TECHNICAL REPORT

Qualitative Evaluation of Breakthrough ACTION/Nigeria's Community Capacity Strengthening Approach to Sustaining Integrated Social and Behavior Change Programming: Phase I

JUNE 2022

Acknowledgments

The research team would like to thank Usman Inuwa, Amina Bala, Shittu Abdu-Aguye at Breakthrough ACTION Nigeria for their input on the evaluation findings and invaluable contributions toward the completion of this study. Finally, we would like to thank Amanda Kalamar and Laura Reichenbach at Population Council and Foyeke Oyedokun-Adebagbo at the United States Agency for International Development Nigeria Mission for their technical reviews.

Breakthrough RESEARCH is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of cooperative agreement no. AID-OAA-A-17-00018. The contents of this document are the sole responsibility of the Breakthrough RESEARCH and Population Council and do not necessarily reflect the views of USAID or the United States Government.

The Population Council confronts critical health and development issues—from stopping the spread of HIV to improving reproductive health and ensuring that young people lead full and productive lives. Through biomedical, social science and public health research in about 50 countries, the Council works with our partners to deliver solutions that lead to more effective policies, programs, and technologies to improve lives worldwide. Established in 1952 and headquartered in New York, the Council is a nongovernmental, nonprofit organization with an international board of trustees.

Breakthrough RESEARCH catalyzes social and behavior change (SBC) by conducting state-of-the-art research and evaluation and promoting evidence-based solutions to improve health and development programs around the world. Breakthrough RESEARCH is a consortium led by the Population Council in partnership with Avenir Health, ideas42, Institute for Reproductive Health at Georgetown University, Population Reference Bureau, and Tulane University.

As stewards of the first school of public health in the United States, the Tulane University School of Public Health and Tropical Medicine cultivates independent thinkers, innovative leaders, fierce advocates, and accomplished scholars.

From the neighborhoods of New Orleans to communities worldwide, we conduct research and collaborate with our partners to ensure that all of humanity has an equitable opportunity to be healthy and pursue optimal well-being.

We train the problem solvers. Find us on the Front Lines.

Suggested Citation

Silva, Martha, Nrupa Jani, Adetayo Adetunji, and Mayokun Adediran. 2022. "Qualitative evaluation of Breakthrough ACTION/ Nigeria’s community capacity strengthening approach to sustaining integrated social and behavior change programming: Phase I," *Breakthrough RESEARCH Technical Report*. Washington, DC: Population Council.

Contact

4301 Connecticut Avenue NW, Suite 280 | Washington, DC 20008
+1 202 237 9400 | BreakthroughResearch@popcouncil.org
breakthroughactionandresearch.org

Cover photo credit: KC Nwakalor for USAID/Digital Development Communications

©2022 The Population Council. All rights reserved.

TECHNICAL REPORT JUNE 2022

Qualitative Evaluation of Breakthrough ACTION/Nigeria's Community Capacity Strengthening Approach to Sustaining Integrated Social and Behavior Change Programming: Phase I

Martha Silva[1] **Nrupa Jani[2]** **Adetayo Adetunji[3]**

Mayokun Adediran[3]

[1]Tulane University
[2]Population Council, Washington, DC
[3]Population Council, Nigeria

Acronyms

ANC	Antenatal care
CCS	Community capacity strengthening
CHARP	Community Health Action Resource Plan
CHC	Community health committee
CV	Community volunteer
EBF	Exclusive breastfeeding
FGD	Focus group discussion
FP	Family planning
IDI	In-depth interview
IPC	Interpersonal communication
KII	Key informant interview
LGA	Local government area
MNCH	Maternal, neonatal, and child health
MNCH + N	Maternal, neonatal, and child health and nutrition
PHC	Primary health care
SBC	Social and behavior change
VDC	Village development committee
WDC	Ward development committee

Table of Contents

Acronyms ii

Executive Summary 1
- Background 1
- Results 2
- Participant recommendations 3
- Programmatic implication 4
- Recommendations for additional research 4

Background 5
- Study relationships 6
- CCS approach 6

Study Objectives 10

Methods 11
- Study design 11
- Study area 11
- Study population 11
- Instruments 12
- Data collection 13
- Data management and analysis 13
- Ethical considerations 13

Results 14
- Research question 1 14
- Research question 2 19
- Research question 3 28
- Research question 4 31

Recommendations 33
- Program beneficiaries 33
- Community structures (WDC/VDC/CV) 34

Discussion and Conclusion 35
- Programmatic implications 36
- Recommendation for additional research 36
- Limitations 37

References 39

Annex 1 40

Executive Summary

Background

Community capacity is broadly conceived as the individual and aggregate strengths of members to overcome barriers and find or cultivate opportunities to improve the overall wellbeing of a given community as well as that of individual community members. Previous research has identified six domains that encompass community capacity: social cohesion, collective efficacy, type of leadership, participation/self-efficacy, conflict management, and effective leadership. Community health committees (CHCs) and other local governance structures in Nigeria such as ward development committees (WDCs) and village development committees (VDCs), can be effective mechanisms to ensure local leadership, legitimacy, participation, and governance. However, these committees require continued training and investment. The WDC members are unpaid volunteers who meet regularly to discuss health and development issues, encourage community participation in health and drive local accountability for health care. The WDC supports the primary health care (PHC) system in identifying health needs of communities within the sociocultural context, disseminating health information, promoting acceptance of healthy practices, and advocating for quality health services.

To ensure the maintenance and sustainability of social and behavior change (SBC), **Breakthrough ACTION/Nigeria**, funded by the U.S. Agency for International Development (USAID), is implementing a community capacity strengthening (CCS) approach (starting in 2018 and ending in 2025) that focuses on engaging existing community leaders and structures—namely WDCs—to increase community self-efficacy, coordinate and support the health ecosystem in general, and to ensure sustained community-level activities supporting behavior change and positive social norms for improved health outcomes. The CCS approach assists WDCs to take a leadership role in improving health and social outcomes among their constituents. By the end of the project, Breakthrough ACTION/Nigeria expects to see WDCs plan, implement, maintain and monitor SBC activities; support community volunteers (CVs) who were engaged and trained by Breakthrough ACTION/Nigeria; while also monitoring health and social indicators in the areas of maternal, neonatal, and child health and nutrition (MNCH+N), malaria, and family planning (FP).

Breakthrough ACTION/Nigeria is implementing a phased, performance-based capacity strengthening approach. In the **first stage of intensive implementation** in August 2019 and ending in September 2021, a total of 73 wards (33 in Bauchi, 20 in Sokoto, and 20 in Kebbi) were trained to begin developing a Community Health Action Resource Plan (CHARP)—living documents in which WDCs prioritize health issues and implement priority activities using locally mobilized resources available to them. WDCs have also been oriented on the community SBC materials and booklets across health areas to familiarize them with the key messages CVs are bringing to communities through house-to-house visits, compound meetings, and community dialogues. During this first stage of CHARP implementation, Breakthrough ACTION/Nigeria provided supportive supervision to WDCs and CVs, particularly to facilitate monthly micro-planning meetings, support community monitoring and evaluation, and to enable use of data for decision-making. Breakthrough ACTION/Nigeria also monitored fulfillment of the quota for female representation outlined in the PHC national guidelines where all WDCs should maintain a 35% female membership. In this first stage, Breakthrough ACTION/Nigeria's support focused on supporting WDCs to address barriers to uptake of some MNCH+N services. Interim outputs and outcomes include WDC planning and support for "quick wins" to improve health facilities, in response to community input and needs. **Currently, Breakthrough ACTION/Nigeria is implementing the second stage, maintenance support**, in which Breakthrough ACTION/Nigeria provides additional capacity strengthening and training opportunities tailored to the community's needs as identified by an analysis of capacity gaps and heightened support for community SBC activities specifically. Stage 2 training started in August 2021 and full implementation began in October of the same year.

At the conclusion of Breakthrough ACTION/Nigeria's project support in 2025, Breakthrough ACTION/Nigeria envisions that the respective local government areas (LGAs) of the intervention, through their PHC departments, will work with the WDCs and communities to successfully sustain the SBC programming established

during this period, and, through the CCS, enhance its impact over time.

This report presents results from a study led by **Breakthrough RESEARCH,** funded by USAID, that took place in the third quarter of 2021 in selected wards of the Bauchi and Sokoto states in Nigeria to assess early success, threats, and opportunities for Breakthrough ACTION/Nigeria's CCS Phase 1 approach. This research addresses and documents:

1. To what extent have efforts to improve community ownership and self-reliance through WDC's CCS shown early success in increasing community self-efficacy, community cohesion, and sense of ownership, as well as success in achieving any "quick wins?"
2. What threats and opportunities exist for functionality and sustainability of WDC's engagement in collective action to address health and social outcomes among their constituents and do they vary by health area (FP, MNCH, and malaria)?
3. Are there intransigent restrictive and/or harmful gender and social norms and / or other contextual factors limiting success (e.g., community cohesion, past success/failures in problem solving, violence/insecurity, other social determinants)?
4. Are there unanticipated positive or negative results that may impact transition to community ownership and sustainability of SBC programming across health areas (e.g., from (dis)continued financial support to CVs who deliver this programming within communities)?

The study utilized a qualitative design and was conducted in two out of the three integrated SBC implementation states of Nigeria: Bauchi and Sokoto. The qualitative data methods included 14 in-depth interviews with WDC members, 15 with VDC members, 10 with CVs, 2 with traditional leaders, 8 with LGA officials, 10 key informant interviews with Breakthrough ACTION/Nigeria staff, and 32 focus group discussions with male and female beneficiaries.

Results

Our findings indicate that there was an **increased awareness and knowledge ("enlightenment") of health issues across all target health areas including FP, child health, malaria, immunization, antenatal care (ANC), and nutrition**. Program beneficiaries report that this increase in knowledge has led to the adoption of healthier behaviors. In addition, program beneficiaries perceive that Breakthrough ACTION/Nigeria's SBC sensitization messages have led to informed decision-making and healthier choices, such as abandoning harmful traditional nutritional practices like feeding water to newborn babies. We find heavy emphasis on knowledge or awareness as determining factors for sustainability of both WDC's ownership over the ecosystem that supports community health, and community level behavior change, yet **other ideational factors beyond knowledge acquisition were rarely discussed**. Nonetheless, all participant groups expressed some degree of difficulty in convincing community members about the importance of certain health issues and challenging accepted religious and cultural norms that act as barriers to healthier behaviors. Shifting social norms in support of these health behaviors, such as those related to birth spacing, offers an opportunity for sustained behavior change. Though, when attempting to sensitize communities in villages with limited education or exposure, some people equate their messages to westernization and thus outright oppose it, often making it difficult to encourage wives to take children for immunization or practice child spacing.

Community structures including **WDCs, VDCs, and CVs have a strong sense of self-reliance and project a high level of capacity to effect positive changes** in health behavior and health infrastructure, particularly in the realm of facility maintenance and improvement. We found that the resource mobilization strategies that WDCs have used so far are mostly limited to fundraising within their own membership or other prominent community members, which may not be sustainable given that not all WDC members have the capacity to donate or raise significant financial resources. While some committee members suggest they can continue much of their current work (community health promotion and support to facilities) without external funding, reflecting confidence in advocating for private funding, others note that **financial self-reliance has very real limits** and that funding is necessary for certain components of the CCS approach.

WDCs undoubtedly are recipients of other stakeholders' confidence when asked about their likelihood to be able to sustain community level SBC and health achievements to date. LGA officials, CVs and Breakthrough ACTION/Nigeria staff qualify most WDC members as highly motivated. WDC members are described as being known and respected members of the community, which facilitates

CVs' work. By accompanying CVs to community events, they enable a trusting relationship between community members and CVs. **Transparency and trust established thus far also present an important opportunity for sustaining community SBC gains achieved to date**, yet the anticipated removal of the regular in-person and telephone based supportive supervision provided by Breakthrough ACTION/Nigeria was raised as a potential threat to sustainability. Although participants allude to the fact that government structures will replace Breakthrough ACTION/Nigeria in providing supervision, technical, and moral support, interview participants did not present a clear vision or plan for this type of institutional support. Although many WDCs are meeting the PHC national quota for female representation, **there are very few female WDC members in leadership roles and there is a perception that female members' participation is seen in somewhat tokenistic terms**. This is contrasted by the need for additional women to take on sensitization efforts given cultural norms and preferences that preclude male volunteers from educating or liaising with married women, particularly during house visits.

Program beneficiaries report that **SBC messages have led to more participation of men in health care services** uptake when taking women for services such as ANC and in increased joint-decision-making between couples regarding health service use. However, at the same time there were mixed opinions regarding who holds the ultimate decision-making responsibility. In line with cultural norms, many believed that the husband, as the head of household, should be responsible for deciding what health behaviors his family members would and would not adopt, regardless of the health domain, and especially when there was a need for financial resources. Relatedly, **WDC members are not exempt from norms about gender roles that may limit the success of the CCS strategy**, as some male members perceive some health issues such as nutrition are not for men. However, social norms may be slowly shifting as communities begin to accept and follow community health sensitization messaging, regardless of the domain, which may offer an opportunity for sustained behavior. Incentives in health facilities such as newborn care packages are one of the tools funded by WDCs to encourage behavioral uptake and reach a critical mass that creates a normative shift. While incentives are needed to nudge behavior change, as communities experience normative shifts, behavioral changes will become more and more self-sustaining.

Another threat to sustainability raised by different categories of respondents concerns service delivery and the possibility that **supply may not match the increasing service demand** at facilities. Insufficient female health personnel in health facilities as well as limited availability of health personnel on weekends could limit the advances that the CCS approach is making and make them harder to sustain. If increased demand is met with insufficient or subpar services, service users may be discouraged from returning.

One potential unanticipated consequence of promoting community ownership of health problems/activities could be an overemphasis of the power of "zeal" and its relation to sustainability of community activities. However, questions remain as to what extent activities can be sustained without the contribution of donor funding, obviating the need for technical, moral, and financial support to sustainability.

Participant recommendations

1. Committee members and volunteers must have patience when conducting home visits, as some concepts may not be readily understood or accepted by certain communities.
2. The program should have greater involvement of religious leaders and influential community leaders, such as district heads, to support community structures in reinforcing Breakthrough ACTION/Nigeria's SBC messaging. Beneficiaries and WDC members agree that liaising with traditional and religious leaders would be a welcome if not necessary partnership to addressing community health related challenges and increasing SBC message understanding and uptake.
3. The program must provide additional reinforcement to WDCs to support both male and female CVs to convince male household heads/husbands of the benefits of using ANC and FP services for their wives.
4. Increase the number of female outreach workers, as they can reach inside the household. Relatedly, one community specifically asked to increase the number of female health care workers at their local facility as the presence of a sole male doctor was deterring both men and women from feeling comfortable accessing ANC services there.

5. Provide refresher trainings for WDCs, VDCs, and CVs, on both health content areas and interpersonal communication, to better equip them to interact with a wider breadth of community members and leaders and achieve greater success toward their goal of influencing additional community members for normative shifts and behavior change.
6. Facilitate greater support and collaboration from WDCs and VDCs in conducting house to house visits and conducting community dialogue sessions with traditional and influential community leaders.

Programmatic implications

- Support the diversification of WDCs' and VDCs' fund generation strategies.
- Strengthen capacity for addressing a wider range of behavior influences sustaining change, including practicing holding government and other stakeholders accountable to their commitments to support community health and advocacy.
- Further promote female participation in WDC and community structure leadership.
- Support further clarification of roles and responsibilities, primarily between WDC, VDC members, and CVs.
- Reinforce the use of community data collection to monitor barriers to uptake of target behaviors to practice programmatic course correction.
- Reinforce WDCs' capacity for non-coercive leadership and communication.

Recommendations for additional research

Sustainability planning and transitioning to a community-led model must include allowances for institutional and structural support to ensure sustainability. Therefore, a second phase of evaluation of the CCS approach is proposed to advance our understanding of the conditions under which the current Phase 1 programming may be successfully sustained and to assess how Breakthrough ACTION/Nigeria adapted their programming and sustainability plans in response to the findings of this study as they continue Phase 2 implementation. Specifically, a Phase 2 evaluation could help further explore and assess the following three domains of CCS programming:

1. Understand and compare performance of WDCs that were directly supported by Breakthrough ACTION/Nigeria CCS activities versus those that were supported by the community mobilization team, a new entity that serves as a liaison between LGAs and wards.
2. Assess changes in the WDC transition of stage 1 versus stage 2 of CHARP implementation, in which the additional elements of gender, WDC financial management and governance, and resource mobilization are to be incorporated.
3. Understand what inputs at higher levels of the health system are needed to ensure support for sustained community engagement and ownership of community health.

Background

Community capacity is broadly conceived as the individual and aggregate strengths of members to overcome barriers and find or cultivate opportunities to improve the overall wellbeing of a given community as well as that of individual community members.[1] Qualitative research conducted in Zambia identified six domains that encompassed community capacity: social cohesion, collective efficacy, type of leadership, participation/self-efficacy, conflict management, and effective leadership.[1] Other terms such as community capability are also conceptualized as the extent to which communities are empowered and possess social capital to positively affect individual and communal health.[2] A systematic review of domains included in studies assessing community capability found that external linkages and partnerships, elements of inclusive participation, and strong local leadership were the most commonly studied aspects of community capability.[3]

Several studies conducted in lower- or middle-income countries have underscored the importance of building the capacity of communities to promote health care seeking behaviors.[2-4] A systematic review of literature assessing the role of community participation in contributing to improved population-level infant and child health outcomes, such as reduction of mortality in children under 5 years old, found similar evidence. Increased social cohesion, trust, social capital, and perceived collective self-efficacy have documented effects on infant and child health outcomes.[3] A mixed methods evaluation of a community capacity strengthening (CCS) approach conducted in Zambia provides evidence that CCS increases target health behaviors such as women's contraceptive use, HIV testing, and children's bed net use, through increased community action.[1] A quantitative polled analysis using cross-sectional household data across Bangladesh, India, and Uganda found that community capability was a significant and meaningful determinant of maternal and child health outcomes such as institutional deliveries.[4] A third quantitative cross-sectional study conducted in the Republic of Guinea explored the effect of community capacity and individual exposure variables on women's use of antenatal care (ANC), institutional delivery, and care of complications. Results showed that women living in communities with high community capacity scores were more than twice as likely as women in communities with low scores to utilize health care services for ANC, institutional delivery, and care of complications.[5] Although evidence of a strong link between community capacity and the health outcomes of interest exists, there is very limited evidence on the transition from external donor-funded implementation to community ownership and whether community engagement to increased community capacity leads to sustained effects on health outcomes.

Community health committees (CHCs) and other local governance structures such as ward development committees (WDCs) and village development committees (VDCs), can be effective mechanisms to ensure local leadership, legitimacy, participation, and governance. However, these committees require continued training and investment. A synthesis of best practices and most common problems CHCs face highlights equitable representation of the community as particularly important for effective community management structures.[6]

Nigeria's National Primary Health Care Development Agency adopted the Ward Health System in 2000 to strengthen the primary health care (PHC) system, with varying degrees of functionality.[7] They consist of influential men and women responsible for overseeing development at the sub-district level.[8] Prior studies have highlighted that WDCs support village health workers by helping mediate with the community, helping to monitor village health workers, and participating in monthly review meetings. However, a study conducted in Ebonyi state found that over 60% of wards assessed did not have a functioning WDC.[9] Per the national minimum standards for PHC in Nigeria, WDCs' roles and responsibilities range from identifying and planning for health and social needs, supervising the implementation of developed workplans, raising funds for community programs and being accountable to the community for these funds, and supervising village health workers.[10] WDCs provide a platform to facilitate community participation and ownership of community engagement activities for primary health such as community mobilization; maternal, neonatal, child health and nutrition (MNCH+N); reproductive health; and health promotion. The WDC members are unpaid volunteers who meet regularly to discuss health and development issues, encourage community

participation in health and drive local accountability for health care.[9] Executive members of the WDC are elected for two-year terms, and potential candidates are identified by community leaders. Non-leadership WDC positions do not expire. Previous research has identified challenges faced by WDCs, including financial constraints to fulfill their assigned role, such as lack of transportation, tools, equipment, and space to meet.[11] In addition to these, WDCs also identified low awareness and respect for WDCs work, as a demotivating factor and a challenge.[9]

Study relationships

The Breakthrough RESEARCH project is the U.S. Agency for International Development's (USAID) flagship social and behavior change (SBC) research and evaluation project, led by the Population Council, in consortium with five other partners. Breakthrough RESEARCH catalyzes SBC by conducting state-of-the-art research and evaluation and promoting evidence-based solutions to improve health and development programs around the world. Breakthrough ACTION is USAID's flagship SBC programming project and works in partnership with governments, civil society, and communities to implement creative and sustainable SBC programming, nurture SBC champions, mainstream new techniques and technologies, and advocate strategic and sustained investment in SBC.

This report presents results from a **Breakthrough RESEARCH**-led study conducted in 2021 that took place in selected wards of the Bauchi and Sokoto states in Nigeria, where Breakthrough ACTION implemented programming, building on the ward health system which was adopted in the year 2000 to strengthen the Nigerian PHC system.

In Nigeria, USAID-funded **Breakthrough ACTION** is implementing an intensive community SBC approach[a] from 2018 to 2023 by engaging individuals in interpersonal and group dialogue at the community level. Breakthrough ACTION/Nigeria's SBC integrated approach in Nigeria has three core programmatic components: 1) advocacy outreach to religious and traditional opinion leaders and community influencers; 2) engagement of community members through household visits and community dialogues directed at target populations, with referrals for services as needed; and 3) complementary integrated SBC messaging through mass and mid-media and mobile phones. Breakthrough ACTION Nigeria's SBC program leverages religious, traditional, and community opinion leaders to influence community norms and household behaviors to improve malaria prevention and treatment, improve MNCH+N, and family planning (FP) behaviors.

The community SBC approach targets specific behaviors with targeted messaging by life stage and associated behavioral determinants across multiple health areas (MNCH+N, malaria, FP). These behavioral determinants are described by Breakthrough ACTION as ideations, or pathways to impact by health areas, including such ideations as knowledge, attitudes, risk perception, and self-efficacy. Breakthrough ACTION programming also addresses social and gender norms as gateway factors that contribute to behavior change. The five gender and social norms identified by Breakthrough ACTION as priorities are: 1) limited mobility and social interaction, 2) unequal agency on health decision-making, 3) acceptance of early marriage/childbearing, 4) traditional nutritional practices and restrictions, and 5) belief in the effectiveness of traditional remedies for maternal, neonatal, and child health (MNCH) problems.

During the first stage of intensive program implementation lasting approximately 24 months, the community SBC approach in integrated programming states (Sokoto, Kebbi, and Bauchi) ensured that most women, their families, and community members were reached by home visits or compound meetings and received SBC messages across health areas based on the life stage approach. Community dialogues also focused on family and male involvement in support of priority health areas. Additionally, beneficiaries have been referred to facilities for counseling or service uptake, using referral cards. Lastly, beneficiaries have been reached through mobile, digital, or mass media activities.

Breakthrough RESEARCH is tasked with evaluating Breakthrough ACTION Nigeria's CCS approach and its pathway toward sustainable SBC programming targeting multiple health areas, including FP, MNCH+N, and malaria.

CCS approach

To ensure the maintenance and sustainability of community SBC, Breakthrough ACTION/Nigeria is implementing a CCS approach that focuses on engaging community

[a]For a full description of Breakthrough ACTION/Nigeria's community mobilization plan, see: "Community Mobilization Operational Plan: Community SBCC & Community Capacity Strengthening". July 2019.

leaders and structures—namely WDCs—to increase community agency, coordinate and support the health ecosystem in general (e.g., advocacy for changes to health facilities and processes) and to ensure sustained community-level activities supporting behavior change for improved health outcomes. The CCS approach assists WDCs to take a leadership role in improving health and social outcomes among their constituents. As such, Breakthrough ACTION/Nigeria expects to see WDCs plan, implement, maintain, and monitor SBC activities, while also monitoring health and social indicators in the areas of MNCH+N, malaria, and FP, in alignment with PHC's established guidelines for WDC roles and responsibilities. **The CCS approach has three specific objectives to**: (1) help communities to identify priority health areas and behaviors in the areas of FP, MNCH+N, and malaria, and demand appropriate and quality health services; (2) empower communities to mobilize resources (both financial and in-kind), enhance participation in health services, and address underlying barriers to improved health, including gender biases and norms; and (3) increase community ownership and sustainability by developing systems to ensure continued community involvement and participation.[9]

Breakthrough ACTION/Nigeria is reaching these objectives by implementing a phased, performance-based capacity strengthening approach (see Table 1 for timeline and Table 2 for detail on responsibilities during the phased approach). In the fi**rst stage of intensive implementation,** which began in fiscal year 2019, a total of 73 wards (33 in Bauchi, 20 in Sokoto and 20 in Kebbi) were trained to begin developing a Community Health Action Resource Plan (CHARP)—living documents where WDCs prioritize health issues and implement priority activities using locally mobilized. WDCs have also been oriented on the community SBC materials and booklets across health areas to familiarize them with the key messages CVs are

TABLE 1 BREAKTHROUGH ACTION PROGRAM IMPLEMENTATION TIMELINE

PROJECT TIMELINE	CCS	COMMUNITY SBC
June–Aug 2019	Stage 1 CHARP began: • Training of CVs and WDCs on interpersonal communication ([IPC] training and facilitation methodologies), key messages by life stage, priority setting, planning, and developing and monitoring the CHARP • Supportive supervision and mentoring comprising on the job mentoring and WDC capacity building • Review meetings 29 WDCs began implementation outlines in their action plans (infrastructure, commodities, emergency transport system)	• Radio programming began • Official launch of expanded SBC activities (compound meetings, 321 service, home visits, community health dialogues)
Sep–Dec 2019		Expanded SBC activities continue
Jan–Mar 2020	Suspended in person activities—virtual supervision via WhatsApp groups for those with Android phones	Suspended in-person community activities in March
Apr–May 2020	Capacity building conducted using WhatsApp	Suspended in-person community activities
Jun–Aug 2020		Suspended in-person community activities
Sep–Dec 2020	Breakthrough ACTION/Nigeria conducted mid-year assessment of WDCs	Resumed in-person community activities at reduced frequency and reach
Jan–Mar 2021		
Apr–May 2021		Reverted back to pre-COVID frequency and reach of community activities
Jun–Aug 2021*	Conducted training for Stage 2 CHARP with WDCs	
Sep–Dec 2021	Stage 2 CHARP began: focus on gender, financial management and governance, resource mobilization. Breakthrough ACTION/Nigeria still covers the community volunteer (CV) stipend	

* Field work for this study occurred

TABLE 2 BREAKTHROUGH ACTION/NIGERIA'S INPUTS AND RESPONSIBLE STAKEHOLDERS THROUGH THE PHASED APPROACH

INPUTS	INTENSIVE PHASE	MAINTENANCE PHASE	EXIT
CCS trainings	Stage 1 CHARP	Stage 2 CHARP	State, LGA, WDC, Communities
CHARP	Breakthrough ACTION/Nigeria, LGA	LGA, Breakthrough ACTION/Nigeria	
Public recognition and experience sharing	Breakthrough ACTION/Nigeria, LGA, WDC	WDC/community	
Monthly meetings	Breakthrough ACTION/Nigeria	WDC	
Quarterly review meeting and participatory monitoring	—	Breakthrough ACTION/Nigeria—quarterly	
Trainings—CHARP Stage 2	—	Breakthrough ACTION/Nigeria	
Mentoring and supportive supervision for CVs	WDC, Breakthrough ACTION/Nigeria	WDC	
Mentoring and supportive supervision for WDCs	LGA, Breakthrough ACTION/Nigeria	LGA, Breakthrough ACTION/Nigeria	

bringing to communities through house-to-house visits, compound meetings, and community dialogues. During this first stage of CHARP implementation, Breakthrough ACTION/Nigeria provided supportive supervision to WDCs and CVs to reinforce training, first involving in-person visits particularly to facilitate monthly micro-planning meetings, and subsequently using WhatsApp groups and voice messages when the COVID-19 pandemic made face-to-face interactions impossible. Supportive supervision also aimed to improve community monitoring and evaluation and to enable use of data for decision-making by reviewing available and collected data alongside them and support prioritization of action plans. Breakthrough ACTION/Nigeria also supported the national quota for female representation within WDCs of 35% female membership. Breakthrough ACTION/Nigeria covered the CV stipend and training during this stage, while WDCs raised the resources (money, material, donations) needed for CHARP development and implementation.

In this first stage, Breakthrough ACTION/Nigeria's support focused on "quick wins," to build self-efficacy and build trust for the WDC in the community. Thus, they supported WDCs to address barriers to uptake of some MNCH+N services, with specific focus on providing:

1. Transportation for ANC and delivery.
2. Delivery items for women that cannot afford it.
3. Support to the facilities, e.g., through purchase of consumables, repairs, renovations, advocating for health care providers.

Part of the rationale for having WDCs focus on building infrastructure and providing commodities and emergency transportation in the first stage was to boost self-efficacy by suggested much needed and demanded improvements and build WDC capacity in terms of leadership and governance in preparation for the second stage of WDC support and maintenance, and sustained community SBC programming.

Approximately two years after training and implementation of stage 1 CHARP, the 73 WDCs progressed to the **second and current stage**, support maintenance during which Breakthrough ACTION/Nigeria is providing additional capacity strengthening and training opportunities tailored to the community's needs as identified by an analysis of capacity gaps. Stage 2 training started in August 2021 and full implementation began in October of the same year. Stage 2 training focuses on enabling WDCs to adopt a stronger focus on gender and social norms related to community SBC and within the WDC itself, resource mobilization, and management and community governance as well as more direct support to community SBC activities across health areas. Phase 2 will also emphasize coordination of all WDC activities, including community SBC, to be able to better guide and ensure sustained community SBC activities. During this second phase, Breakthrough ACTION/Nigeria planned to only provide half of the CV stipend while the local government area (LGA) or community was expected to provide half the value of the stipend in cash or in-kind. However, this transfer of responsibilities has been postponed and Breakthrough ACTION/Nigeria continues to provide the full CV stipend to date. In Stage 2, mentoring and supportive supervision is led by the WDC, although

Breakthrough ACTION/Nigeria continues to provide training on CHARP stage 2 through review meetings, supportive supervision, and continuous on the job mentoring. In stage 2 Breakthrough ACTION/Nigeria will also provide coordination support to CVs (via mobile phones) to ensure that they are able to sustain SBC activities and behavior change gains made in stage 1.

Breakthrough ACTION/Nigeria continues to explore appropriate avenues to sustain SBC programming established during their project support. One potential pathway could be the respective LGAs of intervention, through their PHC departments, will work with the WDCs and communities to successfully sustain the SBC programming established during this time period, and, through the CCS, enhance its impact over time. Other possible alternatives that Breakthrough ACTION/Nigeria is exploring includes state-level support through the Primary Health Care Development Agency or the federal and state funded Basic Health Care Providing Fund initiative.

The Breakthrough ACTION/Nigeria project and Breakthrough RESEARCH's study described in this report were developed with the following primary objectives of the program in mind:

- CCS through WDCs will institutionalize collective community action (i.e., enable communities to explore, plan, act, monitor, and manage local resources) which will enable sustained support for community-led implementation of SBC.
- Sustained community SBC will ultimately lead to improved health ideations, health-seeking behaviors and outcomes across multiple health areas (MNCH+N, malaria, and FP), while also improving social and gender norms that may have broader health and development impacts.

Study Objectives

The overall objective of this research study was to assess the early successes and challenges of the efforts to prepare communities to transition from Breakthrough ACTION/Nigeria's intensive SBC program model to self-reliance and community ownership through CCS; assessing its potential successes, challenges, and unanticipated results that effect MNCH+N, FP, and malaria outcomes.

This research addresses and documents:

1. To what extent have efforts to improve community ownership and self-reliance through WDC's CCS shown early success in increasing community self-efficacy, community cohesion, and sense of ownership?
2. What threats and opportunities exist for functionality and sustainability of WDC's engagement in collective action to address health and social outcomes among their constituents and do they vary by health area (FP, MNCH, and malaria)?
3. Are there intransigent restrictive and/or harmful gender and social norms and/or other contextual factors limiting success (e.g., community cohesion, past success/failures in problem solving, violence/insecurity, other social determinants)?
4. Are there unanticipated positive or negative results that may impact transition to community ownership and sustainability of SBC programming across health areas (e.g., from (dis)continued financial support to CVs who deliver this programming within communities)?

Methods

Study design

The study utilized a qualitative design and was conducted in two out of the three integrated SBC implementation states of Nigeria: Bauchi and Sokoto. The qualitative data methods included in-depth interviews (IDIs), key informant interviews (KIIs), and focus group discussions (FGDs). IDIs were conducted among WDC members, VDC members, CVs, local government officials and traditional leaders to gather insights on the potential effects of CCS on the community SBC activities. KIIs were conducted among Breakthrough ACTION/Nigeria staff to garner information on the implementation of community SBC activities and early transition toward community ownership. FGDs were conducted among CCS implementation beneficiaries to understand the effect and acceptability of the community SBC component and early impressions of the transition from Breakthrough ACTION/Nigeria intensive phase to community ownership.

TABLE 3 STUDY LGAS AND WARDS

STATES	LGAS	WARDS	TYPE OF WARDS
Bauchi			
	Bauchi	Dankade	High performing
	Ningi	Ningi East	High performing
	Kirfi	Badara	Low performing
		Kwagal	Low performing
Sokoto			
	Wurno	Achida	High performing
		Tunga	Low performing
	Kware	Durbawa	High performing
		Gandu	Low performing

Study area

The Nigerian states of Bauchi and Sokoto were identified in consultation with Breakthrough ACTION/Nigeria as research settings for the study (Table 3). These states were chosen because they are implementation states for the Breakthrough ACTION/Nigeria.

Bauchi

Bauchi state is situated in the northeastern zone of Nigeria and is administratively divided into 20 LGAs; it occupies a total land area of 49,119 km² which represents 5% of Nigeria's landmass. The National Population Commission projected population estimate for 2016 was 6,537,314 for Bauchi state, and females constitute 49.1% of the population.[10] The 2018 Nigeria Demographic and Health Survey showed the fertility rate for Bauchi to be 7.0 births per woman of child-bearing age between 15 and 49 years. In addition, for Bauchi state, the modern contraception prevalence rate is 5.2%, and 33.1% of pregnant women did not attend ANC in 2018.[10]

Sokoto

Sokoto state is situated in the northwestern part of Nigeria and has 23 LGAs with a total land area of 25,973 km². The National Population Commission projected population estimate for 2016 was 4,998,090 for Sokoto state, and females constitute 49.9% of the population.[11] The 2018 Nigeria Demographic and Health Survey showed the fertility rate for Sokoto state to be 7.2 births per woman of child-bearing age between 15 and 49 years. In addition, for Sokoto state, the modern contraception prevalence rate is 2.1%, and 53.1% of pregnant women did not attend ANC in 2018.[11]

Study LGAs and wards were selected based on Breakthrough ACTION/Nigeria's mid-year assessment of WDCs, particularly their performance at CHARP stage 1. High performing wards represented wards with perfect scores in the assessment, while low-performing wards represented those with the lowest scores (see Annex 1 for a list of assessment categories and scores for selected wards). Additionally, security and logistical assessments contributed to the eventual selection of study LGAs and wards across the states.

Study population

The populations for this study were purposively selected and comprised members of community organizations and local government, traditional leaders, community health workers/CVs, Breakthrough ACTION/Nigeria project staff, and beneficiaries of the CCS approach. The members of community organizations were further divided into WDC and VDC members. The beneficiaries were male and female adults in the specified study communities with at least one child under three years of age living with them.

Inclusion criteria

WDC members/VDC members/CVs/local government officials/traditional leaders are:

- A key actor (per categories above) within the selected ward.
- Willing and able to provide informed consent.

Beneficiaries

Selection criteria for participation in FGDs with men and women:

1. Aged between 18 and 49.
2. Living in a community where the study is taking place.
3. Exposed to Breakthrough ACTION/Nigeria community SBC programming by participating in household visits, compound meetings, radio and/or other programming.
4. Has at least one child within the 1,000 days window/ less than three years of age.
5. Not a member of the WDC, VDC, CV, or a government official.
6. Provides consent to participate.

Coincidentally, traditional leaders in wards that were designated as low performing in both Bauchi and Sokoto were unavailable to participate in IDIs on the days the team were present in their communities.

Instruments

The instruments used for this study comprised the guides for IDIs, KIIs, and FGDs. The interview guides were developed and adapted based on previous research conducted by Johns Hopkins University in Zambia.[1] Other resources included information from existing peer-reviewed scientific literature and other resources developed by the Population Council from studies in the region. The instruments capture a greater understanding of CCs, facilitators and barriers, and health-seeking behaviors among the beneficiary population in the study context. The guides were drafted by the core research team, validated by in-country stakeholders, and all IDI and FGD guides were translated to Hausa.

IDI guides were tailored to different informants to elicit appropriate information from the WDC members, VDC members, CVs, LGA officials, and traditional leaders. These guides helped elicit information on effective community leadership and ownership; community cohesion; information equity; community self-efficacy; gender equality; experiences with Breakthrough ACTION/ Nigeria's supportive supervision; perceived facilitators/ barriers to sustainability by health area, gender, and social norms; and unanticipated results. Additionally, for CVs, the instrument helped the research team understand their participation and experience with the Breakthrough ACTION/Nigeria CCS implementation, their engagement with WDCs and VDCs and perceived support, lessons learned from the implementation, and suggestions for WDCs as community coordination entity.

The KII guide helped elicit information on the CCS approach, including scope, current experience, and related training activities. Additionally, the guide comprised questions on experience working with WDCs, VDCs, and CVs; challenges and successes experienced in implementing CCS; and barriers and facilitators to sustainability of health programs. The FGD guide obtained information from male and female beneficiaries of the CCS implementation. Information provided by the tool includes the effect and acceptability of the community SBC component and early impressions of the transition from the Breakthrough ACTION/Nigeria intensive phase to community ownership.

TABLE 4 BREAKDOWN OF ACTIVITIES PER STUDY STATE

TARGET AUDIENCE	HIGH PERFORMING		LOW PERFORMING		TOTAL
	BAUCHI	SOKOTO	BAUCHI	SOKOTO	
IDIs					
WDC members	2	4	4	4	14
VDC members	4	4	4	3	15
CVs	3	3	2	2	10
Traditional leaders	1	1	—	—	2
LGA officials	1	2	2	3	8
FGDs					
Female beneficiaries	4	4	4	4	16
Male beneficiaries	4	4	4	4	16

*KIIs with Breakthrough ACTION staff; 5 per study state bringing the total to 10.

Data collection

This study's data-gathering activities were conducted in three LGAs in Bauchi State—Bauchi, Kirfi, and Ningi, and two LGAs in Sokoto State—Wurno and Kware. The data were collected over two weeks from 26 July to 6 August 2021. Fieldwork was implemented simultaneously in the two study states with the aid of eight trained field assistants, two research officers, and two research analysts coordinating the study. Based on the defined inclusion criteria of the study, participants were recruited with the aid of local government health educators and community mobilizers who were conversant with the terrain and understood the fundamentals of the Breakthrough ACTION/Nigeria project. Additionally, trained field assistants constantly liaised with the mobilizers to ensure that the right participants were selected for fieldwork. Data collection procedures were guided by the study's security and COVID-19 risk mitigation plans.

Data collection started with the pilot of tools, and an average of three days was used for data gathering activities per LGA. Duration of data collection activities lasted for six hours daily, with the team debriefing on the activities done at the end of the day. The data collection activities were conducted in a safe, suitable atmosphere, considering ethical and cultural sensitivity. At least four FGDs were conducted per study ward. These were comprised of one FGD per the following categories: males aged 18–24 years, males aged 25–49 years, females aged 18–24 years, and females aged 25–49 years. The number of IDI sessions conducted per other categories such as WDC members, VDC members, CVs, local government officials, and traditional leaders varied across study wards. However, at least one IDI session was conducted among each of these categories. Five KII sessions were conducted with Breakthrough ACTION/Nigeria staff per state.

Data management and analysis

All IDIs and FGDs were audio recorded with the consent of participants and all audio recordings were transferred daily from the audio recorders to a password-protected computer. The audio files were properly labelled, translated, and transcribed at the end of data collection. The transcripts were reviewed for correctness and stored on password-protected computers. Nvivo[12] software was used to manage data throughout the analysis. Selected transcribed qualitative data underwent an initial review by six researchers to ensure initial familiarization with the data during a week-long coding review meeting. The themes identified during data collection were further explored, and the research staff identified new emerging themes. Codes were drafted and systematized in a codebook to explore the various themes related to the study objectives. A team of four researchers collaborated in coding the dataset, with each transcript coded by a single coder. Team meetings were used to discuss and resolve disagreements in coding. These disagreements were centered on the appropriateness of some codes, code names, and description. Resolved differences were used to update the codebook to ensure consistent application across the dataset.

Thematic content analysis, a research method for the subjective interpretation of the content of text data through the systematic classification process of identifying themes or patterns, was used.[13] Following thematic content analysis, emergent themes were refined using a constant comparative method in which themes were compared to assess whether the same concept emerged within and across study sites and population.[14] Triangulation of data from different participant categories (i.e., using these data sources to understand the phenomenon under study) and analytic triangulation (i.e., using multiple analysts to understand different ways of looking at the data) contributed to analytical rigor.[15] Findings from the analysis was summarized, compiled, and used to develop the final study report.

Ethical considerations

The study received ethical approvals from the Tulane University Human Research Protection Office Institutional Review Board, the National Health Research Ethics Committee, and the Sokoto and Bauchi State health ethical review boards. Steps were taken to minimize risk for all study participants. Information provided by participants was treated with confidentiality by the study team. This was done by removing identifiers from study materials. During the informed consent process, the aims of the study and possible risks were thoroughly explained. Additionally, participants were assured of their rights and that their responses will not be shared in an identifiable manner with other parties.

Results

Research question 1

To what extent have efforts to improve community ownership and self-reliance through WDC's CCS shown early success in increasing community self-efficacy, community cohesion, and sense of ownership?

Early success in self-efficacy

Participants' sense of self-efficacy emerged most strongly when talking about community-based sensitization of health information and behaviors. As noted by a male WDC member in Sokoto:

> **"The job of sensitizing the people is the only thing we can do [without] outside funds because we have been doing it so we can continue.**

As a whole, community committees such as WDCs and VDCs are described by all categories of stakeholders as the "do-ers," making improvements in health facilities and transportation conditions and projecting a high level of capacity to do so. Examples of this include improving infrastructure and medical stock at facilities and mobilizing the community to use facilities. Interviewees project confidence about their ability to sustain this work, in part because of the supportive supervision and health programming knowledge and awareness gained from Breakthrough ACTION/Nigeria.

> **"We will stand on our own. The VDC is already working with WDC to sustain the health programs that BA is teaching us. This is done through the support of the district head, stakeholders, and other concerned citizens. We make decisions regarding our health facility and other health challenges confronting our community. We are on our way to attaining independence.**
>
> **—Sokoto, Male VDC member**

Numerous successes are highlighted in the realm of facility maintenance or infrastructure improvement such as replacement of old equipment, acquisition of new beds, and construction of benches for the waiting area, both in wards designated as high or low performing, and usually in collaboration with the local government and community members.

> **"What the WDC now did was that they were able to gather money, they now made a bore hole in the community in the health facility then they now gathered money again and dug another bore hole in the community. So that anyone that comes for ANC or is in the hospital will have water to use. Then at the community level now they allow people to come and take drinking water but anyone that fetches water maybe ten naira. The money is very little but from that money that is where they gather their resources to do their other activities.**
>
> **—Sokoto, Breakthrough ACTION/Nigeria staff**

Beneficiaries likened the level of facility maintenance and amenities to health facilities in developed cities such as Abuja. Additionally, the purchase of commodities such as FP methods and financial assistance with bills were also examples highlighted to WDC success stories.

> **"It is the coming of Albishirin Ku! that we got the privilege of repairing our hospital beds, and renovation of hospital buildings and financial assistance to women who cannot afford hospital bills, and assistance with family planning for women.**
>
> **—Sokoto, Male FGD participant, 25–49 years old**

> **"We succeeded; we brought electricity to our hospital, you see, we**

bought curtains and fixed, we bought buckets to replace the old ones the government bought, we the members of WDC did that.

—Bauchi, Female VDC member

Another example of an activity needing financial resources, raised by WDCs, was fuel for vehicles used as emergency transportation for women in labor.

Social cohesion

Trust was noted as a critical component of cohesion among all levels of community members, including youth, religious, and community leaders, and formed the foundation of any of the community work that WDCs, VDCs, and CVs carry out. Trust in community structure leaders was emphasized as a pre-requisite to the acceptance and accomplishment of Breakthrough ACTION/Nigeria's CCS and SBC programming. Beneficiaries specifically mentioned prudent management of funds and faith in the health education and sensitization content that community structure leaders shared with them that made them likely to engage with WDC and VDC members and CVs and be receptive to their messaging. Several participants noted that without the support and buy-in of key of traditional and community leaders, Breakthrough ACTION/Nigeria community sensitization and education work would not be well received and even likely be met with resistance. LGA officials noted that transparency bolsters trust within the community and allows for donors and other projects to view WDCs as a reliable resource, which in turn helps facilitate Breakthrough ACTION/Nigeria's activities. Importantly, several committee members and community participants alike noted trusting and accountable relationships between community committees and other stakeholders.

"Accountability and transparency are the key things that help me in my work. And I received a lot of support from members because they know I don't joke with their money…. The effective utilization of funds to address emerging health issues with the consent of other members for proper accountability and transparency. Every penny spent is duly accounted for, this makes the people happy with the support and the assistance we render.

—Sokoto, Male VDC member

"…I know what I have done and what I am still doing for the progress of the community, I am loved and everyone is happy I don't cheat, I have made an impact, I can go to any extent for my community to be happy.

—Sokoto, Male WDC member

"We are all united, we've become like a broom tied together. Everyone has a role to play. When we hear any [health] news, we'll look for this party and that other party…we CVs won't be enough, WDCs won't be enough…. When we joined hands, we've been having progress through Breakthrough.

—Sokoto, Female CV

Beneficiaries perceived that the SBC information they received was honest and this has led to acceptance and respect of community organizations. In response to being asked how health-seeking behaviors have changed in her community, one beneficiary noted:

"Seriously in my area, CVs and WDCs used to suffer a great deal because people refuse granting them permission to enter their houses.... But now they are well respected by the community members and a lot of doors are now wide open for them to enter and hold a conversation on health.

—Bauchi, Female FGD, 18–24 years old

Monthly and quarterly WDC and VDC meetings were mentioned as an organizational tool to promote cohesion within the community structures and discuss and overcome common challenges, such as fundraising.

If not for the meetings sincerely the activities we are tasked with wouldn't even be possible…. The meeting itself makes it possible for us to get acquainted with each other and again we get more enlightened and understand the need for cooperation.

—Bauchi, Male VDC member

Ownership: Increased importance and recognition of WDC

As noted by an LGA official, the CCS intervention and related capacity-building possibilities have resulted in WDCs gaining more visibility. Likewise, community organization members and community health workers are now accorded more respect, which has aided their activities.

We did not know what the WDC are into until Breakthrough ACTION came. It builds their capacity and assists them with training and shows them how to operate and how to work with the government and how to seek assistance from the government and they will assist them…they [Breakthrough ACTION/ Nigeria] have taking it upon themselves to identify and help alleviate the health suffering of community and help reduce the hardship the community is going through. Most especially women and children.

—Bauchi, Male LGA official

Additionally, participants shared the perception that WDCs are helping the local government to reach health objectives by involving religious leaders, and village elders/leaders to help educate community members.

Now WDC has reduced the work-load, they have been assisting us very well. Whenever they mobilize people, I just feel they are doing it for me.

—Bauchi, Male LGA official

WDC are respectable people in the community which the people listen to, they have done many things…that are of importance like gathering the people, and WDC will gather the traditional leaders and inform them so they too can inform the people. The WDC committee is a committee that is truly working, and people have seen it, accepted it, and are working with it.

—Sokoto, Male FGD, 18–24 years old

Successes extend to the institutional level, with new state support structures that formally acquire the responsibility to sustain the WDCs' work beyond the completion of Breakthrough ACTION/Nigeria's project.

Some of the sustainability approach is that a state agency that will take over what Breakthrough ACTION is usually monitoring. Now I can boldly say we have a WDC unit in the primary health care unit and the focal person on that unit that we always collaborate and work with.

—Sokoto, Breakthrough ACTION/Nigeria Staff

Capacity to support community SBC

Part of the CCS approach has entailed integrating WDCs into the CV hiring process. At the beginning of project implementation, Breakthrough ACTION/Nigeria advertised for CV positions and interviewed CV candidates together with WDC members and LGA officials. During phase 1 of implementation and up to the date of publication of this report, the CV stipend was entirely paid by Breakthrough ACTION/Nigeria, WDCs had not yet transitioned to paying half of the stipend for CVs as had been agreed upon earlier. Nonetheless, WDC's capacity to provide support for CVs is made evident by CV participants.

WDC support us so well. In fact, before holding any meeting, we will meet them first, together with them we visit households and husbands. When we

are having compound meeting, they will attend. Whatever they have to say, they will say it. If children are rowdy, they will try and put them in order and also organize things very well.

—Bauchi, Female CV

WDC executive members are elected for two-year tenures among the WDC membership for their trustworthiness, willingness to help their community, and relatability to the communities they represent. Part of their role is in supporting the entrance and smooth transition of CVs into communities for community dialogues and home visits, which is essential to ensure the community's receptivity to CVs.

> **"Yes, we attend meetings with WDCs we also visit house to house with WDCs because there are times in which the community might look at us as too young but whenever we are led by our WDCs they give us a form of listening ears and prestige due to the fact that WDCs are older people and are more respected within the community.**
>
> **—Bauchi, Female CV**

Participants' accounts of the relationship between WDCs and CVs reflect a "line of command" that also illustrate how WDCs' actions can support community level SBC.

> **"We will call WDCs, and they will in turn call VDC and local government area supervisors together with the husband and discuss with him. If he still refuses, they will then forward the issue to the king's palace.**
>
> **—Bauchi, Female CV**

> **"WDCs make use of different ways like, if there is a wealthy person in the community like the king, they will meet him when there is a health care problem. He will then call on people in the community so that funds can be raised to tackle the problem…. They also visit houses and distribute gifts to people. We, volunteers don't have the authority to do all that. Ours is to tell them the importance and ways to improve their health, but it must be done through the WDC.**
>
> **—Bauchi, Female CV**

Participants also provided examples of WDCs' roles in rallying the community and showing leadership in seeking the cooperation of many different community actors.

> **"The other progress they had is in working together. When we call people for, working in unity they give us their cooperation. They come, gather, and do it because we used to inform the people that this thing is not just ours alone, it Is for all of us, and this community is ours if we keep it clean, it will benefit us all. It will not benefit WDC. It will benefit all of us, we the community. Therefore, the people are giving us their maximum support in this thing. There are Islamic clerics in mosques and churches giving us their support in informing the people. We have progressed in this also. Yes. We used to have stuffs like eggs, banana, oranges, things like detergent, soap and things that pertains to foodstuff. We [have had] do have help like this and distribute in our hospital.**
>
> **—Bauchi, Male WDC member**

Perceived early successes in key community-level behavioral outcomes

Increased community knowledge on health issues

The most widely reported successes perceived as attributable to Breakthrough ACTION/Nigeria's community SBC strategy and the CCS approach were an increase in awareness of health issues and their causes alongside recommended behaviors to improve health. Participants generally referred to this as the process of "enlightenment."

> Norms are gradually changing because of education and the day-to-day enlightenment we receive.
>
> —Bauchi, Male FGD, 25–49 years old

> Actually, I feel people in this community prefer community volunteers that visit our houses from time to time because they actually enlighten us on diverse areas about child immunization, child spacing, and a lot of other issues.
>
> —Bauchi, Female FGD, 25–49 years old

Furthermore, community committee members drew a line between community enlightenment and the uptake of health services. A female beneficiary noted that Breakthrough ACTION/Nigeria's intervention has brought more awareness which has increased the knowledge of community members and resulted in uptake of services such as ANC.

> Seriously.... The rate at which women in this community go for ANC has drastically improved due to frequent enlightenment that we have been receiving. In the past you will find out that a lot stay back home until the seventh month of pregnancy before they go for checkup, but our eyes have now opened.
>
> —Bauchi, Female FGD, 25–49 years old

VDC members mentioned the training received in IPC as part of CCS as helping them know how to approach people in a way that will ensure they are receptive to the message.

> We know that right language and tone to use for every community in order to get them enlightened on family planning and other health related issues.
>
> —Bauchi, Male VDC member

Increased joint health decisions

Despite continued evidence of a gender skew in decision-making power (discussed in more detail in results for Research Question 3), men's participation in service uptake and joint decision-making is becoming increasingly relevant and important. When compared to the pre-intervention context, couples now place a greater emphasis on discussing health services such as delivery at a health institution.

> Because of the sensitization that VDC did the couples now understand that they have the right, for instance, if a man and his wife want to decide about birth spacing, it will not be right for the woman to go alone, the man has to go with her. Or the man should decide without asking about her opinion.
>
> —Bauchi, Male VDC member

Although the VDC member quoted above is expressing the normative belief that women should not seek services by themselves, he is also advocating for joint participation in decision-making, however, then defaults to the view that the man should have the last say.

By contrast, a male beneficiary notes a departure from the consensus view, suggesting family health benefits of shared household decision-making.

> In addition, about decision-making, in the past, the woman will tell her husband that she wants to go to the hospital, and he will say he did not agree for her to go to the hospital, she will go to the hospital to do what? But now, this program has truly encouraged us, which between husband and wife they sit and discuss very important issues that give them the impetus to take good care of themselves and their children altogether.
>
> —Sokoto, Male FGD, 25–49 years old

Increased male participation

Beneficiaries reported that SBC messages have led to more participation of men in health care services uptake when taking women for services such as ANC. As a

result of the intervention, it is seen as normal that men and friends take the woman to the facility for relevant services.

> **Many men do not send their spouses to the hospital without accompanying them. Because these men accept and agree with what is been done at the hospital that is why they accompany their wives to the hospital to hear what the health care worker has to say. Also to watch closely what is to be done for the child.**
>
> **—Bauchi, Male FGD, 18–24 years old**

> **Before in all honesty, firstly, if my wife is pregnant, I am not the one that takes her for antenatal care but because of me listening to Albishirin Ku!, I learnt one thing that made me take her to meet the doctor. If he explains something to her after wards, I will meet him to sensitize me on what it is and what is right. That has boosted my knowledge because I listened to Albishirin Ku!.**
>
> **—Bauchi, Male FGD, 18–24 years old**

Changes in attitudes, norms, and tradition

WDC members reported that the uptake of services such as ANC has increased drastically, although the study team did not verify this perception with service utilization data. CVs confirm that there has been a change in attitude about facility-based deliveries, as the benefits associated with services received have convinced beneficiaries of continuing with this practice. Beneficiaries themselves confirm the perception that Breakthrough ACTION/Nigeria's SBC sensitization messages have led to informed decision-making and healthier choices. As further explored in Research Question 2, beneficiaries found messages on nutrition to be initially unappealing, yet subsequent practice and resulting benefits encouraged them to adopt nutritional target behaviors. Based on the intervention, beneficiaries are abandoning harmful traditional practices such as giving water to newborn babies and adopting healthier practices related to MNCH.

> **Now, you even see women, aligning with themselves and going to seek health services together even without been told. And that has been like a motivation to other women because even if a woman is not interested in taking her children for immunization or not interested in going to seek for ANC, by seeing and hearing her fellow women will be most likely to practice what other women are doing.**
>
> **—Bauchi, Male FGD, 25–49 years old**

> **…Before, our people usually sieve the milk and throw it away…. [Breakthrough ACTION/Nigeria] explains to us that the breastmilk is part of what will enhance the health of the child. … Some even feed the baby on what is not milk. Honestly, that has stopped now.**
>
> **—Sokoto, Male VDC member**

Research question 2

What threats and opportunities exist for functionality and sustainability of WDC's engagement in collective action to address health and social outcomes among their constituents and do they vary by health area (MNCH, FP, malaria)?

Threats to WDC sustainability

Financial and logistical challenges

We found that the resource mobilization strategies that WDCs have used so far are mostly limited to fundraising within their own membership or other prominent community members, which may not be sustainable given that not all WDC members have the capacity to donate or raise significant financial resources.

At the same time, out-of-pocket financial costs were one of the most widely mentioned challenges by WDCs. While WDCs solicit contributions from the community

for immediate use and to create reserve funds to address health issues in the future as needed, in general WDCs need to recruit/have members with financial means so that they can finance community projects. Several WDC members expressed confidence in their ability to rally community leadership to a certain extent, but other WDC members expressed serious concerns when a community project demanded additional funds.

> **There are tasks which we desire to carry out but because of the situation…. Looking at the financial strength of the community here in [name of village], we desire to conduct an electrification project in this community. You see, this is something even though the community desires it, it is not capable of carrying out such a project for itself.**
>
> **—Bauchi, Female WDC member**

This financial challenge was compounded because WDC members also experience poor socioeconomic conditions themselves, and when WDC and VDC members are unable to donate from personal funds for a community activity, they may be perceived as uncooperative. WDC and VDC members often have other livelihood generation responsibilities, outside of their committee roles, which sometimes present as competing priorities in engaging in collective action, as noted in the quote here.

> **Taking women to access medical services in health facilities often conflict with my role as a farmer.**
>
> **—Sokoto, Male VDC member**

Additionally, community members often expected that committee members would provide them with a material incentive (e.g., money, medicines, or commodities) during home visits, often outright resisting the health messaging that WDC/VDC members and CVs came to share. These expectations ranged from mosquito nets, malaria medicines, FP commodities, or even cash itself.

> **When mobilizing people for community dialogue…they sometimes resist saying they need to be compensated with money.**
>
> **—Bauchi, Male CV**

> **We once visited a village community, while talking with them about visit a health facility, they said what will they gain? That when their children are suffering from malaria, they are not given free drugs….**
>
> **—Sokoto, Male FGD, 25–49 years old**

This is further compounded by public transport challenges due to poor roads and weather conditions, particularly in hard-to-reach areas. Areas that are geographically distant or difficult to travel to due to terrain or insecurity threats may limit the coverage of community SBC activities, as mentioned specifically by CVs.

> **Sincerely, the challenge is the means of transportation. We encounter such problems a lot, we the workers don't have means of transportation, to be frank. If you are assigned a task to carry out, you just have to look for means to board a motorcycle to and fro… Now you see in this season the challenge is lack of access road because there is no access road in some places. Again, at some places, there is erosion washing off the paths we do take as an alternative path coupled with a lack of finances.**
>
> **—Bauchi, Male VDC member**

Lastly, there were added complications experienced during the COVID-19 pandemic which resulted in interrupted programming, affecting community visits and activities, e.g., review meetings organized by the WDCs, which left WDCs and other community structures with remote supervision and training via WhatsApp instead of face-to-face activities.

Future supervision

WDCs, VDCs, CVs, and LGA officials described and appreciated various aspects of supportive supervision provided by Breakthrough ACTION/Nigeria including advisement on proper health facility maintenance, community mobilization, particularly of mothers, and IPC training and sensitization about how to discuss health issues with community members. However, the anticipated removal of the supportive supervision provided by Breakthrough ACTION/Nigeria was raised as a potential threat to

sustainability. Although participants alluded to the fact that government structures will replace Breakthrough ACTION/Nigeria in providing supervision, technical, and moral support, interview participants did not present a clear vision or plan for this type of institutional support. Several Breakthrough ACTION/Nigeria staff emphasized that their aim for WDCs was to eventually take on full ownership of community and ward level activities in sustaining health among their constituents. In particular, staff from high performing wards noted that sustaining health behaviors, not limited to just providing facility support, was within Breakthrough ACTION/Nigeria's vision and expectation of what WDCs can and will be able to accomplish.

> **"The role of community voluntary setting, under Breakthrough ACTION/Nigeria in our community is actually to strengthen the capacity of the local people, to be able to actually do what is expected of them in the areas of improving health behavior, the changes. The seventeen priority behaviors that we have through the structure that is called Ward development committee especially. It is one structure that we are actually working with to strengthen their capacity so that they will take the leadership and continue to work in their respective wards…to improve the health indices in their wards and together with the primary health care department and officials particularly the health promotion officers, the committee engagement focal persons and other key personnel or the department.**
>
> **—Bauchi, Breakthrough ACTION/Nigeria staff**

While Breakthrough ACTION/Nigeria has been developing WDC organizational capacity to manage finances and document progress achieved for accountability purposes, as reflected in the first quote below, some WDCs continue to have trouble documenting processes due to a lack of capability.

> **"The effective utilization of funds to address emerging health issues with the consent of other members for proper accountability and transparency. Every penny spent is duly accounted for, this makes the people happy with the support and the assistance we render.**
>
> **—Sokoto, Male VDC member**

> **"And then the documentation is also a challenge, considering their level of literacy. So, we give them format on how to document minutes of meeting, how to document the activities they implemented, how to share their own success through WhatsApp platform you know, so that they can take pictures when they are doing their activities and then share it for people in Bauchi and other LGAs and Abuja to see.**
>
> **—Bauchi, Breakthrough ACTION/Nigeria staff**

Additionally, according to Breakthrough ACTION/Nigeria staff, LGAs officials' willingness, ability, and capacity to provide supportive supervision will in large part determine sustainability of the work done under the CCS approach in support of community-level SBC, behavioral uptake, and overall improved health of the community.

> **"The state primary health care and the primary health care department in the local government areas, how committed would they be in terms of ensuring the continued follow up, supportive supervision to these structures that we found are formed already. It is one thing to have them embedded in the law, it is even one thing to give them formed activities and it is another thing to ensure that they are doing the right thing. Who will follow them to ensure they are doing the right thing?**
>
> **—Bauchi, Breakthrough ACTION/Nigeria staff**

Threats related to service delivery

Another threat to sustainability raised by different groups of respondents concerns service delivery and the possibility that supply may not match the increasing service demand at facilities.

...a lot of volunteers are creating demand [for people to go to] the health facility, and there was no staff. The WDC is doing a lot of sensitizations using the health facility and they come to the health facility and there is not enough staff. So that is also a big challenge.

—Sokoto, Breakthrough ACTION/Nigeria staff

Insufficient female health personnel in health facilities as well as limited availability of health personnel on weekends could limit the advances that the CCS approach is making and make them harder to sustain. Likewise, CVs are considered burdened with workload, particularly female CVs, given male CVs' inability to enter households to speak to women. One VDC member in Sokoto points out they have a single female CV in their community, "How will she cope? She cannot visit everywhere." As noted by a male LGA official in Bauchi, "We do not have sufficient CVs to reach all the nooks and crannies. There are still people who have not been enlightened."

Additionally, health care provider behavior and disrespectful care were also highlighted as threats to sustaining the community level SBC work.

...when our people [community members] visit the health care facilities, they should not be humiliated. Humiliation brings about the turn off to hospital visits. But when they are not humiliated, but attended to nicely whatever happens to them, they will go straight to the hospitals. When they get there and they are screamed at and what have you, they are not happy. So, they feel reluctant to go to the hospital.

—Bauchi, Male VDC member

Some women noted that in the past pregnant women were mistreated by health care workers during delivery, but that practice seems to be diminishing.

They [health workers] don't treat us with contempt. Before when a woman goes for delivery, they even beat her to open her legs and push, but now, they don't do—that they take care of us.

—Sokoto, Female FGD, 25–49 years old

Lastly, although not dependent on Breakthrough ACTION/Nigeria since the project does not procure them, termination of free commodities and subsidized drugs may be a threat to the sustainability of gains in service utilization, unless long term plans to help WDC's replace or reduce subsidy are in place.

What will make people stop going to the hospital...if the people are no longer given free drugs. If this kind of free or subsidized drugs given to the people as a result of the committee of the village efforts to help their people were to stop the people are most likely going to stop coming.

—Bauchi, Female FGD, 18–24 years old

Moving SBC beyond knowledge and awareness

Several committee members expressed difficulties in convincing some community members about the importance of health issues, e.g., polio vaccination and ANC, and surpassing accepted religious and cultural norms to do so. When attempting to educate/sensitize communities in villages with limited education or exposure, many people equate their messages to westernization and thus outright oppose it. WDC and VDC members mentioned that this resistance often makes it difficult to encourage wives to take children for immunization or practice child spacing.

If we are conducting the work of polio, enlightening the community on the importance, we encounter a lot of problems. They do not listen to us, and you can't carry something, and possibility force it on someone, you can only explain to someone if they understand it fine, if they don't understand then....

—Bauchi, Male VDC member

If you someone that is not educated especially the contemporary

knowledge, meaning the western education and you are trying to tell him to send his wives for ANC, immunization at the hospital, that one that is given to the children at the age of 9 month, and immunization against other disease like polio and other diseases, he will take you as westerner that [you are] there to show him that he is educated or to show him that he deals with educated people.

—Bauchi, Male VDC member

There was a heavy emphasis on knowledge or awareness as determining factors for sustainability, describing community committee members, community leaders, and beneficiaries as having been enlightened, with little mention of what else could hamper sustained programming and sustained behavior change at the community level. Some participants believed that WDC motivation would eventually wane because they had little incentive beyond their initial enthusiasm and commitment, which could likely diminish over time.

Among those that perceived that community engagement is sustainable with the training and support provided thus far by Breakthrough ACTION/Nigeria, there were not many specifics offered on how this can or will be sustained.

We also found evidence of gender biases within the WDCs where some SBC messages, e.g., nutrition related, are considered better suited for women, suggesting a weaker buy-in in the male community members' role in reinforcing and promoting these health behaviors.

Opportunities for sustainability

WDC members self-describe their roles and responsibilities as: (1) bridging the knowledge gap for improved health behaviors in their communities through public awareness activities, (2) liaising with facilities to help solve problems, (3) advocating and fundraising, (4) helping resolve conflicts within the community, and (5) promoting livelihood improvement initiatives within the community.

Notably, only one female WDC member mentioned equitable representation across villages within a ward as an important part of the WDCs' mandate.

"We choose members from every village so as to have equal representation from every village under [ward] so issues peculiar to each village is tabled out one after the other to ensure no village is left out of our intervention. Thereby leading to equal benefits across villages. So also if there is any material intervention, the commodity is equally shared amongst these representatives that came from the various villages.

—Bauchi, Female WDC member

Evidence of self-reliance

Diverging opinions emerged when discussing the community's ability to rally financial support when needed. Just as there are participants who claim there is much work that can continue without external funding and reflect confidence in advocating for private funding and see this as an opportunity, there are also those who claim that their financial self-reliance has very real limits and view removal of external funding as a threat to sustainability. The following quote comes from a female WDC member expressing confidence in their collective ability to advocate for funds.

"We now know that we could actually raise funds within and outside our community by carrying out advocacy visits, letting our elites understand the yearnings and sufferings of the people in our community and seek support in areas of need. Mostly pertaining the health care services rendered within the community and explore how we can help alleviate the suffering of the less privileged members of our community....

—Bauchi, Female WDC member

Fundraising efforts are mainly achieved by donations from WDC or VDC members, plus other prominent community members. The financial commitment of committee chairpersons provides an example for others in the community and may influence others in the community.

Reliance on established community structures

At the community level, health care providers, LGA chairpersons, WDC chairpersons, and traditional leaders were all mentioned as being responsible for health-related issues. There is a sense of hierarchy and due process in each category of community actor's engagement to address health concerns within the community. These established community responsibilities within a clear structure present an opportunity for community level governance and accountability that will contribute to sustained health improvements.

> **Basically, it is the Mai-Angwab and WDCs that are saddled with this responsibility. Whenever there is any issue that goes beyond the CV, and WDC the Mai-Angwa takes the final say because he is on top of the hierarchy of community decision-making.**
>
> **—Bauchi, Male CV**

> **Well, the CVs are always at the root of every decision-making because they are the ones who meet directly with the community members on a more constant basis... Reaching out to them in their respective houses and closely interacting with them to know their areas of challenges and help them work on it. Or refer them to hospitals by issuing them referral cards.**
>
> **—Bauchi, Male CV**

WDC membership's strong drive and commitment to sustaining community health

WDCs undoubtedly were recipients of other stakeholders' confidence when asked about their likelihood to be able to sustain community-level SBC and health achievements to date. LGA officials, CVs, and Breakthrough ACTION/Nigeria staff indicated most WDC members are highly motivated.

> **If selected WDC leaders have the zeal to help their community, I don't think there will be any reason that will stop it, even if Breakthrough is not there. Because they have to be enlightened and showed ways to continue. If it is for the progress of the community, they won't stop.**
>
> **—Sokoto, Male LGA official**

WDCs and Breakthrough ACTION/Nigeria staff both reported that eventually, as their capacity to mobilize the community grows, WDCs are encouraged to support other WDCs in wards where Breakthrough ACTION/Nigeria does not intervene, however details about this process were not provided.

WDC's capacity for leadership and guidance of CVs

WDC members were described as known and respected members of the community, which facilitates the CVs work. By accompanying CVs to community events, they enable a trusting relationship between community members and CVs.

> **Working together with the CVs. Yes, because I just remember when we did that second activity in 'Bancham', people didn't even listen to us until we allowed the WDC to talk to them. …know them already, some of them are politicians, community leaders so they called for them and then they [WDC] explained to the people and they allowed us to talk. So you see, if we didn't go with the WDC, they wouldn't have listened to us. So you see working with the CVs makes it wonderful.**
>
> **—Sokoto, Male CV**

Similarly, CVs reported the WDC's role and contribution in planning the community SBC activities together with them.

> **We have a work plan, where we outline activities to assist the WDCs. They know people and the community more, they know when these people can be mobilized and where, so we do this work plan together with the WDC. We outline with timelines, time for advocacy,**

[b]Mai-Angwa is a general team for a community leader in northern states

mapping and community dialog 1,2,3, etc.

—Sokoto, Male CV

Diffusion of behaviors

Shifting social norms in support of these health outcomes offer an opportunity for sustained behavior. Incentives in health facilities such as newborn care packages are one of the tools used by WDCs to encourage behavioral uptake and reach a critical mass that creates a normative shift. While incentives are needed to nudge behavior change, as communities experience normative shifts, behavioral changes will become more and more self-sustaining.

> **“So you see even when a woman has planned not to have a hospital delivery [an incentive] would motivate her to attend. If we can continually get these things it would result in behavioral change among the community. Even when such incentives later stop, they would realize that the care and services they got in the hospital is better off and therefore continue with hospital visits for the sake of their health.**
>
> **—Bauchi, Breakthrough ACTION/Nigeria staff**

Beneficiaries confirmed this same dynamic, as for many women delivering in a hospital were incentivized due to the free gifts given to mother and baby upon delivery.

> **“…she will go because of her health. Because if she stays at home, she will be sick. But if you go to the hospital, the medication is free and also after delivery, there are other medication they will give you. They will give you mosquito nets. They will give you medications. All are free and they will take care of your health…that will make them go to the hospital so as to take care of their health and that of the baby in their womb.**
>
> **—Bauchi, Male FGD, 18–24 years old**

> **“[Women] would rush back to the hospital to get the gifts. So then we used to get a lot of women to go to the hospital but when the program stopped, some women stopped going but a lot continued because they know the benefit.**
>
> **—Sokoto, Male VDC**

> **“Now, you even see women aligning with themselves [each other] and going to seek health services together even without being told. And that has been like a motivation for other women because even if a woman is not interested in taking her children to immunization or not interested in going to seek ANC, by seeing and hearing her fellow women, will be more likely to practice what other women are doing.**
>
> **—Bauchi, Male FGD, 25–49 years old**

Likewise, the use of mosquito nets for malaria prevention seems to have passed a certain threshold where from a group of male beneficiaries’ perspective, a lack of subsidy for mosquito nets may not affect demand.

> **“Back then we do not have such knowledge but thank God now sensitizations have been ongoing regarding the need to place children in mosquito nets, and we who are youths have been sensitized on how to improve our health. We have taken such messages to heart because back then when you approach us with such messages you will end up beaten. But as time passes by we got more enlightened and we are now at a point where even if it is sold we would use our money to buy those things.**
>
> **—Bauchi, Male FGD, 18–24 years old**

Opportunities related to the SBC strategy

Preferred information channel: Among community beneficiaries, community leaders were seen as a preferred information channel because of the trust community members have in them. They are comfortable with a plethora of leaders such as ward heads, traditional rulers, and religious leaders among others. WDCs' partnership with community leaders has helped introduce CVs into communities.

> **"Our people especially those in the villages trust their village rulers and religious leaders [Imams] because they are your leaders, and they know they have their best interest at heart. Say for instance the Imam in the Mosque has an influence on the people and anything he says they take very seriously.**
>
> **—Sokoto, Male FGD, 25–49 years old**

The fact that community organization members and CVs are part of the communities they work in allows for trust and acceptance of messages. Some beneficiaries appear to prefer female WDCs because they are the ones seen delivering messages at the household level. They also prefer this information channel because of the privacy it offers for discussion.

> **"CVs, WDCs have made this possible because it is said 'you win a war with an insider.' Since these people are our siblings, friends and relatives and we trust they wouldn't bring anything that isn't good for us, and as such, we accept it wholeheartedly.**
>
> **—Bauchi Male FGD, 25–49 years old**

> **"To be very frank with you there are a lot of private issues we do not feel comfortable discussing in the hospital because the person providing the service might even be a man and we find it difficult opening up to an opposite gender. Therefore, for me, I will think we are more comfortable with the community volunteers from Albishirin Ku! as they are fellow women like ourselves and we feel free to receive information from them and also air out any of our challenges without any reservation.**
>
> **—Bauchi, Female FGD, 25–49 years old**

Lastly, beneficiaries also mentioned to a lesser degree preferring information from health workers because of their competence on health issues.

> **"They get this information from health care workers. They trust such information from them because it is their area, and they know a lot about it. Messages from friends are not taken so serious as those from the health care workers who they know are experts in the field.**
>
> **—Bauchi, Male FGD, 25–49 years old**

In terms of preferred information platforms, radio was by far the most mentioned, with Viamo's 3-2-1 phone service mentioned only in a few instances.

> **"Sincerely, the [Albishirin Ku!] program impresses me a lot since I started hearing it on the radio. I have taken note of the time they are airing such a program because we have been learning from it.**
>
> **—Bauchi, Male FGD, 18–24 years old**

Resonant messages: Messages that resonated most with program participants were those related to child spacing, followed by ANC, exclusive breastfeeding (EBF), immunization, and use of mosquito nets for malaria prevention. The following quote demonstrates how messages about EBF helped women understand nutritional benefits of delaying introducing water/other foods.

> **"A lot of us now feed our babies exclusively until when they are above six months of age. Reason is because we have been enlightened about the benefits and we have also compared and contrast[ed] between children fed strictly with breast milk and those who**

were not. And the difference is very clear that those children who were fed exclusively with only breast milk turned out stronger, healthier, and more vibrant.

—Bauchi, Female FGD 18–24 years old

Seeing evidence of the benefits of certain health behaviors exemplified in the community served as a primary motivator for others to follow in suit. For example, seeing vaccinated children fall sick less often than non-vaccinated children encouraged families to accept routine immunization schedules. Similarly, seeing babies who were EBF for the first six month grow up to be healthier than babies who were fed water or gruel in lieu of breast milk served as a clear reminder to mothers of the benefits of EBF.

“Now even when the husband is not around they allow their children to be immunized because of the much exposure gained. Back then the wife has to ask for permission from the husband first before accepting immunization. So this program has sensitized the women too and now they are aware.

—Bauchi, Male FGD, 25–49 years old

Least resonant messages: Unsupportive social norms about childbearing and rearing made messages on EBF and FP least resonating for beneficiaries. Additionally, messages on immunization resonated the least due to perceptions that it made children cry and become ill. The fact that these same health topics appear as both most and least resonant messages may indicate a lack of consensus, with participants situated within a wide range of levels of perception and acceptance of these topics. Nutrition was also raised as a message that resonated less with beneficiaries, particularly due to the perception that improving nutrition required a financial commitment. Lastly, early marriage was also mentioned as a topic that is not well received by some.

“Honestly, family planning issue has not really gone down well with some people yet. Especially those who are in polygamous homes. Because most women get jealous of themselves…and all of that. If you see any woman agreeing to family planning, it means she is in a monogamous home; she is the only one married to her husband at the moment.

—Bauchi, Female FGD, 25–49 years old

“I will also take us back please bear with me. Our people have this belief they carry so dearly which is against exclusive breastfeeding and child spacing. They do not believe a child shouldn’t be given water as he is breastfed for six months. Some people feel something might even happen to the child if he is not given water, but because of this sensitization which is going on about 75% out of 100 has initiated such practices…. These are part of the messages which didn’t resonate well with people when it was first brought to us, and it is as a result of such beliefs which people hold on to so dearly. We are grateful your organization came in and now our people are getting more knowledgeable on such things and taking up the practice.

—Bauchi, Male FGD, 25–49 years old

“Regarding messages on routine immunization, I will say in our area this message is not accepted. Back then we had experts who come to sensitize us on several issues, they give us details of what this thing is, its advantages and disadvantages but we didn’t get experts who could explain better to us what routine immunization is. In totality, we didn’t get experts as we had on the previous messages to enlighten us on this immunization. This is the truth of the matter.

—Bauchi, Male FGD, 25–49 years old

“Okay, for me it’s nutrition. Because every man decides what his family feeds based on his financial strength, I think this message has the least

importance to me. So, I think it resonates least with me.

—Sokoto, Male FGD, 25–49 years old

"Honestly the one that does not sit well is the talk of marrying out your child early, no one will decide for you, maybe you want to marry her out quickly so that she will not be wayward.

—Sokoto, Male FGD, 25–49 years old

Research question 3

Are there intransigent restrictive and/or harmful gender and social norms and/or other contextual factors limiting success (e.g., community cohesion, past success/failures in problem solving, violence/insecurity, other social determinants)?

Implications of social and gender norms on sustainability of community action

There were mixed opinions across all participant cadres and across nearly all health areas examined, including FP, ANC, routine immunization, malaria, and child health, regarding who has ultimate health-seeking decision-making responsibility. In line with cultural norms, many believed that the husband, as the head of household, should be responsible for deciding what health behaviors his family members would and would not adopt, regardless of the health domain. Once again, financial considerations enter into the rationale for reserving decision-making to male head of household. Where money is to be spent, the male head of household must have the power to decide. In their absence, even neighbors are mentioned as being responsible for health-related issues.

"It is the head of the household. Because he is the one that is ahead of everyone in the house. The woman in the house is under his care, he has the right to give instructions on what to be done in the house.

—Bauchi, Male VDC member

Female community members provided a more nuanced perspective about decision-making for childhood illness. Although the male partner retains the responsibility for deciding to seek health care services, the responsibility to alert him of the child illnesses is the mothers. Some participants go as far as proclaiming their own agency. Younger female FGD participants raise their voice to put forward the opinion that they should be able to be responsible for themselves.

"A matter of fact even the sick woman should be able stand up by herself and go to the hospital without waiting for all this procedure.

—Bauchi, Female FGD, 18–24 years old

Alternatively, others reported that women should be given the responsibility regarding matters pertaining to ANC and child health, specifically nutrition and immunization, as they spend the majority of time with children in the home, or that ultimately both parents should hold joint responsibility because while mothers are primary caregivers, fathers provide the financial means of accessing and utilizing health services.

"The mother has the right to take him, like she said, the child fainted at once, in that she won't wait for the husband to come. She told me the daughter is becoming stiff, she tried her best, she had to rush her to the hospital, you see, she didn't seek permission from the husband. Even before he came back, he was phoned. If there is a phone with him, he could be called, but when it becomes an emergency like childbirth, we do tell them, the husband should give the wife the right to go out when something like an emergency comes up so she can go the hospital.

—Bauchi, Female CV

"Up until now, I think it is the father that is supposed to advise going to the hospital since he is the one that

knows his pocket but even if there go together, it is still good like [participant] said.

—Bauchi, Male FGD, 25–49 years old

However, we note that women remain excluded from decision-making narratives:

> **Health care-related conflicts or decision-making can be resolved by the husband, after the husband, then his parents, the community head, WDCs and VDCs, and when it worsens, then it will be taken to the community head. For instance, if a child is sick and his/her condition is worsening, they will tell the child's father, if he refused, they will tell his grandparents, if they refuse, then the matter will be taken to community head and if it worsening, then WDC and VDC will forward it to the king's palace. The king makes the final decision.**
>
> **—Bauchi, Female CV**

Norms about gender roles seem to also be limiting the success of the CCS strategy, as it appears that some health areas, such as nutrition as noted above, are not for men. As discussed, decision-making within households often seemed skewed toward the husband's domain, as men are still named the household decision maker across most health areas. However, social norms may be slowly shifting as noted by this quote from a male beneficiary in Bauchi suggesting how men will be chastised by community members if they do not take their wife to seek ANC care in this case, due to financial constraints.

> **The castigation you are likely to receive from people will make you wish that you did [take] her to the hospital and went to seek a loan somewhere to settle the bills.**
>
> **—Bauchi, Male FGD, Ages 18–24**

Additionally, WDCs are tasked with intervening in such instances where women are denied health care by their husbands, with safeguards in place for such men to be reported to traditional and other community leaders to be sensitized otherwise.

> **What you want to ask us about what type of measures will the community take if they find a man that stops a woman from going to the hospital, right. What they will do is we the community will have a meeting and send two or three people to the person that stops his wife from going to the hospital…. We will show him the importance and the value of going to the hospital. …if he does not agree, we tell our leaders to give him advice about these things. If he does not agree still, we will take it to the mothers and the traditional leaders for them to explain more to him so that he will understand and allow his family go to the hospital.**
>
> **—Sokoto, Male FGD, 25–49 years old**

> **The action we take on this, if a man did not allow his wife to go for ANC or delivery in the hospital or take his children to the hospital if they are sick, we have a committee where he will be called at the house of the village head, he will be educated and given health advice and what will follow as a result of not allowing his wife to go to the hospital for ANC, delivery or taking children if they are sick. This is the way we follow, he will be called and advised on the issues of health care.**
>
> **—Sokoto, Male FGD, 25–49 years old**

Although we do see that many WDCs are nearing the national quota for female representation, there are very few female WDC members in leadership roles, and we also have detected the perception that female members' participation is seen in somewhat tokenistic terms. Further, female Breakthrough ACTION/Nigeria staff did not always feel male WDC members listened to them. For example, when dealing with education about food

choices, some male WDC members did not feel the need to be concerned about that.

> **"I am going to conduct a session with probably the village head, the Imams now and I'm going alone as a lady sometimes they may listen to you but they won't listen to you as much as they will listen if you are there with a male.**
>
> **—Sokoto, Breakthrough ACTION/Nigeria staff**

There is also a juxtaposition of having fewer females in community structures, including positions of leadership within the WDCs, VDCs, and CVs, while simultaneously needing additional women to take on female-to-female sensitization efforts given cultural norms and preferences that preclude male volunteers from educating or liaising with married women, particularly during house visits.

> **"…they are doing immunization, you will see they don't have someone that will go and carry the child for them from the room. The father of the newborn wants to go to work, will he wait and bring the child for them to immunize him? …he will not allow his wife to come out since the person that will come is a man. We have a law we don't want a married woman to deal with a man because they don't know what will result. Some have a good heart and others don't have a good heart…."**
>
> **—Sokoto, Male FGD, 25–49 years old**

> **"Only women are allowed to enter houses without any problem. Even if the husband is not around, a woman can enter a particular house. A man will not be happy to meet two giant men in his house and his wife is not presentable. You know men are too jealous. Even though he likes what they came to offer, he will not accept it due to intense jealousy. That is why more women are needed as community volunteers."**
>
> **—Bauchi, Female CV**

Despite this, there may be opportunities for women CVs to acquire certain rights, privileges, or status as part of her involvement as a CV.

> **"Yes. A woman from community volunteer can stay with men and enlighten them. The husband will agree to it because it's the work they are doing and he can also be present there to see what you are doing. Also, if there is no man close by from community volunteer, a woman can enlighten another man."**
>
> **—Sokoto, Female CV**

Challenges and drivers to transitioning to community ownership

One potential driver to transitioning the CCS approach to community ownership lies in the recruitment strategy for WDC and VDC members and CVs. Nearly all participants mentioned that gender is a key criterion for WDC selection, partly due to the cultural and religious norms discussed, and that female volunteers are respected and needed to do the work that male volunteers cannot.

> **"Members are chosen based on their outstanding qualities because they are being seen as models and people look up to them…. The women are view[ed] with respect are seen as role models because they speak to their women on health issues."**
>
> **—Sokoto, Male VDC**

One female CV went as far as saying:

> **"There is no such thing as gender inequality in the selection process even though our activities may not be the same i.e., men reach out to men and do not go for house-to-house visit.... While we the women are the ones who go from house to house ensuring we talk to our fellow women and enlighten them in areas they need understanding about.**
>
> **—Bauchi, Female CV**

For women there is Unguzomac, which is a position that stand[s] on its own, also women leaders, you know also is a position that stand on its own too, we have a secretary is also know a position that stand on it[s] own.

—Sokoto, Male WDC

At the same token, recruiting female volunteers was also met with resistance by some spouses who do not approve of women to work outside of the home.

You know in this region, there are challenges of women getting involved in some spheres…. We men, our work is mostly outside. While for women, it is inside the house to enlighten other women.

—Sokoto, Male VDC

However, the sentiment toward female involvement in committee membership seems to be slowly turning a cultural tide as men no longer feel their own masculinity being threatened by a woman's participation in community education and outreach.

It's not every man that will allow his wife to be involved in that kind of job. But later on, they are seen as people who bring awareness. Unlike before, where every man who allowed his wife to be involved in this kind of job is seen as someone who is not capable of being a man.

—Bauchi, Male VDC

Lastly, a challenge for WDC's work with potential to interfere with sustainability of community structure leadership is a noted coercive and at times authoritarian attitude toward community "enlightenment," suggesting that WDC members can exhibit a rigid mindset that may be less about mediating for a solution and perhaps more about showing people that they are "in the wrong".

For instance, if a conflict arises regarding health issues or for instance if the doctor is having issues, the WDC will go and sit with him and also the workers of that hospital for them to discuss and find a way out. If it means scolding them and telling them the truth so they can change, and if they don't change, the WDC will join hands with the leaders of the land…so they will tell him his lapses and if he doesn't change WDC and the leaders will sit and discuss on where we will go to for help.

—Bauchi, Male WDC

The second quote illustrates how CVs defer to WDCs for this type of communication, highlighting this as an important capacity strengthening component to include in future programming with WDCs.

If a woman does something that is not right, they will tell her what you did was wrong, you do things this way or that way. We, the CVs, don't have the capacity to address such issues. Only the WDCs [do].

—Bauchi, Female CV

Research question 4

Are there unanticipated positive or negative results that may impact transition to community ownership and sustainability of SBC programming across health areas (e.g., from (dis)continued financial support to CVs who deliver this programming within communities)?

An unanticipated consequence of promoting community ownership of health problems could be an overemphasis of the power of "zeal" and its relation to sustainability of community activities.

Seriously they need to have the zeal and take ownership, let them hold it and not let it get spoilt, and show that with or without help, they can maintain

[c] "Unguzoma" are older women who are local midwives or traditional birth attendants and are influential in local northern communities.

it by their selves. If they have this zeal and take ownership, even if there is no organization, they will do their best, by all means, to continue what they have started.

—Sokoto, Female LGA official

Throughout WDC and VDC participants' responses, there is a sense of great pride in "standing on their own two feet" or being self-reliant in aspects such as mobilizing resources and problem solving from aspects that range from community and facility infrastructure repairs to conflict resolution among community members. This result is an expected outcome of a CCS approach. However, a vocal minority of participants question to what extent one can really sustain activities without the contribution of donor funding. We pose the question of whether the "pull yourself up from your bootstraps" approach which many participants seem to have fully embraced might ignore or obviate the need for technical, moral, and financial support that is still very much needed and may act as barriers when not present.

Additionally, it's useful to remember that the wards participating in the CCS intervention already had highly committed WDCs. The effect of an approach such as Breakthrough ACTION/Nigeria's CCS on WDCs under different circumstances is not known.

"You know for me in my community, even before the coming of Breakthrough, these people are giving help. So, if Breakthrough leaves, it was just a boost to their morale. As I said, they do you have a committee they are putting together and if someone doesn't sacrifice, they don't put him to be a WDC. Most of them are sacrificial people that even sacrifice their wealth.

—Sokoto, Male CV

Recommendations

Program beneficiaries

Study participants overall appreciated the efforts of WDCs, VDCs, and CVs in "enlightening" them on positive health practices that benefit their own health and the health of their families. Many requested further education and sensitization efforts to help increase their knowledge of healthy practices.

A recurring theme among program participants was a reminder for committee members and volunteers to have patience when conducting home visits, as some concepts may not be readily understood or accepted by certain communities. Several also cautioned that if people do not feel approached in a cordial manner this may result in outright rejection of volunteers from homes.

> **There are times that they will go to talk to some people they might insult them, because some people are stubborn, and they don't understand things easily so they should be patient. Then anyone that wants to educate someone should do it gradually. Some people understand thing once while another you have to be patient and continue repeating it.... They should devise a way of drawing our attention because sometimes you will see them happy, they might accept it on time.**
>
> **—Bauchi, Female FGD, 18–24 years old**

There was also a call for the program to have greater involvement of religious leaders and influential community leaders, such as district heads, to support community structures in reinforcing Breakthrough ACTION/Nigeria's SBC messaging.

> **My advice here is that things should be reshuffled and religious leaders brought into this. They must do such because they are influential people in the community. Their advice in giving any form of relief is important as well.**
>
> **—Bauchi, Male FGD, 25–49 years old**

> **Any time they are out in the community and did not get support from the community leaders…they won't be welcomed by the people into their houses. Once you don't get the support of community leaders who are WDCs themselves or teachers who are WDCs themselves, it will be difficult to speak to the community as expected. Once you have their support to speak with the people and they can even request you come back another day.**
>
> **—Sokoto, Male FGD, 25–49 years old**

In the context of appropriate male and female interactions given existing cultural and gender norms, several participants requested additional reinforcement from both male and female CVs to convince male household heads/husbands of the benefits of using ANC and FP services for their wives.

> **I would advise they share them into two because some men don't allow their wives to go for family planning and antenatal. So, if they could go to the husbands and explain to them to allow their wives to go for antenatal, family planning, and also take the children for immunization.**
>
> **—Sokoto, Female FGD, 18–24 years old**

Importantly, as male volunteers/committee members are not culturally welcome to address women in the home in the absence of their husband, several respondents noted the value in increasing the number of female outreach workers. Relatedly, one community specifically asked to

increase the number of female health care workers at their local facility in Tunga as the presence of the sole male doctor was deterring both men and women from feeling comfortable accessing ANC services there.

> **Some men won't allow the male to check their wives due to jealousy and even among us the women, we feel freer with female health workers, because even you that is seated here now, if you were to be a male, we will not be this free and be talking with you.**
>
> **—Sokoto, Female FGD, 25–49 years old**

> **If it is possible to have a female doctor that will always be available for consultations our husbands will allow us to visit for antenatal cares services in Tunga.**
>
> **—Sokoto, Female FGD, 25–49 years old**

Additional participant recommendations included more training and information, education, and communication materials for WDCs to engage in and share with community members; receiving payment or materials (e.g., mosquito nets, malaria medicines, or FP commodities) from CVs/community structures during home visits; and overall increased efforts and additional volunteers to sustain current Breakthrough ACTION/Nigeria SBC programming efforts in community outreach and education, with many suggesting that WDC members should be financially compensated for their volunteer time and efforts, particularly travel related costs.

> **The advice is they should find them something, everyone knows how they do it, give them something little to motivate them.**
>
> **—Sokoto, Male FGD, 25–49 years old**

Community structures (WDC/VDC/CV)

Overall, WDC and VDC committee members and CVs seemed generally pleased with their responsibilities as part of Breakthrough ACTION/Nigeria's programming and their ability to reach and share their messaging with intended recipients.

However, WDC/VDC members and CVs did advocate for additional refresher trainings, on both health content areas and IPC, to better equip them to interact with a wider breadth of community members and leaders and achieve greater success toward their goal of reaching additional community members.

Like program beneficiaries, they also agreed that liaising with traditional and religious leaders would be a welcome if not necessary partnership to addressing community health related challenges and increasing SBC message understanding and uptake. Some CVs advocated for greater support and collaboration from WDCs and VDCs in conducting house to house visits and conducting community dialogue sessions with traditional and influential community leaders.

> **There was a time one woman had a serious health complication, she was bleeding and her husband refuse[d] her to go to the hospital, we had to call an Imam to preach to him before he finally agreed.**
>
> **—Sokoto, Male WDC member**

Several committee and CVs also noted that (additional) financial compensation would be a welcome incentive to sustaining their workload.

> **I feel they should provide us with some little funds to serve as a source of motivation for us to keep doing this job.**
>
> **—Bauchi, Female CV**

Discussion and Conclusion

Breakthrough ACTION/Nigeria's CCS approach has three specific objectives: (1) help communities to identify priority health areas and behaviors in the areas of FP, MNCH+N and malaria, and demand appropriate and quality health services; (2) empower communities to mobilize resources, enhance participation in health services, and address underlying barriers to improved health, including gender biases and norms; and (3) increase community ownership and sustainability by developing systems to ensure continued community involvement and participation. Breakthrough ACTION/Nigeria seeks to achieve this by working directly with WDCs (comprised of unpaid volunteers) to plan, implement, maintain and monitor community health, including SBC activities; support CVs who were installed and trained by Breakthrough ACTION/Nigeria; while also monitoring health and social indicators in the areas of MNCH+N, malaria and FP.

Our findings indicate that there was an increased awareness ("enlightenment") of health issues across all target health areas including FP, child health, malaria, immunization, ANC, and nutrition. Program beneficiaries report that this increase in knowledge has led to the adoption of healthier behaviors and positive decision-making, although more traction is perceived in some health areas more so than others. Specifically, program beneficiaries perceive that Breakthrough ACTION/Nigeria's SBC sensitization messages have led to informed decision-making and healthier choices, such as abandoning harmful nutritional traditional practices like feeding water to newborn babies. Despite heavy emphasis on knowledge or awareness as determining factors for sustainability, additional considerations for threats to sustained programming and sustained community level behavior change were not explicitly discussed. Nonetheless, participants expressed difficulties in convincing community members about the importance of certain health issues and surpassing accepted religious and cultural norms to do so. Shifting social norms in support of these health outcomes offer an opportunity for sustained behavior change. Though, when attempting to sensitize communities in villages where its members have limited education or exposure, many people equate their messages to westernization and thus outright oppose it, often making it difficult for CVs or WDC members to encourage wives to take children for immunization or practice child spacing.

Community structures including WDCs, VDCs, and CVs have a strong sense of self-reliance and project a high level of capacity to effect positive changes in health behavior and health infrastructure, particularly in the realm of facility maintenance and improvement. While some committee members contended that they can continue much of their current work without external funding, reflecting confidence in advocating for private funding, others noted that financial self-reliance has very real limits as they remain unpaid volunteers, while funding is necessary for certain tasks that form part of their role, such as providing incentives for service utilization, and ensuring emergency transportation for those in need.

Transparency and trust established thus far also present an important opportunity for sustaining community SBC gains achieved to date. Although many WDCs are meeting Breakthrough ACTION/Nigeria's quota for female representation, there are very few female WDC members in leadership roles and there is a perception that female members' participation is seen in somewhat tokenistic terms. This is contrasted by the need for additional women to take on sensitization efforts given cultural norms and preferences that preclude male volunteers from educating or liaising with married women, particularly during house visits.

Program beneficiaries report that SBC messages have led to more participation of men in health care services uptake when taking women for services such as ANC and in increased joint decision-making between couples regarding health service use. However, at the same time there were mixed opinions regarding who holds the ultimate decision-making responsibility. In line with cultural norms, many believed that the husband, as the head of household, should be responsible for deciding what health behaviors his family members would and would not adopt, regardless of the health domain, and especially when there was a need for financial resources. Relatedly, norms about gender roles seem to also be limiting the success of the CCS strategy, as it appears that some health issues such as nutrition are perceived as not for men. However, social norms based on SBC community programming may be slowly shifting as communities begin to accept and follow community health sensitization messaging, regardless of the domain, and appear to

value shared responsibilities in health care decision-making However, this shift in gender roles does not seem to be reflected within WDCs given limited female leadership and participation.

One potential unanticipated consequence of promoting community ownership of health problems/activities could be an overemphasis of the power of “zeal” and its relation to sustainability of community activities. However, questions remain as to what extent activities can be sustained without the contribution of donor funding, obviating the need for technical, moral, and financial support to sustainability.

Of note, while participants were sampled and data were intended to be analyzed across wards that had scored as high and low performing, as deemed by Breakthrough ACTION/Nigeria’s mid-year WDC assessment, the Breakthrough RESEARCH study team found no salient differences between respondents from high and low performing wards.

Programmatic implications

- **Support the diversification of WDCs’ and VDCs’ fund generation strategies.** This study found a limited number of funding strategies, with high reliance on self-funding through WDC membership donations and a potential threat to the sustainability of the CCS approach if diverse funding sources are not identified as Breakthrough ACTION/Nigeria support transitions out. The assessment of funding strategy diversification should be a focus of a phase 2 evaluation.
- **Build capacity for addressing a wider range of behavior influences sustaining change.** Develop messaging and skill building interventions to help individuals navigate other behavioral barriers and strengthen capacity for addressing a wider range of influences on sustained behavior change. While we acknowledge that knowledge is necessary, it alone is not sufficient for behavior change. There is also recognition that commodities and health service provision and quality of care are essential, but we recommend that Breakthrough ACTION/Nigeria increase CCS activities that promote the recognition of other behavioral determinants both at the community level as well as within the WDC, VDC, and CV organizational structure and work, including advocating for the health system to honor their commitments to support community health.
- **Further promote female participation in WDC and community structure leadership.** Social and gender norms restricting the ability of women to serve within community structures and limiting women’s health care decision-making severely constrain the implementation and reach of the sustainability of community action, suggesting the need for additional or complementary organizational coaching and social norms interventions to address the role of women in community structures and promote female participation beyond tokenistic or stereotypical roles.
- **Further clarification of roles and responsibilities.** Although participants point to a cohesive collaboration in support of community level SBC, descriptions of WDC, VDC, and CV roles and responsibilities overlap to a great extent. Phase 2 programming must further clarify stakeholders’ distinct yet complementary roles and responsibilities as pertains to community SBC.
- **Reinforce the use of community data collection** to monitor barriers to uptake of target behaviors and practice evidence-based programmatic course correction.
- **Reinforce WDC’s capacity for non-coercive leadership and communication,** respecting community members behavior change process.
- **Reinforce WDCs capacity to hold health system accountable.** Phase 2 programming must further clarify WDC’s leadership role not only addressing health behaviors and use of services, but also holding the health system accountable for support needed to continue this work.

Recommendation for additional research

This study contributes evidence alongside other research from Nigeria assessing the effectiveness of WDC capacity strengthening activities on their support and engagement to improve access to quality care services,[19] as well as WDCs’ contribution to successful coordination of MNCH interventions.[20] However, these studies do not actually assess sustainability of health programs by WDCs once external funding is withdrawn.

Although participants suggest that other state government support structures will replace Breakthrough ACTION/Nigeria in providing supervision to sustain the WDCs beyond the Breakthrough ACTION/Nigeria CCS project, at the time of data collection, no clear vision was presented as to the type and composition of institutional support. LGA supportive supervision of committee structures is also meant to help ensure community sustainability. Breakthrough ACTION/Nigeria intentionally designed stage 1 of the CCS approach to focus on WDC support in building infrastructure, procuring commodities, and providing emergency transportation to enhance their coordination role within the ward by engaging communities and addressing barriers, within and beyond SBC activities. This was done by design in preparation for Phase 2 of the CCS approach which should focus explicitly on WDCs' capacity to sustain integrated SBC community-level programming.

This opinion is shared by traditional leaders, who recognize that there is only so much that should be placed on the community. The government also needs to provide support and resources.

> **"What is most important to facilitate healthy living in our community, we need our people to put in more effort and also understand the importance of going to the hospital, and they should continue going, that's the first. Secondly, I want the government to help with some drugs that people can receive for free because someone can have malaria, and that person might not have had breakfast because of Nigeria economic situation, he doesn't have money.**
>
> **—Sokoto, Male traditional leader**

> **"The government should be involved in getting all the necessary drugs and portable drinking all water, they should ensure they do their best to provide all necessary commodities.**
>
> **—Sokoto, Male LGA official**

Breakthrough RESEARCH is currently conducting another study across five states in Nigeria that is aimed at assessing Breakthrough ACTION/Nigeria's SBC public sector capacity strengthening approach which focuses on strengthening the SBC capacity of public sector individuals, organizations, and systems at the ward, local, state, and national levels. Using elements from the SBC Ecosystem™, developed by USAID's Health Communication Capacity Collaborative Project, the study will examine through qualitative inquiry the extent to which the Breakthrough ACTION/Nigeria approach has been able to enhance the capacity of national and sub-national entities to coordinate and oversee quality SBC programming.

In addition to this study, and because sustainability planning and transitioning to a community-led model must include allowances for institutional and structural support to ensure sustainability, a second phase of evaluation of the CCS approach is proposed to advance our understanding of the conditions under which the current Phase 1 programming may be successfully sustained and how Breakthrough ACTION/Nigeria adapted their programming and sustainability plans in response to the findings of this study as they continue Phase 2 implementation. Specifically, a Phase 2 evaluation could help further explore and assess the following three domains of CCS programming:

1. Understand and compare performance of WDCs that were directly supported by Breakthrough ACTION/Nigeria CCS activities versus those that are supported by the community mobilization team, a new entity that serves as a liaison between LGAs and wards;
2. Assess changes in the WDC transition of stage 1 versus stage 2 of CHARP implementation, in which the additional elements of gender, WDC financial management and governance, and resource mobilization are being incorporated; and
3. Understand the linkages between WDCs and other government structures with respect to institutional capacity strengthening and their capacity to absorb Breakthrough ACTION/Nigeria CCS programming.

Limitations

Four main study limitations are worthy of note. First, the Breakthrough RESEARCH study team found it difficult to recruit traditional leaders. While the team was eventually able to elicit the needed information from this population, the sample was small. A larger sample could have provided more information that would have better

shaped the findings of this study. Second, this study does not include data from comparison sites to assess wards that do not receive Breakthrough ACTION/Nigeria's CCS intervention. Furthermore, there is clear evidence of several organizations' activities with the same wards supported by Breakthrough ACTION/Nigeria, therefore Breakthrough ACTION/Nigeria's exclusive contributions to early successes are unclear. Third, the study team was unable to complete an IDI with a female WDC chairperson due to the inaccessibility of one of the study sites in Bauchi state and the ethics committee's non-responsiveness in our attempts to amend the study protocol to reach her virtually. The team believes that data from this activity may have offered a different perspective on female leadership, roles, and responsibilities, specifically, within the WDC structure. Lastly, there are also some inherent limitations to qualitative data which include the inability to generalize study findings to a broader audience beyond the study geography and participants. While the data from this study provided in-depth insights on Breakthrough ACTION/Nigeria's CCS model, the study design does not allow for generalization beyond the population investigated in the study locations. However, we believe the findings are very relevant and useful for SBC program implementation.

Despite these limitations, the present study results present a detailed description of early successes, threats and opportunities related to the CCS approach's effectiveness in preparing WDCs for community ownership of SBC activities for improved community health.

References

1. Underwood, C. et al. 2013. "Community capacity as means to improved health practices and an end in itself: Evidence from a multi-stage study," *International Quarterly of Community Health Education* 33(2): 105–127. doi: 10.2190/IQ.33.2.b

2. George, A.S. et al. 2016. "Synergies, strengths and challenges: findings on community capability from a systematic health systems research literature review," *BMC Health Services Research* 16: 623. doi: 10.1186/s12913-016-1860-1.

3. Farnsworth, S. Katherine et al. 2014. "Community engagement to enhance child survival and early development in low- and middle-income countries: An evidence review," *Journal of Health Communication* 19 (sup1): 67–88. doi: 10.1080/10810730.2014.941519.

4. Paina, L. et al. 2016. "What is the role of community capabilities for maternal health? An exploration of community capabilities as determinants to institutional deliveries in Bangladesh, India, and Uganda," *BMC Health Services Research* 16: 621. doi: 10.1186/s12913-016-1861-0.

5. Brazier, E., R. Fiorentino, M. Saidou Barry, and M. Diallo. 2015. "The value of building health promotion capacities within communities: Evidence from a maternal health intervention in Guinea," *Health Policy and Planning* 30(7): 885–894. doi: 10.1093/heapol/czu089.

6. LeBan, K., H. Perry, L. Crigler, and C. Colvin. 2013. "Community participation in large-scale community health worker programs." Accessed in: https://www.mchip.net/sites/default/files/mchipfiles/12_CHW_Communities.pdf.

7. Primary health care systems (PRIMASYS): case study from Nigeria. 2017. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO https://www.who.int/alliance-hpsr/projects/alliancehpsr_nigeriaprimasys.pdf?ua=1

8. Wickremasinghe, D. 2019. "'Their own project for their own people' [i]: Community participation in the Village Health Worker Scheme in Gombe State, Nigeria [Internet]," *Health Systems Global*, 5 February. Accessed March 30: https://healthsystemsglobal.org/news/their-own-project-for-their-own-peoplei-community-participation-in-the-village-health-worker-scheme-in-gombe-state-nigeria/

9. Oko, O. F. O., O. L. Ulu, O. M. M. Okechukwu, and A. Benedict. 2017. "How ready are the ward development committees to facilitate universal health coverage in Ebonyi State, Nigeria?," *Journal of Primary Health Care and General Practice* 1(3): 005.

10. National Primary Health Care Development Agency. n.d. "Minimum standards for primary health care in Nigeria." Abuja: Department of Planning, Research, and Statistics. http://hfr.health.gov.ng/resources/download/Minimum%20Standards%20for%20Primary%20Health%20Care%20in%20Nigeria.pdf

11. Ezinwa, A. D. 2017. "The role and challenges of ward development committees in promoting grassroots health awareness in Ogun State Nigeria," *Journal of Business and Management* 19(7): 41–48.

12. Breakthrough ACTION. 2019. "Community mobilization operational plan: Community SBCC & community capacity strengthening."

13. National Bureau of Statistics. 2017. *Demographic Statistics Bulletin*. https://nigerianstat.gov.ng/elibrary?queries[search]=population

14. National Population Commission (NPC) [Nigeria] and ICF. 2019. *Nigeria Demographic and Health Survey 2018*. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF. https://www.dhsprogram.com/pubs/pdf/FR359/FR359.pdf

15. QSR International Pty Ltd. NVivo 12 (released in March 2020). https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

16. Hsieh, H. F. and S. E. Shannon. 2005. "Three approaches to qualitative content analysis," *Qualitative Health Research* 15(9): 1277–1288. doi:10.1177/1049732305276687

17. Glaser, B. G. and A. L. Strauss. 2009. *The Discovery of Grounded Theory: Strategies for qualitative research*. New Brunswick, NJ: Transaction Publishers. https://books.google.com.ng/books?id=rtiNK68Xt08C&source=gbs_book_other_versions

18. Patton, M. Q. 2002. *Qualitative Research & Evaluation Methods*. Thousand Oaks, CA: SAGE Publications Inc.

19. Ekpo, H. E. and N. O. Atulomah. 2021. "Strengthening capacities of Ward Development Committees to promote health in Nigeria: A case study of Osun state," *Texila International Journal of Public Health* 9(3). doi: 10.21522/TIJPH.2013.09.03.Art0013

20. Ntoimo, L. F. C. et al. 2021. "Building community ownership of maternal and child health interventions in rural Nigeria: A community-based participatory approach," *African Journal of Reproductive Health* 25(3). doi: 10.29063/ajrh2021/v25i3s.5

Annex 1

STATE	LGA	WARD	APPROPRIATE COMPOSITION OF MEMBERS	35% FEMALE REPRESENTATION	APPROPRIATE LEADERSHIP SETUP	CHARP ACTIVITIES IMPLEMENTATION	USE OF COMMUNITY INFORMATION BOARD (CIB)	MONTHLY REVIEW MEETING	COMMUNITY ENGAGEMENT AND PARTICIPATION	TRANSPORT ARRANGEMENTS ANC AND FACILITY DELIVERY	HEALTH FACILITY SUPPORT	RESOURCE MOBILIZATION	TOTAL SCORE
Bauchi	Bauchi	Dankade	2	2	2	2	2	2	2	2	2	2	20
	Ningi	Ningi East	2	2	2	2	2	2	2	2	2	2	20
	Kirfi	Badara	2	2	2	1	0	1	0	1	0	2	11
		Kwagal	2	2	2	2	0	1	1	1	1	1	13
Sokoto	Wurno	Tunga	2	2	1	1	2	1	1	1	1	1	13
		Achida	2	2	2	2	2	2	2	2	2	1	19
	Kware	Durbawa	2	2	2	2	2	2	2	2	2	1	19
		Gandu	2	1	2	2	1	2	0	0	2	0	12

Key:

0 = not achieved
1= partially achieved
2= fully achieved

Population Council

4301 Connecticut Ave., NW | Suite 280
Washington, DC 20008
+1 202 237 9400
breakthroughactionandresearch.org