TECHNICAL REPORT

Qualitative Research on Breakthrough ACTION's Advocacy Core Group Model for Integrated Social Behavior Change Programming in Nigeria

MARCH 2023

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Cover photo: Focus group discussion with women.
Credit: Adetayo Adetunji

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Acronyms

ACG	Advocacy Core Group
ANC	Antenatal care
CC	Community conversation
FGD	Focus group discussion
GBV	Gender-based violence
HC3	Health Communication Capacity Collaborative
IDI	In-depth interview
LGA	Local government area
MNCH+N	Maternal, newborn, and child health plus nutrition
NHREC	National Health Research Ethics Committee
NURHI	Nigerian Urban Reproductive Health Initiative
RMNCH	Reproductive, maternal, newborn, and child health
RMNCH+N	Reproductive, maternal, newborn, and child health plus nutrition
SBC	Social and behavior change
SNA	Social network analysis
SNE	Social norms exploration
USAID	United States Agency for International Development

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Executive Summary

This report describes the results of a qualitative assessment conducted by Breakthrough RESEARCH/Nigeria of the Advocacy Core Group (ACG) model implemented by Breakthrough ACTION/Nigeria. The overall research goal of the study was to examine, through qualitative inquiry, the operation and potential effectiveness of the ACG model, which works through key opinion leaders and influencers to influence community-level health norms and individual behaviors, focusing specifically on the uptake of essential reproductive, maternal, newborn, and child health services. Results are intended to inform Breakthrough ACTION/Nigeria's program implementation, as well as to contribute toward the broader social and behavior change (SBC) implementation science literature surrounding the roles, effectiveness, successes, and challenges of leveraging religious and traditional leaders and social structures to improve social normative environments for health. The work further addresses issues surrounding the ACG model within the context of integrated SBC programming.

As this study utilizes a qualitative approach, the data reflect an inquiry based on perceptions of implementers and program beneficiaries. The summary of results described in this report focus on one programmatic component of the Breakthrough ACTION/Nigeria integrated SBC program, namely, advocacy outreach to religious and traditional opinion leaders and community influencers to promote priority maternal, newborn, and child health plus nutrition (MNCH+N), malaria, birth spacing, and postpartum family planning behaviors, by influencing community level norms and individual ideations and behaviors that influence the uptake of health services and other positive health behaviors.

The research was undertaken in two phases to provide a comprehensive and additive approach to the qualitative evaluation. Researchers sought to examine the effectiveness, success, and challenges of the ACG approach, particularly in the context of integrated SBC programming across health areas, per the approved study protocol.

Methods

The qualitative research focused on the lived experiences of individual participants, described as naturalized phenomenology.[1] This report presents results from the two-phase data collection process in two states: Bauchi and Sokoto.

In Phase I, social norms exploration (SNE)[2,3] and reflexive thematic analysis of interview data[4] were utilized to find meaning in the data collected and to synthesize information to report insights. Data were collected using community conversations (CCs) and in-depth interviews (IDIs) as well as the 'My social network' tool, and the 'Five whys' tool as seen in Annex 1 (page 38). These tools were intended to help understand the activities of the ACG—which is a formalized structure of natural social groups—and probe for possible shifts in the social norms that influence key behaviors, as well as any shifts in other behavioral determinants across the priority health areas. The approaches allowed researchers to explore social norms in a way that reduces discomfort for participants in revealing personal or sensitive information. Four CCs were conducted per local government areas (LGAs), and the total number of all CCs conducted across both study states was 24. Out of this total, 12 CCs were conducted among members of the ACG (religious, women, traditional, and youth leaders); the remaining 12 CCs were conducted evenly among men and women but across different age categories. At least 8 IDIs were also conducted per LGA, and the total number of IDIs conducted across both states was 51. Out of this total, 14 IDIs were conducted among members of the ACG. The remaining 36 IDIs were conducted evenly among men and women across different age categories. Data collection occurred in three LGAs per study state. In Sokoto, these LGAs were Wammako, Dange Shuni, and Kware. In Bauchi, the LGAs were Bauchi, Ganjuwa, and Misau. The data for the phase I of this study were collected over two weeks from 17 to 28 May 2021.

In Phase II, the principal qualitative methods used were social network analysis (SNA) and IDIs. The objective of SNA, critical for answering the research objectives, is to

examine social structures using networks and graph theory (analysis of graphs to examine connections between networks). SNA defines the networked systems of individuals and was adopted in this study to understand information flows and possible facilitators and barriers for normative behavior change. Phase II data collection also consisted of IDIs with 15 ACG members and 36 ACG beneficiaries. Data were collected in three LGAs in Bauchi and just one LGA in Sokoto due to security reasons. The data were collected over two weeks, from 15 to 26 November 2021. Fieldwork was implemented simultaneously in the two study states with the aid of eight trained field assistants, research officers, and research analysts coordinating the study.

Nvivo software was used for the management of data throughout the analysis process. The study received ethical approvals from the Institutional Review Board of Tulane University, the National Health Research Ethics Committee (Nigeria), and the Sokoto and Bauchi State Ethical Review Boards.

Findings

Study objectives

The synthesized Phase I and Phase II findings are presented below in relation to the two research objectives for the study defined at the protocol stage:

- ***Objective #1***: Assess the context in which the integrated SBC ACG model is operating in the early period of Breakthrough ACTION/Nigeria programming (social networks, information flows) and the potential facilitators and barriers to normative, ideational, and behavior change.
- ***Objective #2***: Investigate how implementation of the integrated ACG approach is changing/influencing prioritized social and gender norms identified by Breakthrough ACTION: 1) unequal agency on health decision-making, 2) acceptance of early marriage/childbearing, 3) traditional nutritional practices and restrictions, and 4) belief in traditional remedies for MNCH problems) and the adoption and practice of select behaviors.[a]

[a]At the time of data collection four norms were provided by Breakthrough ACTION but a revised list of priority norms was provided by Breakthrough ACTION in July 2022, this is included below with information available from the dataset.

Objective #1: Assess the context in which the integrated SBC ACG model is operating in the early period of Breakthrough ACTION/Nigeria programming (social networks, information flows) and the potential facilitators and barriers to normative, ideational and behavior change.

The study aimed to explore how the ACG model, as an integrated SBC platform and integral part of Breakthrough ACTION/Nigeria programming, has been functioning, along with its successes and challenges. Qualitative analysis in both phases explored the lived experiences of participants, shared through interviews, social network analysis, and CCs.

Operationally, the ACG model appears to be working as intended per the experiences of individuals both providing and receiving programming. The ACG roles and responsibilities as described by ACG members themselves align closely with those set out by Breakthrough ACTION/Nigeria. These include: 1) functioning as advocates, 2) engaging with stakeholders around the priority health areas, 3) promoting the benefits of childbirth spacing, and 4) supporting the establishment of strong linkages between communities and health facilities. Selection of ACG members is tied to having experience leading existing community groups and associations. This experience was critical for the functioning of the ACG model.

The study noted ACG model successes in the following areas:

1. ***Engagement with the community***: ACG members reported directly engaging community members through various means, including community religious events and ceremonies, household visits, and community dialogues. They also mentioned referring community members to health facilities for services. Interactions with community members using community platforms and face-to-face meetings facilitate messaging on the project's priority health behaviors and create demand in communities for MNCH+N, malaria, and child spacing services. Well-attended and culturally relevant community platforms are routinely used for advocacy and sharing of health promotion messages, allowing for the model to work through the expected channels (e.g., town hall meetings, sermons, and social events such as naming and wedding ceremonies).
2. ***Performance***: ACG members reported perceptions of positively influencing community members on all practices related to the priority health behaviors

(e.g., family planning, antenatal care (ANC), immunization), including demand creation for MCHN+N and childbirth spacing services. This perception was linked most closely to perceptions of reductions in home births, increase in adoption of child spacing methods, and improvements in care-seeking for childhood illnesses.

3. ***Linkages with the healthcare community***: The model appears to have succeeded in facilitating linkages between ACG members and health care workers for example, by advocating for needed improvements in health facilities. This, in turn, has helped to build demand for critical health services and advocacy for quality improvement.

4. ***Reach***: ACG structures involving religious leaders were described as having a wider reach relative to other traditional and community leaders. Religious leaders regularly use sermons infused with health messages and capitalize on their more elevated status in the social ecology to achieve broad support for messaging. Other ACG members have worked through narrower population sub-groups, facilitating linkages with community associations such as those for youth, women, and other community groups. The perception is that religious leaders who are ACG members may have a broader impact because they are able to work across all population groups.

Objective #2: Investigate how implementation of the integrated ACG approach is changing/influencing prioritized social and gender norms identified by Breakthrough ACTION/Nigeria: 1) unequal agency on health decision-making, 2) acceptance of early marriage/childbearing, 3) traditional nutritional practices and restrictions, and 4) belief in traditional remedies for MNCH problems) and the adoption and practice of select behaviors.[b]

The social norms exploration component of the study, which was intended to look for potential shifts in social norms influencing key behaviors that might be attributable to the ACGs, yielded important findings related to the gender norms that Breakthrough ACTION/Nigeria has prioritized in their SBC programming, including those noted below. However, due to the qualitative nature of the study, it was not possible to directly demonstrate measurable changes in norms.

1. ***Limited mobility and social interactions for women***: Traditionally, women require permission from husbands or male guardians to seek health care, both for themselves and for their children, except in cases of emergency. However, there is data indicating that this attitude is shifting. ACG members perceived that husbands/male guardians are increasingly likely to grant "advanced permission" for women to seek necessary healthcare. ACG beneficiaries reported the same. However, this does not appear to be a true shift in norms, rather a change to the timing of granting permission.

2. ***Unequal agency in health decision-making***: Traditionally, husbands are the ultimate decision makers for many health behaviors. There is the perception that it is a wife's responsibility to convince her husband of the need for health services, perhaps through enlisting the support of mothers-in-law, religious leaders, and traditional leaders. For this latter role, ACGs appear to be fulfilling their responsibilities by actively discussing and encouraging shared decision-making on health matters. This has led to perceptions of shifts toward more shared decision-making, particularly with respect to ANC and facility-based deliveries.

3. ***Acceptance of early marriage/childbearing***: Total fertility among women in these areas remains high, and they are traditionally expected to allow as many pregnancies as their husbands/in-laws deem appropriate. As with decisions about using health services, husbands are the principal decision makers around birth spacing, which was considered by some participants to be against religious tenets, even though this latter norm might not be formally endorsed by religious leaders. The data collection did not result in any information on changes to norms around early marriage. By enlisting religious leaders into their model, the ACG approach is working to shift norms promoting greater acceptance of reproductive health services, including ANC, facility deliveries, and family planning.

4. ***Tolerance for gender-based violence (GBV)***: GBV toward women has been historically tolerated as a correctional measure and a consequence of 'disrespect' for male authority. Disrespect is perceived as a wife's stubbornness or refusal to accept a husband's viewpoint and decisions, including about healthcare.

[b]At the time of data collection four norms were provided by Breakthrough ACTION, but a revised list of priority norms was provided by Breakthrough ACTION in July 2022, this is included with information available from the dataset.

It is also perceived that there is a religious rationale for GBV in cases of disobedience, and subjective norms tolerating GBV are entrenched within social groups. GBV is socially tolerated more among young men/those who had early marriage as compared with older couples. Community norms related to GBV appear to be shifting due to modernization and progressive beliefs. An example of this was assertion of ACG beneficiaries that incidents of GBV has reduced owing to increased education among community members. ACG members received training on creating awareness and understanding to reduce it.

5. ***Traditional nutritional practices and restrictions***: Women have not historically been encouraged to breastfeed a newborn immediately after delivery, and adverse social norms hold great weight, adding difficulties to the work of the ACGs. Infants are often given holy water and denied first breast milk under the belief that colostrum, because of being perceived as dirty or polluted, has no benefit. Exclusive breastfeeding is far from the norm as many people believe that breast milk is not sufficient for children's energy needs and growth. ACG members note that they encourage exclusive breastfeeding for the first six months of life, although the exact definition of "exclusive" used by ACG members is sometimes unclear. ACG members also encouraged community members to seek health care workers' opinions for complementary feeding after six months of exclusive breastfeeding, but traditional nutritional practices and restrictions are slow to change.

6. ***Belief in traditional practices for MNCH issues***: Receiving treatment at home with traditional remedies, or using medicines acquired outside of health facilities, is perceived to save money for the family and show that a woman is strong. Health care workers in facilities are often not kind and regularly mistreat patients. For women who are healthy and robust, ANC is not seen as compulsory. Women who have an illness or have had a previous complicated pregnancy are more likely to seek care. Immunizations are not perceived as important for infants' health, nor are they considered compulsory. Side effects are believed to make immunization dangerous. ACG members have been encouraging and facilitating the utilization of health services for MNCH issues, but these norms are slow to change.

The synthesis of Phase I and Phase II data centered on the learning question: What are the promises and pitfalls of integrated SBC messaging within the ACG model, and what is the potential for impact?

Work across both phases of the study highlighted important facets of the program that encourage success, as well pitfalls that may constrain overall effectiveness.

What are the promises and pitfalls of integrated SBC messaging within the ACG model, and what is the potential for impact?

Promising areas

Skill-building in community engagement and community liaison: ACG members described receiving supportive training from Breakthrough ACTION on how to mobilize communities, which is beneficial even beyond their roles as health advocates. They further reported that the formalized structure of the ACG program provides a good entry to communities and serves as an important conduit by which district heads can reach those communities, again providing useful community support beyond health.

Combination of mid- and mass media: ACG members noted that their work has been bolstered by radio broadcasters transmitting similar SBC messages, lending credibility and support to their own work, reinforcing health messaging, and reaching broader audiences. This complementarity between the ACG model and mass media SBC, a central component of the Breakthrough ACTION/Nigeria approach, may warrant further exploration and could serve as a promising avenue for future SBC programming and expansion.

ACG model setup: The structure of the ACG model, based on close liaison and social support from government leaders at all levels to mobilize and reach communities of interest, provides a source of intrinsic motivation to ACG members, despite the lack of financial remuneration. Members feel empowered to do their work given the strong social connections and support for advocacy. As a result, ACG members find the work inherently rewarding, a fact that speaks to the overall operability and potential sustainability of the model.

Reach of ACGs: The potential of ACGs to influence health appears strong yet can vary by geography and health topic. Analyses of information flows in Sokoto show that respondents were influenced by religious or traditional leaders for ANC, immunizations, and child spacing, with traditional leaders appearing to be more influential than

religious leaders. This would appear to indicate that ACGs in Sokoto could continue to serve as an important source of information and motivation (and perhaps an enhanced role) to improve the health of community members.

In Bauchi though, the potential influence of ACGs appears somewhat smaller, and may be overshadowed by the influence of spouses and family (however, the qualitative sampling was not based on probability and thus is not statistically validated). Across health topics, traditional leaders were cited as influencers by few respondents. No respondents cited religious leaders as influencers on the treatment of child illnesses and few respondents cited religious leaders as influencers for child nutrition, ANC, and immunizations. The health area for which they were most frequently cited as influencers was child spacing, yet even there they were deemed far less influential than spouses (the majority) and family members. Other models, or tweaks to the existing ACG model, may be required to improve effectiveness. (NB: data collected within this qualitative study were not based on probability sampling and therefore are not broadly generalizable).

Pitfalls

Talk may be cheap: Some ACG members expressed concern that they were not able to offer tangible benefits to the communities they reach. Members felt their advocacy efforts could be strengthened if they could offer incentives. The nature of the incentives was not discussed but may be worth future consideration.

Broad reach versus intensive reach: Some ACG members speculated that face-to-face and in-person events such as sermons and community meetings might be less effective or efficient than mass media radio broadcasts simply because radio can reach more people. Reinforcing ACG members' sense of self-efficacy in achieving lasting behavior change could further empower them and contribute to sustainability.

Potential for impact

Influence of traditional and religious leaders: Traditional and religious leaders are revered and influential in their communities, as well as being efficient community organizers, and therefore are likely to have strong potential for impact in their role as ACG members. This impact is seen as being enhanced by ongoing efforts to work with youth leaders.

Mode: ACG members felt that the community-based approach fostered their ability to discuss/disseminate the priority behaviors with the populations of interest in a short amount of time, making the ACG approach both feasible and acceptable to communities. ACG members also noted that this approach allowed them frequent contact with community members (1–2x/week) and repeated dissemination of key behavior messaging, further enhancing their potential for impact.

Innovation: The close relationship between ACG members and other community members allows for a two-way communication, which enables ACG members to hear and respond to the concerns of the latter group. This has led to some unique innovations fostering creative feedback and communication. Religious leaders in one community created a WhatsApp group to share their ACG-related activities with other ACG members, allowing the latter group to keep abreast of their peers' activities and to refine their own.

Health gains: ACG members and beneficiaries noted increased health knowledge and increased use of health facilities in the communities where the ACGs are working. There were perceptions of reductions in home births and child illnesses and greater long-term impacts on perinatal health. Cross-referencing these perceptions with quantitative data on health service utilization is warranted.

Conclusion and recommendations

Data from this study indicate that among many key health areas—including child spacing, MNCH+N, and malaria—there has been increased awareness of health issues because of the ACG activities. Some areas appear slower to change, such as immunization, GBV, and nutrition, potentially a result of entrenched social norms. Both ACG members and beneficiaries of the program expressed a positive regard for the work and a perceived resultant improvement in health and behavior in line with the aims of the program. Challenges or pitfalls were described mainly in relation to the lack of tangible benefits that ACG members could provide to communities, as well as the perception that media may be more effective than person-to-person communication. Based on the findings from both phases of this qualitative enquiry, the following programmatic implications and recommendations are noted:

1. Continue to support the ACG members in the same way as before but with additional resources—who are well-respected in their communities and have wide reach and easy access to their community members—in their roles as reliable sources of information on key health areas, although perhaps with some tweaks to the model such as promoting further involvement of ACG in complementary media campaigns and providing greater supportive supervision.
2. Increase the reach and effectiveness of the ACG model through mass media and other channels, which provide important reinforcement for and enhance the credibility of messages delivered by the ACG.
3. Strengthen the ability of ACG members to advocate for beneficiaries in matters of health service quality improvement.
4. Examine other mechanisms of motivating ACG members. While ACG members reported feeling intrinsic motivation from directly benefiting their communities and from the broad support or recognition they receive from government and local leaders, such intangible benefits may only go so far. It warrants exploration of supportive structures to maintain this high level of motivation and pro-social commitment.
5. Provide additional support in the form of incentives or linkages with complementary programs to ACG members for addressing entrenched norms that appear slower to change such as on immunization, GBV, and nutrition. Because of their influence and access to communities, ACG members are well-positioned to affect normative and behavioral change.
6. Proactively address potential issues of sustainability, such as lack of financial support to ACG members and the perception that they do not have tangible incentives to offer program beneficiaries. This could be achieved by preparing local governance structures to support ACG members to continue their work through sensitization and providing evidence of benefit.
7. Compare perceptions of increased service utilization with quantitative data on health service utilization in areas where the ACG model is active (as well as in control areas where the ACG model does not operate). This may provide additional empirical support for the effectiveness of the ACG model.

Background

In northern Nigeria, traditional and religious leaders are highly influential in all aspects of peoples' lives.[1] This influence can even extend to health-related issues particularly ones related to reproductive health and fertility, issues that are often assumed to be "up to God."[6] It would therefore seem logical for health programs in this region to enlist the assistance of these influential leaders to work to promote better health among their populations. This study sought to provide more information on the effectiveness of working through traditional and religious leaders to shift norms and behaviors related to better health.

Studies in Nigeria and other West African countries have identified a possible role for religious leaders in improving health, although the focus has principally been in family planning. A recent study by Adedini and colleagues, for example, assessed the association of exposure to religious leaders' tailored scriptural family planning messages with contraceptive use in Nigeria through cross-sectional survey data from 2015 in four Nigerian states—Federal Capital Territory, Kaduna, Kwara, and Oyo. The authors noted that about 40% of women of reproductive age had been exposed to family planning messages from religious leaders in the past year.[7] Multivariate analysis revealed significantly higher contraceptive uptake among women who had exposure to family planning messages from religious leaders relative to those with no exposure, although the study could not identify whether the relationship was causal or simply that women who heard such messages were different in ways that influenced their contraceptive use.[7]

Similar studies have also identified a link between exposure to religious leaders' family planning messages and increased uptake of contraception, although in the case of Speizer et al. (2018), the authors are quick to note that they "cannot show causal relationships between program activities [involving religious leaders] and the outcomes of interest."[8] Other recent studies have utilized religious and traditional leaders to address sexual and reproductive health services in Zambia,[9] female genital mutilation,[10] and support for HIV prevention and care for men who have sex with men in Kenya,[11] as well as male circumcision.[12] Community- based qualitative work around emergency transport for obstetric emergencies in Nigeria has also indicated that religious leaders were perceived as a key group to be involved in demand creation.[13]

Religious leaders have also been shown to be influential on the healthcare supply side. A recent study by Walker et al. used a matched subject study design to compare health care providers' performance in health facilities where conservative Muslim opinion leaders were utilized as champions and health communicators to train health providers on correct religious precepts related to maternal, newborn, and child health (MNCH).[14] The authors found a significant difference both in perceptions and in practices with respect to MNCH uptake between health care providers in intervention and control facilities.

Breakthrough ACTION/Nigeria

In northwestern Nigeria, the USAID-funded Breakthrough ACTION project has been working with religious and community leaders using an approach known as the Advocacy Core Group (ACG) model. Breakthrough ACTION/Nigeria is the follow-on project to the Johns Hopkins Center for Communications Programs Health Communication Capacity Collaborative (HC3) project (2014 to 2018).[15] Operating in three northern states (Bauchi, Sokoto and Kebbi), HC3 sought population health improvements through three principal mechanisms: 1) advocacy outreach to opinion leaders and community influencers at state and LGA levels; 2) direct engagement of community members through community dialogues and group meetings that included referrals for services; and 3) complementary social and behavior change (SBC) messaging through mass and mid-media.

While HC3 worked to influence religious and community leaders, Breakthrough ACTION/Nigeria extends the approach by enlisting those leaders to share positive health messages among their constituents in what is known as the ACG model. ACG activities encompass work under the overarching concept of *'adalci'* which is a Nigerian term for Islamic guidance on family and community principles, and programming focuses on addressing the gender norms described in this report. The goal of adalci is to provide a level playing field and is rooted in Islamic teachings that guide family and community life.

Using the lens of adalci, Breakthrough ACTION/Nigeria is implementing interventions with the deliberate inclusion of women, particularly female religious leaders, to disseminate information in the community and bring the needs of women to the forefront. ACG members undertake several roles and responsibilities (listed in Table 1) through advocacy, facilitation, engagement with communities, and general support.

To assess the operation and potential effectiveness of the ACG model in influencing community-level norms and individual behaviors, this study uses a qualitative approach based on the perceptions of implementers and program beneficiaries. The study had two distinct phases. The objective for the first phase of research was to explore how the ACG model, as an integrated SBC platform, is working. Specifically, the research sought to assess existing social networks and health information flows by health area with the objective of identifying facilitators and potential barriers to normative, ideational, and behavior change in the context of the application of the ACG model. Due to the COVID-19 pandemic, data collection for Phase I of this study was delayed. At the time of data collection in 2021, the ACG approach had already been implemented in the study areas, so findings from the first phase reflect a context influenced by the pandemic, security concerns, and prior experience by participants with the model. It is possible that early implementation of the approach might have impacted baseline norms and behaviors, but we are unable to account for this possibility and, as this is a qualitative study, it is not intended to specifically quantify changes in norms and behaviors rather it provides insight into the lived experiences and reported perceptions, understandings, and beliefs of those who participate. The results of the first phase also informed the development of research and tools for the second phase of inquiry, which assessed how implementation of the ACG model has shifted Breakthrough ACTION/Nigeria's prioritized gender and social norms, ideations, and potentially impacted the practice of priority behaviors across targeted health behaviors. The second phase built on the work of the first phase to add social network analysis (SNA) and additional data from in-depth interviews (IDIs) to allow Phase II analysis and synthesis of the larger body of data for answering the two research objectives and to provide the broader picture of potential for effectiveness as well as the promises and pitfalls of the ACG model.

TABLE 1 RESPONSIBILITIES OF SBC-ACG MEMBERS

AT ALL LEVELS
Address barriers, wrongful beliefs, and misconceptions on reproductive, maternal, newborn, and child health plus nutrition (RMNCH+N) interventions.
Support demand creation for MNCH interventions, including childbirth spacing.
Engage with community, traditional, key opinion, and influential leaders in the local government areas (LGAs) and communities.
Facilitate discussions aimed at reducing barriers and increasing access to RMNCH+N interventions.
Support efforts to ensure the messages used for demand creation are culturally appropriate and acceptable.
Facilitate dissemination of correct information on RMNCH+N interventions, including childbirth spacing through mass media.
Support efforts to ensure special groups including women, youth, married adolescents, disabled people, internally displaced persons, and refugees have access to correct information on RMNCH+N interventions.
Advocate for resources and support to governments, communities, non-governmental organizations, relevant institutions, and other stakeholders.
Advocate with government and implementing partners on establishment and provision of accessible and quality RMNCH+N services.
Contribute to development and implementation of RMNCH+N and childbirth spacing programs in the states.
Perform other tasks as deemed necessary by the chair/co-chair.
STATE LEVEL
Serve as a critical mass of faith leaders and other stakeholders who are advocates of RMNCH+N at the state level.
Disseminate accurate religious and cultural perspectives on RMNCH+N interventions on mass media, during community activities and at formal state or national functions (meetings, seminars, conferences, etc.).
Promote the benefits of childbirth spacing for the health of mothers, newborns, families, and communities.
Advise on religious and other concerns hindering utilization of RMNCH+N at state and LGA levels.
Engage with stakeholders at state and LGA level to increase awareness and support, and mobilize resources for RMNCH+N interventions.
LGA LEVEL
Serve as a critical mass of faith leaders and other stakeholders who are RMNCH+N advocates at LGA level.
Engage with stakeholders at LGA level to positively change harmful social norms, beliefs, and practices, increase awareness, support, and demand for RMNCH+N interventions in the LGA.
Promote the benefits of childbirth spacing for the health of mothers, newborns, families, and communities.
Support establishment of strong linkages between communities and health facilities to increase utilization of life saving RMNCH+N services.

Methodology

Study design

The study was qualitative in design and was conducted in Bauchi and Sokoto states of Nigeria. Preparation of the study design, protocol, tools, and approach were discussed and agreed upon with Breakthrough ACTION/Nigeria partners through exchanges of materials and meetings. The qualitative methods in Phase I included IDIs and community conversations (CCs) that were designed using the social norms exploration (SNE) methodology.[2] The SNE helped to better understand facilitators and barriers of behavior change in the context of the ACG model and the effectiveness of Breakthrough ACTION/Nigeria integrated messaging through the ACG model. CCs focused on identifying key influencers/decision makers for healthcare decision-making within households and communities, social norms that shape gender roles, and behaviors of interest within families/communities. 'My social networks' tool was used to identify reference groups for community members while the 'Five whys' tool was used to elicit information on reasons for behaviors of interest. These tools ('My social networks' and 'Five whys') are guides adapted from the SNE methodology as designed by the Institute for Reproductive Health at Georgetown University.[2]

Study tools on CCs and IDIs were designed in the form of vignettes to ensure that participants feel more confident expressing their beliefs and expectations. Qualitative methods in Phase II included IDIs and SNA methodology, the practice of examining social structures using network theory and graph theory. Namely by defining networked systems in terms of their nodes and the connections, edges, or links that connect those nodes to one another.

SNE methodology

SNE is a participatory technique that has been used to identify social norms that influence target behaviors of interest within a given context, and the findings guide the design of the intervention and evaluation tools to monitor results.[2,3] According to the guidelines provided by the Institute for Reproductive Health at Georgetown University, there are five major steps when conducting SNE; which are planning, identification of reference groups, exploration of social norms, analysis of findings, and application of findings. The first four steps have been adapted for this study.

1. **Planning**: In the first phase, the research team reflected on possible social norms that may be influencing behaviors of interest. Subsequently, the aim of the SNE and the population groups were defined and exercises to be used in the fieldwork were prepared.
2. **Identification of reference groups**: As part of field exercises, IDIs particularly incorporated an exercise that allowed participants to identify their reference groups especially across the health areas of interest which were family planning, malaria, and MNCH+N.
3. **Exploration of social norms**: CCs with potential reference groups who were ACG members and community leaders and IDIs with possible beneficiaries used vignettes to garner factors influencing specific behaviors, unpack norms, and their relative influence.
4. **Analysis of findings**: the research team conducted a participatory rapid analysis to compare, contrast and identify norms to help shape the overall findings of the study. The exercise was conducted during the familiarization phase of the overall reflexive thematic analysis of the data.

SNA methodology

The SNA technique aids in the comprehension of social relationships, how they are structured, and how social interactions impact social learning and influence. Individual relationships are the focus of SNA, and the most widely studied relationships are friendship and kinship, communication, advice-giving, sexual ties, and, most importantly, acquaintanceship.[16] These relationships serve as channels for knowledge, social support, social pressure, and resources, among other things. One key finding in the study of health behaviors is that people rarely make decisions in isolation; instead, they are frequently impacted by the people who surround them, both directly and indirectly.[16,17]

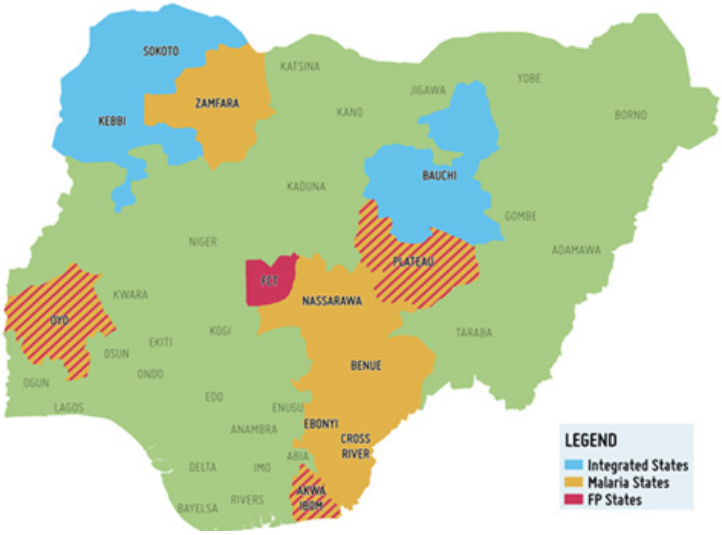
Qualitative network approaches, which have significant origins in the study of anthropology, are used to gain insights into how social relationships impact behavior. Furthermore, ethnographic network mapping is ideal to describe the constellation of decision makers, how people define themselves in relation to other decision

makers, lines of authority, and the nature and relationship of social network partners.[18,19] The methodological techniques on which network analysis was initially developed and continues to be employed in modern qualitative and mixed methods studies include unstructured ethnographic interviews, in-depth semi-structured interviews, and problem-centered interviews.[20–24] In addition to these techniques, a complementary method has been developed for improving ethnographic network interviews by constructing visual representations of the social network, or sociograms.[25] This is a participatory activity between the interviewer and participant that aims to facilitate a conversation about important social interactions, the manner and contexts in which network partners are linked, how social influence and support are felt, and perceptions of power and authority. To this end, this study adopted a qualitative social network analysis methodology that is based on the stated ethnographic and participatory techniques.

The data collection for the Phase II component of this study was adapted from the qualitative social network interviews reference guide developed by Shell-Duncan, Moreau, Smith, and Shakya (2019).[16] Subsequently, the SNA qualitative interviews were conducted with a set of "seed" informants also known in the SNA parlance as "egos". In this study, the ego is the male or female program beneficiary. Interviews were also conducted with at least one influential network partner named by the ego. Network partners are individuals who are tied or connected to the ego based on a form of relationship. For example, this could be a familial, friendship, or professional relationship.[26] In these interviews, the network partner, which also doubles as an influential network partner named by the program beneficiary, becomes the ego when the network is further explored. During the interview, general name generator questions are used to compile a "network partner" list. This list was then narrowed down to identify two categories of people:

1. **Decision makers for issues related to MNCH.** These are people who could make decisions for the ego regarding MNCH (e.g., the husband (a network partner) who makes decisions on whether his wife (the ego) should go to the health facility for delivery).
2. **Core influencers.** These are individuals who can influence the behavior of the ego. Unlike the first category of network partners, they are not decision makers.

FIGURE 1 BREAKTHROUGH ACTION/NIGERIA AREAS



Details of the interaction were used to determine whether the information involved the following types of social support: the exchange of information or advice, provision of direct care, offering or requesting material support, or offering emotional support. This information was then used to create a participatory network map. This was done through the modification of the Net-Map Interview Tool, which was developed and used for understanding the influence of social networks on strategic planning for community development.[27] Network maps were photographed, and later digitized and anonymized.

Study area

The Nigerian states of Bauchi and Sokoto were the research settings for the study. These states and LGAs were chosen in coordination with Breakthrough ACTION/Nigeria team members because they are implementation areas for their program and allowed for security precautions and access for the study team. See Tables 2 and 3 (pages 13 and 14) for detailed LGA locations and breakdown of data collection activities per study LGA.

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 km^2 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.[28] The fertility rate is estimated to be 7.0% among women of child-bearing age (15–49 years). In addition, for Bauchi state, the modern contraception

prevalence rate is 5.2%, and non-uptake of antenatal care (ANC) is 33.1%.[29]

Sokoto

Sokoto state is situated in the northwestern part of Nigeria and has 23 LGAs with a total land area of 25,973 km^2.[17] The National Population Commission projected population estimate for 2016 was 4,998,090 for Sokoto state and females constitute 49.9 % of the population.[28] The fertility rate is estimated to be 7.2 % among women of child-bearing age (15–49 years). In addition, for Bauchi state, the modern contraception prevalence rate is 2.1%, and the non-uptake of ANC is 53.1%.[29]

Study population

The population for this study was categorized into ACG members and beneficiaries/community members. ACG members included the following:

- Religious leaders including imam and pastors.
- Women leaders including women group leaders, Market women leaders/secretary.
- Youth leaders including leaders/presidents/secretary.
- Traditional leaders.

The community members were beneficiaries of the Breakthrough ACTION/Nigeria SBC-ACG intervention in the community. Community members were further subdivided into youth (16–24 years), younger men and women (25–35 years), older men and women (above 35 years).

Inclusion criteria

ACG members

1. Must be an active ACG member.
2. Live in the same community in which the ACG work takes place.
3. Must provide informed consent.

Beneficiaries/community members

1. Women aged 15 to 49 years who are currently pregnant or parent/caregiver of a child under 2 years.
2. Men aged 15 to 49 years who are currently parents/caregivers of a child under 2 years.
3. Has been a beneficiaryc of Breakthrough ACTION program.
4. Must provide informed consent.

Instruments Phase I

The instruments used for phase 1 of this study consisted of CC guide, IDI guide, and as part of the SNE process, the 'My social networks' tool, and the 'Five whys' tool[2] were included.

CC guide: CCs with key opinion leaders and influencers were facilitated with the CC guide. The guide used vignettes, or hypothetical stories related to the behaviors of interest for respondents to discuss and comment about. The vignettes allowed for less personalization and helped reduce concerns about stigma related to disclosing personal information in front of others. The vignettes were developed drawing from experiences within the study context and in consultation with field assistants and stakeholders to ensure that the stories reflect the behaviors of interest. The guide elicited information on perceptions and social norms related to the following: use of family planning, malaria prevention, and MNCH services; treatment for fever, diarrhea, cough, and other illness symptoms; child nutrition and breastfeeding; gender norms; and exposure to family planning/MNCH+N/malaria messaging and activities.

IDI guide: An IDI guide was used to conduct interviews with ACG beneficiaries including males and females of reproductive age as well as influencers such as parents-in-law, local leaders, and traditional and religious leaders on perceptions and social norms related to similar topics explored with the CCs.

"My social network" tool

This tool was developed to rapidly elicit information from beneficiaries/community members about information flows and reference groups.

"Five whys" tool

This tool was developed to elicit responses to the "why" questions regarding the behaviors of interest. It allows participants to pinpoint the root causes and motivations for negative norms and behaviors.

[c]Exposed to components of the program such as SBC messaging through the speak outs, sermons.

Instruments Phase II

Phase II also used different IDI guides to elicit information from program beneficiaries and ACG members. The guides are described below.

Program beneficiaries

The IDI guide for program beneficiaries was designed using the qualitative SNA methodology for data collection.[16] This comprised of the following:

- Name generator questions to identify individuals in an ego/ACG beneficiaries' network.
- Questions to identify decision makers and influencers in the network.
- Questions to develop network sociograms highlighting the type of support either received or provided to identified decision makers and influencers.
- Questions to understand the views of identified decision makers and influencers on maternal and child health.
- Questions to generate the network density grid.

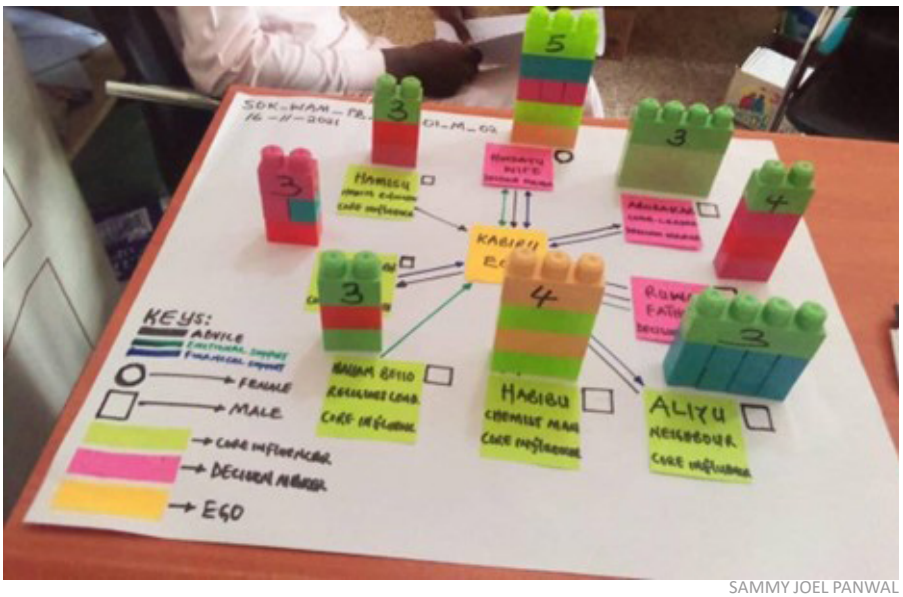
The data collection among program beneficiaries was participatory with participants helping to create their networks and establish the relationships they have with the individuals in their networks. As a result of this approach, other materials for data collection included cardboard papers, different colored post-it notes, markers, and LEGO® bricks to help measure the tower of influence of decision makers and core influencers.

- The first step of data collection involved collecting information on ego's networks. This was done through the completion of the Network Partner Generator Form which had network generator questions such as "Who are the people you feel closest to in your life?" These questions helped generate a list of potential network partners. network partners are individuals who are tied or connected to the ego/participant based on a form of relationship.
- Subsequently, decision makers and influencers on matters pertaining to MNCH are identified from the previously generated network partner list. This is done by asking direct questions such as "Who participates in important decisions related to the upbringing of children in your family?" and "who are the most influential people regarding caregiving of your children?".
- At this stage, network partners who are recurring as answers to questions on decision-making were marked as decision makers with "D" next to their names on the network partner list. Similarly, network partners who were recurring as answers to questions on influence were marked as core influencers with "CI" next to their names on the list.
- The list was subsequently reviewed together with the ego/participant and once the decision makers and core influencers are ascertained, the marked names are written individually on post-it notes.
- The sociogram was subsequently developed.
    - The post-it notes from the previous step were placed on a cardboard paper.
    - Links were drawn by asking about categories of support received from or given to each network partner a) advice, b) emotional support, and c) financial support. Colors indicated the general type of support with advice in black, emotional support in green, and financial support in blue. Arrows were drawn (reflecting the direction of advice or support) between actor cards according to interviewees' directions. Arrows could be one way, or bi-directional, depending on the descriptions of interviewees.
    - Shapes were drawn beside each alter with squares denoting females and circles denoting males. Additionally, post-it notes for decision makers had a different color compared to core influencers.
    - A tower of influence was created by asking how strongly each alter influences the interviewee. Influence ranging from 1 to 5 was explained to the interviewee. The interviewee was then asked to stack LEGO® bricks to represent the degree of influence, with higher towers representing greater influence.
    - Discussion then took place to explain the network map and make any needed adjustments.
- Specific questions were asked about the interviewees' perceptions of each network partner's views on MNCH.
- A network density grid was completed indicating which network partners know one another (in the view of the respondent).
- A demographic survey form was completed for each decision maker and core influencer.

An example of a sociogram developed during fieldwork is shown in Figure 2.

IDI guide: An IDI guide was used to conduct interviews with ACG members such as parents-in-law, local leaders, and traditional and religious leaders on pertinent topics such as their understanding of the SBC-ACG program including their roles and responsibilities as well as the leadership and coordination of the program. Others were perceived multi-level changes as a result of the program, support received from stakeholders and community partners, and the perceived effects of the program in the community.

FIGURE 2 A SOCIOGRAM SHOWING THE NETWORK OF A PROGRAM BENEFICIARY INCLUDING DECISION MAKERS AND CORE INFLUENCERS AS WELL AS LINES OF SUPPORT.



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Data collection

Phase I

Data collection activities for this study were conducted in three LGAs per study state. In Sokoto, these LGAs were Wammako, Dange Shuni, and Kware. In Bauchi, the LGAs were Bauchi, Ganjuwa, and Misau. The ACG intervention implementation area structure, as well as other factors such as distance from the state capital, and the local safety situation related to crime and security, led to the selection of these LGAs. The data were collected over two weeks (17–28 May 2021). Fieldwork was implemented simultaneously in the two study states with the aid of 12 trained field assistants, research officers, and research analysts coordinating the study.

Based on the defined inclusion criteria of the study, participants were purposively sampled and 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 dependent on the local security situation and COVID-19 risk mitigation plans for the study. Data collection started with the pilot of tools, and an average of three days was used for data collection activities per LGA. Duration of data collection activities daily spanned five hours with the team debriefing on the activities at the end of the day. The data collection activities were conducted in safe, conducive environments with consideration for ethical and cultural sensitivity. Four CCs were conducted per LGA, and the total number of all CCs conducted across both study states was 24. Out of this total, 12 CCs were conducted among ACG members (religious, women, traditional, and youth leaders); the remaining 12 CCs were conducted evenly among men and women but across different age categories. At least 8 IDIs were conducted per LGA, and the total number of IDIs conducted across both states was 51. Out of this total, 14 IDIs were conducted among

TABLE 2 BREAKDOWN OF DATA COLLECTION ACTIVITIES CONDUCTED AMONG RESEARCH PARTICIPANTS (ACG BENEFICIARIES AND ACG MEMBERS) PER STUDY LGA FOR PHASE I

STATES AND LGAS	CCS	IDIS
Sokoto		
Wammako	4	8
Dange Shuni	4	9
Kware	4	8
Bauchi		
Bauchi	4	9
Ganjuwa	4	8
Misau	4	9
Total	24	51

ACG members (religious, women, traditional, and youth leaders). The remaining 36 IDIs were conducted evenly among men and women but across different age categories. This brings the total number of data collection activities conducted to 74.

Phase II

Data collection activities for the phase II of this study were conducted in three LGAs in Bauchi and just one LGA in Sokoto due to the security situation in Sokoto, which had deteriorated between Phase I and Phase II. These LGAs were the same as those of Phase I which were Bauchi, Ganjuwa, and Misau LGAs in Bauchi state and Wammako LGA in Sokoto state. The data was collected over two weeks (15–26 November 2021). Fieldwork was implemented simultaneously in the two study states with the aid of eight trained field assistants, research officers, and research analysts coordinating the study. Similar to Phase I, participants were recruited purposively using the defined inclusion criteria of the study. LGA health educators who were familiar with the LGAs and the Breakthrough ACTION/Nigeria project, supported this recruitment. A total of 51 IDIs were conducted across the two study states. Thirty-six IDIs were conducted among program beneficiaries at 18 apiece for both states while 15 IDIs were conducted among ACG members such as religious, traditional, women, and youth leaders. A further breakdown of data collection activities per study state and LGA is shown in Table 3.

Data management and analysis

Across both phases, audio recordings were transferred daily from the audio recorders to a password-protected computer and properly labelled. Most of the data collection activities were conducted in Hausa and were transcribed and translated to English. The transcripts were reviewed for correctness and stored on password-protected computers. NVivo (released in March 2020)[5] software was used for the management of data throughout the analysis process. The data were analyzed using the reflexive thematic analysis steps as spelled out by Braun and Clarke.[4] Selected transcribed qualitative data underwent an initial review by six researchers to ensure initial familiarization with the data. This process culminated in a week-long coding workshop for the research team including qualitative coders at each phase of analysis. The workshop also allowed for participatory analysis of behaviors of interests and networks. Subsequently, immediate codes were noted and were used to develop the coding framework containing codes and descriptions. The coding framework was reviewed by the research team and discrepancies were addressed. Four researchers then coded the transcripts with the aid of the coding framework to ensure that codes were consistently applied. The resulting discrepancies were resolved through a consensus-building approach guided by the research objectives. Codes were subsequently organized into initial themes. The initial themes were reviewed and well defined after a consensus agreement to generate the final themes used for analysis.

TABLE 3 BREAKDOWN OF DATA COLLECTION ACTIVITIES PER STUDY LGA FOR PHASE II

STATES AND LGAS	IDIS AMONG ACG MEMBERS	IDIS AMONG BENEFICIARIES
Sokoto		
Wammako	8	18
Bauchi		
Bauchi	3	6
Ganjuwa	3	6
Misau	1	6
Total	15	36

Ethical considerations

The study received ethical approvals from the Institutional Review Board of Tulane University, the National Health Research Ethics Committee, and the Sokoto and Bauchi State Ethical Review Boards. Steps were taken to minimize risk for facility heads and other interviewees that participated in the study. Information provided by participants was treated with confidentiality by the study team. This was done by removing personal identifiers from study materials. During the informed consent process, the aims of the study and possible risks were thoroughly explained. Participants were assured of their rights and that their responses will not be shared with other parties in a way that identifies them.

Findings

Participants' demographics

Phase I

The demographic profiles of research participants in Bauchi and Sokoto states are presented below in Table 4. A total of 51 IDIs were conducted including 26 in Bauchi State and 25 in Sokoto State. We also conducted a series of CCs that included 162 people in total, or 86 in Bauchi State and 76 in Sokoto State respectively. Across these interviews and conversations, most participants were married (48/51 IDIs and 135/162 CCs), practiced Islam (48/51 IDIs and 161/162 CCs) and were Hausa (21/51 IDIs and 101/162 CCs), which is consistent with the predominant religion and ethnicity in this area. More than half of participants were male (28/51 IDIs and 97/162 CCs) and were 35 years old or younger (30/51 IDIs and 86/162 CCs). Nearly all participants had attended some formal education level with many attending at least tertiary education (25/51 IDIs and 84/162 CCs), whereas most participants in the BSS baseline survey had attended Islamic or other informal education only.

Phase II

The demographic profiles of research participants for the phase II of the study are presented in Tables 5 and 6 (page 15). A total of 51 IDIs were conducted including 26 in Sokoto State and 25 in Bauchi State. Additionally, 36 IDIs were conducted among ACG beneficiaries with the remaining 15 IDIs conducted among ACG members. Across these interviews, more than half of the participants were males (30/51 IDIs) and most were aged 25 years and above (39/51 IDIs). All program beneficiaries were married, more than half were Hausa (21/38 IDIs) and had children aged 13–24 months (19/34 IDIs). Just under half of the participants had at least two children (16/38 IDIs). More than half of the program beneficiaries had lived in the community for at least 21 years (21/36 IDIs). Majority of ACG members had tertiary education (11/15 IDIs) and almost half were religious leaders (7/15 IDIs).

TABLE 4 DEMOGRAPHIC CHARACTERISTICS OF RESEARCH PARTICIPANTS (PROGRAM BENEFICIARIES AND ACG MEMBERS)

DEMOGRAPHICS	IDIS (N=51)		CCS (N=24)	
	BAUCHI (N=26)	SOKOTO (N=25)	BAUCHI (N=86)	SOKOTO (N=76)
Sex				
Male	14	14	52	45
Female	12	11	34	31
Age				
16–19	3	—	—	—
20–24	6	6	14	6
25–35	6	9	26	40
>35	10	10	46	30
Marital status				
Single	1	2	13	13
Married	25	23	72	63
Divorced	—	—	1	—
Education				
None	—	1	—	5
Primary	2	1	11	3
Secondary	6	6	19	38
Tertiary	18	17	54	30
Religion				
Islam	23	25	85	76
Christianity	3	—	1	—
Ethnic group				
Hausa	9	12	49	52
Hausa Fulani	1	9	6	17
Fulani	7	4	19	7
Others*	9	—	12	—

*Others: Yoruba/Kanuri=1, Barebari=1, Jere=1, Geji=2, Denawa=1, Tarok=1, Igala=1, Bolawa=1, Kanuri=3, Fulfulde=1, Bagenya=1, Bagudinya=2, Gaar=1, Jarawa=1, Karikari =1

TABLE 5 DEMOGRAPHIC CHARACTERISTICS OF PROGRAM BENEFICIARIES

DEMOGRAPHICS	BAUCHI (N=18)	SOKOTO (N=18)
Sex		
Male	9	9
Female	9	9
Age (in years)		
16–19	1	_
20–24	5	6
25–35	8	6
>35	4	6
Married status		
Married	18	18
Ethnic group		
Hausa	8	13
Hausa Fulani	4	4
Fulani	4	1
Others*	2*	—
Number of children		
1	3	4
2	9	7
3	4	1
≥4	2	6
Age of child (in months) **		
0–6	2	2
7–12	9	2
13–18	4	11
19–24	1	3
Duration lived in community (in years) **		
≤10	5	5
11–20	_	4
21–30	6	4
≥31	6	5

*Barebari=1, Jere=1, **Missing data for Bauchi

TABLE 6 DEMOGRAPHIC CHARACTERISTICS FOR ACG MEMBERS

DEMOGRAPHICS	BAUCHI (N=7)	SOKOTO (N=8)
Sex		
Male	6	6
Female	1	2
Age (in years)		
≤39	2	4
40–49	2	1
≥50	3	3
Education level		
Primary	1	—
Secondary	2	1
Tertiary	4	7
Leadership role in the community		
Religious	3	4
Traditional	2	2
Woman	1	1
Youth	1	1

Objective #1

Qualitatively assess the context in which the integrated SBC-ACG model is operating in the early period of Breakthrough ACTION/Nigeria programming (social networks, information flows) and the potential facilitators and barriers to normative, ideational and behavior change.

ACG Model

The findings on the activities of ACG members and community impact are presented in this section.

Perceived roles and responsibilities

The roles and responsibilities of ACG members were explored in comparison with the description provided in Breakthrough ACTION/Nigeria materials.

ACG members trained by Breakthrough ACTION project staff were asked to highlight their roles and responsibilities in their communities. Participants stated that they directly engaged community members through various means, including community religious events and ceremonies, household visits, and community dialogues; they

also mentioned referring community members to health facilities for services. When asked about their roles and responsibilities, ACG members reported their perceived roles and responsibilities primarily to include:

a. Trying to positively influence community members on practices related to the priority health behaviors.

> **"Yes, frankly, as a result of my participation in ACG, we have meetings with other youths to sensitize them on health issues because that is what we were being educated on during our ACG meetings. We ensure that we pass the message across to the youths.**
>
> **—Youth Leader, Bauchi**

b. Supporting demand creation for MNCH+N and family planning services.

> **"I have also helped change the patronage or dependence on traditional caregivers. I made them understand some of the dangers that come with receiving medical advice or substance from them without a doctor's prescription. Now, the majority of people are embracing safer practices of going to the hospital to get care.**
>
> **—Religious Leader, Bauchi**

Membership in ACG

Findings showed that ACG members comprised religious, traditional, youth, and women leaders who were active members of their respective communities. Participants described that inclusion in the ACG model was by election or appointment. Members for the ACG were chosen based on their experience leading existing community structures, religious groups, and associations.

> **"I was selected into the program when they came…**
>
> **—Community Leader, Sokoto**

> **"…the Breakthrough ACTION ACG officials did their selection by assessing different groups and the support they can provide to the program, they decided to involve me because the association is a target group and I am the youth leader, I can easily get the message across to my fellow youths.**
>
> **—Youth Leader, Bauchi**

Activities

As part of the ACG approach, the key influencers were expected to engage in activities such as using community platforms and face-to-face interactions to facilitate messaging on the project's priority health behaviors and create demand in the communities for MNCH+N, malaria, and child spacing services. Community platforms routinely used in advocacy and sharing health promotion messages include town hall meetings, sermons, and naming and wedding ceremonies. Additionally, participants reported the use of social and mass media platforms for awareness generation. ACG members worked with health care workers to create demand for health services among community members, and commented on the importance of accessible, quality health care as an important determinant of health.

There was a consensus among ACG members that they were trained by Breakthrough ACTION staff to expand their capacities on health areas selected for the program to positively influence community members from religious and cultural perspectives. However, none of them discussed how frequently they received training in the health areas or if they were re-trained periodically.

> **"…they go for house to house to inform people, to enlighten them to go to the hospital in terms of sickness and childbirth**
>
> **—Older woman, Bauchi**

> **"…actually, now almost every house you go to, you can never see the wives refusing to go for antenatal; the reason is there is a lot of emphasis on this issue on TV, Radio, and even face to face enlightenment going on, all in regards to the need for antenatal care.**
>
> **—Younger female, Bauchi**

> **"I go house-to-house and do such orientation, but not every house. The one that concerns me as a man, I do. The one that does not need me, we give a woman a chance to orientate the women…."**
>
> **—Youth leader, Sokoto**

> **"It was done in the mosques after the sermon, and then we had discussions while seated and it was also broadcasted via radio station…."**
>
> **—Older Male, Bauchi**

Reach of ACG members

ACG members reported that they had varying degrees of influence in their respective communities. ACG members were then asked to describe which types of community members they were most and least able to reach for sensitization. In all study locations, religious leaders had access to all categories of community members by using religious platforms to infuse health messages in their sermons. In other words, among the categories of ACG members, religious leaders may have had a wider reach than for example members of women's groups, who would not reach out to males. Categories of ACG members such as youth, women, and community leaders had a specific reach that was influenced by their constituencies and various community associations. Additional information on levels of influence is presented in Phase II findings utilizing SNA, please see Results of SNA for more details.

Objective #2

Investigate how implementation of the integrated ACG approach is changing/ influencing prioritized social and gender norms identified by Breakthrough ACTION: 1) unequal agency on health decision-making, 2) acceptance of early marriage/ childbearing, 3) traditional nutritional practices and restrictions, and 4) belief in traditional remedies for MNCH problems) and the adoption and practice of select behaviors.[d]

SNE

This section presents the findings of the SNE with community and ACG members, both of whom were asked to discuss a vignette presenting a young couple experiencing various situations related to health behaviors and social norms in the areas identified by Breakthrough ACTION/Nigeria as focal to the ACG programming.

Priority health behaviors

Participants, including ACG members and community members, shared views in reaction to the vignettes presented on health areas, including factors that drive behaviors, per health area. These are described below.

1. **Family planning**: Both ACG and community member beneficiaries responded to the vignette that using a child spacing approach is beneficial to both the mother and the child's health. Community participants noted that they had been exposed to information on the benefits of family planning by religious, opinion leaders, and mass media platforms and indicated the increased knowledge has generally resulted in a positive shift in perception and behavior. The findings also indicated that religious beliefs had an impact on contraceptive use. An example of this was the belief expressed by a few participants that child spacing is a ploy to stop birth and is against religious tenets. According to those participants, some religious leaders preach against it. However, ACG participants themselves, as well as community members who participated, endorsed a favorable perception and attitude toward child spacing. Some

[d]At the time of data collection four norms were provided by Breakthrough ACTION but a revised list of priority norms was provided by Breakthrough ACTION in July 2022, this is included with as much information as possible from the dataset.

key community influencers mentioned the benefits of obtaining family planning services. The 'My social networks tool' was used to identify the most important reference groups whose opinions matter in deciding whether a couple would prioritize using contraceptives. As highlighted in Figure 2, most participants in Sokoto state affirmed that opinions of the husband (as the head of the family) along with traditional and religious leaders were respected. In Bauchi (Figure 3), participants mentioned the wife (this was mentioned particularly by male respondents), husbands, and religious leaders as trusted sources of information.

2. **ANC:** When community and ACG members were asked if there were any community or social norms affecting women's desire and ability to attend ANC, both community and ACG members reported that in some cases community members would prefer herbs to health facilities. This is a norm that was considered prevalent in remote communities. This is presented in the excerpt below:

> **"On health, we face some challenges despite the sensitization, for example, our people in the interior villages, you have to always include them in the sensitization, the challenge is they don't always do as they are told. The people in the interior villages still don't agree on the importance of allowing pregnant women to go for ANC during pregnancy despite the sensitization. They don't prioritize visiting a health facility, they give their pregnant women herbs during a pregnancy instead of visiting a health facility, they only go to a health facility when there is a complication like excessive bleeding that can't be managed at home. That is a big challenge.**
>
> **—Older Woman, Bauchi**

When presented with a vignette about the benefits of attending ANC, both the community members and ACG members highlighted the importance of ANC attendance and potential risks associated with non-attendance. In addition, participants from both categories unanimously demonstrated a favorable attitude toward ANC, although very few discussed the importance of four or more ANC visits. Additionally, most participants, particularly ACG members, alluded to the fact that most pregnant women in their communities understood the benefits of ANC and would show a favorable attitude toward ANC visits, however they noted that women did not feel able to attend these visits without explicit permission.

Community members identified the reference groups in the communities whose opinions matter or the categories of people they would listen to on matters relating to ANC attendance. As shown in Figure 2, in Sokoto, husbands, traditional and religious leaders, and health care workers were identified while wives, husbands, and religious leaders were identified in Bauchi (see Figures 2 and 3).

3. **Immunization**: When presented with the vignette related to immunization, community members described it as normal to have some reluctance toward immunization, specifically regarding side effects. The reasons described for this related to concerns over perceived health side effects from immunization. Community members described that many women would not get their children vaccinated, while others would start but not complete the vaccination course. Examples of the normative reasons for these behaviors are stated below, indicating a continued norm that infants are not immunized:

   - Some parents are hesitant to immunize their infants because they believe the child will never be fertile if they do so.
   - Parents refuse to vaccinate their children because they believe vaccines will lead to side effects.

   Community members were asked about people whose opinions are important on whether they immunize their children. Community members in Sokoto mentioned husbands, traditional and religious leaders, and health care workers as trusted sources, while wives, husbands, and religious leaders were identified in Bauchi (see Figures 3 and 4, page 20).

4. **Exclusive breastfeeding and child nutrition**: In exploring perceptions and norms influencing exclusive breastfeeding through the vignette, ACG leaders and community members discussed normative beliefs and how they influence behaviors on breastfeeding. While exclusive breastfeeding was endorsed as an important practice by both community members and ACG leaders, it was not clear that

the exact definition of exclusive breastfeeding was being referenced or understood when carried out by community members (i.e., providing nothing but colostrum and breast milk to the infant, including no water, from birth onwards). The norm of not exclusively breastfeeding remains persistent.

Additionally, participant beneficiaries believed women should seek health care workers' opinions for complementary feeding after six months of exclusive breastfeeding. In addition, there was a shared or general understanding by both ACG members and community members that a child needs a balanced diet to stay healthy. In other words, most participant beneficiaries understood the benefits of quality nutrition. However, some barriers were uncovered. For example:

- Infants are given holy water from pilgrimage (*ruwan zamzam*) after delivery (Sokoto).
- Infants are denied the first breast milk with the assumption that the colostrum has no benefit. Participants also stated it is contaminated; they would rather give cow or goat milk (Bauchi and Sokoto).
- Exclusive breastfeeding is not accepted in some communities because they believe it is insufficient for the child's growth (Sokoto and Bauchi).
- In Sokoto, one normative belief that could negatively influence nutritional behavior was that children should not be fed with eggs, so they will not become thieves.

5. **Maternal nutrition**: Nutrition for women was another behavior of interest that was explored through a vignette presenting a scenario of a newly married couple and their health plans as a family including information on nutritional practices for the mother and the baby. Community member participants believed that pregnant and post-partum (lactating) women should strive for adequate nutrition for themselves and the infant, also emphasizing the importance of maternal nutrition for breastfeeding.

Health information flows

Figures 3 and 4 describe results from data collection on health information flows by health area based on data gathered in Phase I SNE.

FIGURE 3 INFLUENCERS IN MATERNAL AND CHILD HEALTH CARE IN SOKOTO

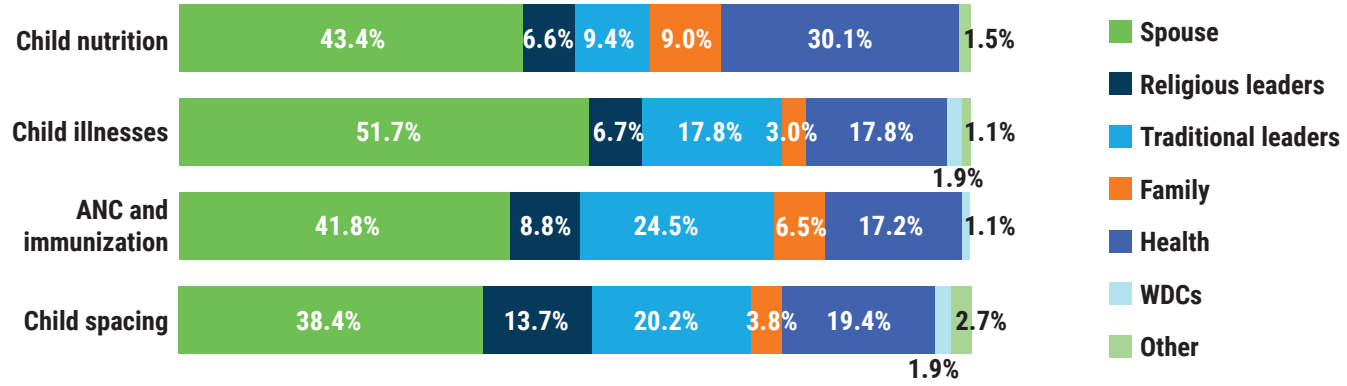
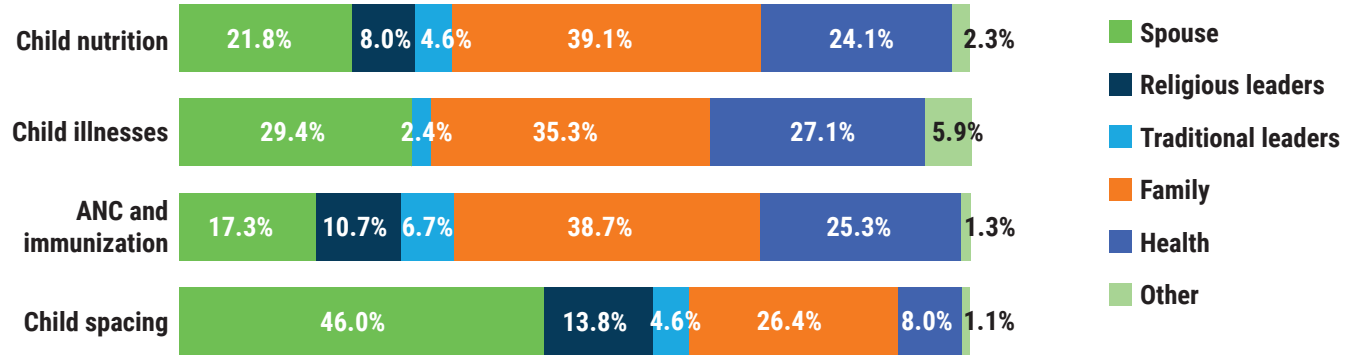


FIGURE 4 INFLUENCERS IN MATERNAL AND CHILD HEALTH CARE IN BAUCHI



Gender norms: Unequal decision-making

Findings in reaction to the vignettes about decision-making by both ACG and community members showed that women do not have the agency to make health decisions and independently take action to seek care in pregnancy, childbirth, childcare, and family planning. Both women and men (as community and ACG members) viewed men as the decision makers, and this was reflected in the perceptions about decision-making regarding health decisions in the household. Furthermore, women were required to seek permission from their husbands before making any health-related decisions for themselves or for children, reflecting unequal power relations. Some younger women community members also endorsed the idea that even if a woman has her own money to pay for health care, she must nonetheless seek her husband's approval for care. The need to obtain approval to seek healthcare likely results in negative impacts on healthcare access, as described by participants relating stories of people they recalled. The decision-making power of men was also described by community members in reaction to vignettes as being reinforced by culture, religion, and the dependence on men to meet the family's financial needs.

While reacting to the study's fictional story of Dongoyaro (the husband) refusing his wife Aisha's request to go for ANC visits, community member participants, particularly older and younger men rather than middle-aged men, disagreed with Dongoyaro's decision to not allow her to seek care. However, both men and women (and both ACG and community members) noted it was Aisha's responsibility to convince Dongoyaro of the need to visit the hospital for ANC. Furthermore, community participants and ACG members alike stated that she should do so in socially prescribed, gender-specific ways (affectionately and gently). Community and ACG members stated that she could seek the support of reference groups like mothers-in-law and religious and traditional leaders to convince her husband. Many ACG beneficiaries mentioned that health-seeking decisions should be made jointly by the man and the woman across all health areas. The implication is that husbands and mothers-in-law were significant determinants of health-seeking behavior for women on their health and that of their children.

> **"To me or in our tradition, a man is more than a woman in terms of opinion because until he says something, nothing can be done….**
>
> **—Youth Male, Sokoto**

However, it was considered acceptable by both ACG beneficiaries and ACG members for women to seek care in case of extremely urgent conditions (such as a sickle cell crisis) or during a life-or-death emergency such as where a woman may be bleeding uncontrollably in pregnancy/childbirth.

> **"What has to do with life, they don't wait, she just must take the child without any excuse. She just takes the child without any excuse. She doesn't need to wait for her husband.**
>
> **—Youth Leader, Bauchi**

Consequences and sanctions for making health decisions

The expectation to seek approval from husbands or husbands' relatives (if the husband was not present) was described by community members as an injunctive norm, and failure to act within this norm would result in sanctions. When participants were asked how the community would view such actions, community members mentioned individual and community rebuke, potential divorce, and spousal distrust. When the vignette described that the husband would beat his wife, participants from both ACG and community member groups did not individually condone the behavior, but they did state that some other people might condone such behavior (particularly the husband's family members).

> **"It happens, and I have witnessed it once. There was a case that a woman insisted on going for ANC against her husband's wish. When she went… at the point of delivery, there was a need for blood transfusion, but the husband refused to make any attempt to render any assistance until the woman later died.**
>
> **—Younger Female, Bauchi**

> **"…if Aisha insists on it is a must what she wants to do she must do it, she will have issues… her husband (can) divorce her, if she gets another husband, they will tell him once she is pregnant if you like it or not, she must go for antenatal, from there they will mock**

her, and people may not like her, and the community will hate her for it.

—Younger Male, Sokoto

Gender-based violence (GBV) norms

Participants were further asked to comment on Dongo-yaro hitting his wife Aisha as a result of her persisting in seeking access to ANC care. Participants appeared to explain violence as a correctional measure and consequence of 'disrespect' for the authority of the man on health decisions. This authority is grounded in the perception that men are the providers for the household.

> **"Finally, when all said and done, she caused it due to her refusal to use soothing words, if she does that, he won't beat her up with pregnancy; but if she disrespects him, he will beat her not minding the pregnancy. That is why speaking harshly even to your siblings is not good; speaking mildly is go for any situation.**
>
> **—Women Leader, Bauchi**

> **"I feel Dogonyaro is very right because he is the burden bearer to everything as he shoulders all the needs of the house. So, Aisha is under him. So, I have the right to keep on insisting over an idea I do not like. I don't see slapping her as an issue rather, it will serve as deterrent to other women who want to behave like her (laughs).**
>
> **—Older Male, Bauchi**

> **"It is her persistence that irritated him, and in his mind, he thought doing that will stop her from bringing it up again.**
>
> **—Youth Leader, Sokoto**

Violence results from perceived stubbornness of the woman and her refusal to accept the man's viewpoint.

> **"He beats her because there's no understanding in this issue that is why he said no and she said she would go ahead. So why won't she pamper him? But she wants to prove stubborn that is why he hit her. He said no, but she kept saying yes. Definitely, he would beat her.**
>
> **—Youth Leader, Sokoto**

> **"In my own opinion, it is because he feels she didn't listen to him. If he had said no and she left him, he would have thought about it himself and maybe, let her go, but since he feels she is stubborn and didn't listen to him that's why he beat her.**
>
> **—Youth Leader, Sokoto**

There is a religious support for violence as a consequence of disobedience.

> **"Truly, in religious right, she has failed… because religion tells her to follow and obey her husband. If he says stop, she should stay. That is why he eventually beat her.**
>
> **—Youth Leader, Sokoto**

Negative subjective norms and relationships with those who have the same attitude will encourage violent behavior.

> **"Like his friends that their behavior is almost the same or maybe they should say their culture is almost the same, that community or something…. they can agree with what he did. They will not even see his fault. Some even his parents, because of culture… can agree with the behavior that he did, that he is right.**
>
> **—Older Woman, Bauchi**

Violence appeared to be perceived as more common among young men and those in the early phase of

marriages compared to elders who will condemn such behavior.

> **"It's few men that will agree that beating their wives is good or justify hitting a woman. I think it's most common with young boys that just got married. If there are elders or religious leaders there, they will condemn such attitude and caution him.**
>
> **—Youth Female, Sokoto**

Lack of education and exposure contribute to for violence toward women.

> **"Many men that are not enlightened will agree with the way he treated Aisha and those that are enlightened, will not agree with the way he treated her.**
>
> **—Older Woman, Bauchi**

> **"People will see him as uneducated man, that is not exposed. They will say he don't know what he is doing, because he doesn't know the importance of health and child health and they will take him as a fool that don't know what he is doing.**
>
> **—Youth Leader, Sokoto**

People in the community are more likely to condemn violent behavior due to modernization and progressive beliefs.

> **"The community would think he doesn't have integrity and doesn't care about the health of his family, he is just someone who is focused on his farm work and providing food for them that's all. If he is reprimanded and corrected for this outdated behavior, it will deter other people who are similar to him from trying to beat their wives. This kind of times has passed.**
>
> **—Women Leader, Sokoto**

Phase I and II learning questions

What are the promises and pitfalls of integrated SBC messaging as experienced within the ACG model, by health area? What is the evidence of potential for impact?

Promises

Several promising outcomes from the qualitative research were noted. Firstly, ACG members described receiving supportive training from Breakthrough ACTION/Nigeria on how to mobilize communities and that they have good entry to the communities and influence to be allowed by District heads to do their work through the ACG program. Integration is also planned with Sokoto State Primary Health Care (PHC) through the co-hosting of ACG members as part of the State PHC Committee for Sustainability.

> **"Glory to God, we have been given training on these aspects too by these Albishirinku [Breakthrough ACTION] and they also gave us the work for three months which we do, and thank God every district head that we talk always agree with us and we take the number of people that we talk to.**
>
> **—Traditional Leader, Male, Sokoto**

Secondly, there is a complementary effect wherein media such as radio broadcasters also bolster the work of the ACG members to spread integrated SBC messages on health to a broad audience and reinforce the key health areas.

> **"You see in the past, we had 30 minutes on air, at once Breakthrough ACTION of Nigeria requested for more time and it was done immediately… because he also knows the importance of it. Normally when we are having our training he is also invited in his capacity as the media person…there could be some information he might need to broadcast.**
>
> **—Youth Leader, Male, Bauchi**

Though financial support is not provided at the state or traditional level for ACG activities, social capital is a valuable support, e.g., the support of the First Lady. Also, good lines of communication with local and government leaders also allowed the ACG members to advocate on behalf of the communities. A cordial relationship between Breakthrough ACTION and the ACG has positively influenced the SBC intervention process.

> **"What we did was to pay advocacy visit to the wife of the Governor who we agree will be our matron, and also to the Sultan whom we let know all our activities, the Commissioner of Health and the Executive Secretary, so what we did is to have a good collaboration and working relationship.**
>
> **—Religious Leader, Male, Sokoto**

> **"Coordination is, from the state level there is no problem between us, from the leadership and its members and the office too, there is a good relationship between us and the office, because if there is no good and cordial relationship, the work will not be perfect.**
>
> **—ACG Member, Male, Sokoto**

Overall, ACG members find their work inherently rewarding, and they receive social support from government leaders at all levels to mobilize and reach communities of interest. This social support increases intrinsic motivation, in spite of the lack of financial remuneration which, though challenging, could improve the sustainability of the program.

> **"This work we do it for reward, we do it for our communities, and for the desired healthy living of our community. We don't get anything, we have never gone anywhere looking for help but we go to the district head and inform him about our plans and for him to help us mobilize people for us to sensitize them because anywhere we enter, these people know us.**
>
> **—Traditional Leader, Male, Sokoto**

The continual involvement of community influencers and local governance structures could sustain the program despite the challenge of integration of the program within existing formal structures such as the State Primary Health Care Development Agency. One member described it this way:

> **"...With what we are seeing, even if they integrate the ACG into their committee it will be a kind of..., unless if the ACG members will just manage and continue but there won't be perfect sustainability, you know its state government and its politics.**
>
> **—ACG Member, Male, Sokoto**

ACG members feel empowered to do their work given the strong social connections and support for advocacy, for example in Sokoto they were able to speak to the state's First Lady and Commissioner of Health and Primary Health Care and ask them to intervene to improve health worker attitudes. ACG members also advocated for improving equipment and lights in the health facilities successfully through these supportive relationships, and to the First Lady to ensure that sponsored training for nursing education at State Nursing and Midwifery College was equitably distributed.

> **"If any of such challenge is reported or observed, we notify them...and if there is any challenge with a hospital, maybe there is no light or equipment, we inform them to address it because it's their responsibility. That's what we did.**
>
> **—Religious Leader, Male, Sokoto**

Pitfalls

Despite promising outcomes, there remain some challenges or potential pitfalls for the ACG program as explored through the qualitative interviews gathering the perceptions of members. For example, there may be a perception by ACG members that they don't have tangible benefits to offer communities who they are reaching on health topics. The ability to offer incentives appears to the something the members would feel could strengthen their advocacy efforts.

> **Well in that, there is a problem; because sometimes we tell people to meet us, but we have nothing to give the people in the meeting not even us the leaders in ACG, but those traditional leaders, and the other leaders we invited, yes they use to give but we want them to do more.**
>
> **—Women's Leader, Female, Sokoto**

Additionally, a perception was expressed that media approaches, such as radio broadcasts, may be seen as preferable to face-to-face work that ACG members undertake. In other words, they felt it could be more efficient than one-to-one contact to disseminate the key health behaviors in order to reach more people, and travel farther out to the State level, than sermons or other types of in-person meetings. This could mean that ACG members may perceive their in-person work as less effective than media.

> **You see for media, I have been to the radio station twice this month and the program I did was repeated yesterday. All radio stations in Sokoto I have gone there, and if I don't go another ACG member will go, It's very effective. Because when you do a program, a lot of people are listening, it reaches a lot of places in the state, even to the villages and during this program at the radio station, people call to express their joy on the program.**
>
> **—Traditional Leader, Male, Sokoto**

Evidence of potential for impact

In qualitative assessment of evidence of potential for impact, as explored through the interviews and qualitative methods, several factors were noted. Firstly, traditional leaders are certainly revered and influential in the community, as well as are efficient community organizers, thus are likely to have strong potential for impact as individual actors.

Given that ACG members are socially active and it is beneficial for them to continue to be seen as providing relevant and reliable support to their communities, there is also a strong potential benefit to working through these individuals for disseminating SBC information. Specifically, there can be a synergistic opportunity for the ACG leaders to maintain and even increase their social status, where dissemination of beneficial priority health behaviors occurs to the community through their work, which in turn can improve community members' trust in the ACG.

> **When people hear that you spoke with the traditional leader or some influential people in the community, community members will come and whatever we tell them to do they do, that because they respect their traditional leaders and whatever they ask of them, they will do it without complain and doubt, and also to the traditional leader they will be strengthened to enlighten their people.**
>
> **—Traditional leader, Male, Sokoto**

This is borne out in the insight that association of newer community leaders (e.g., youth leaders) with the ACG improved confidence in that newer group of leaders, ensuring a virtuous cycle where ACG dissemination of helpful health information strengthened their status as leaders and also their ability to proffer trust in associated ACG leaders such as youth leaders. The quote below is illustrative of this:

> **We had to liaise with ACG to be present during such gatherings. It was this move that boosted their confidence in us.**
>
> **—Youth Leader, Male, Sokoto**

ACG members described their ease of sharing SBC information and that the 17 priority behaviors have been disseminated successfully by traditional leaders with the perception that good progress has been made in two areas in particular: exclusive breastfeeding and child spacing. Child spacing had been part of the previous SBC programming prior to integration of additional health behaviors, while breastfeeding is a widely accepted, and practical, behavior which provides inexpensive nutrition to infants. The quote below from a religious leader expands on this:

> **At the priority behavior, the issue of exclusive breastfeeding has worked well, the issue of child spacing is now getting a huge amount of people and I know this through the nurses, they usually tell me.**
>
> **—Religious Leader, Male, Sokoto**

In relation to this, the ability of the ACG members to discuss/disseminate the priority behaviors with the populations of interest in a short amount of time was described as a strength and speaks to the potential for impact given feasibility and acceptability (e.g., they noted they can speak to women about the priority health behaviors over a short period easily). Leaders in the ACG study also described disseminating key behavior messaging through community meetings on a weekly basis (1–2x/week), which was perceived as manageable given other competing priorities. The description provided by an interviewee is presented below.

> **As I said, I find it very interesting, particularly the seventeen priority behaviors that were selected, one finds it very easy within 15 to 30 minutes you can talk to women about it and encourage them, and it makes an impact.**
>
> **—Religious Leader, Female, Sokoto**

Another area relevant to potential for impact is the support and feedback among ACG members and the importance of this for the success and sustainment of programming. Evidence of mutual support and peer feedback was noted in the qualitative data collection. The supportive feedback described by the ACG members involved developing creative feedback and communication mechanisms. Religious leaders in one community created a WhatsApp group where they share their ACG-related activities which was noted to be helpful to other ACG members in that it allowed them to stay abreast of their peers' activities and conduct their own. Another aspect of support and feedback related to informal meetings between the different ACG members help to discuss challenges and solve problems that they encountered. A participant described it this way:

> **The way religious leaders relate and created a WhatsApp group where you can share your activities conducted and it motivates others to conduct their activities too so as not to be left behind, to me it helps seriously. And we sometimes do things outside our plan, we meet together to discuss issues and find ways in solving them.**
>
> **—Religious Leader, Female, Sokoto**

Changes in health behavior (short-term)

Participants noted increased health knowledge and increased use of health facilities in the communities where the ACG is working. Participants noted that more community members were utilizing nutrition, malaria, ANC and family planning, and immunization services.

> **Based on our practices as Hausa people, if a woman was sick or her child was sick, it was difficult, very difficult, for a woman to take herself to the hospital if the husband was not around, even if the child will die, so be it. Right now, even if she doesn't let the husband know, she will go to the hospital, and when he returns, he will even appreciate her. You see this has changed, earlier there were restrictions.**
>
> **—Community Leader, Male, Bauchi**

> **In the area of using mosquito nets in times past, people did not know the relevance of using mosquito nets as we sometimes see some of them using it as window and door blinds in their houses, some even use it for fishing, while some use it to demarcate their farms. But all these have changed all because of the awareness that our community volunteers are doing.**
>
> **—Program Beneficiary, Male, Bauchi**

Across the data collection areas, participants reported that they perceived longer-term changes in reducing home births and child illness. Participants described many improvements over the long term related to perinatal health, though it is not possible to ascertain the

specific impact of Breakthrough ACTION participation, and capacity to solve health issues. Child spacing has been reported to be very well accepted in areas where ACG members are operating, even among remote populations. The ACG members have been equipped with tools that help with acceptance of health behaviors, like a card that women can use to go to the hospital for child spacing.

The traditional leaders in ACG have seen progress on improving health behaviors of interest over time since the program started, though there are still communities that are 'discovering' the health information being disseminated.

> **"The first [most successful] is child spacing, even a Fulani man who stays in the bush comes with his wife for child spacing, the coordination for this is a hundred percent.**
>
> **—Religious Leader, Male, Bauchi**

> **"But this group enlighten us and they also give a card to women to go to the hospital with for child spacing, women are also trained to enlighten community women in their houses, and sincerely we have seen progress and it's a group that I have seen progress in their activities compared to how we were before, even though daily there are discoveries that comes to the community.**
>
> **—Traditional Leader, Male, Sokoto**

Some demotivating factors and barriers for health-seeking behavior were reported: negative attitude of health workers, inadequate number of health care workers, distance to the health facilities, and inadequate medical commodities.

From the perspectives of the community members, factors such as socioeconomic status, spousal disapproval, and misconception about routine immunization and family planning still impact health-seeking behavior.

Health-seeking behavior was perceived to be improved where ACG facilitates or advocates for adequate health facilities, with experienced health workers, incentives, improved access/proximity, quality care and reduced wait times. While the data on these (described above) was reported by participants, it could not be causally linked with ACG members activities through this qualitative research.

Influence on health behaviors by area: Results of a SNA

Phase II sought to explore influencers and people important to the acceptance and improvement of prioritized health behaviors, particularly to understand a. whether the ACG messages are endorsed by key decision makers and influencers, as well as the relative strengths of ACG members versus other influencers such as other community members, family members, or spouses. The data collected from Phase II on social network analysis is presented below. Influences on priority health behaviors have been explored through this method. The egos/program beneficiaries interviewed as part of this study identified a total of 240 alters, out of which more than half were over 34 years (137/240), 195 were men and 93 were decision makers, as shown in Table 7. Egos affirmed that they engage in discussions with a majority of the identified alters about ANC (227/240), exclusive breastfeeding (222/240), child spacing (230/240), and malaria (235/240). This indicates that many of the prioritized health behaviors are being discussed generally among

TABLE 7 DEMOGRAPHICS OF NETWORK PARTNERS

DEMOGRAPHICS	FREQUENCY
Age (in years)	
15–24	32
25–34	62
35–44	53
>44	84
Sex of network partners	
Male	135
Female	105
Type of influencer	
Decision maker	93
Core influencer	147
Tower of influence score (in points)	
1	16
2	50
3	72
4	56
5	46

communities where the ACG members are operating, signifying potential effectiveness of ACG programming.

On MNCH, the majority of egos/program beneficiaries expect their network partners (as noted in the Methods section, network partners are individuals who are tied or connected to the ego/participant based on a form of relationship) will hold the following views: that it is important to seek ANC at least four times during pregnancy (237/240), pregnant women should deliver in a health facility/birth attended by skilled personnel (239/240), and infants under six months old should be exclusively breastfed (235/240). In addition, egos perceived that the identified network partners accepted child spacing methods (232/240), think the consequences of malaria are serious (240), and children under fiive years old should use long-lasting insecticidal nets (240).

To understand the roles and relationships of people involved in decision-making for MNCH issues, we worked with the informants to collaboratively create a network map/sociogram (a visual representation of core influencers and decision makers). The sociograms suggest how informants are influenced by their perception of what others in their network expect or believe, called social influence. In the interviews, we explored patterns and levels of influence the core influencers and decision makers had in influencing the informants on some health areas. In SNA, visual drawing of the levels of influence is known as the "tower of influence." The levels of influence were ascertained by requesting our informants to rank the decision makers and core influencers in their network—the ranking was achieved by asking to stack building blocks, on a range of 1 to 5, on the core influencers and decision makers they considered most influential to least influential. Each additional building block represented a higher influence. The levels of influence were drawn on network maps/sociograms.

An assessment of the tower of influence showed that 102 network partners scored more than three points. This implies that these network partners have a high level of influence on the egos/program beneficiaries they are connected to. This is further buttressed by a close examination of selected sociograms from the study as shown in Figures 5 and 6. These figures together depict eight sociograms, four selected randomly per state. Each sociogram depicts the network of an ego/beneficiary of the SBC-ACG program. This comprises the relationships they have with individuals/network partners in their network, the support provided or received, and the level of influence these individuals have on the beneficiaries.

Sociogram A shows the network of Ego 1 who is a woman and has four network partners. These network partners are the mother-in-law and her husband who are decision makers for MNCH issues. Also, the network has her friend and a community volunteer who are core influencers on her behavior and decision-making process. The mother-in-law provides emotional support and advice

TABLE 8 SPECIFIC QUESTIONS ON MNCH COMMUNICATION WITH NETWORK PARTNERS AND PERCEIVED VIEWS

MNCH COMMUNICATION WITH ALTERS AND THEIR PERCEIVED VIEWS	FREQUENCY	
	YES	NO
Communication with network partners on MNCH issues		
Whether ego speak to network partner about ANC	227	13
Whether ego speak to network partner about exclusive breastfeeding	222	18
Whether ego speak to network partner about child spacing	230	10
Whether ego speak to network partner about malaria	235	5
Perceived network partner views on MNCH issues		
It is important to seek ANC at least 4 times during pregnancy	237	3
Pregnant women should deliver in a health facility/birth attended to by skilled personnel	239	1
Infants < 6 months should be exclusively breastfed	235	5
Whether network partner accept child spacing methods*	232	3
Consequences of malaria are serious	240	—
Children under 5 years old use long-lasting insecticidal nets	240	—

*Total was 235 for this question.

while the husband provides financial support in addition to emotional support and advice. The mother -in law and the husband also have the highest levels of influence. In contrast, Sociogram D shows the network for Ego 4, who is a man and has eight network partners. His network comprises his wife, mother, friend, and a women leader who are all decision makers for him as it regards MNCH. Other network partners in his network were core influencers. The relationship between the ego and his mother shows a bi-directional emotional and financial support. The provision of advice was also bi-directional. Similarly, the provision of advice and emotional support was bi-directional between the ego and his wife. However, only the ego provided emotional support to his wife. Tower of influence scores shows that the wife, the mother, and a friend had more influence on him compared to other network partners.

Sociogram E shows the network of a female ego with six network partners. In this case, the only decision maker is the husband while the ego identified the other network partners (3 health workers, and 2 community volunteers) as core influencers of behavior and the decision-making process. The relationship between the husband and the ego shows that while financial support is bi-directional, the husband provides advice and emotional support to the wife. The relationship between the ego and the first ACG member shows a bi-directional financial support and advice while the ACG member provides emotional support to the ego. This suggests the possibility of a personal relationship beyond the designation of the ACG member. The husband and the first ACG member had more influence on the ego compared to other network partners. Sociogram H shows the network of a male ego with nine network partners out of which three were decision makers and six were core influencers. The decision makers were the ego's wife, mother, and brother. The wife provides emotional support and advice, and the mother provides financial support and advice.

The sociogram shows that the wife and mother have the highest influence on the ego as it pertains to MNCH issues.

The assessments of the sociograms presented show that decision makers were family members especially, mothers, mothers-in-law, wives, husbands, and sometimes brothers. While husbands are generally regarded as providers of different forms of support to the wife, an assessment of the sociograms reveal that wives could also play that role. As shown previously, egos generally affirmed that identified network partners had a good perception of MNCH issues. This implies that interviewed program beneficiaries have network partners that would provide favorable support and either favorably influence or make good decisions for them as it regards MNCH.

Key to sociograms

- An ego/program beneficiary is represented by a rounded rectangle.
- A network partner/program beneficiary is represented by a circle.
- Males are represented by a blue color which could be filled in a circle or a rounded rectangle.
- Females are represented by a green color which could be filled in a circle or a rounded rectangle.
- Arrows represent support given or support received. Arrows can be bi-directional to indicate that support is both provided and received.
    - Green arrow represents emotional support.
    - Bright blue arrow represents financial support.
    - Black arrow represents advice provided.
- DM means decision maker.
- CI means core influencer.

FIGURE 5 SELECTED SOCIOGRAMS FROM BAUCHI STATE

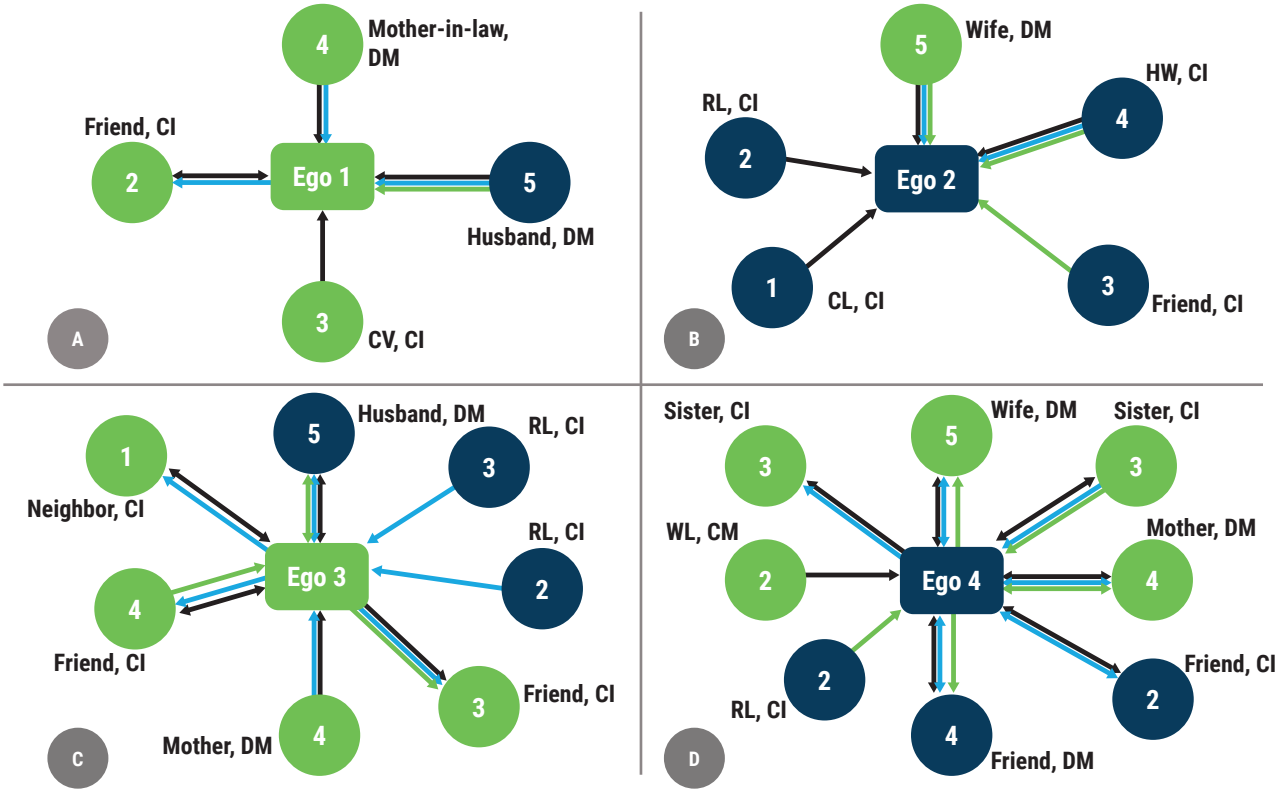
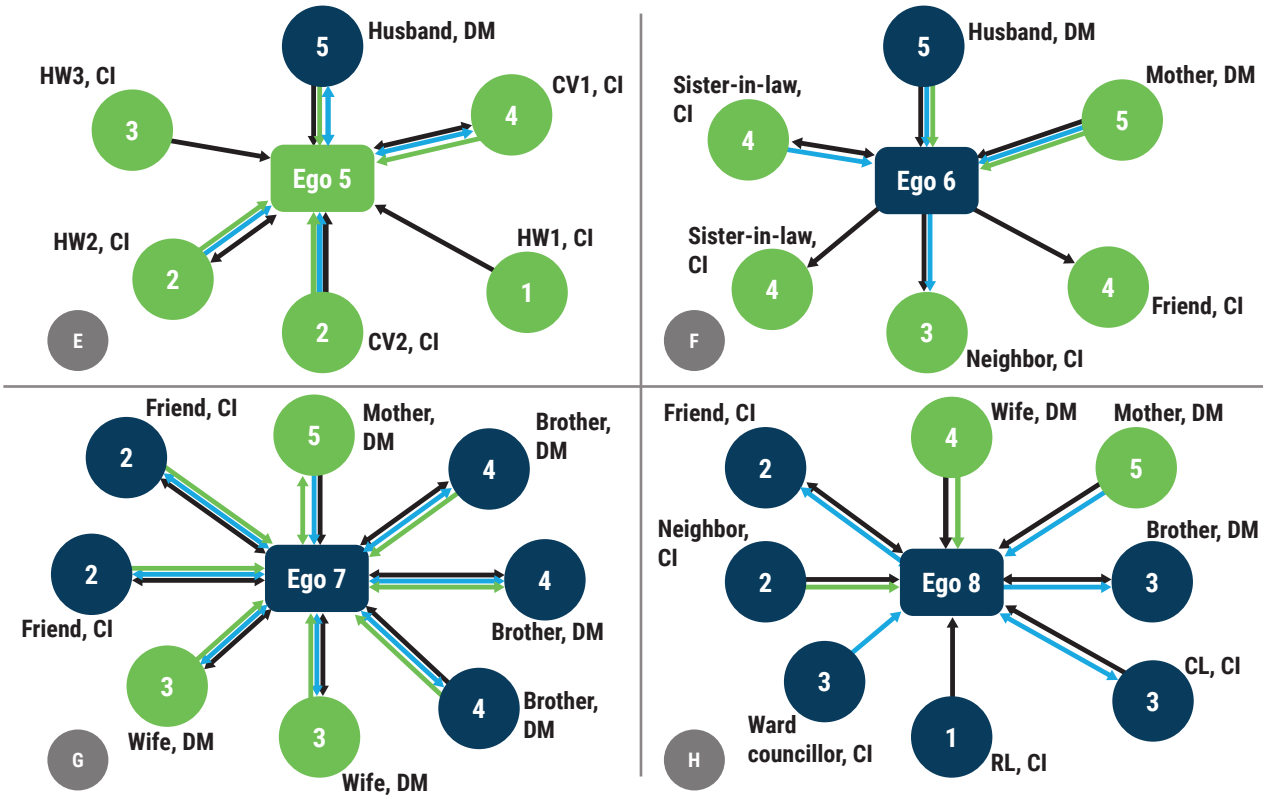


FIGURE 6 SELECTED SOCIOGRAMS FROM SOKOTO STATE



Ego/program beneficiary=rounded rectangle;network partner/program=-circle; males=blue color (circle or rounded rectangle); females=green color (circle or rounded rectangle)

Arrows=support given and/or support received (bi-directional=both); green arrow=emotional support; bright blue arrow=financial support; black arrow=advice provided

DM=decision maker; CI=core influencer.

Discussion and Programmatic Implications

This report has provided results from both phases of the qualitative study on the ACG. Data from this study indicate that among many key health areas—including child spacing, MNCH, malaria, and nutrition—there has been increased awareness of health issues as a result of the ACG activities. There are some areas that continue to be slower to change, potentially as a result of the extent of entrenchment of social norms that have been prioritized by the ACG, such as immunization, GBV, and nutrition. Both ACG members and beneficiaries of the program expressed a positive regard for the work of the program and a perceived resultant improvement in health and behavior in line with the aims of the program. Challenges or pitfalls were described mainly in relation to the lack of tangible benefits that ACG members could provide to communities, as well as the perception that media may be more effective than person-to-person communication.

Successes

The study noted ACG model successes in the following areas:

Engagement with community: ACG members reported directly engaging community members through various means, including community religious events and ceremonies, household visits, and community dialogues. They also mentioned referring community members to health facilities for services. Interactions with community members using community platforms and face-to-face meetings facilitate messaging on the project's priority health behaviors and create demand in communities for MNCH+N, malaria, and child spacing services. Well-attended and culturally relevant community platforms are routinely used for advocacy and sharing of health promotion messages, allowing for the model to work through the expected channels (e.g., town hall meetings, sermons, social events such as naming and wedding ceremonies).

Performance: ACG members reported perceptions of positively influencing community members on all practices related to the priority health behaviors (e.g., family planning, ANC, immunization) including demand creation for MCHN+N and childbirth spacing services. This perception was linked most closely to perceptions of reductions in home births, increase in adoption of child spacing methods, and improvements in care-seeking for child illnesses.

Linkages with the healthcare community: The model appears to have succeeded in facilitating linkages between ACG members and health care workers for example by advocating for needed improvements in health facilities. This in turn has helped to build demand for critical health services and advocacy for quality improvement.

Reach: ACG structures involving religious leaders were described as having a wider reach relative to other traditional and community leaders. Religious leaders regularly use sermons infused with health messages and capitalize on their more elevated status in the social ecology to achieve broad support for messaging. Other ACG members have worked through narrower population subgroups, facilitating linkages with community associations such as those for youth, women, and other community groups. The perception is that religious leaders who are ACG members may have a broader impact because they are able to work across all population groups.

The SNE component of the study, which was intended to look for potential shifts in social norms influencing key behaviors that might be attributable to the ACGs, yielded important findings related to the gender norms that Breakthrough ACTION/Nigeria has prioritized in their SBC programming, including the following:

1. ***Limited mobility and social interactions for women***: Traditionally, women require permission from husbands or male guardians to seek health care, both for themselves and for their children, except in cases of emergency. However, there is data indicating that this attitude is shifting. ACG members perceived that husbands/male guardians are increasingly likely to grant "advanced permission" for women to seek necessary healthcare. ACG beneficiaries reported

the same. However, this does not appear to be a true shift in norms, rather a change to the timing of granting permission.

2. ***Unequal agency in health decision-making***: Traditionally, husbands are the ultimate decision makers for many health behaviors. There is the perception that it is a wife's responsibility to convince her husband of the need for health services, perhaps through enlisting the support of mothers-in-law, religious leaders, and traditional leaders. For this latter role, ACGs appear to be fulfilling their responsibilities by actively discussing and encouraging shared decision-making on health matters. This has led to perceptions of shifts toward more shared decision-making, particularly with respect to ANC and facility-based deliveries.

3. ***Acceptance of early marriage/childbearing***: Total fertility among women in these areas remains high, and they are traditionally expected to allow as many pregnancies as their husbands/in-laws deem appropriate. As with decisions about using health services, husbands are the principal decision makers around birth spacing, which was considered by some participants to be against religious tenets, even though this latter norm might not be formally endorsed by religious leaders. The data collection did not result in any information on changes to norms around early marriage. By enlisting religious leaders into their model, the ACG approach is working to shift norms promoting greater acceptance of reproductive health services, including ANC, facility deliveries, and family planning.

4. ***Tolerance for GBV***: GBV toward women has been historically tolerated as a correctional measure and a consequence of 'disrespect' for male authority. Disrespect is perceived as a wife's stubbornness or refusal to accept a husband's viewpoint and decisions, including about healthcare. It is also perceived that there is a religious rationale for GBV in cases of disobedience, and subjective norms tolerating GBV are entrenched within social groups. GBV is socially tolerated more among young men/those who had early marriage as compared with older couples. Community norms related to GBV appear to be shifting due to modernization and progressive beliefs. An example of this was assertion of ACG beneficiaries that incidents of GBV has reduced owing to increased education among community members. ACG members received training on creating awareness and understanding to reduce it.

5. ***Traditional nutritional practices and restrictions***: Women have not historically been encouraged to breastfeed a newborn immediately after delivery, and adverse social norms hold great weight, adding difficulties to the work of the ACGs. Infants are often given holy water and denied first breast milk under the belief that colostrum, as a result of being perceived as dirty or polluted, has no benefit. Exclusive breastfeeding is far from the norm as many people believe that breast milk is not sufficient for children's energy needs and growth. ACG members note that they encourage exclusive breastfeeding for the first six months of life, although the exact definition of "exclusive" used by ACG members is sometimes unclear. ACG members also encouraged community members to seek health care workers' opinions for complementary feeding after six months of exclusive breastfeeding, but traditional nutritional practices and restrictions are slow to change.

6. ***Belief in traditional practices for MNCH issues***: Receiving treatment at home with traditional remedies, or using medicines acquired outside of health facilities, is perceived to save money for the family and show that a woman is strong. Health care workers in facilities are often not kind and regularly mistreat patients. For women who are healthy and strong, ANC is not seen as compulsory. Women who have an illness or have had a previous complicated pregnancy are more likely to seek care. Immunizations are not perceived as important for infants' health, nor are they considered compulsory. Side effects are believed to make immunization dangerous. ACG members have been encouraging and facilitating utilization of health services for MNCH issues but these norms are slow to change.

Limitations

Given the qualitative nature of this study, it was not possible to objectively measure changes in social norms. Understanding social norms such as those identified in this report is key for social behavior change research and its potential to inform programming. Wallen and Romulo describe a social norm as: "a normative social belief, which is an individual's beliefs about the behaviors and evaluations of others in a social setting: that is, a cognitive construct and mental representation of the actual social norm."[30] Caution is required in presuming

that changes in norms automatically result in changes in behavior.[31] Given that norms are in effect a cognitive representation of community-beliefs, the use of qualitative research and psychological phenomenological grounding to explore them is more appropriate than quantitative methods.[32]

Other study limitations include social desirability bias, which is a common issue in evaluation of programming, as well as recall bias. The SNA methodology is specifically limited in that it is not based on probability sampling, and thus cannot be considered statistically valid for generalizability; SNA data are illustrative rather than definitive in terms of identifying influencers. Security limitations prevented the team from entering the same study sites in Phase II as in Phase I, however this did not impact the qualitative validity. Similarly, the pandemic emergency context in which the study was conducted may be different from normal operational contexts and thereby influenced the experiences and responses of individuals.

The synthesis of Phase I and Phase II data centered on the learning question: What are the promises and pitfalls of integrated SBC messaging within the ACG model, and what is the potential for impact?

Work across both phases of the study highlighted important facets of the program that encourage success, as well pitfalls that may constrain overall effectiveness.

What are the promises and pitfalls of integrated SBC messaging within the ACG model, and what is the potential for impact?

Promising areas

Skill-building in community engagement and community liaison: ACG members described receiving supportive training from Breakthrough ACTION on how to mobilize communities, which is beneficial even beyond their roles as health advocates. They further reported that the formalized structure of the ACG program provides a good entry to communities and serves as an important conduit by which district heads can reach those communities, again providing useful community support beyond health.

Combination of mid- and mass media: ACG members noted that their work has been bolstered by radio broadcasters transmitting similar SBC messages, lending credibility and support to their own work, reinforcing health messaging, and reaching broader audiences. This complementarity between the ACG model and mass media SBC, a central component of the Breakthrough ACTION/Nigeria approach, may warrant further exploration and could serve as a promising avenue for future SBC programming and expansion.

ACG model setup: The structure of the ACG model, based on close liaison and social support from government leaders at all levels to mobilize and reach communities of interest, provides a source of intrinsic motivation to ACG members, in spite of the lack of financial remuneration. Members feel empowered to do their work given the strong social connections and support for advocacy. As a result, ACG members find the work inherently rewarding, a fact that speaks to the overall operability and potential sustainability of the model.

Reach of ACGs: The potential of ACGs to influence health appears strong yet can vary by geography and health topic. Analyses of information flows in Sokoto show that respondents were influenced by religious or traditional leaders for ANC, immunizations, and child spacing, with traditional leaders appearing to be more influential than religious leaders. This would appear to indicate that ACGs in Sokoto could continue to serve as an important source of information and motivation (and perhaps an enhanced role) to improve the health of community members.

In Bauchi though, the potential influence of ACGs appears somewhat smaller, and may be overshadowed by the influence of spouses and family (however, the qualitative sampling was not based on probability and thus is not statistically validated). Across health topics, traditional leaders were cited as influencers by few respondents. No respondents cited religious leaders as influencers on treatment of child illnesses and few respondents cited religious leaders as influencers for child nutrition, ANC, and immunizations. The health area for which they were most frequently cited as influencers was child spacing, yet even there they were deemed far less influential than spouses (the majority) and family members. Other models, or tweaks to the existing ACG model, may be required to improve effectiveness. (NB: data collected within this qualitative study were not based on probability sampling and therefore are not broadly generalizable).

Pitfalls

Talk may be cheap: Some ACG members expressed concern that they were not able to offer tangible benefits to the communities they reach. The ability to offer incentives is an area where members feel their advocacy efforts could be strengthened. The nature of the incentives was not discussed but may be worth future consideration.

Broad reach versus intensive reach: Some ACG members speculated that face-to-face and in-person events such as sermons and community meetings might be less effective or efficient than mass media radio broadcasts simply because radio can reach more people. Reinforcing ACG members' sense of self-efficacy in achieving lasting behavior change could further empower them and contribute to sustainability.

Potential for impact

Influence of traditional and religious leaders*:* Traditional and religious leaders are revered and influential in their communities and have a role but the data suggest more needs to be done to bring about change. They are efficient community organizers, and therefore are likely to have strong potential for impact in their role as ACG members. This impact is seen as being enhanced by ongoing efforts to work with youth leaders.

Mode: ACG members felt that the community-based approach fostered their ability to discuss/disseminate the priority behaviours with the populations of interest in a short amount of time, making the ACG approach both feasible and acceptable to communities. Leaders in the ACG study also noted that this approach allowed them frequent contact with community members (1-2x/week) and repeated dissemination of key behaviour messaging, further enhancing their potential for impact.

Innovation: The close relationship between ACG members and other community members allows for a two-way communication, which enables ACG members to hear and respond to the concerns of the latter group. This has led to some unique innovations fostering creative feedback and communication. Religious leaders in one community created a WhatsApp group to share their ACG-related activities with other ACG members, allowing the latter group to keep abreast of their peers' activities and to refine their own.

Health gains: Participants noted increased health knowledge and increased use of health facilities in the communities where the ACGs are working. There were perceptions of reductions in home births and child illnesses and greater long-term impacts on perinatal health. Cross-referencing these perceptions with quantitative data on health service utilization is warranted.

Conclusion and Recommendations

Data from this study indicate that among many key health areas—including child spacing, MNCH, malaria, and nutrition—there has been increased awareness of health issues as a result of the ACG activities. Some areas appear slower to change, such as immunization, GBV, and nutrition, potentially as a result of entrenched social norms. Both ACG members and beneficiaries of the program expressed a positive regard for the work and a perceived resultant improvement in health and behavior in line with the aims of the program. Challenges or pitfalls were described mainly in relation to the lack of tangible benefits that ACG members could provide to communities, as well as the perception that media may be more effective than person-to-person communication. Based on the findings from both phases of this qualitative enquiry, the following programmatic implications and recommendations are noted:

1. Continue to support the ACG members in the same way as before but with additional resources—who are well-respected in their communities and have wide reach and easy access to their community members—in their roles as reliable sources of information on key health areas, although perhaps with some tweaks to the model such as promoting further involvement of ACG in complementary media campaigns and providing greater supportive supervision.
2. Increase the reach and effectiveness of the ACG model through mass media and other channels, which provide important reinforcement for and enhance the credibility of messages delivered by the ACG.
3. Strengthen the ability of ACG members to advocate for beneficiaries in matters of health service quality improvement.
4. Examine other mechanisms of motivating ACG members. While ACG members report feeling intrinsic motivation from directly benefiting their communities and from the broad support or recognition they receive from government and local leaders, such intangible benefits may only go so far. It warrants exploration of supportive structures to maintain this high level of motivation and pro-social commitment.
5. Provide additional support in the form of incentives or linkages with complementary programs to ACG members for addressing entrenched norms that appear slower to change such as on immunization, GBV, and nutrition. Because of their influence and access to communities, ACG members are well-positioned to affect normative and behavioral change.
6. Proactively address potential issues of sustainability, such as lack of financial support to ACG members and the perception that they do not have tangible incentives to offer program beneficiaries. This could be achieved by preparing local governance structures to support ACG members to continue their work through sensitization and providing evidence of benefit.
7. Compare perceptions of increased service utilization with quantitative data on health service utilization in areas where the ACG model is active (as well as in control areas where the ACG model does not operate). This may provide additional empirical support for the effectiveness of the ACG model.

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Annex 1: Phase 1 Tools

Draft IDI Discussion Guide for Key Community Influencer Selected to Participate in the Breakthrough ACTION ACG programming activities

Interviewers note: this is a discussion guide NOT a questionnaire. The focus should be on probing and encouraging the person to talk as much as possible about their experience. It is not necessary to finish all questions in the discussion guide, but rather please try to get full experiences and generate discussion.

Interviewer: Hello, my name is _____, and I want to thank you for agreeing to share with me some of your thoughts. We have provided the informed consent information to you and you know what this study is about. Do you have any questions before we begin?

Thank you and welcome to this interview which will be like a conversation back and forth. Your opinions are very important, and no opinion is right or wrong; we just want to hear from you.

PARTICIPANT DEMOGRAPHIC DATA
Title (as community leader):
Age:
Gender:
Number of years in the position:
Religion:
Ethnicity:
Highest completed education:
Other note:

1. **Please tell me a little about your role in the community and what your official title is? Can you describe a little bit about your activities?**

- How did you come to be in this position in the community? Can you tell me how long you have been working in your present capacity?
- How does your role on the ACG affect the way you carry out other responsibilities in the community?
- Who do you interact with inside your community? Outside your community? (Probe for the context of the interaction within and outside the community)
- How did you come to participate in (Breakthrough ACTION ACG programming) activities in your community and how have you been engaged?
- What have you been doing differently since you came to participate in (Breakthrough ACTION ACG programming activities) in your community?

2. **Let's begin by talking about overall health trends that you see in the community.**

- Who is responsible for health? Who should be responsible for these health issues?
- What do you know about health issues in this community?
- In this community, what would you say are some of the most common (then most serious) health issues that families experience?
  - What types of changes, if any, have you seen in this health issue in the last year or two?
  - Why do you think these changes are happening/ not happening?
  - For positive changes: Has that improved the lives of families? How?
  - If there are negative changes: What has been the consequence of that for family health?
- What are some of the barriers that prevent families from achieving positive health changes?
- What is the role of community leaders in helping families here achieve better health?

3. **'Tell me about the things you do as an ACG member'? (Probe for frequency: How often do you do that?)**

- What kinds of community members are you most likely to be in touch with (Probe: older, younger, male, female)?
- What kinds of community members are you least likely to talk with about health issues and why?

- What are all the ways you use your role in the community to influence community members to address their health issues?

4. **What kinds of topics do you discuss with community members?**

- What is your perception on these health topics? (Probe: Immunization, Childbirth Spacing, Breastfeeding practices, Newborn care, GBV, gender equality and shared responsibility for health within the family?
- Are there topics that you have specific knowledge/ experience about that you can help people with?
- How did you get knowledge on these?
- Which health topics are harder or easier to talk about (Probe: Immunization, childbirth spacing, breastfeeding, newborn care, GBV, gender equality and shared responsibility for health within the family)?

5. **Can you please tell us about the last time that you spoke about health topics to community members (or peers—such as other elected leaders—or policy makers, probe for influence)—please describe it in as much detail as possible. (Probe: where was it, how did you start the conversation, who was the audience, what topics did you talk about, how was the information received)?**

6. **What is the best way for you to communicate on health topics to your community and why does that way suit you? (Probe: Speak outs, sermons, mass media, modeling in your household)**

- What attributes or skills help you most in your role as ACG?
- What part of your role do you like most? What is most difficult?

7. **Is there anything else you would like to tell us about your work sharing health information with your community?**

Thank you for your participation!

IDI Discussion Guide for Reproductive-Age Community Members

Interviewers note: this is a discussion guide NOT a questionnaire. The focus should be on probing and encouraging the person to talk as much as possible about their experience. It is not necessary to finish all questions in the discussion guide, but rather please try to get full experiences and generate discussion.

Interviewer: Hello, my name is _____, and I want to thank you for agreeing to share with me some of your thoughts. We have provided the informed consent information to you and you know what this study is about. Do you have any questions before we begin?

Thank you and welcome to this interview which will be like a conversation back and forth. Your opinions are very important, and no opinion is right or wrong; we just want to hear from you.

PARTICIPANT DEMOGRAPHIC DATA
Geographic location (LGA):
Age:
Gender:
Religion:
Ethnicity:
Highest completed education:
Other note:

1. **Please tell me a little about you and your family.**

- Who lives in your household?
- What activities are you engaged in (school, work, religious life)?
- What about other members of your household, what do they do?
- What are some of the common health issues your family faces?
- How is the health of your family currently?
- Who is responsible for health in a family and children?
- How are decisions made regarding the health of the family and children?

2. **Let's talk about a story of a young couple. I will start with some ideas and then I would like you to fill in the details according to your ideas. And then we can go back and forth. Remember, there is no right or wrong answers to this story. We are trying to create a very interesting story. Ready?**

Aminu and Zauna [insert most appropriate names for the community] are a young couple like many others in their village. They got married a few months ago in a traditional ceremony conducted in Zauna's village, attended by many family members, friends, neighbors, and traditional leaders from the community. The next day, the newly married couple returned to Aminu's village in [Bauchi, or Sokoto as appropriate] where they now live.

- What are their goals as a family?
- Who will they turn to for advice and support to achieve their goals?
- Do you think they will discuss having children? (Probe for: why/ why not)
- If they decide to have children, what kinds of things will they discuss? Who else will they talk to when thinking about having children?

It is now 6 months later and Zauna is pregnant. Let's think about what the couple will do while she is pregnant.

- When they discover that Zauna is pregnant, what plans do you think they will discuss? Who will they talk to about those plans? Are the persons Aminu talk to likely to be different from those Zauna will?
- What do you think Zauna will be concerned about during her pregnancy? Do you think she will worry much about her or the baby's health during pregnancy? Do you think Aminu and Zauna will discuss these issues?
- Do you think Zauna will go to a health clinic for antenatal care – (probe for why/why not)?
    - What will they will both discuss about going to antenatal care in a health clinic?
    - If Zauna goes, how many times and if not, why not?
    - Who might help Zauna to make up her mind about this? Who might help Aminu to make up his mind about this?
    - In this community what would influence Zauna's uptake of ANC services?
- If Zauna is not able to attend antenatal care, what do you think are some of the things that prevented her from going?
- Will Aminu accompany Zauna to visit a health facility during pregnancy?
- If they receive any medicines to take during pregnancy from the health facility will Zauna take them (why/why not)?
- If Zauna is thinking about delivering in the health facility, who would she talk with? Who would decide to do this in their family?
- Now, Zauna has given birth to the baby, let us talk about what will happen in the days after the baby is newly born
    - Do you think Zauna will breastfeed the baby in the first hour after the birth? If not, why do you think she would not have breastfed the baby right away?
- Who will advise or help her in caring for the baby in the first days after the birth and what kind of care will they give (probe: bathing the baby, providing water in addition to breastfeeding, care of the umbilical cord)?
- What would Aminu/Zauna think about childbirth spacing after the baby is born? What would s/he think about trying to avoid getting pregnant for some time? What would likely influence his? What ways could Aminu and Zauna use to space their births?
- Who makes the decisions on childbirth spacing? What do your community leaders think about childbirth spacing?

Now their baby is 9 months old and growing strong. Let us talk about the child's health.

- Why do you think this baby is growing strong?
- What helps the baby to grow strong? (Probe: breast milk, other foods, other liquids?)
- How much food is provided to the baby and would it differ by male or female? Are there certain usual ways that families feed their children? Who determines these?
- What would the couples in the community think about immunizations (probe: will they give any, will they give all that are recommended)?

- Are the community leaders ever giving information on this? What information is provided?
- What role would Aminu have in the care of the child? Who else in the family would care for the child?

Aminu and Zauna's child begins to have a fever and the child does not seem healthy.

- What actions would Zauna take to care for the child's fever?
- Who would Zauna talk to or seek advice about the child's fever? What role would Aminu have? How about others in their household or community?
- How long do you think they would wait until they seek advice or care for the child's fever? Why that long a time?
- If they do not seek care from a health facility, what are some of the reasons that may have prevented them from doing so?
- If they do seek care from a health facility, what care do you think the baby would receive?

3. **Who are the people in the community that Aminu and Zauna would listen to about the health of their family?**

- What kinds of community members have the most knowledge on health?
- Who do community people listen to on health-related matters? How important is each to families, such as Aminu's and Zauna's
- Are there reasons community members listen to these people?
- What topics do leaders in the community talk about and what do they say?
    - Probe by health area: ANC, birth spacing, malaria, nutrition, immunization, childhood illnesses.
- What are some of the barriers that prevent families from achieving positive health changes? (Probe for health areas such as pregnancy and childbirth, family planning, breastfeeding, malaria, immunization, and childhood illnesses.

4. **What kinds of health topics can you learn about from religious or traditional leaders?**

- Are there topics that they have specific knowledge about that can help people in the community? Are there other reasons people listen to them?
- In your opinion, how did they get knowledge on these?
- Which health topics are harder or easier to talk about with these leaders and why (Probe: Immunization, Childbirth Spacing, family planning, Breastfeeding, Newborn care)?
- How much do men in this community trust health information from religious and traditional leaders?

5. **Can you please tell us about the last time that you heard about health topics from community leaders—please describe it in as much detail as possible. (Probe: was it in religious worship, mass media, direct consultation?)**

- What were your thoughts on the health topics? Did those talks resonate with you? How?
- Did you think of doing anything differently because of what you heard? Did you share with others? what, why?

6. **What is the best way for you to learn about health topics in your community and why does that way suit you? (Probe: from family, community leaders, doctors, health care workers)**

7. **Is there anything else you would like to tell us about your experience of learning health information in your community?**

Thank you for your participation!

Community Conversation Guide for Community Members and Key Influencers

Note: This is a GUIDE, not a questionnaire. This means that the focus should be on probing and exploring the answers that are provided, not on finishing all the questions in this discussion guide.

Antenatal care

Facilitator: Hello, my name is _____, and I want to thank you for agreeing to share with me some of your thoughts. You have read the Informed Consent form and now know what this study is about. Are there any questions before we begin?

Thank you very much, and welcome to this discussion. Please feel free to contribute to the discussion; your opinions are very important. No opinion is right or wrong; we simply ask you to be honest in our discussion today. Let us get started.

Let's start with storytelling. So, I will start with a story and then I would like you to fill in the details. And we can go back and forth. You can take the story in any direction you want. Remember, there is no right or wrong answer.

Part 1

Aishat is a 25 years old market seller and is married to Dongoyaro, a 30 years old farmer. The couple lives in a village called Dantata. Most men in the village are farmers while most women are either housewives or traders. Aishat and Dongoyaro have 3 children and Aishat is pregnant with the fourth child. The 3 children were born at home, Aishat did not visit any health facility for antenatal, delivery or post-natal care. Aishat is primarily responsible for household chores and childcare while Dongoyaro is focused on farm work.

Aishat's friend Mariam recently delivered her baby in a primary health centre. She shared her experience with Aishat and explained the care and health education she received about pregnancy, childcare and child spacing. Aishat became convinced that she had a lot to gain by going for antenatal care at the primary health centre. She discussed this issue with her husband, unfortunately Dongoyaro did not see the need for her to go for ante-natal care.

1. a. What is your opinion of Aishat wanting to go for antenatal care?

   b. Are there women who do not wish to go for antenatal care? – what is your opinion about them?

   c. How common is this in your community and among your friends? (This question applies to 1a and 1b)

2. What is your opinion about Aishat's raising her desire to go to antenatal care with Dongoyaro?

3. Why do you think Dongoyaro is against Aishat going for ante-natal care? Do you agree with him? Why/ Why not?

4. What are the best ways for Aishat and Dongoyaro to solve their differences in opinions regarding antenatal care?

5. In your opinion, in communities like your own to what extent can women make health decisions for their families?

   To what extent should women in the communities make decisions for their families?

6. What other difficulties will someone like Aishat face if she wants to go for antenatal care?

7. How many women in this community will go against their husbands' decision about not allowing them make decisions about their health?

8. What do you think will be the consequences if Aishat decides to go for to antenatal care without her husband's consent?

   Do these consequences occur in this community? (probe for experiences and stories)

Part 2

Aishat keeps raising the issue of antenatal care with Dongoyaro and requested that he accompanies her to the health centre. Dongoyaro felt that Aishat did not respect his opinion and role as the head of the household. He was also concerned that the information Aishat will receive from the health centre is not useful or necessary. Additionally, he pointed out that doing so would incur more cost on the family, deplete their limited resource. Dongayaro informed Aisha that he does not want her to attend antenatal care and would not accompany her for her visits. Their arguments continued and he insulted Aishat, hit her a few times and threatened to have her leave his house. Aishat insisted on seeking health care

during her pregnancy because of the benefits to her and Dongoyaro forced her to leave his house.

1. What do you think about Aishat repeatedly raising the issue of antenatal care with her husband after he told her how he felt? How many husbands in this community would react like Dongoyaro has done? (none, some, many, most)?
2. What do you think about Dongoyaro insulting, hitting and threatening his wife?
3. What do you think about Dongoyaro not accompanying Aishat to ante-natal clinic?
4. What other reasons do men and women of reproductive age have for refusing ANC uptake in this community?
5. How many men in this community would do what Dongoyaro did in forcing Aishat to leave his house (none, some, many, and most)?
6. How many will agree with Dongoyaro for insulting, hitting and threatening his wife (none, some, many, and most)?
7. How many will agree with Dongoyaro forcing Aishat to leave his house (none, some, many, most)?
8. Who in this community do you think will agree with Aishat's repeatedly raising these issues with Dongoyaro? Who do you think would disagree?
9. Who in this community do you think will agree with Dongoyaro's action towards Aishat? Who do you think would disagree? (Mother-in-laws, mothers, fathers, relatives, religious and traditional leaders)
10. How do you think the community will react to Dongoyaro if they found out that he forced his wife to leave the home?
11. Who in this community do you think might do something to address the situation in Dongoyaro's home? (Mother-in-laws, mothers, fathers, relatives, religious and traditional leaders)
12. What do you think Aishat can do to get help in her situation?
13. Besides this situation, can you think of other situations that might lead to conflicts in decision-making in the home?

Part 3

Aisha took off to her mother-in-law and informed her of what transpired between her and her husband. She pointed out the benefits of ANC to the mother in-law. The mother-in-law consented to Aisha trying the ANC while the family monitors the benefit. Since Aishat had been sent out of her home, the mother in-law sent for Mallam Usman who is the waliyi of her son during his wedding to help sort out the issue. Mallam Usman who happens to have a daughter who had enjoyed the benefits of ANC sent for Dogonyaro and also had a talk with him about allowing Aishat try ANC, he also spoke with him to take Aisha back into his home. Dogonyaro because of the respect he had for his mother and the Waliyi took back his wife and permitted her to go for ANC.

1. What is your opinion about Aisha going to her mother-in-law to mediate the issue?
2. Why do you think the mother-in-law was convinced?
3. How many mothers-in-law would be convinced like Aishat's in this community? (none, some, many, most). Why will they be convinced or why won't they be convinced?
4. How many women like Aishat will go to their mother-in-law to mediate cases like this in this community? (none, some, many, most)
5. How many leaders do you think are knowledgeable about ANC in this community? (none, some, many, most)
6. How many leaders would mediate in health-related issues in the family like Mallam Usman did?
7. How do you think other men in this community will react to Dongoyaro taking his wife back?
8. Finally, is there anything else that you want to talk to me about? Is there anything that we should have talked about, but we didn't talk about?

Social Networks/Influence Mapping Exercise

1. Tell us all the people in this community whose opinion is important on whether you use a method of child spacing/immunisation/ANC or receive treatment for diarrhoea/cough/ fever/child nutrition.

   This can be people who agree or disagree with you (on child spacing/immunisation/ANC or receive treatment for diarrhoea/cough/ fever/child nutrition). Reflect on all the people whose opinion is important to you.

Probe for relationships or titles, for example friends, neighbours, co-workers, partner, mother, mother-in-law, uncle, aunt, sister, brother etc.). Explore the level of influence from most influential to least influential.

2. Tell us all the people in this community whose opinion is important to you for decision making in your family and how you treat your wife/husband in your relationship. (looking for relationships, or titles, for example friends, neighbours, co-workers, partner, mother, mother-in-law, uncle, aunt, sister, brother, etc.)
3. In your opinion, what kind of problems is your community facing? Who in the community is trying to work to solve those problems?

Whys exercise

1. Why do some couples not practice child spacing/ immunisation/ANC or receive treatment for diarrhoea/cough/ fever/child nutrition in this community?

   Why, Why, Why, Why?

2. Why is decision-making the sole prerogative of the husbands in this community? (The specifics will be explored during field work)

   Why, Why, Why, Why?

My Social Network				Location:			
Behaviour of Interest:							
Question:							
Sub-populations:							
Responses	Mother	Religious Leaders	TL	Mother-in-law	Husbands	Father	Neighbours
Individual 1							
Individual 2							
Individual 3							
Individual 4							
Individual 5							
Individual 6							
Individual 7							
Individual 8							
Total							

Annex 2: Phase 2 Tools

ACG Phase 2: SNA Guide for Program Beneficiaries

Interview guidelines

Program beneficiaries (women, fathers, in-laws, and caregivers)

These interviews are to be audio-recorded, transcribed, and translated. The sociogram (network map) is to be developed by research participants with the help of interviewers. The interviewers will photograph the map after the exercise. General name generator questions are to be used to compile a "network partner list." The list will then be narrowed down to identify two categories: the core influencers and the decision makers.

Inclusion Criteria:

1. Woman aged 15 to 49 years who is currently pregnant or with a child under two years
2. Man aged 15 to 49 years who currently has a child under two years
3. Caregiver who currently has a child under two years
4. Has been a beneficiary of the Breakthrough ACTION program

STEP 1: Obtain informed consent using annex/form X

Interview start and end time should be recorded on the socio-demographic forms: _____

STEP 2: Respondent's background

2.1 Respondent's name

2.2 Age

2.3 Ethnicity

2.4 Marital status

2.5 Ethnicity of husband/wife (where applicable)

2.6 Number of children

2.7 Age of the child (the one who is between 0 month and 2 years of age)

2.8 How long has the respondent lived in this community?

2.9 Sex

Section A: Sociogram

STEP 3: Name Generator Questions (Who is involved?)

(Instructions: The questions below should be used to complete the network partner Generator Form. For each person mentioned, obtain their name and their relationship to the respondent. Also, record the number of the question that led to the mention of each name)

3.1 From time to time, most people discuss health matters with other people. With whom do you discuss health-related matters?

3.2 If you feel upset or worried or have a problem and want to talk to someone about it, who do you talk to?

3.3 Who are the people you feel closest to in your life? And why are they the closest?

3.4 When you or your child is sick, who would you ask to help? Again, probe for examples, particularly on the areas of priorities.

3.5 Are there people who call on you when they are sick or in need of help?

3.6 If you want information about maternal and childcare, who would you ask?

3.7 Who comes to you for health information?

3.8 Who are the people that you spend your time with within your free time?

3.9 With whom do you talk when you are out, such as market or while working?

3.10 Who are the people you talk to when attending groups (which groups)?

3.11 Are there people close to you who you have not mentioned yet? (Probe if the spouse is not listed)

3.12 Besides the people you listed, who in this community do you consider to be influential?

Example: Name Generator Form

Name: Halima		Date: August 20, 2020	
Interviewers			
Name	**Relationship (Identify faux kin from real kin)**	**Nomination Questions**	**Decision maker or Core influencer?**
1. Binta	Sister	2.1	
2. Aminat	Women community leader	2.1, 2.2. 2.3	CI
3. Audu	Husband	2.1, 2.2, 2.3	D

STEP 4: Identifying Decision Makers and Influencers on Matters Pertaining to Maternal and Child Wellbeing (Who is involved?)

(Instructions: Refer to the list of network partners on the Name Generator form. Mark "D" next to people who are identified as decision makers ON MATTERS PERTAINING TO MATERNAL AND CHILD WELL BEING. There is no limit on the number of people who can be named. Use the following questions to identify decision makers). Also, note: if the Ego is a decision maker, please indicate on the name generator form and indicate the questions that generated the response.

4.1 Who participates in important decisions related to the upbringing of children in your family and how?

4.2 Who decides if you should seek medical care when you or your child is sick?

4.3 Who decides where you should seek medical care when you or your child is sick?

4.4 Who participates in other important decisions about you or your child? Probe for Immunisation, Childbirth Spacing, Breastfeeding, Newborn Care, Health decisions within the family?

*Instruction: **Refer to names listed from the name generator list.** Mark the name generator list with "CI" next to the most influential people. Allow respondents to record **up to 5 people**. Use the following question:*

4.5 In addition to the people who participate in decision-making, who are the most influential people on the caregiving of your children? This could be someone whose opinions or advice you hold in high esteem, someone who can make you change your mind about a decision or action, or someone whose experience you draw from to make up your mind about a topic or issue/action.

4.6 Tell us the people whose opinion is important on whether you use a method of child spacing/ immunization/ANC or receive treatment for diarrhoea/cough/ fever/child nutrition. This can be people who agree or disagree with you (on child spacing/immunization/ANC or receive treatment for diarrhoea/cough/ fever/child nutrition). Reflect on all the people whose opinion is important to you.

Probe for relationships or titles, for example, friends, neighbours, co-workers, partner, mother, mother-in-law, uncle, aunt, sister, brother, etc.).

STEP 5: Create the Network Map (How are they linked?)

(Instructions: List all decision makers on the network diagram on Post-it Notes. Then list up to 5 most influential persons.)

Color code: Decision makers = pink
Core influencers = blue
Respondent (ego) = green

Use a black marker to draw a shape next to each name to indicate gender:
Draw a square to indicate male
Draw a circle to indicate female

*(Note: It is OK if the respondent, Ego, wants to add different decision makers or core influencers to the map. But there can be **only 5 core influencers**. If they add a 6th influential person, one must be removed. There is no maximum on decision makers, but the maximum number of core influencers is 5.)*

STEP 6: Draw Arrows for Advice, Assistance, And Financial Support

(Instructions: Next, draw arrows showing advice, help, and financial support. The arrow should show the direction of the support. The arrow can be a one-way arrow → or a

two-way arrow ↔.). ***All questions should be narrowed to the areas of interest***

"I would like to know more about these people in your family and community who are concerned about your wellbeing and that of your child. We would like you to tell us about the people who are concerned about you and your child and the types of concerns they have."

Advice (black lines and arrows)—I would like to ask you about people who give you advice about your child or people you advise. (Flow of information)

6.1 Who advises you on child health and wellbeing? (Probe for the content of the advice)

6.2 Did anyone advise you on when it was time to introduce foods other than breast milk? Who?

6.3 Who advises you on care when your child does not feel well?

6.4 Do people come to you for advice about their children? If yes, who?

Emotional Support (green lines and arrows)—I would like to ask you about people who give you emotional support when you are worried or upset about the health of your child.

6.5 Who gives you encouragement or emotional support when you are worried or upset about your child's health or wellbeing?

Financial Support (blue lines and arrows)

6.6 Who helps you pay for your children's expenses when needed?

6.7 Who asks you for financial help?

6.8 Who helps pay for medicine for you or your child?

STEP 7: Tower of Influence (How influential are they?)

(Instructions: Stack chips represent who has the most influence over how you give healthcare for yourself and your child (1 = least influence, 5= most influence). Make sure you go through all the actors on your map and keep in mind that it is crucial to understand not only why they are influential and powerful but also why others are seen as having the least influence)

7.1 I see you have put this actor as the most influential; why? Probe for priority health areas?

7.2 Probe for those who have the same level of influence and why? What happens if they disagree? Is their influence based on the same grounds?

7.3 Probe for those with the least influence and ask why?

STEP 8: Questions on Decision makers and Core Influencers

(Instructions: Fill out one Decision maker and Core Influencer Form on the next page for ***each person on the network map****. You should fill out one survey for each alter, but the questions are asked from the Ego)*

Step 9: Network Density Grid

(Instructions: Use the Network Density Grid [page 49] form to mark an "X" to indicate any decision makers and core influencers who DO NOT KNOW EACH OTHER)

NETWORK DENSITY GRID (List the decision makers and core influencers. Does (name of network partner) know the others? (Place an X in a cell if people DO NOT know each other)).

Section B: Specific Questions on Maternal and Childcare Messaging

1. What are the common health problems faced by members of your community? Probe for specific health problems faced by women and children. Have there been changes in these conditions over the past two years?
2. What platforms exist in your community where maternal and child health topics are discussed, e.g., community meetings, women self-help groups, community leaders, words of mouth, and leaflets? (**Probe** for how people in the community learn about childcare and maternal health).
3. Have you or your spouse ever participated in these platforms? If yes, how recently was this? If yes, ask for the content of the meetings and lessons learned.
4. What changes have you or others in the community experienced due to these community platforms? (**Probe** for knowledge, attitude, and practice changes)
5. What health topics have you heard or seen messaging about in the past six months, *e.g., ANC, child delivery, contraceptives use, care for LLINs, breastfeeding, newborn care, and immunization*? (**Probe** for

Decision maker and Core Influencer Survey

Respondent type: e.g., mother	**Date:**
Interviewers:	**Community/LGA**

(Complete one survey for every decision maker or core influencer (Alter) on the network map. Note: respondent (Ego) provides this information, and not the named network partner (Alter))

Interviewee's code	
Category of respondent	
State and LG	
1. Name of the Alter (copy from the network map)	
2. A decision maker or core influencer? (Copy from the network map)	
3. Sex of ego	
4. Sex of alter	
5. Relationship of interviewee (Ego) to Alter (copy from name generator form)	
6. Community where Alter resides	
7. Does the Alter live in the same household as the respondent (Ego)?	
8. What is alter's ethnicity?	
9. How long has respondent (Ego) known alter?	
10. How often has respondent (Ego) talked to alter in person in the last month?	None, rarely, sometimes, often, always
11. Does Ego speak to Alter about:	
• ANC?	Yes/No
• Exclusive breastfeeding?	Yes/No
• Child spacing?	Yes/No
• Malaria?	Yes/No
12. Does Alter believe it is important to seek ANC at least four times during pregnancy?	Yes/No
13. Does the Alter think Pregnant women should deliver in a health facility/birth attended by skilled personnel?	Yes/No
14. Does the Ego approve of ANC and delivery at health facilities?	Yes/No
15. Does Alter think that Infants < 6 months should be exclusively breastfed?	Yes/No
16. Does the Ego approve of exclusive breastfeeding?	Yes/No
17. Does Alter accept modern child spacing methods?	Yes/No
18. Does Ego approve of modern child spacing methods?	Yes/No
19. For female egos, answer Q19 and Q20	Yes/No
20. Does Ego currently use modern child spacing methods?	Yes/No
21. Has Ego previously used modern child spacing methods?	Yes/No
22. Does Alter think the consequences of malaria are serious	Yes/No
23. Does Alter think children under 5 years old sleep under an long-lasting insecticidal net (LLIN) the previous night?	Yes/No
24. Does Ego approve of LLIN use?	Yes/No
25. Tower of influence score for alter (copy from network map)	

Network Density Grid

Name:	**Date:**
Interviewer:	
Interviewee's Code:	
Category of respondent	

		1	2	3	4	5	6	7	8	9	10	11
	Name											
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												

Who discusses these, e.g., community or religious leaders). What were the health topics discussed?

a. How have these messages you heard or saw influenced your decision on *ANC, child delivery, use of contraceptives, breastfeeding, newborn care, and immunization*?

6. Where do you go for care during i) pregnancy, ii) preventive services for children under 5 years of age, such as immunization, growth monitoring, and other newborn care? (**Probe** for what informs choice)

7. Where do you go when children under 5 years of age are sick? (**Probe** for what informs choice?)

ACG Phase 2: Interview Guide for ACG Members at Local and State Levels

Guidelines for Interviews with Social Behaviour Change Advocacy Core Group (SBC ACG) at LGA and State Levels

I. The procedure of Selecting Participants

a. The IDI will be conducted in a purposively selected project LGAs in the project states

II. Instructions for Facilitators

a. This Interview Guide is simply a roadmap for the interview. The broad items suggest the areas that one has to explore. The sub-items under each broad item are possible probe questions.
b. However, as indicated in the guide itself, all probe points should be asked in some cases.
c. The facilitator is encouraged to keep a notepad for noting down personal observations or reflexive thoughts.
d. Do not prompt the answers to any of the questions; however, if you observe that the discussion is completely out of context, you may gently remind the respondent of the present topic of discussion.
e. Start with some general discussions with the respondent to build a rapport. Then move on to the following guidelines and let the respondent discuss.
f. Carry out the interview in a private setting, i.e., a separate room where no interruptions are likely

III. Interview Guide

1. Background Icebreaker: Can you please tell me a bit about yourself?

a. Where are you from?

b. Where did you study? This includes quranic education and other forms of education that differ from formal education.
c. Where did you work before?

2. Introduction: Would you please give a little background on the Social Behaviour Change Advocacy Core Group (SBC ACG)?
   a. Did you receive training as a member? What training did you receive?
   b. How is the ACG financed?
   c. What are your roles and responsibilities as an ACG member?
   d. How do you achieve these roles and responsibilities?

3. Leadership and Coordination: Would you please provide information on how this program is coordinated at the state, local, and community levels?
   a. Probe for: how supervision is done at various levels. What kind of feedback do you provide?
   b. Probe for meetings with the ACG members at state, local, and community levels? (How often do they have meetings? For what purpose?)
   c. Probe if they provide training

4. According to you, what are the main changes that have occurred, or what changes have you observed at the state, local government, and community levels due to the program?
   a. Would you please give examples of changes in the select harmful traditional norms at the individual and community level? Probe for areas such as unequal agency in health decisions, traditional nutritional practices, and restrictions, and belief in traditional remedies for MNCH problems

5. What support have you received from stakeholders and other community partners in carrying out your activities?

6. What are your thoughts on the effects of this program in the community?
   a. What have been the challenges experienced in working as a member of the SBC-ACG?
   b. In what areas have any aspects of the program motivated you? (Probe for what they liked about the program, probe for key lessons, probe for areas of discontent.
   c. What challenges or barriers did you encounter in carrying out your roles and responsibilities in the communities? (Probe for adequacy of resources, capacity building, planning, and logistics. Probe for challenges on demand creation of RMNCH services)
   d. What has worked well in the overall program implementation. Probe for aspects of the ACG which is more/less useful compared to others? Please provide reasons for your choices
   e. In your opinion, how can the ACG be sustained?
   f. What changes in the program design and/or implementation will help you perform better?

7. Is there anything else you would like to tell us about your work sharing health information with your community?

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