMD v Non MMD

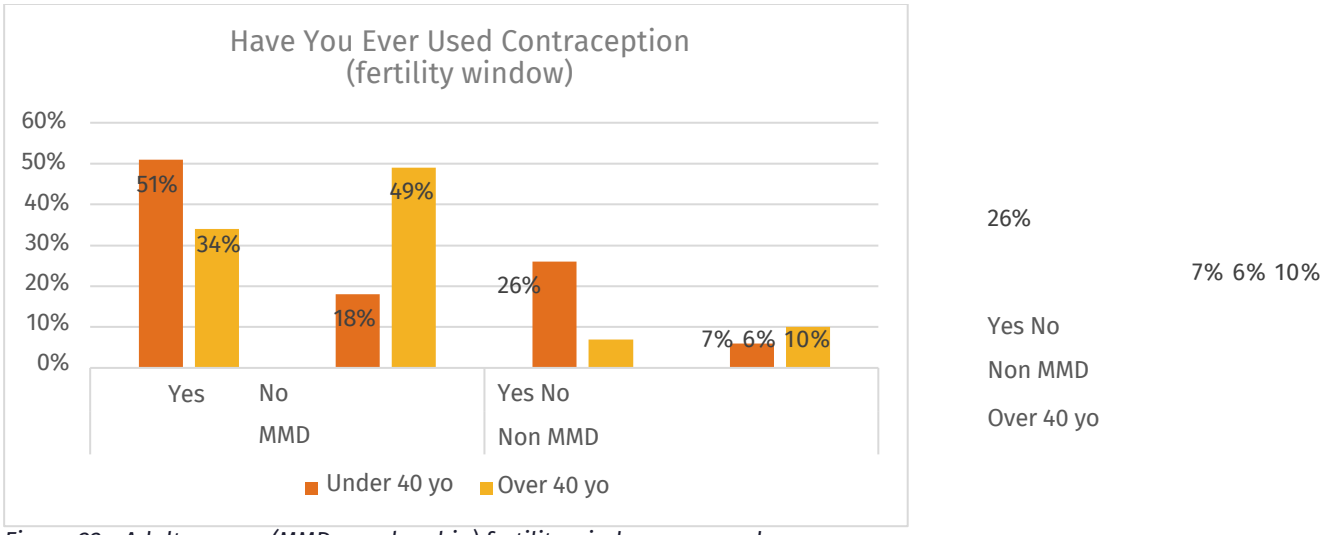


Figure 23 - Adult women (MMD membership) fertility window ever used contraception.

Across the four regions of this study, respondents reported that health centers were a place to seek and receive information and access contraception. Minor variations included some community members in Dosso saying the health center doesn't always have the information on contraception that they need. Overall, women in the community agree that health centers meet their demands for contraception. In Tahoua, women trust the local health center with the provision of information on contraception, an observation shared by non MMD respondents: "women who come to the health center are the most welcome, which encourages them to use contraception." In some villages there is a dedicated day at the health center to learn about contraception: every Wednesday, women gather and listen to an audio class. This open attitude seems to also affect men who "adopt behaviors favorable to the use of reproductive health services." Women members of MMD from Zinder say, "The changes have come about thanks to the awareness-raising campaigns run by development NGOs and those that MMD women continue to run." (FGD, Tahoua). Knowledge of contraceptive methods is unprecedented for a population that has only recently come to know the health center. Similarly, across the four regions, respondents agreed that women who do not go to the health center for information or prenatal care are "not too aware or awake" and are considered "reckless."

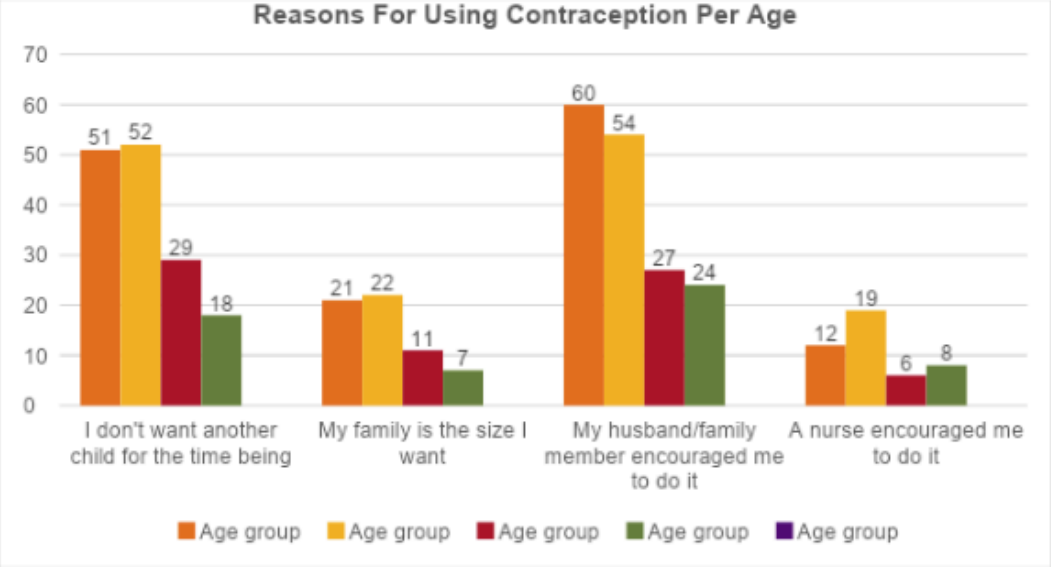


Figure 24 - Reasons for using contraception (n=421)

When asked about their reasons for using contraception, most women report that it's because they don't want another child (88%), or their family is the size they want (89%). In 86% of the cases, their husband encourages them and in 67% of the cases, a family member encourages them. 69% were encouraged by a nurse to use contraception. More women across age ranges reported that they did not want another child at the moment or that their husband or family member encouraged her to use contraception (Figure 24). Only a small number reported nurses encouraging them to use contraception; though the qualitative conversations revealed a high level of trust among health center staff, they are clearly not the main influence on women's decision-making.

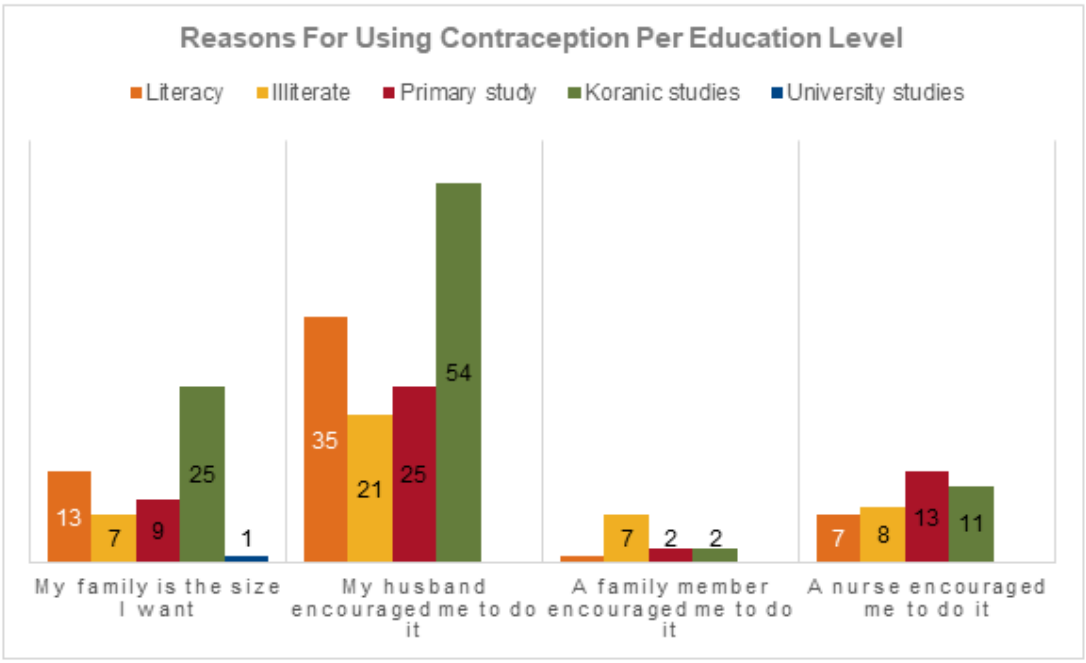


Figure 25 – Women's contraception uses and education level (n= 421)

Levels of education offer an interesting insight in the weight of the different types of education women receive. Koranic studies are open to boys and girls from age 3. They are free to also attend public (secular) schools during the holidays from the koranic schools. The education focuses only on religious matters.

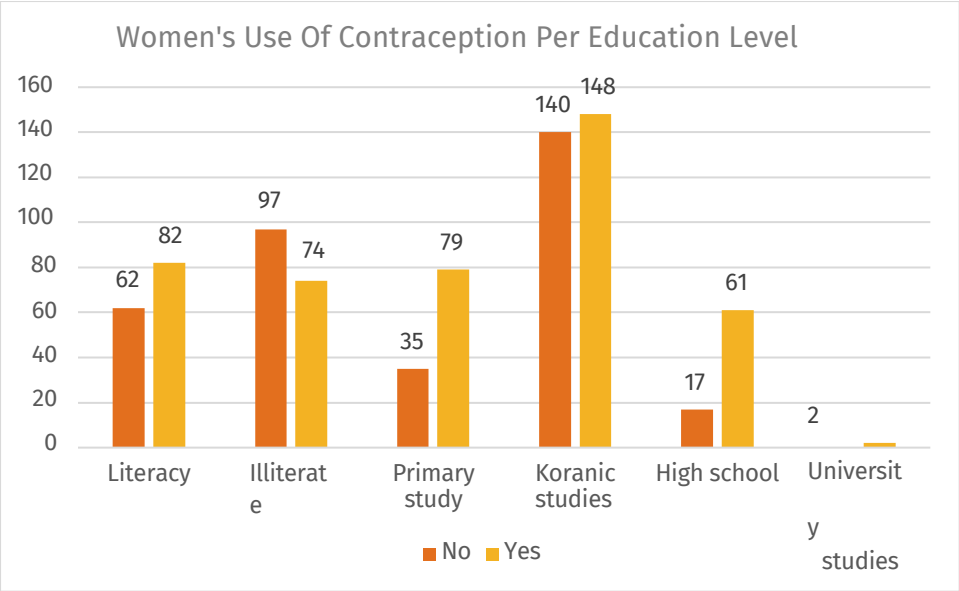


Figure 26 - Contraception use by level of education (women)

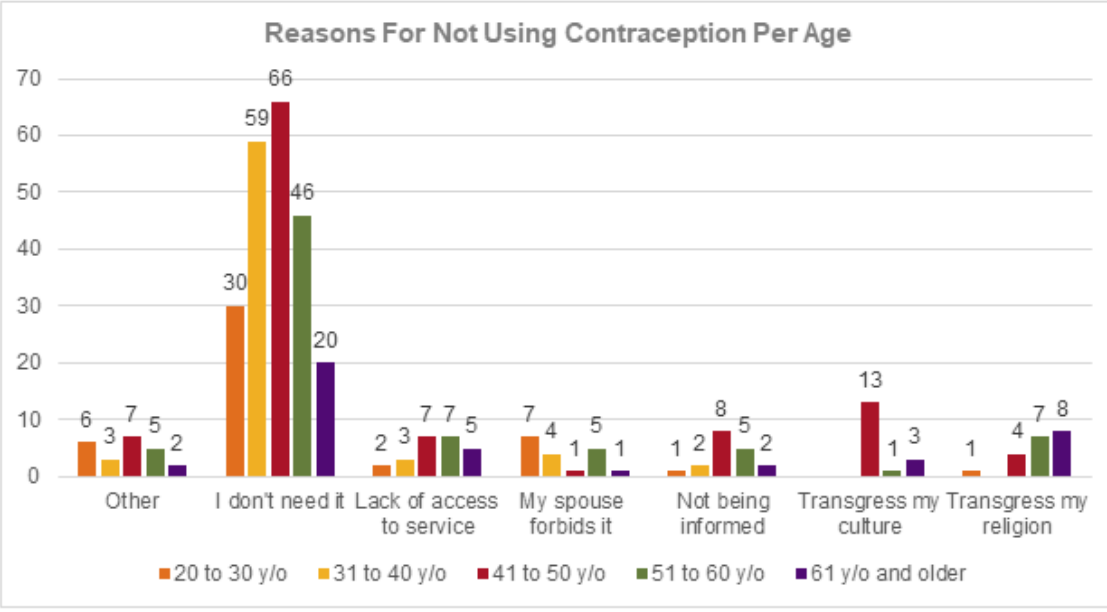


Figure 27 - Reasons against use of contraception.

Looking further into the women who responded that they don't need contraception, we see that they tend to be older and have more children compared with women who do use contraception. They are also more likely to be literate or have at least primary education. In fact, illiteracy and koranic studies are negatively correlated and statistically significantly related to non-contraception use while primary, high school, and university studies are positively correlated with contraceptive use. Interestingly, MMD membership is not an indicator of contraceptive use (Figure 20), which may require further study to understand. It is likely that social pressure around contraception is greater than the influence of MMD education around family planning.

CARE's team highlights the fact that there are two opposing views on contraception usage: religious beliefs and prescriptions which prohibit the use of contraception and the economic reality that families face preventing them from supporting a high birth rate.

6.2.2.2 Men's use of contraception

Sixty percent of men reported not using contraception. Looking by age, most men across age groups report non-usage of contraception, indicating that contraceptive use among men is not widely practiced. However, we see an increase in usage in the 31–40-year-old group, which indicates couples slowing down fertility rate or increasing birth spacing. Looking at men's contraceptive use by education level, Figure 29 indicates a relationship between education and contraceptive use; the more education a man reports, the more likely he seems to be to use contraception. For those with high school or university level education, nearly as many said no (n=18) as yes (n=16).

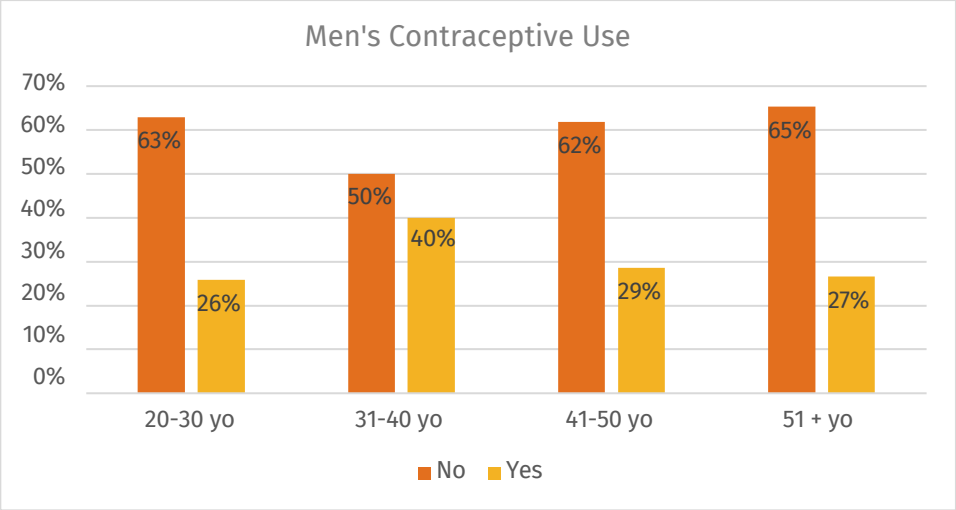


*Figure 28 - Men's use of contraception *n=184, 17 no answer)*

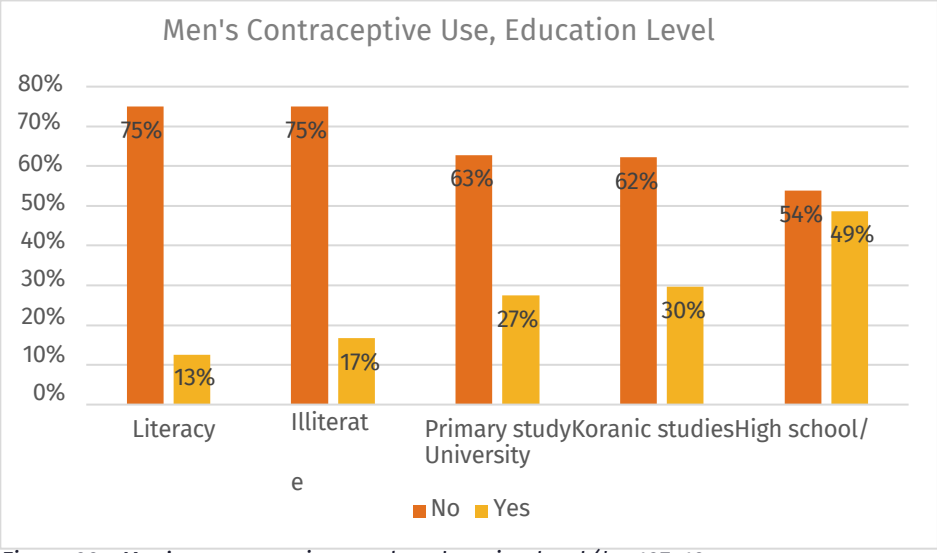


*Figure 29 - Men's contraception use by education level (*n=187, 18 no answers)*

Although we did not ask why men have such a low contraception usage rate, a meta study from the National Institutes of Health (NIH) exploring men's attitudes and practice about contraception using research from Nigeria and Ethiopia show that 89% of men in Nigeria "approve of their spouses using family planning" but will not accompany their spouses to a health center (65% disapprove).33 It may be that contraception is perceived as a female issue, especially long-term solutions. The overall attitude of men from the qualitative discussions was largely positive toward their wives' contraceptive use and their active roles in accompanying them to the health centers.

33 "Male Involvement in Family Planning Decision Making in Sub-Saharan Africa – what evidence suggests", M.Zambou Vouking; Ch. Evina, C. Nouboudem Tadenfok, Pan African Medicine Journal, 2014.

6.2.3 Birth spacing & Decision to have first child

One area of focus for this study was to see whether MMD groups had changed a deeply entrenched community norm around newlyweds and the birth of their first child. Overall, newlyweds are expected to have their first child as soon as possible after their wedding, as a sign of their fertility and health of their union. Qualitative discussions asked about how the community would respond to a fictional young couple waiting to have their first child. Overall, responses were negative – most people said young couples must have a child right away. Health agents reported that there is still pressure on newlyweds and young couples to have their first child soon after getting married to "test their fertility and avoid prejudice from society." Birth spacing is recognized as a positive strategy in Maradi, thanks to the intervention of MMD groups. Responses from MMD members showed some flexibility in this norm with women from Zinder reporting some young couples using contraception and women from Dosso saying, "Each couple makes their choice according to their needs, but most of them have a child first before taking contraception." However, many community members reported that young couples must have a child right away of face social stigma. It is more likely that they choose to use contraception after the birth of their first child.

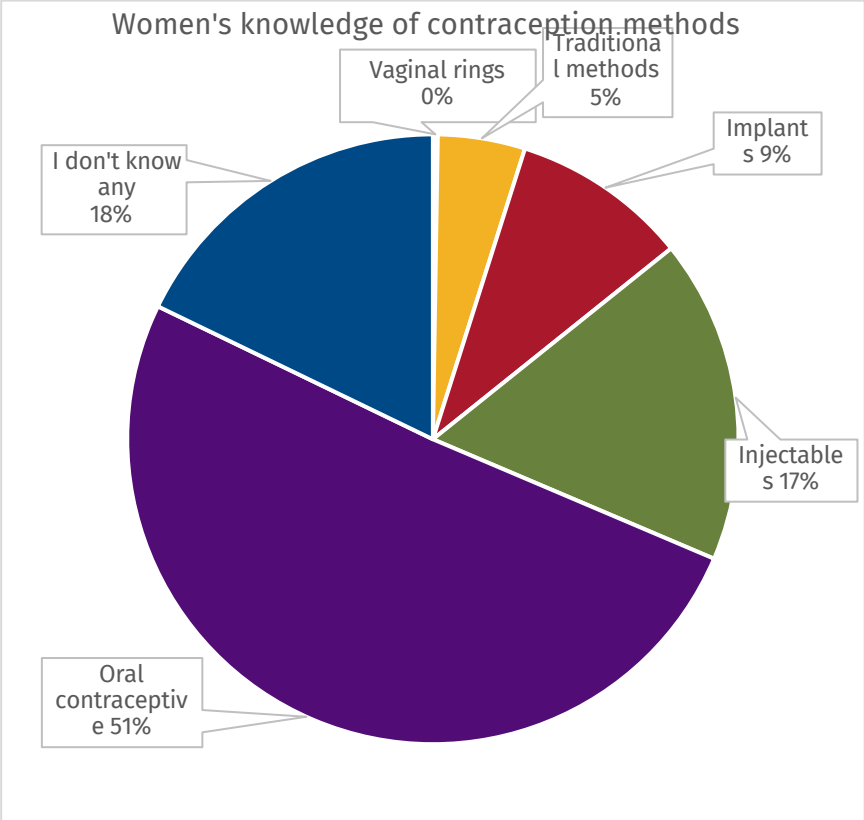


Figure 30 - Women's knowledge of contraception (n = 780)

Survey respondents were asked about the depth of their knowledge of contraception methods (Figure 30). Just over half of women reported they had heard of oral contraceptives, the highest number of responses across contraceptive types. Other methods such as injectables and implants made up a smaller proportion, followed by women reporting they didn't know of any types of contraception. Only 5% of women reported knowing about traditional methods, illustrating that modern contraception is widely known and preferred among women of childbearing age.

6.2.4 Men's involvement in prenatal care

MMD members and non-members along with health agents observe an increase in the number of men accompanying their wives to health centers for prenatal consultations but are unsure of the number of times a man does go with his wife and feel that a man who actually goes eight times must be rare. With the multiplication of nearby health centers, the need to be accompanied by a man has diminished. "Before, the men would accompany the women to the health center because of the distance, as there was no center in the village. Now there's a center nearby...Since the health center is right next to the village, the men no longer accompany the women..." Women members of MMD groups feel that not many men do prenatal care with their wives, while non-members feel the number of men involved may be greater (Zinder). A generational shift may have taken place with the perception that it's mostly young/younger men who go to the health center with their wives (in Maradi). Finally, some will go halfway: walk to the center with their wives but wait for them outside the gate (in Maradi).

Agricultural work can present obstacles for men to accompany their wives. Some men are still reluctant to having a male obstetrician or nurse help their wives in the delivery room. Both women MMD and health agents shared that a woman who does not visit the health center during her pregnancy will look irresponsible. There is agreement that health centers have a lot of information to offer women (and men) on prenatal and maternal health and health agents and staff are capable of answering questions. In Maradi, forgoing prenatal care and delivery at the health center is a costly mistake with a fine of 5,000 Francs, created in 2018.

Older women in Dosso differed slightly from younger women around men accompanying their wives to a health center. Young women (15-24 years old) said it was absolutely likely a man would go with his wife to the center while older women (40 years old and above) said it was less likely. Similarly, in Tahoua, men are increasingly accompanying their wives to the center. This is a change as health centers were previously little used. Across the regions, most say it is not uncommon to see men accompanying their wives to the health center, though it depends on the agricultural season. Many men in Maradi accompany their wives to the health center as they are beginning to understand the importance. However, medical staff said they do not see men entering the building. Women report that health center staff provide information and access to contraception.

6.3 Maternal Health: Social Movements

In the Niger context, social movements related to maternal health are extremely localized. Women tend to advocate to improve the health services nearest to them, bearing in mind that 49% of the rural population has access to a health center within 5 km of their home.[34]There are multiple national initiatives from international agencies, but the survey found no evidence that women interviewed are linked to efforts beyond their own villages. Survey respondents were asked whether they knew of an organization that advocates for maternal health - 57% of women, 55% of men, and 40% of youth reported they did. Most of the actions undertaken by these associations involve training and raising awareness (51%) and a combination of training, awareness and either equipment donations (13%), access to care (12%), advocacy (10%) and changing degrading norms (7%). Half of women respondents said they have attended meetings with advocacy groups on maternal health topics. Only 39% of men responded the same. Of the men who reported they have not joined these groups, half (49%) said the topic was not of their concern and a quarter (24%) said they were not informed on the meeting or event. Women are not attending those meetings because they don't feel concerned or interested (49%), they are not aware of the meeting (33%), and some don't have an answer (18%).

34 "Rapid Results Initiatives in Niger: Advancing women's health outcomes", World Bank, June 2020

When asked about the biggest changes MMD has brought to their communities relating to maternal health, MMD women in Maradi said, “Women attend the health centers en masse – especially in the context of maternal and child health.” Husbands of these women state respect for maternal health rules as one of their biggest changes. Husbands of non-MMD women in Maradi also talked about maternal health related changes, saying a big change was “high attendance at the health centers” and “delivery at the health center and exclusive breastfeeding,” suggesting significant systemic spillover on these crucial topics. Non-MMD women in Zinder report that it is because of MMD that they see “the massive attendance of women at the clinic and awareness-raising on exclusive breastfeeding.” Notably, MMD women in Dosso say, “the women have changed the way they treat illness, because before they were only interested in traditional medicine – all illnesses were treated by traditional practitioners.” This is a huge shift that they are attributing to the work of MMD groups. Other MMD women from the same communities said that now a majority of women go to the health center for consultations.” Husbands of non-MMD women in Dosso agree reporting the biggest change they see is that now women attend health centers.

6.4 Maternal Health: Service system strengthening and social accountability

A vast majority (91%) of women are aware of the existence of their local health center. Those who attend are informed by their neighbors (35%), at MMD meetings (19%) and 27% are informed by a combination or radio, TV and other means. Once they get to the health center, seeing medical staff is relatively quick. When asked about how long it takes to be seen at their health center, half of women said it took less than half an hour and a quarter said it took between 30-60 minutes (see Figure 31). This is important because the shorter the wait time, the more likely it is that a woman will return. Women’s time is already limited given all their care and livelihood responsibilities; a long wait time could be discouraging and lead to women not being checked out. This is especially significant given the fact that few new health centers have been built in the last 5 to 10 years. Only 36% of women recall seeing a new health center built in the last five years; and only 9% in the past 10 years.

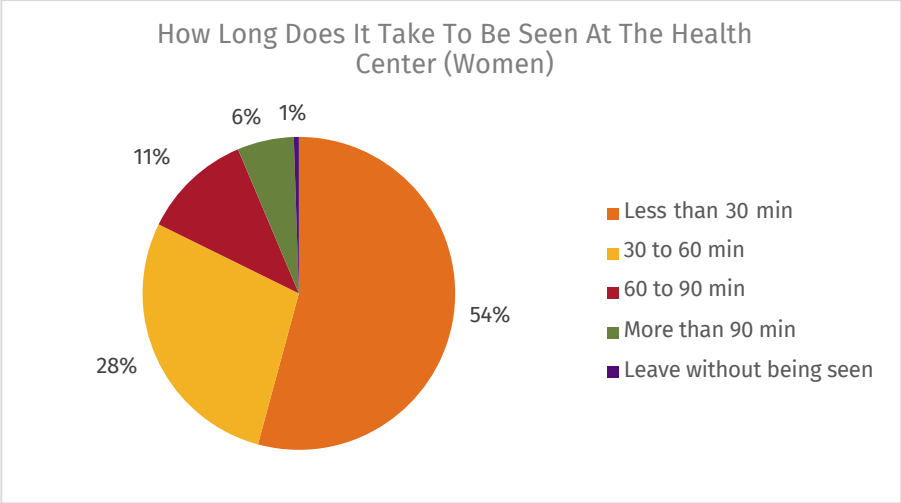


Figure 31 - Time to medical consultation, women.

Maternal Health conclusion

The influence of MMD groups on maternal health continues to produce effects through awareness training and information sharing from the groups. MMD women have positively shifted major social norms: husbands participate in prenatal care by going with their wives to the health centers and women have increased their attendance at health centers.

In some cases, delivering a child at home can be punished by a fine and overall, women have been successful at lobbying local authorities to increase either staff, equipment or buildings. However, the perception that young couples must have their first child as soon as possible after getting married is hard to shift.

However, some stereotypes persist: using contraception could lead to women's infertility (Tahoua); and "If they accompany their wives to the health center, men will be frowned upon and judged clingy by the community" (Maradi). The cultural weight put on young married couple to have a child as early as possible after being married is persisting.

7. Early and Forced Child Marriage

Niger Context

The Convention on the Rights of the Child defines a child as anyone under the age of 18 "unless under the law applicable to the child, majority is attained earlier"[35]. While the legal age of marriage in Niger is 18 years old for boys and 15 for girls, customary law marriage is much more informal yet carries more value, especially in rural areas, than a civil marriage. When a girl under 15 years old is married, there is no legal recourse or sanctions as the law does not state any sanctions.[36] Despite a commitment by the government to reach the SDG goal 5.3.1. to eliminate child marriage by 2030, and a downward trend in child marriages in Niger over the past 30 years, Niger remains home to the highest rate of early child marriage in the world: 76% of girls are married before their 18th birthday and 28% are married before they are 15 years old. About 6% of boys are also married before they turn 18.[37]

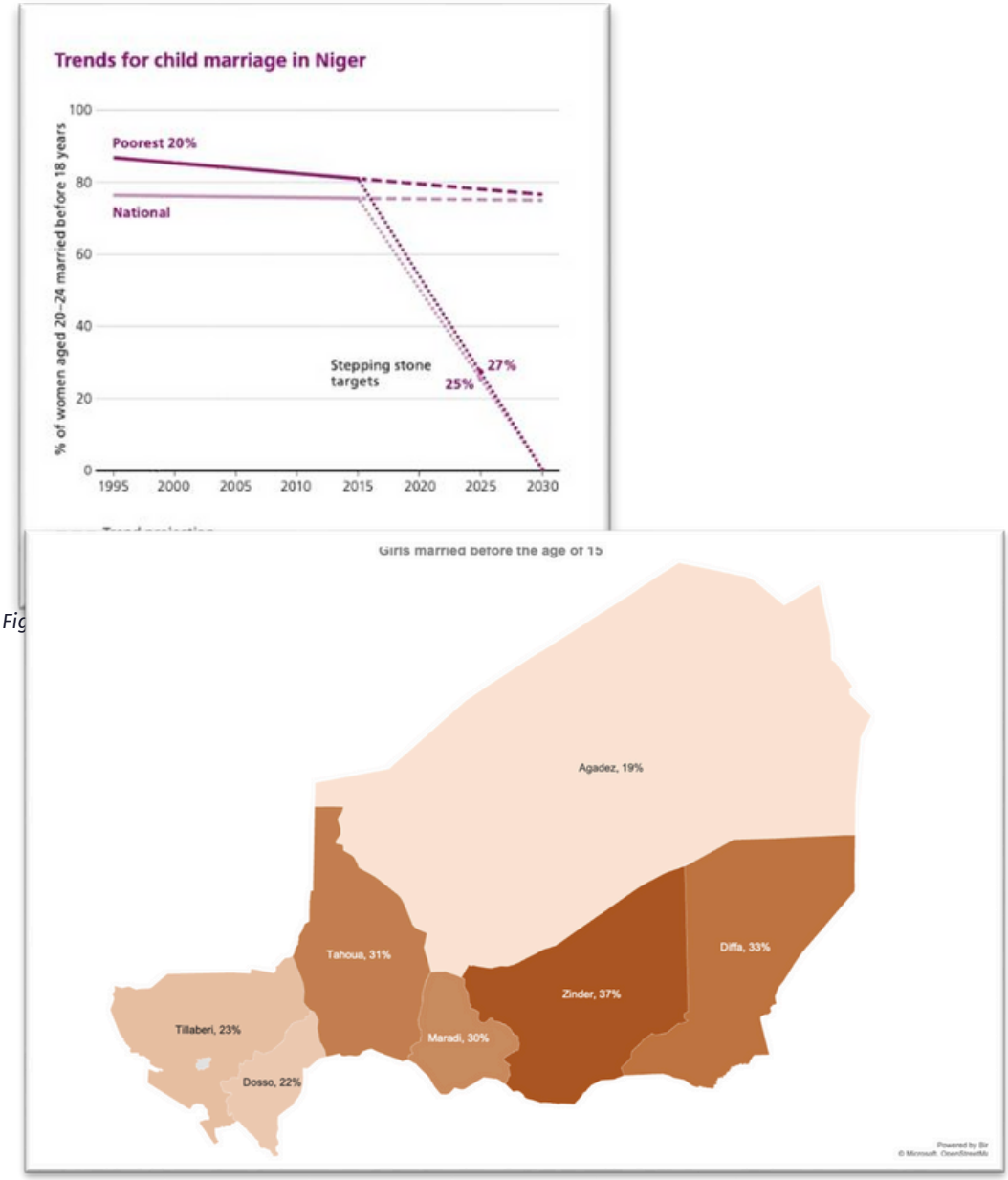


Figure 33 - Percentage of women, aged 20 - 24 married before age 15 (2012, data source UNFPA) [38]

35 UNICEF: Convention on the rights of the child

36 "Child Marriage in Niger": collective fact sheet, Care, Concern, Oxfam, Conide, CONGAFEN, CTB Niger, Coopération Belge, Mercy Corps, Plan International, Save the Children, UNFPA, UNICEF

37 Girls not Bride: Niger fact sheet; accessed November 2023

Figure 33 shows the rate of marriage before 15 years old for women currently between 20-24 years old in each region of Niger. There are notable differences between Agadez, which is in the Sahel, and Zinder or Maradi, which have large urban populations.

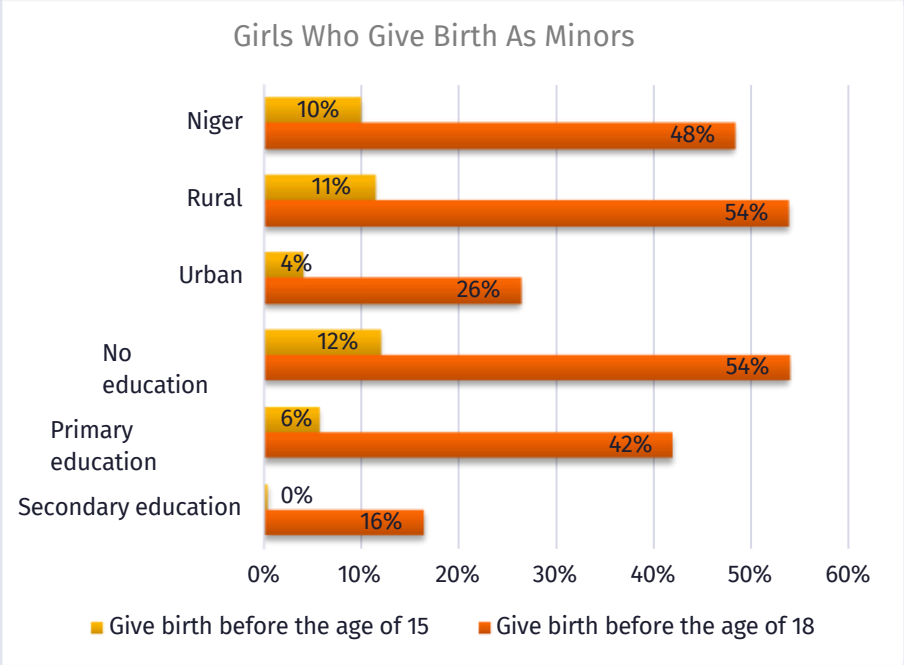


Figure 34 - Percentage of girls, aged 20-24, who gave birth as minors, source UNFPA [39]

The number of women who have given birth before 15 or 18 years old is quite high: almost half of women aged 20-24 years old had their first child before they turned 18 while 10% of them were not 15 years old. Globally, adolescent fertility is downward trending: 100 of every 1,000 girls aged 15-19 gave birth in 2021 in Sub-Saharan Africa, higher than the global average standing at 42.[40]

Pathway	Expected outcome	Quantitative & Qualitative synthesis
Advocacy to influence policies and programs	Policies to reduce early and forced marriage implemented at regional and district level	Yes
	Budgets increased and strengthened to further policy changes at municipal level to reduce early and forced child marriage	No evidence
	Elected positions use local public policies to reduce early and forced child marriage	No evidence
	CARE training given to local actors to continue/begin the policy advocacy at the local level to reduce early and forced marriage	Yes
	CARE training given to local actors to demand change around early and forced child marriage	Yes

38 Source: UNFPA – accessed November 29, 2023
39 Source: Source: UNFPA – accessed November 29, 2023
40 World Bank, Gender Data Portal, Accessed February 2023

Changes in social norms	Girls under the age of 15 are expected to remain unmarried	Yes
	People report any child marriage to authorities	Yes
	Unmarried pregnant girls are expected to remain in their parent's house	No
	Unmarried pregnant girls are expected to stay in school	No
	Young people are expected to openly discuss SRH (premarital sex, FP, protection)	No
	Religious leaders champion girls marrying at 15 years old and older	No
	Religious leader, council men and boys to marry girls 15 years old and older	Yes
Social movements	Removing girls from school to be married is no longer celebrated	Yes
	Women speak out against early and forced marriage	Yes
Strengthening system & social responsibility	Districts and regional governments offer support services to unmarried pregnant girls	No
	Schools integrate family planning/reproductive health curriculum into all secondary classes	No
	More elected personnel involved in creating and furthering the formulation of local public policies in support of girls' education	No
	Reporting mechanisms put in place to report on instances of early and forced child marriage	Yes

7.1 Early Child Marriage: Changes in social norms

Within the context of this study, men and women were asked whether they had daughters in their household who were married and the daughters' ages when they were married. About half of men responded they had daughters in their household who were married, over half (51%) of whom were married between 15-18 years old. About 40% were married at 18 or older and only 7% were married before they turned 15 years old. Over half of women responded they had daughters who were married. Women's responses largely echo men's because our sample is made up of spouses of MMD members, though we did not identify couples in our data. The slight variations are likely due to the variability of human memory recall. The qualitative data further confirm that parents are waiting longer to marry their daughters, marking another way in which MMD groups influence community behaviors and attitudes.

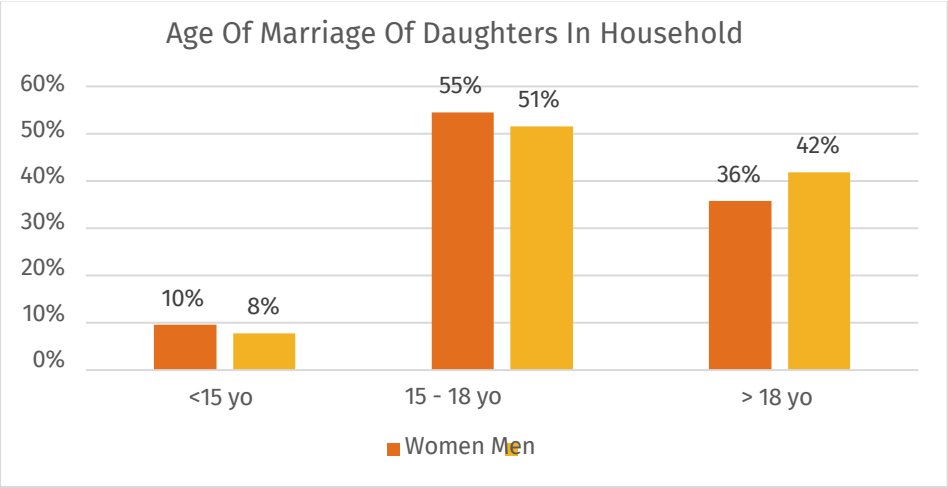


Figure 35 - Girls married by age and by gender of parent

Looking further into the difference between MMD and non-MMD women members, we find a notable difference. Girls in MMD households between 15-18 years old are more likely to be married than in non-MMD households. Figure 36 shows the rates of girls married across the three age ranges by the total number of girls in MMD or non-MMD households. Respondents were asked the number of girls in their households; we assume these girls are unmarried. It is difficult to account for the exact reason for the ten-percentage point difference for girls between 15-18 years old; further analysis is recommended. Respondents were asked about their overall attitudes toward early child marriage: only 7% of MMD women said it was normal for girls under 15 to be married while 91% said it was not normal. Non-MMD members showed a similar trend, with less than 2% claiming it was normal and 97% saying it was not normal.

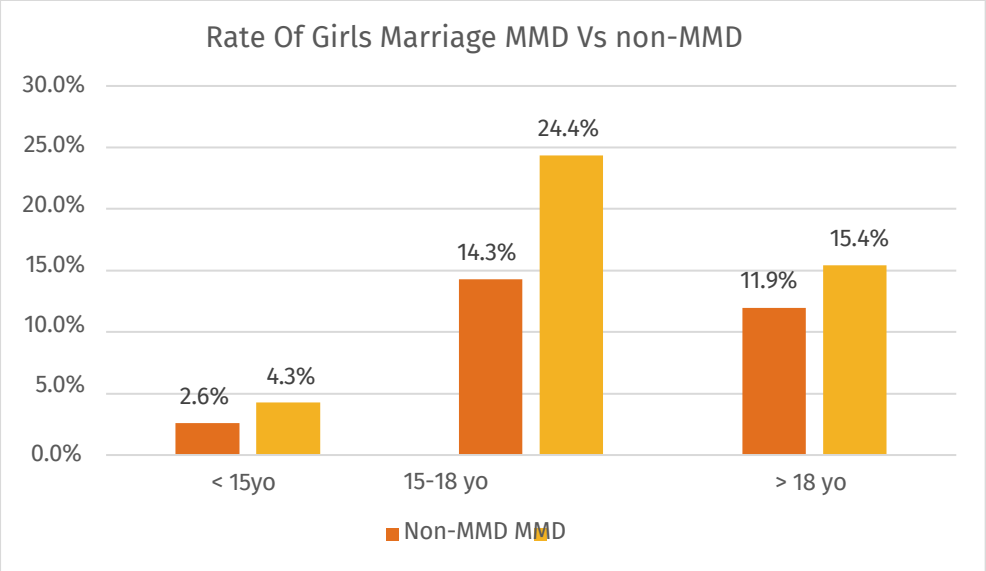


Figure 36 - Rate of girls' marriage by MMD membership, adult women respondents

One of the ways MMD groups have educated their communities on early marriage is by sharing the risks for girls. Respondents were asked to name some consequences of early marriage without prompts. A vast majority of men and women said that early marriage possed risks to the girls' health. Half reported that it was risky to her children, presumably due to childbirth at such a young age. About a quarter of men and women noted the risk that she will become pregnant if married. And only 19% of men and 29% of women reported that early marriage interupts a girls' education. Among youth respondents, 78% say they recognize that early

marriage can have negative consequences on a girls' well-being and over half (57%) say that early marriage is a risk to the girls' health.

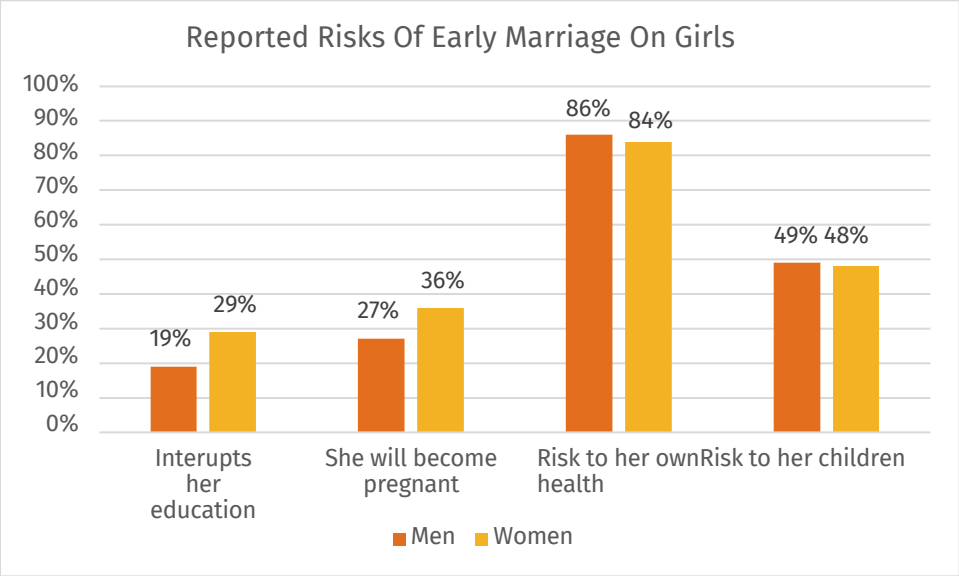


Figure 37 - Women's and men's understanding of early marriage risks for girls

Respondent's answers are in line with global understanding of the impacts of early marriage and pregnancy on a girl's health. Health risks are known and well documented and include early pregnancy/childbirth with heightened risk of complications as leading cause of death in girls aged 15 – 19.[41] Increase in sexually transmitted diseases, including HIV/AIDS, female genital mutilation, and domestic violence (girls married before the age of 15 are 50% more likely to suffer from intimate partner violence).[42] Additionally, underage girls are less likely to give birth in a health care facility. There are no documented positive outcomes in terms of health for girls who are married at a young age. Yet, social norms, economic pressure and other external factors override the concern for girls' health and wellbeing despite a clear understanding of the consequences.

At the national level, the government of Niger "with support from the World Bank, the Global Financing Facility for Women, Children and Adolescents, UNICEF, UNFPA, CARE International, Plan International and Save the Children, and others" has "reformed its legal framework to allow married adolescent girls[43] to access family planning services without being accompanied by an adult parent or husband." Locally, women who are engaged in income generating activities are becoming more "independent within their household, but also their communities since they take part in decisions made at home." Furthermore, they are respected for their opinions especially, "when the question is about marrying their daughter, since they finance 80% of the marriage. With the training they received, women members of MMD groups can successfully convince other women to [forego] an early or forced marriage" for their daughters (Tahoua). School teachers also play a critical role when girls are underperforming in school, convincing them to stay in school and not get married too early (Tahoua).

41 Girls not Brides website: Child marriage and health, accessed November 28, 2023
42 Ibid
43 World Bank Blogs: "How new laws are protecting women and girls, and changing mindsets in Niger", January 2022.

Reactions to early marriage overwhelmingly stress the fact that it's "not normal" to see girls younger than 15 being married, despite its continuing at low rates. Men and women were asked if they had daughters who were married before the age of 15 and why this happened. Men and women who said they had daughters under 18 years old who were married said their top reasons were to avoid pregnancy out of marriage and juvenile delinquency. Insights from the CARE team indicate that having an "out-of-wedlock pregnancy" would result in two uncomfortable situations for the girl and her family: the girl could be stigmatized in the community for carrying a child out of wedlock, her family would have little credibility, and the girl would have less chance of getting married because of this "accidental past." In other words, social stigma is more powerful than health consequences to a girl.

Group discussions further confirmed early marriages have declined, with husbands of MMD women in Dosso saying, "With the advent of MMD, early child marriage has decreased" and young MMD women in Dosso saying that early child marriage was a thing of the past. In Maradi, a female community leader said that "Changes in mentalities are being observed in relation to early marriage thanks to awareness-raising." MMD members in Maradi say one of the biggest changes due to MMD were campaigns for women's and children's rights and reduce early and forced marriage.

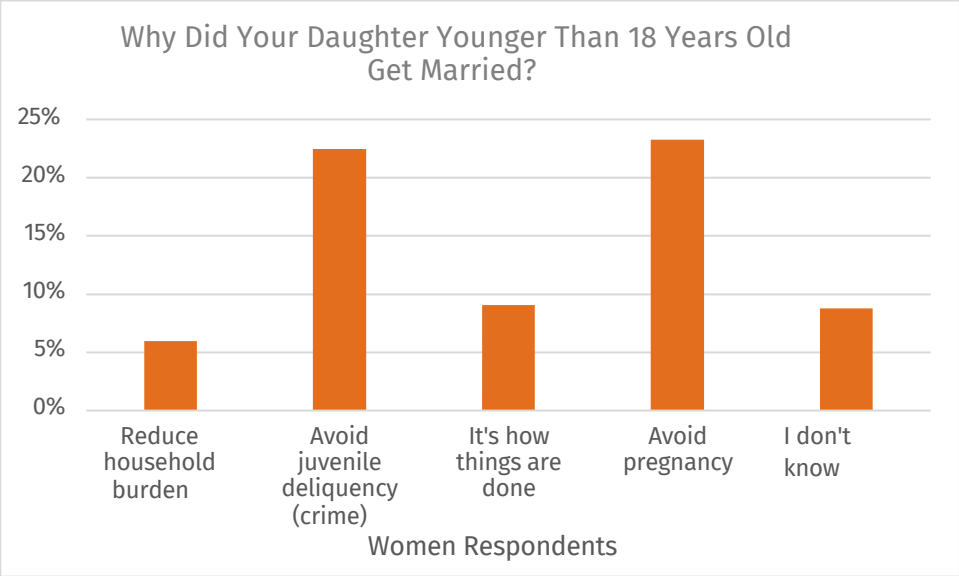


Figure 38 - Women's reasons justifying early marriage

Children in "conflict with the law" (formerly referred to as juvenile delinquency)

The term "juvenile delinquency" or youth crime is slowly being replaced by that of "Children in conflict with the law," as an attempt to decriminalize behaviors, sanctions and perceptions. It covers vastly different realities: from young villagers who move to cities without understanding urban codes and behaviors to other marginalized youth. In the case of young women, the reality can cover prostitution, drug consumption, and other behaviors deemed socially unacceptable. Out of school teenage mothers often lack employment opportunities and may resort to unsafe behaviors to survive in an environment where they have very little assistance available. For parents, having children in conflict with the law carries a reputational risk. The latest available statistics show more than 500 children being detained,[44] mostly in Niamey, in places that are not equipped to deal with their needs, especially those of young girls and young mothers. Recently, the government of Niger has partnered with the German cooperation and other international institutions to implement alternative solutions to detention for youth.

[44] UNICEF: "Children behind bars," June 2020

On the other hand, attitudes toward investing in girls' education as a strategy to keep them from early marriage aren't universal. About 20% of female respondents and 25% of male respondents agree that it is a waste of resources to keep a girl in school until she graduates. Among youth respondents, 25% of the female youth and 27% of male youth agreed with the statement. These attitudes hold between MMD and non-MMD communities – about 20% of women respondents in both communities agreed. These responses demonstrate there is an opportunity for further education on the value of girls' education and the negative consequences of pulling girls out of school early.

Respondents were also asked whether they attended a community celebration commemorating when a young girl is pulled out of school to get married. Of the respondents, 31 women (3%) and four men (2%) reported attending a celebration in the community when a girl is withdrawn from school. Withdrawing girls from school can be perceived as lowering the risk of pregnancy outside of marriage. Though these are small numbers, it is interesting to compare to the qualitative interviews in which every person reported that this type of celebration doesn't happen in their communities – many stated they had never even heard of such a practice. It is possible that respondents in focus groups felt peer pressure to deny such a practice. Regardless, these numbers indicate that this type of community event is very rare.

Attitudes towards boys and girls talking about sex

To understand community attitudes and expectations around discussions of sex, respondents were asked a series of questions about whether boys and girls discuss sex and with whom. On the whole, men and women say that it is unlikely or not appropriate for girls and boys to discuss sex with friends, parents, religious leaders, or community leaders. Men and women's responses become increasingly negative when asked about various adults in their community when compared to their responses about girls and boys discussing sex with friends. Youth were asked the same series of questions. Their answers largely confirm what adults in their communities said, indicating that the trend toward openly discussing sex is still nascent.

Table 4 - Social norms around girls and boys discussing sex.

		Women	Men	Youth
How likely is it that a girl or boy in your community will discuss sex with their friends?	Very likely	9%	11%	16%
	Somewhat likely	20%	30%	30%
	Not likely	71%	59%	54%
How likely is it that a girl or boy in your community will discuss sex with their parents?	Very likely	5%	7%	7%
	Somewhat likely	11%	16%	14%
	Not likely	84%	76%	78%
How likely is it that a girl or boy in your community will discuss sex with a religious leader?	Very likely	5%	10%	8%
	Somewhat likely	7%	13%	11%
	Not likely	88%	76%	80%
How likely is it that a girl or boy in your community will discuss sex with a community leader?	Very likely	8%	13%	11%
	Somewhat likely	3%	3%	3%
	Not likely	89%	83%	85%

In Table 4, it is clear that few boys and girls discuss sex with most people in their communities, though they are more likely to discuss sex among friends than any other group.

Table 5 - Community approval of girls and boys discussing sex.

		Women	Men	Youth
Most people approve of girls talking about sex with their friends.	Very likely	11%	16%	24%
	Somewhat likely	21%	33%	29%
	Not likely	67%	51%	47%
Most people approve of boys talking about sex with their friends.	Very likely	11%	17%	21%
	Somewhat likely	22%	33%	32%
	Not likely	66%	50%	46%
Most people approve of girls talking about sex with their parents.	Very likely	5%	5%	6%
	Somewhat likely	16%	21%	25%
	Not likely	78%	73%	69%
Most people approve of boys talking about sex with their parents	Very likely	2%	4%	2%
	Somewhat likely	14%	20%	21%
	Not likely	83%	75%	76%

Table 5 shows that attitudes toward girls and boys talking about sex are also not socially acceptable. Though similar, responses here indicate community approval of a conversation which is distinct from whether a respondent thought that it was likely to happen. By asking about approval, we were trying to understand normative attitudes that may be held beyond the individual respondent.

Impact of early marriage & pregnancy on education

In 2019, the government of Niger issued an order requiring that married and/or pregnant students and adolescents stay in school.[45] Our respondents confirm that a pregnant girl will continue to live at home with her parents (93% women, 97% men and 90% youth). In Zinder, respondents noted that living with parents is a significant change compared to previous years, when pregnant girls had to leave their homes and become homeless most of the time. In all regions, it is extremely rare that a young pregnant girl would be welcomed in her the house of the father of her child, without being married to him. There again, the social stigma are strong against unwed pregnant teenagers.

The adolescent birth rate is rising from 146 per 1,000 in 2015, it jumped to 154 in 2016 among women aged 15-19.[46] The impact of an early pregnancy on education is quite sizeable as only 26% of youth, 31% of men and 33% of women say that a pregnant girl will continue to go to school. In focus group discussions the reasons why pregnant girls drop out of school were because they face "insults, being mocked even by her friends. Society will not judge her well, but there are few good practices in our village that would help prevent early pregnancy, except for abstinence." "The whole family will be impacted by the shame of this early pregnancy." (Tahoua, Maradi). The language used by respondents in discussion was quite strong and prescriptive: "Any girl who becomes pregnant has to abandon school; girls who become pregnant never return to school" (Dosso). The weight of prejudice, social norms and other bias is heavy on pregnant young women who receive little support or empathy or are altogether excluded from society: "This situation is unlikely to occur in our community because the pregnant girl is no longer accepted by her peers and society in general." (Maradi)

[45] Human Rights Watch: "Interview: New Niger order protects girls' rights to education,"
[46] August, 2022 UN Women data: Niger, accessed November 29, 2023

Once she becomes a mother, her chance of returning to school are even slimmer with 23% of youth, 24% of women and 28% of men sharing that she can go back to school after giving birth. Teachers are recognized as part of a minuscule support system for pregnant girls. They tend to advocate for keeping girls in school but have more difficulty doing so when it comes to pregnant girls. Despite a strong commitment from the government and the awareness of the new law, in practice, pregnant girls are still turned away from school.

How do youth approach sexual and reproductive health information?

Finding information and partners to talk about sexuality and reproductive health is complicated for both girls and boys. Yet this issue is critical as in the regions of our study, girls have sex at a young age: see Table 6 below with data from UNPFA as we did not ask the question. As shown in Table 4, about 30% of youth respondents feels it is appropriate for them to talk about sex with their friends. Parents, community and religious leaders are much less likely to engage in those conversations with youth. Some youth (39%) and women (47%) agree that the community health center offers information on contraception to young people.

Table 6 - Percentage of girls 15 to 19 sexually active

Zinder	Maradi	Tahoua	Dosso
71.7%	71.3%	68.2%	65.6%

7.2 Early Child Marriage: Social Movements.

MMD groups had a significant influence on the reduction of early and forced child marriage in their communities, according to the discussions. Women in Zinder said that mentalities are changing. Girls are kept in school as long as possible and are not married off at an early age. Husbands of non-MMD women in Zinder also saw this change reporting, “[MMD groups] have raised awareness of early and forced marriages. They are working to get girls into school and keep them there.” In Dosso, husbands of MMD members say that early marriage simply doesn’t happen in their village; they wait until girls are “of age.” And a CARE staff from Maradi noted that “We're seeing a remarkable change now. To get married you need work! Unemployment even prevents boys from getting married very early, taking care of the family, which isn't the case before. With solidarity the person can leave his wife in a large family and [migrate], although some communities have started to counteract this practice."

Protection committees

Funded by UNICEF-UNFPA, among others, local village protection committees work to educate people and eliminate child marriage in their communities. Committee members are trained on the risks of child marriage, monitoring the implementation of the action plan on social change and managing cases of children who are victims of abuse, violence and exploitation, including child marriage. Members of the protection committees include young girls called “Correspondents for Protection” (C4P). They received training in life skills, human rights, and effective communication, which has increased their ability to protect themselves and other girls at risk of child marriage.[47] The World Bank’s SWEDD[48] project is currently financing 50 Child Protection Committees including in the four regions of the study.

Among the women interviewed, 61% knew of the existence of a Protection Committee in their community while only 55% of men did, the same proportion as youth. In discussions among MMD members in Zinder, one woman said, “among us are women who are members of

[47] https://www.spotlightinitiative.org/news/it-takes-village-protection-committees-intercept-child-marriages-niger
[48] Sahel Women’s Empowerment and Demographic Dividend

protection committees They defend children's rights." A minority of respondents - 41% of women, 35% of men and only 27% of youth - knew how many times the protection committee intervened to prevent the marriage of an underage girl. Husbands of non-MMD women in Maradi say that protection committee members are perceived by the community as agents of change in mentality. "For men, they embody bravery. For girls, they are agents of protection because they raise awareness of issues such as sexually transmitted diseases." In Tahoua, respondents note that women are more active than men in respecting roles and responsibilities. This is demonstrated by the competition for positions of responsibility between men and women in the COGES (health and education) and village child protection committees. The status of women who work in protection committees is acknowledged by the community who further shares, "women work for the respect of women's rights, in particular those of young girls. Some women are members of the protection committee and make their own contributions." Women's contribution to protecting children's rights is known and recognized.

Early child marriage conclusion

Despite significant legislative action from the government of Niger to keep girls in school as long as possible, girls are still married at a young age for multiple reasons. They receive very little support from family, friends, religious and community leaders, or teachers if or when they become pregnant, especially outside of wedlock. They bear the brunt of the social stigma which can lead to exclusion and have very little chance of returning to school once they become mothers. Early pregnancy falls within the category of "juvenile delinquency," further marginalizing girls who have almost non existing support networks outside of a family who is judging and condemning their behavior.

The difference between MMD and non MMD households is difficult to explain as both sets of respondents are subject to the same economic reality. They all note that early marriage is not normal, almost unanimously, and they all acknowledge the economic and health risks posed to girls by those early marriages, yet young girls are still married at an alarming rate. Women who participate in child protection committees are heralded as women's and children's rights champions. Yet, early and forced child marriages persist.

CARE's team shared their view that MMDs have had a positive impact on reducing early marriage in many places, by creating tutoring systems (Maradi, Zinder) to support the schooling of girls from communities with no secondary schools (they are directed to concentration centers with general education colleges). This system has enabled many girls to complete their schooling, thus escaping marriage imposed by the community.

8. Girl's Education

Niger Context

Niger's current literacy rate for adults 15 years and older is 37.34% and 29.7% for women 15 years and older.[49] Girls' education in Niger is not only a matter of every child's right to receive an education, but is also a powerful poverty alleviation tool with multiple positive outcomes including "improving the economy, creating safer societies, increasing women's literacy rates,

49 World Bank & UNESCO data

reduc[ing] child marriage and minimiz[ing] conflict."[50] Former President Bazoum[51] made girls' education a key action of his mandate with a pledge to increase the budget allocation to education to reach 22% by 2024.[52] In 2023, Niger received $230m for its education project LIRE (Learning Improvement for Results in Education). Niger schools suffer from a lack of investment: sometimes the walls and roofs are not finished, students cannot afford supplies, etc.

The British Ambassador to Niger stressed the current situation of education in Niger where education prospects remain lower for girls, who receive 2.4 years of quality education in their lifetime, compared to 2.9 years for boys. Only 42% of girls were enrolled in basic education compared to 58% for boys.[53] World Bank data further illustrate the gap with only 15% of girls and 17.3% of boys completing lower secondary school in 2021, putting Niger well below sub-Saharan Africa's and low-income countries' average. [54]

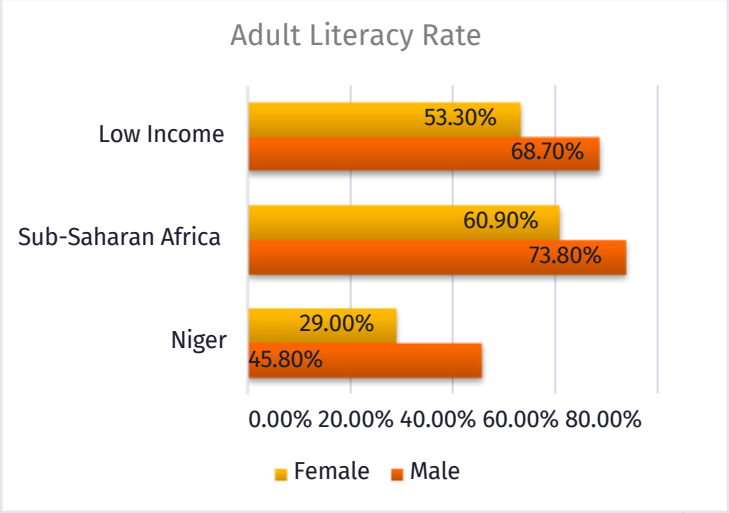


Figure 39 - Literacy rates, by sex for adults 15 years and above (Source World Bank) [55]

Pathway	Expected outcome	Quantitative & Qualitative synthesis
Advocacy to influence policies and programs	Policies to support girls' education implemented at regional and district level	Mixed
	Budgets increased and strengthened to further policy changes at municipal level to support girls' education	No evidence
	More elected personnel involved in creating and furthering the formulation of local public policies in support of girls' education	No evidence
Changes in social norms	Parents are expected to support and equally prioritize their daughters' education as much as their sons'	Yes
	Girls go to and stay in school	Yes
	Teachers expect boys and girls to participate and excel equally	Yes
	Fewer unplanned pregnancies among school-age girl	Unclear
	More men marry educated women	Yes
	Resources are available to support families while girl children are in school	Some
	Teachers treat boys and girls equally/teachers don't perpetuate gender stereotypes at school (especially in STEM fields)	Yes
Social movements	CSOs, women's orgs, local politicians speak in one voice in support of girls education	Yes
	Teachers/teachers 'unions have improved budgets necessary to serve girls	No evidence
	Schools and health care providers share contraceptive information/services in school	No

50 The Borgen Project "Benefits of Girls' Education in Niger", March 2022

51President Bazoum was overthrown by a military coup between April and July 2023.

52 "Niger's need to improve the education of girlshttps://www.chathamhouse.org/2021/07/improving-education-girls-in-niger," Catherine Inglehearn, July 2021

53 Ibid.

54 World Bank – Gender data portal – accessed December 21, 2023

55 World Bank – Gender data portal – accessed December 21, 2023

Strengthening system & social responsibility	Schools are able to accommodate the youth population they serve	Unclear
	Parents understand girl and boy children must remain in school for a similar amount of time/until ## year (until graduation?)	Yes
	Local leaders, religious leaders, women's groups understand the consequences of girls lacking schooling	Yes
	Vocational and skill training facilities reserve % of spots for girls with # of years of schooling	No

8.1 Girls Education: Changes in Social Norms

Men and women respondents were asked about community attitudes and expectations toward girls' schooling. Men and women largely agree that girls and boys have the same educational opportunities, the community approves of girls receiving a secondary level education or higher, and that boys and girls are encouraged to marry someone who has completed their education cycle (high school or higher). Men and women are aligned that boys and girls do not carry out the same household chores, they disagree that the length of a girl's schooling impacts her ability to get married, and both agree that girls are not allowed to have sex before marriage.

However, there are several places where men's and women's responses did not align. For example, more women were in somewhat agreement that girls are expected to leave school once they are married while more men disagreed with that statement. The difference is likely explained by lived experiences – girls are the ones pulled out of school to get married at higher rates than boys. Similarly, more women were in somewhat agreement that parents think that adolescent girls are less attentive to their studies than boys while more men disagreed. It's not clear if this difference is due to women's honest attitudes about their own attentiveness to their studies or that women are more aware of how their children approach their schoolwork.

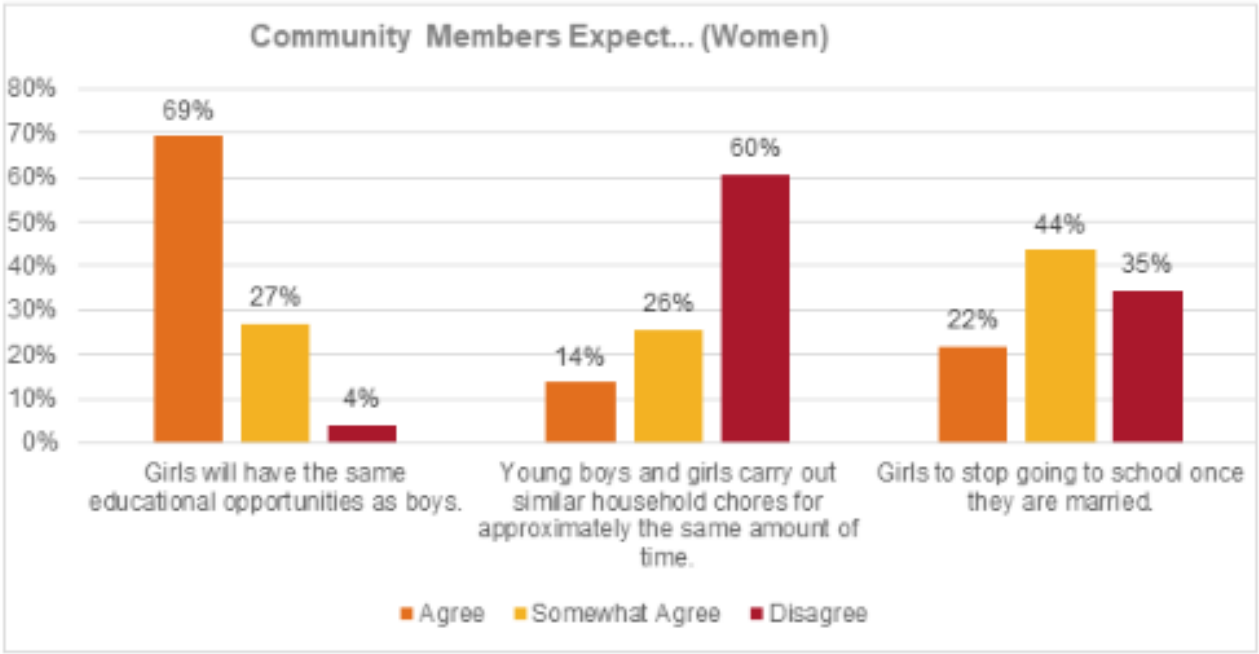


Figure 40 - Women's expectations in terms of girls' education

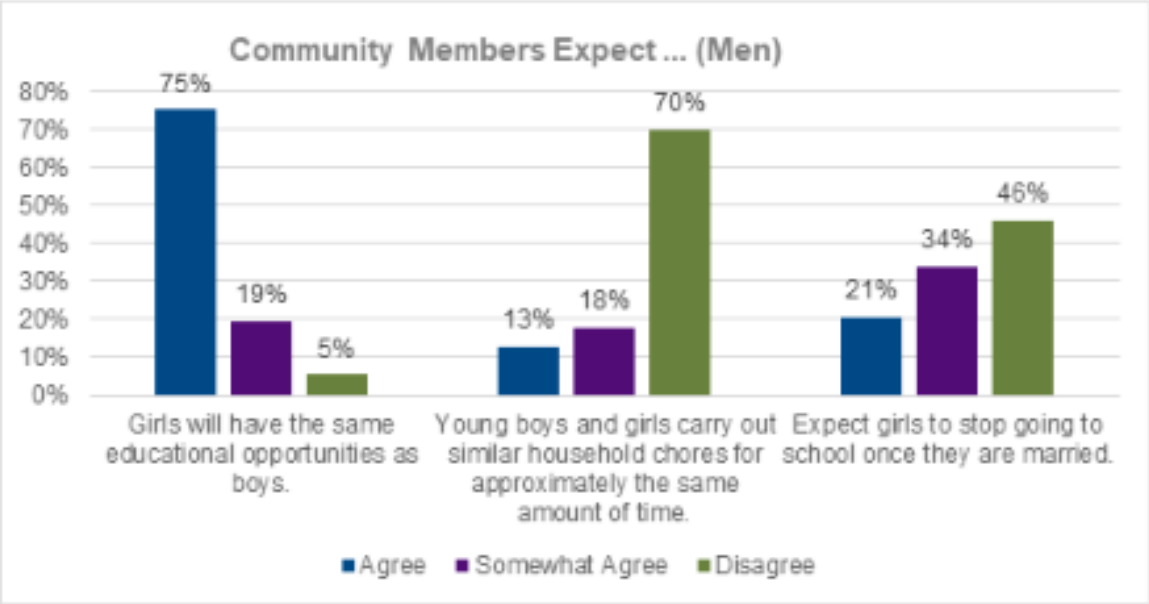


Figure 41 - Men's expectations in terms of girls' education

Figures 40 and 41 show that men and women differ slightly about when newly married girls are expected to stop going to school. Women agree (22%) and somewhat agree (44%) but nearly half of men disagree.

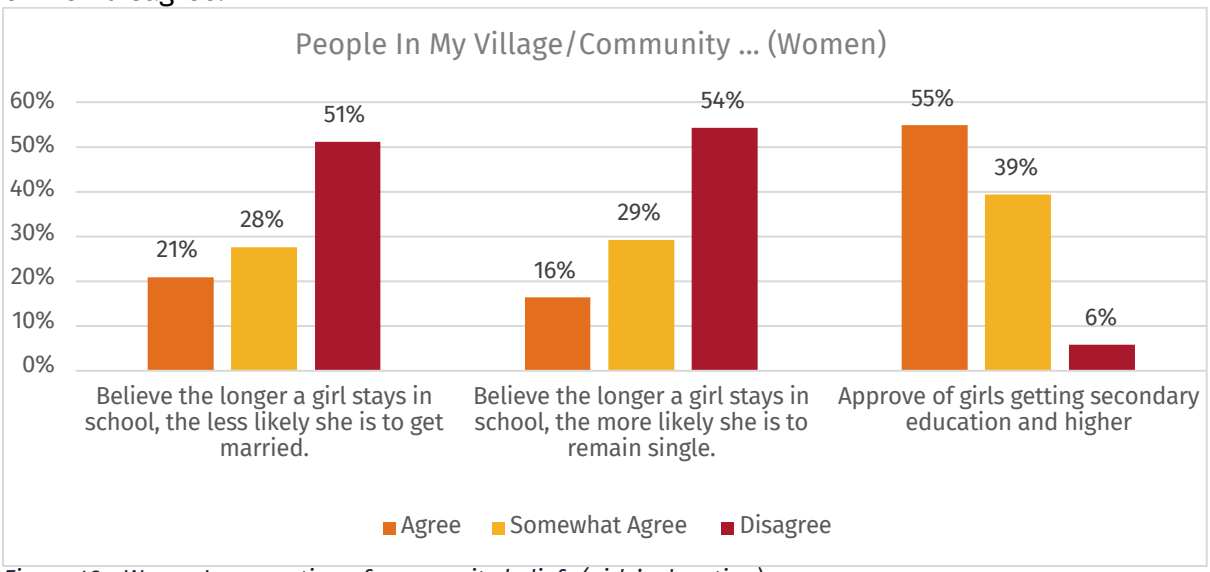


Figure 42 - Women's perception of community beliefs (girls' education)

Figure 42 shows women respondents perceptions of community held norms. Half of women say their community disagrees that girls are less likely to get married or stay single if she stays in school, which is a good sign. And only 21% say the community agrees that a girl staying in school means she's less likely to get married, indicating that attitudes are trending away but haven't completely vanished. And over half (55%) of women say their community approves of girls getting secondary or higher levels of education and only 6% say their communities disagrees.

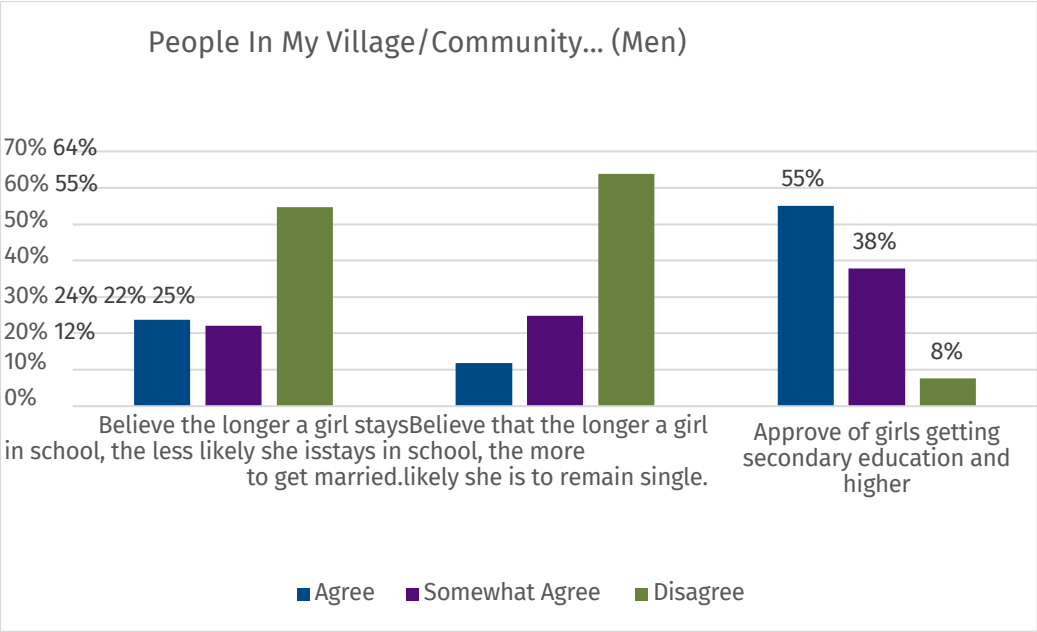


Figure 43 - Men's perception of community beliefs (girls' education)

Figure 43 shows men's responses which largely align with women's. A resounding 64% of men say their community disagrees that the longer a girl stays in school, the more likely it is she will remain single.

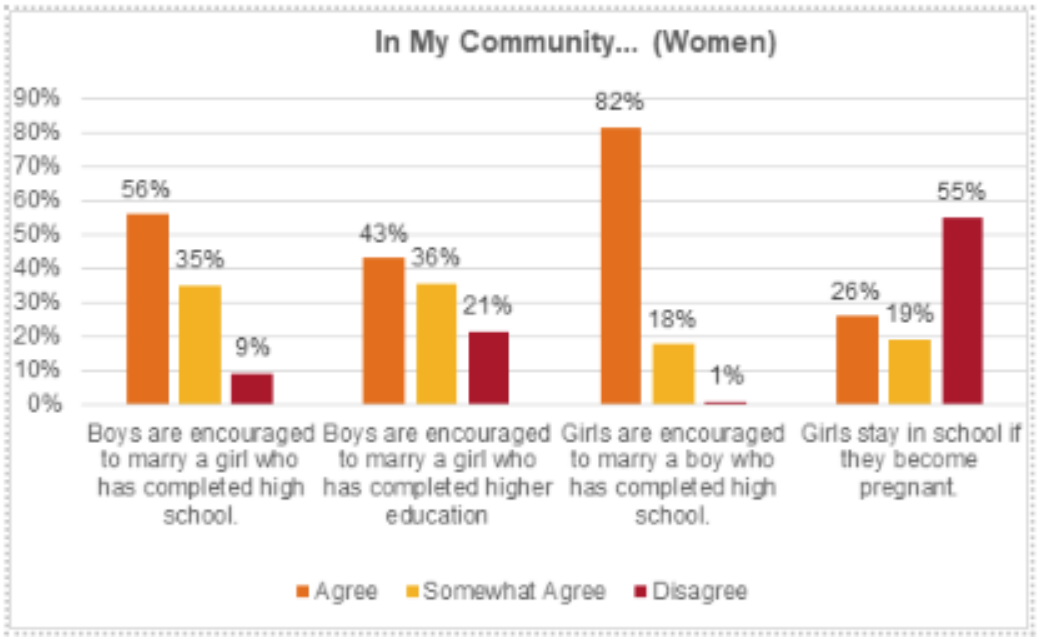


Figure 44 - Women's perception of community beliefs (equal access to education)

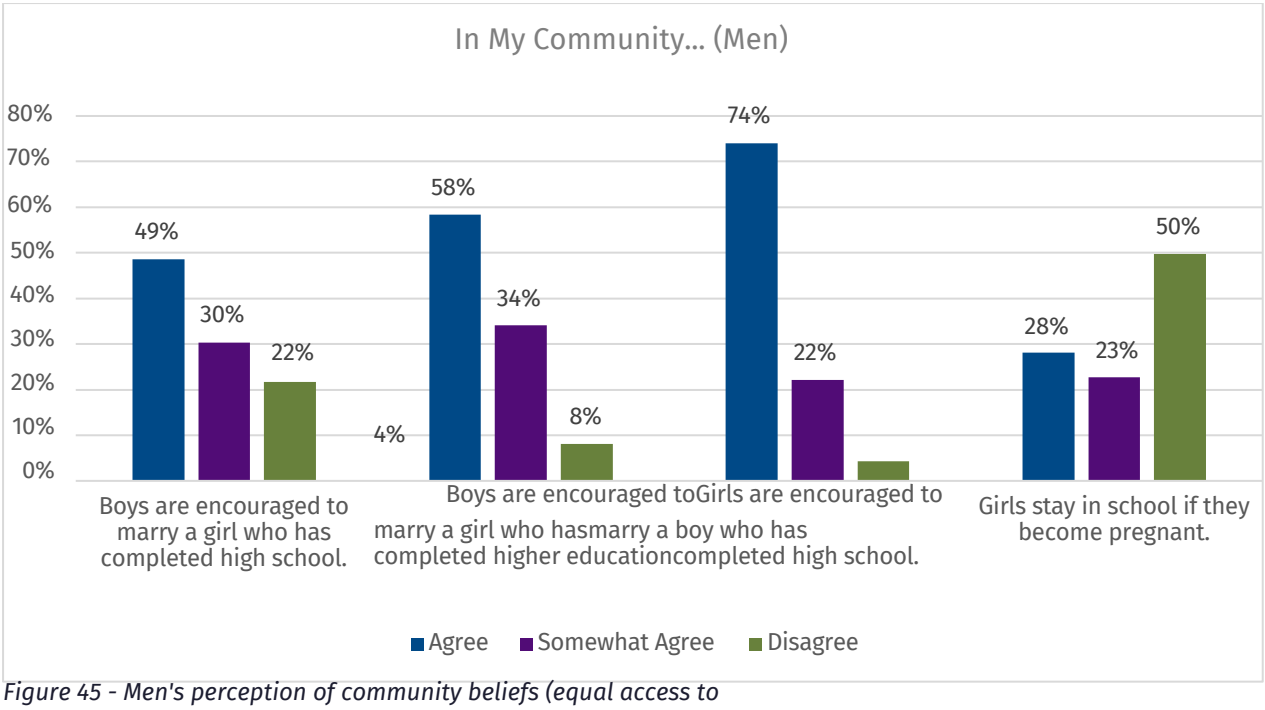


Figure 45 - Men's perception of community beliefs (equal access to education)

It is interesting to note the slight difference between men's and women's responses on their community held beliefs around boys. In Figure 44, 43% of women say their community agrees that boys are encouraged to marry a girl who has completed higher education but 58% of men say the same. 21% of women disagree but only 8% of men do. This difference may again be attributed to differing lived experiences where boys are told one thing and girls another.

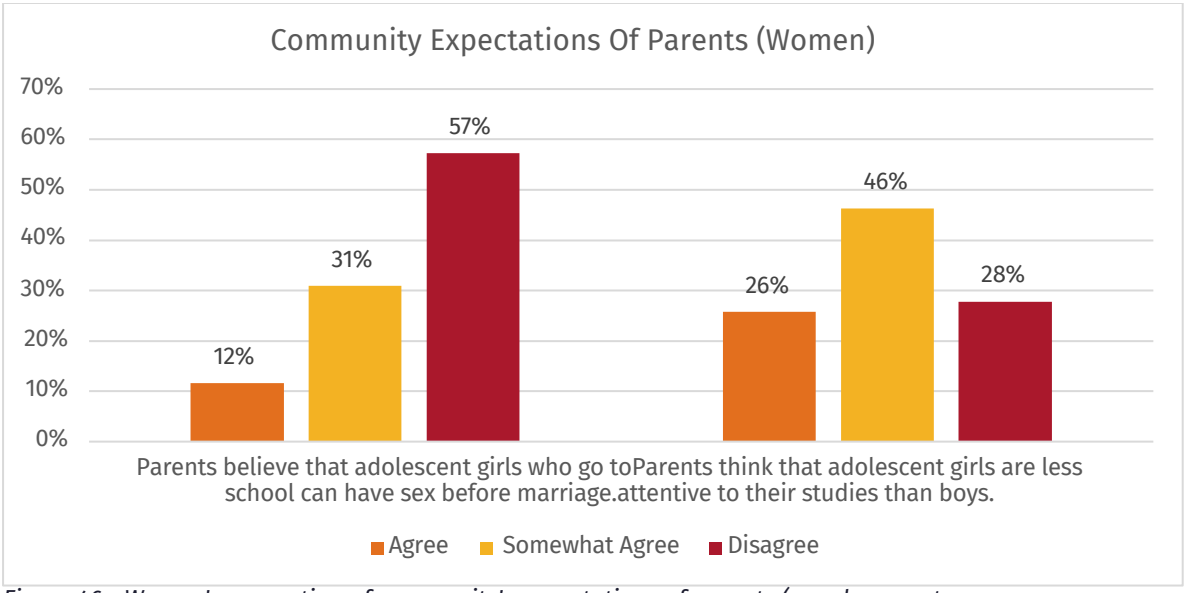


Figure 46 - Women's perception of community's expectations of parents (equal access to education)

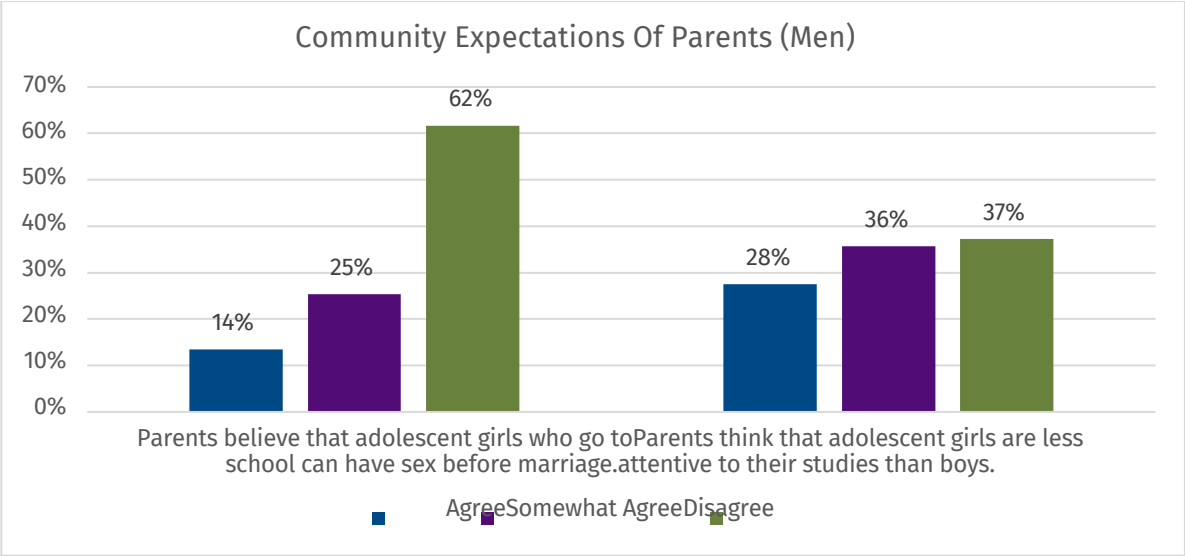


Figure 47 - Men's perception of community's expectations of parents (equal access to education)

Finally, comparing men's and women's responses to their community beliefs around parents, we see slight differences again. Men and women align around the taboo that adolescent girls should not be having sex before marriage. When it comes to studiousness, while the total number of men and women who somewhat agree or disagree that their community thinks adolescent girls are less attentive to their studies than boys is about the same, women put more weight on somewhat agree and men have the most responses in disagree. Still, about a quarter of men and women agree that their community believes girls are less studious than boys.

At what age do girls go to school?

Most girls and boys who go to school start at 7 years old. Some children start when they are 6 years old, but they are less than 16%. Respondents were asked the age of start of school for up to their first three children of both sexes: the oldest girl tends to start school at 7 years old, but the second one tends to not be sent to school by both mother and father. The third one has even fewer chances of going to school.

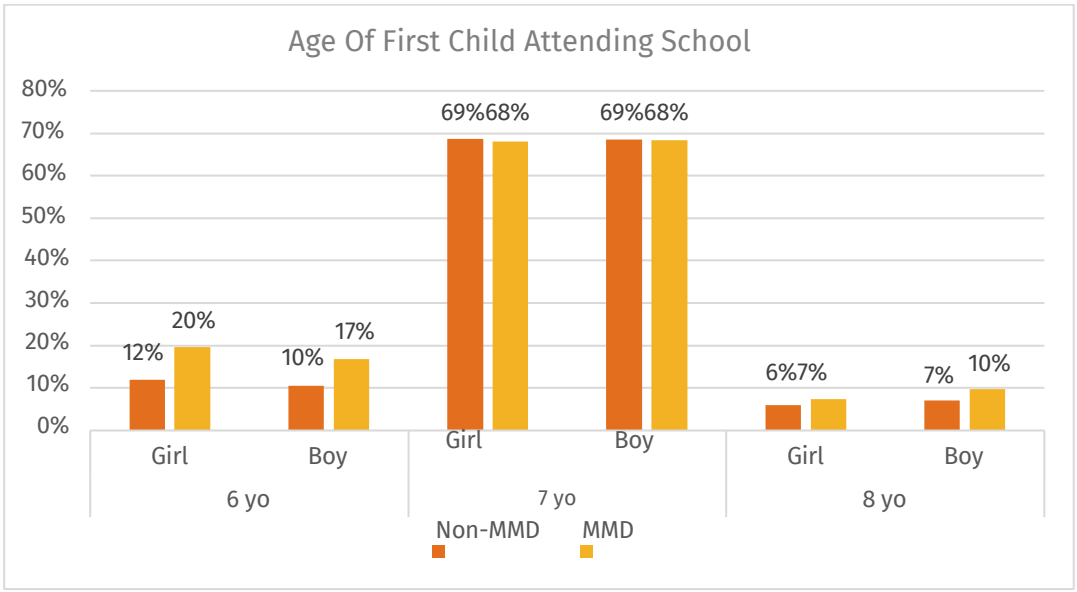


Figure 48 - MMD v non-MMD women's age of first child attending school

From Figure 48, it is clear that most children start school at 7 years old regardless of their mother's MMD membership. When a child goes to school is clearly influenced by factors outside of MMD.

Women members of MMDs note that “nowadays, girls study like boys, in fact we even have female teachers from our villages” and “parents are no longer opposing girls’ education, rather they encourage them.” (Maradi). Most respondents share that a shift has happened with more parents encouraging girls to study and even go to university and link this directly to MMD. “We ourselves are an example, because our daughters used to be kept at home to do housework and other household chores. But with the advent of MMD, we've been awakened to the fact that a woman's life isn't just limited to the home; she has the same right to education as boys. Since then, all our girls have gone to school.” (Zinder). They also note that public boarding school remain out of reach for girls because they are so few of them, but “boys have no problem attending a public boarding school outside of the village, if they can get a scholarship.” When they can get scholarships for daughters, parents encourage them to attend boarding schools, and private schools, even if they are far away. School principals and teachers further note that “If we can put it that way, it's no longer possible for parents to prevent their daughters from going further in their studies, since people are now aware of the importance of secondary and university education.” (Zinder). They also observed that “Through MMD, the community has come to understand that schooling is of paramount importance, and that we must give all girls the opportunity to go to school." (Dosso).

Despite some social norms among parents who believe that the longer a girl stays in school, the slimmer her chances for marriage, “nowadays, boys only like educated girls.” (Zinder).

Why do girls drop out? If they don’t drop out, how many go beyond primary?
When girls drop out of school, the number one reason cited by both mother and father is lack of academic results. The role of MMD is clear in supporting girls’ education as 478 women members of MMD declared having a daughter enrolled beyond primary.

8.2 Girls Education: Social Movements

About 45% of women say there is some type of community-based organization campaigning for the education of girls. These organizations are enrolling girls in school, awareness raising, and creating scholarship funds. Over half of women say that there are women’s organizations campaigning for girls education largely with the same activities; 80% of these women say scholarship funds for school fees are the main activity.

In terms of advocacy, civil society, women’s organizations and political organizations are engaged in supporting girls’ education by primarily running awareness campaigns focusing on keeping girls in school and providing school supplies. Mothers acknowledge that schools provide different services and in-kind donations, like school supplies. However, 57% of them are dissatisfied with those services and in-kind donations.

Sixty percent (60%) of women interviewed agree that girls and boys should stay in school for the same length of time, recognizing that education will provide an advantage to the family (78%), that it promotes gender equality (16%) and enables girls to become teachers (5%).

Multiple organizations advocate for education and undertake projects and action supporting keeping girls in school. Civil society organizations focus on raising awareness on girls’ schooling as their main action and providing school supplies as well.

9. Nutrition

Niger Context

Malnutrition is a "major threat to children's health and development" in Niger, according to UNICEF. With the number unchanged between 2006 and 2018, the UN agency further notes that "15% of children are acutely malnourished."[56] Almost 48% of children suffer from stunting (higher than the average for Africa[57]) and 70% of children under the age of 5 are anemic.

With 83% of the population living in rural areas (approx. 20 million people), most Nigeriens rely on agriculture for their livelihoods, which is increasingly impacted by climate change (e.g., floods, extended droughts, unpredictable rainfall patterns). USAID notes that in 2022, 4.3 million Nigeriens (almost 16% of the population) needed humanitarian assistance.[58]

Half of women of reproductive age (15 to 49 years old) suffer from anemia.[59] However, progress has been made towards achieving exclusive breastfeeding with 21.6% of infants 0 to 5 months old exclusively breastfed.

Pathway	Expected outcome	Quantitative & Qualitative synthesis
Advocacy to influence policies and programs	More elected personnel involved in creating and furthering the formulation of local public policies in support of girls' education	No evidence
	Budgets increased and strengthened to further policy changes at municipal level to support nutrition	No evidence
	More elected personnel to create and further the formulation of local public policies in support of nutrition	No evidence
	More women in management positions (technical positions, town hall secretariat)	No evidence
Changes in social norms	Farmers grow and/or diversify and consume nutritious food.	No
	Women access and cultivate high quality land	No
	Adult family members (husbands, mother in-laws, and other adults) are expected to prioritize and support proper nutrition for pregnant or breast-feeding mothers in their family.	Yes
	Mothers make the final decision on when to stop exclusively breastmilk feeding for their infant and introduce complementary food.	Yes
Social movements	Mothers make the final decision on when to stop exclusively breastmilk feeding for their infant and introduce complementary food.	Some evidence
	Farmers alliance formed?	No
Strengthening system & social responsibility	Communities have greater access to agricultural inputs, skills, storage, etc.	No evidence
	MMD members hold power holders accountable (sporadic organization around access to water, or food supply, or safety, or education)	No evidence

9.1 Nutrition: Changes in social norms

Women don't own land, except when they belong to MMD groups, where we see a higher proportion of women who purchase land compared to women who are in other groups or in no groups. Similarly, women members of MMD groups share that their land is more fertile than women in other groups or in no groups. Access to training through the MMD groups may

56 UNICEF – Niger page – accessed December 1, 2023
57 Global Nutrition Report – Country Nutrition Profiles – Niger, accessed December 1, 2023 USAID – Niger
58 Agriculture Fact Sheet July 2023
59 Global Nutrition Report – Country Nutrition Profiles – Niger, accessed December 1, 2023

explain the difference: capacity building may have led them to be better buyers with more knowledge of what constitutes good versus poor land; access to agricultural training may also explain the higher fertility of their lands.

In MMD groups, women share that there are some women who own fertile lands, but they remain fewer than men. Older women member notice that “there are women who own very fertile lands since they use organic compost and fertilizers.” (Maradi). Women who are not members notice that very few women use compost on their land. Clearly, the notion of fertility of the soil is linked with the capacity to add/use compost and fertilizer: “Women can also have [fertile land] when they invest in soil fertility” (Maradi). The CARE team noticed how training has changed behavior: “Women used to be refused land, but with awareness-raising and the training packages they receive, women are claiming their rights, and this varies from one locality to another.” The traditional perspective is that, "The man is in the best position [to have access to fertile land] because society considers him to be the father of the family, and the whole burden of the household falls on him” (Maradi).

Figure 49 - Women's land ownership

Women members of MMD are well invested in agriculture: for instance, of the 487 women who cultivate cereal, 97% are members of an MMD group. They also breed small ruminants (goats for instance). Larger animals are bred by men (cows mainly). Crops are used for self-consumption (cereal and legumes) while market garden harvests are sold.

Women and youth tend to have a better knowledge and understanding of the relationship between food, nutrition and pregnancy than men. Women and youth seem more willing to sacrifice nutritious food for the wellbeing of mothers-to-be and mothers. In Maradi, almost all respondents agree that the community prioritizes providing expecting mothers and mothers with high nutritious foods. Similar answers are observed in all four regions. In Dosso, women MMD members link the provision of nutritious foods to wealth, saying, “Those who can afford it, look after pregnant and breastfeeding women” and others note that the work burden is also lessened until children have been weaned.

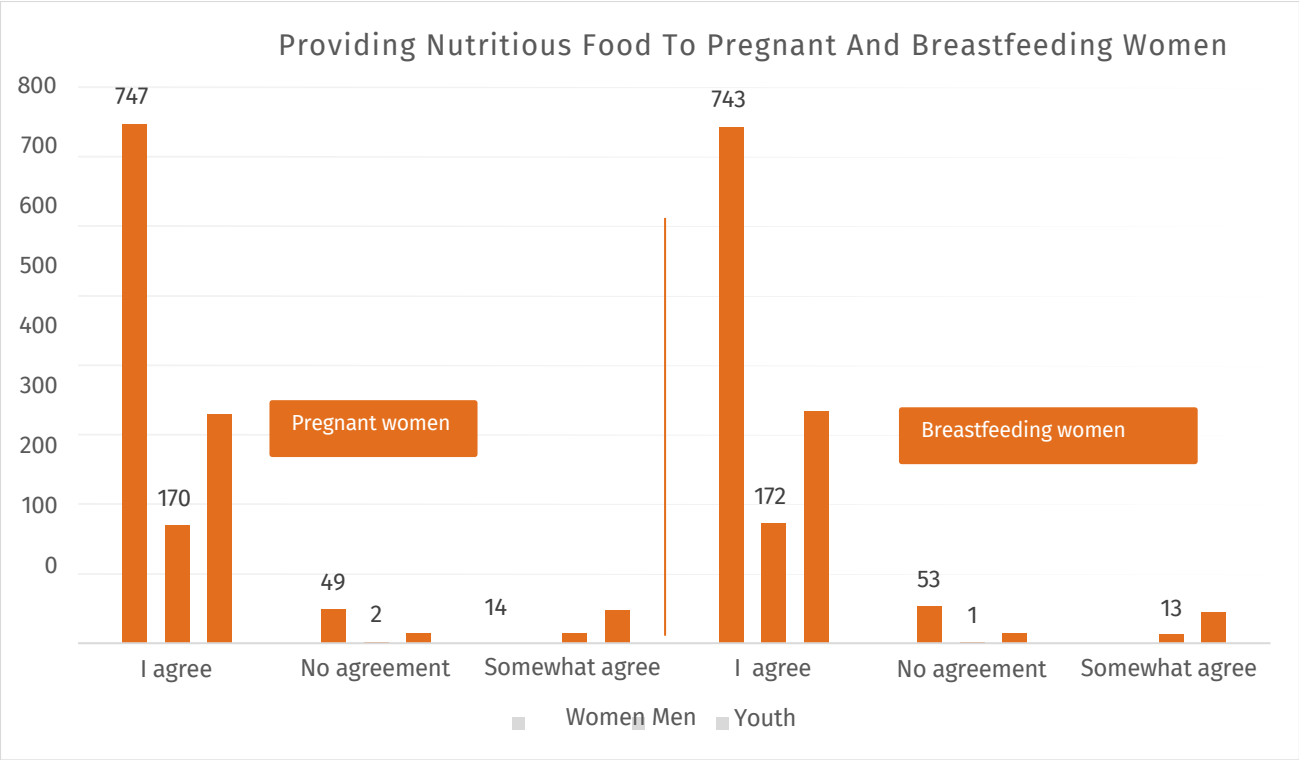


Figure 50 – Attitudes toward providing nutritious food to women who are pregnant or breastfeeding

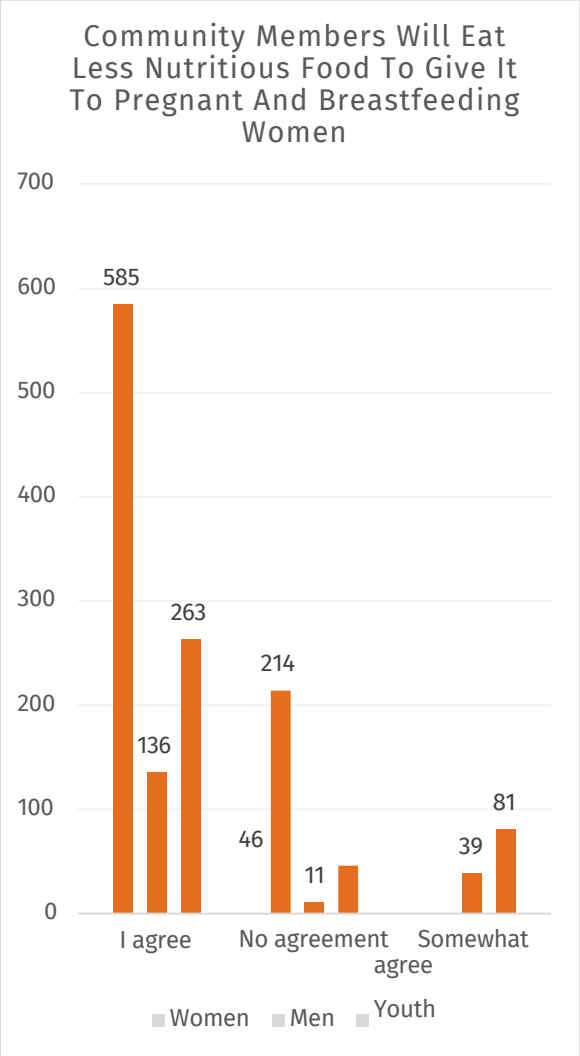


Figure 51 - Community will sacrifice food for pregnant women

While 97% of women know about exclusive breastfeeding, the decision to exclusively breastfeed is not entirely theirs. In 42% of cases, that decision comes from the health agent (or a combination of a wife and health agent; a husband and health agent); or is made together with her husband in 26% of the cases, or on their own only 23% of the time.

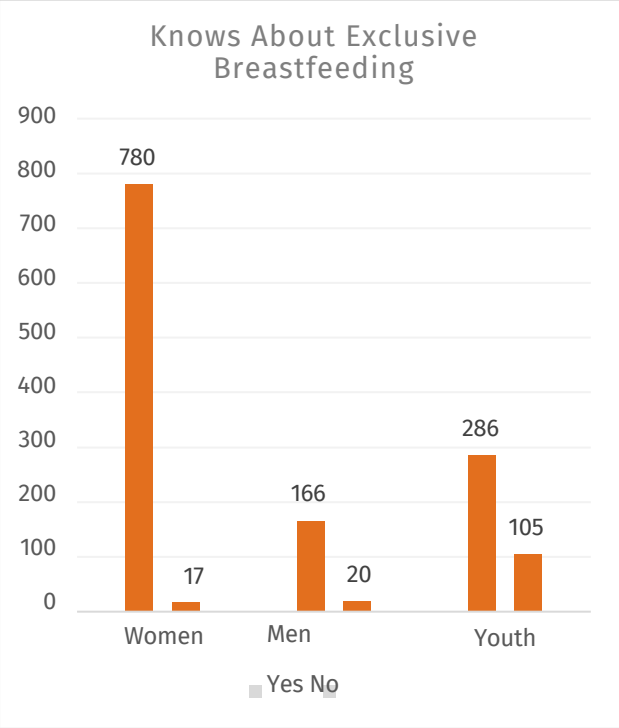


Figure 52 - Exclusive breastfeeding knowledge

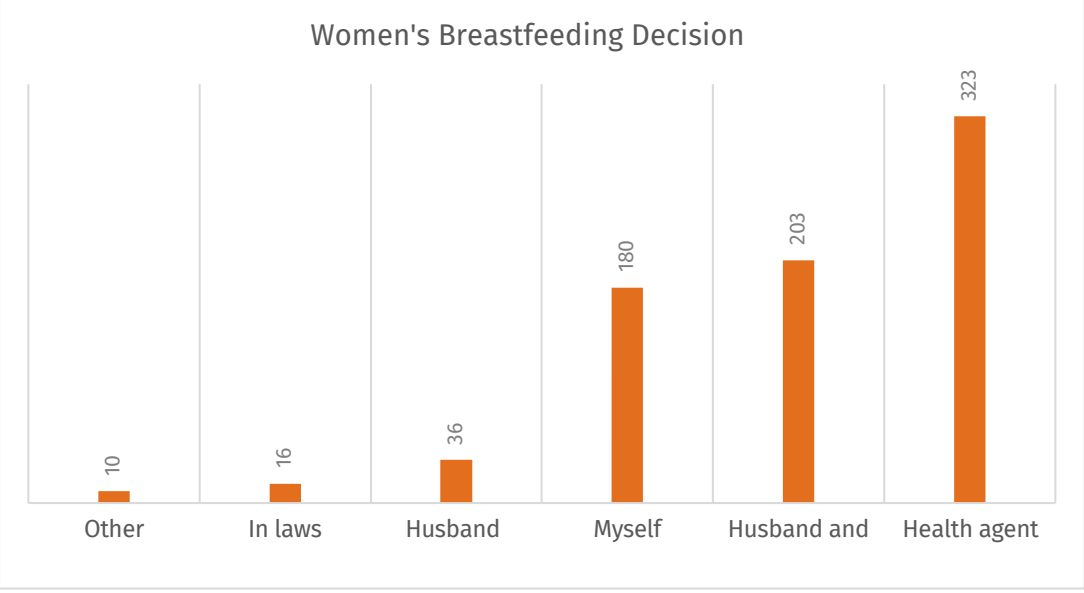


Figure 53 – Women 's decision about breastfeeding (ranked)

9.2 Nutrition: Advocacy & Social Movements

CARE has been implementing "Hamzari" ("Moving quickly and steadily toward the goal" in Hausa) between 2018 and 2023 to address food security. In a partnership with the Government of Niger, CARE has scaled its nutrition platform nationally as well, through MMD groups and their associations.

In Maradi, respondents shared, "A young woman refused exclusive breastfeeding despite advice from health workers, but with the MMD approach and the support of some community members, she was finally convinced."

9.3 Nutrition: Strengthening systems and social responsibility

There are associations working to provide agricultural training according to 68% of women interviewed. Political leaders are less active in this area, with only 13% of women sharing something a political leader did to improve women's access to agricultural training, inputs and equipment. When politicians or political parties do, they distribute improved seeds, or sell them at a discount, help with obtaining retail spaces and provide some equipment and fertilizer.

10. Way Forward: How to leverage the results in Advocacy, Policy and Programming?

While the impacts of climate change was not factored into the framework, we share an important comment from CARE's team: "…People are becoming more aware of the economic situation and climate change, which is having an unprecedented effect on the productivity of agricultural resources. This situation is not conducive to an extended family with dwindling resources."

Going forward, focusing on preventing early and forced marriage of girls is the recommended focus for CARE in Niger with ramifications touching almost every domain of our study: allowing girls to stay in school longer will increase their economic opportunities later in life; pushing their first pregnancy later in life will reduce risks to their health and further their economic outcomes as well. Early marriage has impacts on fertility and population growth; health, nutrition and violence; educational attainment and learning; participation in labor force and type of work; participation in decision-making and investments.[60] Overall, early marriage reduces a women's expected earnings by 9%[61]. But the gain would be considerable for Niger as "ending child marriage and early childbearing would reduce the population by 5% between 2015 – 2030, with significant impacts on national budgets and welfare;" savings would amount to $1.7bn in 2030.[62]

While designing CARE's next phase of work supporting girls and women in Niger, the following stakeholders' involvement would deepen CARE's community implantation and reach:

- Koranic schools are often the only place of education girls have access to in rural areas. While the studies focus on religious topics, advocating for secular schooling in complement of Koranic studies could increase girls' understanding of other critical issues to their welfare (health, economic independence, nutrition, marriage, childbearing, etc.)
- Imams and religious leaders are trusted by communities and so are teachers, school principals and women MMD Leaders. All have an important role to play to increase communities' understanding and knowledge of the consequences of early girls' marriage and can be enrolled to design solutions that will be accepted and implemented jointly.
- Women's decision making processes and changing behaviors. The weight of social norms seems to prevent women from making decisions based on their knowledge. Only 1 in 4 woman makes the decision on her own to breastfeed exclusively; they know the consequences of early child marriage on the health of their daughters, yet, the high rate of child marriages persist. MMD groups can be critical community nodes to support those changes in behaviors and attitudes by enrolling a diversity of leadership (MMD leaders, community and religious leaders, school authorities and local governments, nurses, etc.) to act in concert to reduce early marriage.
- Leverage the results from the "Husbands Schools" initiative which has produced behavioral changes in Zinder (with Save the Children).

60 "The economic impacts of child marriage: Work, earning and household welfare brief" World Bank, 2017
61 "Costs of child marriage: what does the World Bank research say?", Girls not Brides, 2017
62 "Costs of child marriage: what does the World Bank research say?", Girls not Brides, 2017

With the advent of a new Government in Niger in the summer of 2023, it is yet unknown what girls and women in Niger can expect. Women MMD are powerful whether they act individually or collectively. They have been elected at every level from town councilors to national MPs, creating a resilient network that can be activated to influence policies at all levels of the administrative hierarchy in Niger, providing CARE and its partners a basis to continue influencing changes in policies and programs to promote women's and girls' welfare in the future.

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Contributing authors:

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