
CARE Niger

Qualitative Monitoring Improvement Initiative Pilot for the Hamzari Program in Niger: A Learning Brief

Background

Emerging evidence and practical guidance for monitoring and evaluation in development and humanitarian practice highlight the value of and need for integrating quantitative and qualitative methods to improve learning and adaptation. This type of 'complexity-aware' approach is particularly important for programs like Resilience Food Security Activities (RFSA) funded by the United States Agency for International Development, Bureau for Humanitarian Assistance (USAID/BHA). Due to the multiple interventions and stakeholders and the integrated and layered nature of RFSA programming, there are often gaps in understanding when, how and what change happens. These gaps contribute to ineffective learning and adaptive management.

Qualitative methods like —Most Significant Change (MSC), Outcome Mapping (OM), and Outcome Harvesting (OH)—are designed to evaluate change processes. Together these participatory methods (OH, OM, and MSC) enable program staff to monitor whether and how change is happening, including to understand both the significance of changes to those who are experiencing them and how a program or intervention has contributed to change. Strengthening their application and generating and sharing learning related to that practice will improve the overall effectiveness of monitoring, evaluation, adaptation and learning in RFSAs and other complex programs.

In 2022, under a USAID-funded Qualitative Monitoring and Evaluation Program Improvement Award (QPIA) small grant from the IDEAL Activity, CARE implemented a pilot qualitative monitoring activity to test the use of MSC, OM, and OH to monitor progress for RFSAs. This learning brief provides details on the pilot qualitative monitoring activity conducted by Hamzari, (see Box 1 for an activity summary), summarizing the design and results.[1] In addition, it provides lessons learned and recommendations for M&E and program staff, specifically focused on the effective use of monitoring activities to leverage outcome-focused, participatory methods.

BOX 1 : The Hamzari activity

Hamzari, meaning "move quickly and steadily toward the goal" in the Hausa language, is a five-year program (2018 to 2023) implemented by CARE Niger and funded by USAID that aims to directly address underlying causes of food insecurity and malnutrition – while reinforcing and/or strengthening community systems – in one of the poorest regions of Niger. Across 325 villages in the communes of Chadakori, Guidan Roumdji, and Guidan Sori (Maradi region), the program will reach 96,000 direct participants in 32,000 households, including 17,305 pregnant women and 23,961 breastfeeding women receiving food and nutritional counseling. Partner organizations include WaterAid, Karkara, AREN, ANBEF and DEMI-E.

Designing and Implementing the Pilot Qualitative Monitoring Activity

CARE designed this pilot qualitative monitoring activity and the activity conducted by the SHOUHARDO III RFSA to generate learnings related to participatory, outcome-focused qualitative monitoring for programs in different stages of the program cycle and with different needs and uses for qualitative-based insights and learnings. This pilot qualitative monitoring activity supported learning and adaptive management as well as accountability to communities and USAID/BHA. Hamzari carried out the pilot activity from November to December 2022 (in Program Year four), focused on the results of efforts to support the improvement of maternal and child health and nutrition (MCHN) in the Maradi region, particularly in the communes of Chadakori, Guidan Roumdji and Guidan Sori.

The pilot monitoring activity's primary aim, questions, audience and uses are summarized in Box 2. Importantly, the focus was on assessing changes experienced by participants in three program activities: Care Groups, Youth Safe Spaces, Husbands' School. (See Box 3 for summary of activities.)

BOX 2 : Activity aim, questions, audience, and uses

Aim: To understand the changes program participants and communities have experienced related to maternal and child health and how those changes are contributing to program impact and sustainability.

Questions:

1. What are the most significant **changes** participants have experienced?
2. What is the **significance** of these changes?
3. **How** have these changes come about and what is the **contribution** of the program and other stakeholders to these changes?
4. What **unforeseen** changes has Hamzari contributed to?
5. To what extent has Hamzari fulfilled their commitment to the community and has community fulfilled their commitment to Hamzari?
6. What do the change stories imply for the priorities and strategies of the next phase of Hamzari?

Audience: USAID, CARE International and CARE Niger, Hamzari program staff and implementing partners, and the community.
Uses: adaptive management, program learning, progress reporting.
Activity cycle: mid- to -late implementation

[1] The Strengthening Household Abilities to Respond to Development Opportunities (SHOUHARDO) III RFSA conducted also conducted a pilot qualitative monitoring activity. The learning brief can be found here [link to be added when available].

Choice of methods

The program team selected the **MSC method** for this activity. MSC is a qualitative and participatory approach to monitoring and evaluation based on the systematic collection and selection of stories of change-induced by development activities. The MSC technique was developed by Rick Davies[2] in the mid-1990s to address the challenges associated with monitoring and evaluating projects or programs. The method is summarized in Box 4.

BOX 3 : Summary of Hamzari MCHN activities monitored.

1. A **Care Group** is a group of 10 to 15 community-based volunteer health educators who regularly meet with project staff for training and supervision. They are different from typical mothers' groups in that each volunteer is responsible for regularly visiting 10 to 15 of her neighbors, sharing what she has learned and facilitating behavior change at the household level. Hamzari Care Groups focus on several health behaviors related to nutrition, maternal health, reproductive health and sexual health (including family planning).
2. The **Husband's School** is an approach to engaging men to be actively engaged in reproductive and sexual health. Schools meet twice a month to discuss and analyze cases in their community related to reproductive and sexual health. Husbands discuss solutions to problems and share knowledge and experience. Participation is voluntary.
3. **Youth Safe Spaces** are a girls-only space where girls receive information about reproductive and sexual health and health services and share knowledge and experience. Information is shared by peer mentors trained by Hamzari.

Among the three methods (OM, OH, and MSC), MSC was seen as the right-fit for the objectives, audience and uses (See Box 2). Since the final year[3] of the Hamzari program was underway, the focus was primarily on documenting **whether and how change was happening**, both for accountability and for adaptive management as the program entered late implementation.

Design and implementation

Hamzari staff participated in a design workshop to select the areas of change to be monitored, the monitoring questions, the uses and users. The outcome of this workshop was a draft protocol and data collection tools. The monitoring activity team conducted a field test in two communes and used the findings to finalize the design and data collection tools instruments.

To develop most-significant change stories, the activity team used a combination of focus group discussions (FGDs) and in-depth interviews (IDIs). Participants were asked about changes they have experienced related to maternal health, maternal nutrition, child health, infant nutrition, and contraceptive-decision making.

BOX 4 : Designing and implementing an MSC monitoring activity.

1. Identify the questions for the monitoring activity.
2. Identify relevant areas of change.
3. Develop an implementation plan.
4. Determine the sample size and sampling approach.
5. Decide whether to collect photos or make recordings.
6. Consider ethical requirements.
7. Develop an interview guide.
8. Interviews storytellers (program participants).
9. Write stories of change.
10. Collate stories into a dataset or report.
11. Select the "most significant' stories and analyze.

[2] Davies, Rick. (2005). The 'Most Significant Change' (MSC) Technique: A Guide to Its Use". DOI: 10.13140/RG.2.1.4305.3606.
[3] The Hamzari program has since been granted a two-year extension and will close September 31, 2025.

The data collection team included program field agents, field supervisors, field operation managers, a gender specialist, M&E staff, and a Social and Behavior Change coordinator. Between November and December 2022, the team collected 34 stories of significant change among participants residing in three communes. Sixteen stories were from Care Group leaders and participants, four from participants in Husband Schools, and 14 from Youth Safe Spaces. Of the 34 stories, two were collected during FGDs—one with Care Group participants and one with Youth Safe Spaces participants. The sampling approach was pragmatic, designed to capture potential differences in impact across Hamzari's geographic reach and participant groups and as well practical considerations related to time and resources (both for data collection and for analysis).

MSC selection and data analysis

The process of story selection and data analysis is summarized below in Table 1.

TABLE 1: STORY SELECTION AND DATA ANALYSIS.

Step 1: Organize the data	Step 2: Answer the qualitative monitoring questions	Step 3: Select most significant change stories
Maintain and organize interview notes, quality control, cleaning data.	Review change stories.	Convene selection panel. The Hamzari panel included only program staff: M&E staff, field agents and supervisors, field operation managers, the Gender Lead, and the SBC Coordinator.
Review and complete narratives of meaningful change stories, using recordings and notes.	Encode stories according to structure: ID interview; question; text or group of words.	Select six most significant stories.
Develop and populate Excel database (interview ID, basic information about the village, participant, and interview type, etc.).	Analyze stories through grouping, categorization, description, and interpretation.	Record notes on the criteria used for selection, discussions that took place to resolve different points of view, and rationale for selection.

Selection criteria were:

- the story illustrates evidence of a specific behavior change contributable to a program activity.
- the story illustrates a specific shift in behavior beyond the person telling the story and showing an impact that has extended to others.
- the identified change relates to program activities.
- the story reveals a history of dependence and a shift towards self-reliance.
- the type of program participant (of Care Group, Youth Spaces, or Husband's School).
- the intensity and duration of their participation in Hamzari's MCNH and SRH/FP activities.

Results

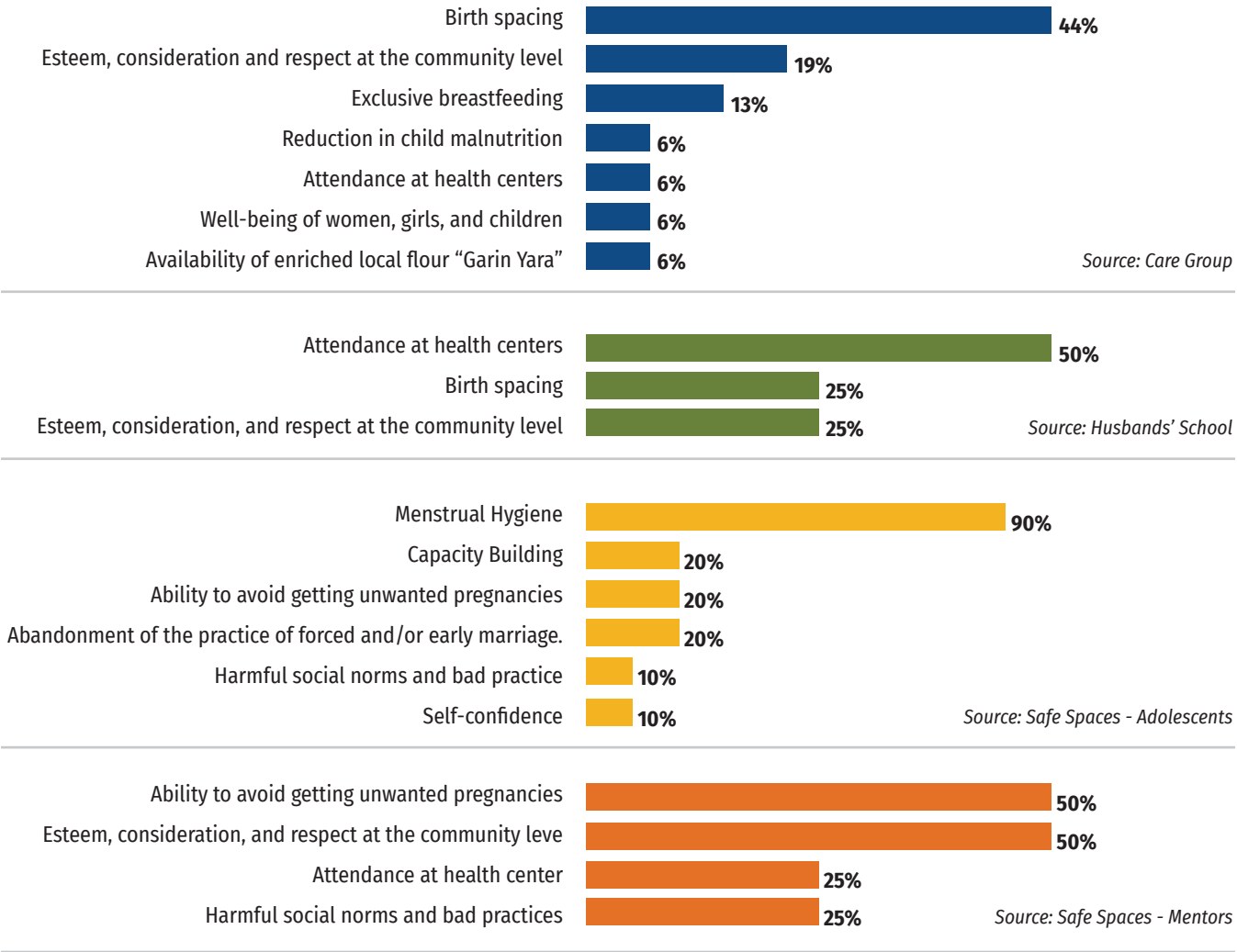
Significant changes

Figure 1 provides a summary of the categories and frequency of significant changes mentioned across the four participant groups. Across the four groups, the most significant changes were: birth spacing, including women's ability to seek contraceptive services to avoid unwanted pregnancies; husbands' engagement in healthcare utilization for both mothers and children; and adoption of menstrual hygiene practices. Below are two examples of changes articulated by program participants.

> **"The most significant change for me is the practice of birth spacing because it allows me to keep my body healthy, (editor's note: keep the youth, beauty and energy of her body) and give good health to the child. Before, I didn't practice it, and I got pregnant frequently, I didn't have good health and my body was tired."**
>
> — CARE Group member, Chadakori

> **"The birth spacing is the most significant change for me because my children are now healthy. There is a certain serenity within my household and the expenses related to the health of the children are forgotten."**
>
> —CARE Group member, Guidan Roumdji

FIGURE 1: MOST SIGNIFICANT CHANGES BY PROGRAM PARTICIPANT.



Sustainability

Program participants in all the three activities reported that they hope to see these program activities continue after Hamzari ends. To sustain the results, participants volunteered to continue the main activities after the program and identify and train the next generation of members of Care Groups, Safe Spaces and Husbands' Schools. They also expressed a desire to contribute to scaling up the approach in neighboring villages to spread change.

Contribution to change

The pilot findings reveal that Hamzari made a significant contribution to the changes experienced among the three communes where the activity carried out interventions. However, results also show that many other actors are key contributors, including:

- **Community actors** who supported the set-up and ongoing implementation of Care Groups, Safe Spaces, and Husbands' Schools.
- **Village chiefs** in the program area who facilitated or encouraged community member participation.
- **Health centers and health workers** present in the program area who were responsible for promoting and implementing government health policies and programs**.**
- **Peer educators** who made on-the-ground connections between the program and the primary health system.
- **Spouses** of participants in Care Groups.

Unanticipated changes

Program participants also reported several unanticipated changes, summarized in Table 2. Hamzari's anticipated changes relate to maternal and child health behaviors, while the results of the pilot activity reflect deeper changes happening that may lead to changes in other behaviors beyond maternal and child health.

TABLE 2: UNANTICIPATED CHANGES REPORTED AMONG HAMZARI PROGRAM PARTICIPANTS, BY TARGET GROUP.

Adult women: Care Groups	Adolescent girls: Youth Safe Spaces	Adult men: Husbands' School
• Prestige, esteem, respect from the community • Understanding, harmony, and cohesion within the marriage • Having voice, leadership, and power of women and young girls, especially related to nutrition • Men's gained knowledge of their roles in health and nutrition • Reduced health care costs • Men's financial contributions to health care • Cash and in-kind contributions from Care Group members	• Girls' increased confidence, voice, and leadership • Keeping girls in school • Reduction of fistula cases • Understanding, harmony, and cohesion within the marriage	• Prestige, esteem, respect from the community • Girls' Confidence, Voice, and Leadership • Women's participation in household decision-making • Reduction of women's work

Learning and adaptive management

Based on these results, the following recommendations were made by the monitoring activity team to program staff to adapt and strengthen Hamzari's MCNH activities.

- **Care Group approach:** The sustainability and scaling up strategies should be adapted or revised to put reproductive health as the core focus of Care Group interventions. This is based on the significance of the changes that have been evidenced in the pilot activity related to contraceptive use and women's empowerment. Overall, in program areas, results from Hamzari's annual survey (September 2022) show that participation in contraceptive decision-making is low. Whereby, important attitudinal and behavioral changes are evidence among women participating in Care Groups. This demonstrates the potential that scaling the reproductive health approach might have in achieving community-wide improvements in women's participation in contraceptive decision-making.
- **Safe Spaces approach:** Similarly, sustainability and scaling strategies for safe spaces interventions in Niger should focus on self-confidence, leadership, menstrual hygiene, and income-generating activities.
- **Husbands' Schools approach:** Male engagement (men and boys) in debates on issues concerning women and girls whose roots lie in social norms is critical to transformative, long-term change. Indeed, the findings from the pilot activity confirm the understanding that men traditionally hold and wield greater decision-making power than women related to health behaviors and care-seeking and that, as boys mature, they become the guardians or defenders of harmful norms they have been taught. Findings demonstrate that participants in programs like Husbands' Schools experience changes that shift the power dynamic towards more equal decision-making and towards behaviors that support better health outcomes for women and infants such as birth spacing and exclusive breastfeeding.

CARE Niger

Implementation Challenges and Lessons Learned

Below are the most important challenges faced by the activity team and which provide important learning for how to improve implementation in the future.

- **Lack of staff experienced in qualitative monitoring to conduct focus group discussions and in-depth interviews and effectively manage qualitative data.** There was a significant investment in training staff as part of this initiative. However, more capacity and expertise were needed for quality implementation of the activity than was possible to develop over the course of the initiative. The need for capacity and expertise has important considerations for how to effectively scale and integrate this kind of qualitative monitoring activity into routine monitoring systems. To sustain an M&E system and processes to integrate qualitative methods and data, implementing organizations, and program teams specifically, M&E teams require particular expertise, capacity and experience in qualitative monitoring and evaluation. This could be achieved through training, mentorship or co-facilitation with qualitative specialists to strengthen the capacity of existing staff, or hiring additional staff with the relevant capacities.
- **Lack of qualitative data processing software to analyze the monitoring data quickly and easily.** Data platforms that streamline qualitative data management and analysis could improve the efficiency and quality of data analysis for most qualitative monitoring activities. One of the reasons why such data platforms were not used for the Hamzari pilot activity was because they required additional training and have a high learning curve for proficiency, which was not feasible. Therefore, the team used Excel to collate data and Mural to facilitate collaborative analysis and sense-making.
- **Limited participation of senior program staff in the qualitative monitoring activity, despite being trained in participatory approaches.** In planning qualitative monitoring activities, it is critical from the beginning to have a clear plan for stakeholder participation, including which stakeholders are targeted and when, how, and for how long participation is required. The lack of participation of certain stakeholders in analysis and sensemaking for qualitative monitoring activities results in less ownership and, as a result, less effective application of insights and lessons learned. To ensure engagement, the plan would include what the ask of senior leadership is and when their time will be needed and would be shared at the beginning of the monitoring activity.
- **Community members' lack of participation in the selection of the most significant stories.** In planning qualitative monitoring activities, trade-offs are inevitable, and staff must make decisions to balance the ideal (full participation of all relevant stakeholders) and the practical (what is feasible based on time and resources, both financial and human). Who selects stories influences which stories are developed, and in turn, the insights and learnings generated. For this pilot activity, program and partner staff selected the most significant change stories. This was a pragmatic decision made based on resource and time constraints and considering how the findings and learnings would be used. In future monitoring activities, it would be helpful to validate story selections with a committee of community members.

The full pilot monitoring activity report is available here, including the consent and data collection forms,.

CONTACT INFORMATION

Caitlin Shannon, Research Lead, CARE USA (caitlin.shannon@care.org)
Ladji Binoko, Ladji Binoko SIDIBE, Monitoring and Evaluation Lead, USAID HAMZARI PROJECT (LadjiBinoko.Sidibe@care.org)
Richard Smith, Consultant (rdsmith27@gmail.com)

DISCLAIMER

This report was made possible by a grant from the Implementer-Led Design, Evidence, Analysis and Learning (IDEAL) Activity. The IDEAL Small Grants Program is made possible by the generous support and contribution of the American people through the United States Agency for International Development (USAID). The contents of the materials produced through the IDEAL Small Grants Program do not necessarily reflect the views of IDEAL, USAID, or the United States Government.