



# How partnering with a women’s civil society organization influenced nutrition practices

**A CASE STUDY FROM NORTHERN NIGERIA**





# :: Introduction

**For more than a decade, Nutrition International has delivered nutrition programs in northern Nigeria, focusing on regions with persistent undernutrition, gender inequality and economic hardship to improve outcomes for women and children.**

Despite significant investments in nutrition services and behaviour change interventions in northern Nigeria, women rarely make independent decisions about antenatal care (ANC), maternal diet, infant feeding or childhood illness treatment. These decisions are usually negotiated within households, where husbands and mothers-in-law control women's mobility, access to resources and adherence to nutrition guidance.<sup>1</sup> For example, a woman's plan to attend antenatal care may be limited by her husband or mother-in-law due to financial constraints or traditional beliefs. Similarly, decisions about a newborn's diet often require approval from senior family members who manage food resources. Although religious and community leaders are not directly involved in household decisions, they shape social norms and expectations that influence family support for women's actions. Religious leaders, for instance, may reinforce values that limit women's autonomy, affecting access to health services. As a result, women can follow nutrition guidance only when permitted, financially supported and protected from social or familial sanctions. In response, Nutrition International integrated gender-responsive approaches into its behaviour change intervention (BCI) strategy, guided by a 2021 sex- and gender-based analysis (SGBA) that identified restrictive norms and male-dominated decision making as barriers to service uptake.<sup>1</sup>

To implement gender-specific components of the strategy, involving a women's civil society organization (CSO) was considered essential for facilitating dialogue with religious leaders, men's and women's groups, and government stakeholders in women's affairs. Nutrition International partnered with a women's CSO, based on research showing that women's CSOs are effective in addressing gendered power relations at the community level.<sup>2</sup> For Nutrition International, partnering with a women's CSO therefore represented a means of strengthening the enabling environment at household and community levels for nutrition programming.



After mapping and a call for proposals, Nutrition International partnered with the Society for Women Development and Empowerment in Nigeria (SWODEN), a women's CSO with deep roots in northern Nigeria. Since 2022, SWODEN, Nutrition International and stakeholders have engaged women, men, leaders, providers and officials to influence agency, decision making and nutrition-related practices.

This case study examines how Nutrition International's partnership with SWODEN influenced women's agency, household decision making, nutrition practices and local institutional engagement in targeted communities in northern Nigeria, drawing lessons for future engagement with women's CSOs.

<sup>i</sup> Behaviour change intervention refers to a structured approach that goes beyond information dissemination to address the social, relational and institutional factors. See: Nutrition International. (2021). *Behaviour change intervention strategy for zinc-LORS and iron folic acid supplementation in Nigeria*.

# :: Methodology



Qualitative methods were employed, including a desk review of program documents, semi-structured interviews and focus group discussions (FGDs).

Purposive sampling was conducted in Abuja and selected SWODEN-supported sites from November 9–19, 2025. In total, SWODEN operates across six states, supporting five local government areas (LGAs) per state and 10 wards per LGA. For this study, fieldwork focused on selected sites in Kano State (Gaya, Wudil and Kano Urban LGAs) and Jigawa State (Dutse-Kudai and Kiyawa LGAs). Sampling targeted 71 individuals (46 men and 25 women) directly engaged with gender norms, including male influencers in *majalisars*;<sup>ii</sup> women (both individually and with their partners); frontline workers; Nutrition International and SWODEN staff; government representatives; and community leaders. Data were thematically analyzed using a contribution lens, with ethical protocols applied throughout.

As this case study is based primarily on qualitative, observational fieldwork from a short-term learning visit with evidence drawn from stakeholder accounts and facility-level observations, the findings should be seen as indicative of how change is described and negotiated within current power structures, rather than as definitive evidence of sustained shifts in women’s decision making authority or institutional practice.

<sup>ii</sup> The Hausa term *majalisar* broadly denotes a council, assembly or meeting space for discussion and decision making. In the context of this learning visit, *majalisar* refers specifically to men’s groups, as male participants used the term to describe their own gathering spaces.

# :: Program overview and approach

The BCI delivery system operated through multiple levels of communication and negotiation, aligning health messages with local structures and expanding women's capacity to act. The behavioural change pathway begins with targeted messaging delivered by intermediaries, such as community health workers and religious leaders. These intermediaries negotiate with gatekeepers, mainly husbands and mothers-in-law, to secure support for women's access to health services. Once approval is obtained, women are more empowered and financially supported to use available services, increasing service uptake. The BCI's effectiveness depends on these intermediaries, targeted messaging and referral pathways connecting communities to health facilities and nutrition practices.

Table 1 summarizes the community engagement structure supporting the BCI delivery system, highlighting the roles of various actors and intermediaries in promoting norm change, household negotiation and service uptake.

**Table 1:** *Community engagement architecture of the gender-responsive BCI*

ENGAGEMENT LAYER	ACTORS INVOLVED	ROLE IN THE BCI DELIVERY SYSTEM
<b>Coordinating intermediary</b>	SWODEN	Embedded BCI within community structures
<b>Community health information network</b>	Community health influencers, promoters and services (CHIPS)	Disseminated BCI messages and referrals through routine community outreach
<b>Moral and normative authority</b>	Religious leaders	Shared BCI messages through sermons and communal events
<b>Male engagement mechanism</b>	Male motivators, husbands, male gatekeepers	Engaged men in spaces to support women's health-seeking
<b>Household-level outreach</b>	Community health workers (CHWs)	Conducted home visits
<b>Platforms</b>	Women leaders, women's rights organizations, women's groups	Integrated gender dialogue into existing women's spaces to reinforce behaviour change
<b>Targeted negotiation</b>	SWODEN facilitators, male gatekeepers	Conducted one-on-one engagement where resistance to women's participation persisted
<b>Capacity strengthening network</b>	Male motivators, CHWs, youth leaders, gender champions	Delivered role-specific BCI messaging on gender norms, nutrition and decision making
<b>Service delivery interface</b>	Health facility staff, frontline health workers	Received and acted on community referrals to translate demand into service uptake

Within this structure, SWODEN acts as a coordinating intermediary, integrating local governance and community systems. SWODEN facilitators describe the BCI approach as structured and responsive, tailoring messages and negotiation strategies to the roles of community actors. As one facilitator explained, "we train [the participants] on how to pass BCI messages in the community, how to approach people ... For service providers, the training process is similar, but the messages vary."

At the operational level, SWODEN identified and recruited influential community actors whose positions provided authority and credibility. These actors helped legitimize nutrition and health messages and increased the social acceptability of women's service uptake. Community health influencers, promoters, and services (CHIPS) supported the spread of BCI messages and referrals across communities, aligning nutrition and gender messages with prevailing health norms.



Mohammed Sankira goes door-to-door connecting with fellow fathers and dads-to-be within his community in Kudai, Jigawa state

**SWODEN engaged religious leaders** through a structured approach that recognized their influence as moral authorities and norm-setters, especially in shaping men's attitudes and public discourse. In collaboration with SWODEN and male motivators, BCI messages were shared in socially accepted spaces such as Friday prayers, weddings, naming ceremonies and other gatherings. SWODEN coordinated this network of community actors, aligning roles, messages and referral pathways within a unified delivery system.

The BCI strategy used both **individual and group engagement** to negotiate with those controlling women's participation in health services. When collective messaging was not enough, SWODEN facilitators engaged directly with male gatekeepers: "We also promote some key messages for BCI to ensure quality services and meet with men where there are challenges or where some men insist that their wives will not participate. We meet with them one-on-one ... when you speak the local language ... they accept you more."

**Training male motivators, community health workers, youth leaders and gender champions was central.**

Modules covered gender norms, respectful care, maternal nutrition, household decision making and referral pathways. Another module focused on how male motivators can support women's health without undermining male authority. Community testimonies highlighted their role in educating men to support their wives' health, emphasizing that male involvement fosters family wellbeing. "Men are the gatekeepers," explained a service provider. "When the man is enlightened, he gives permission, and the wife follows" (Service provider, Wudil).

SWODEN's approach intentionally **linked community sensitization with facility readiness**, ensuring that increased awareness translated into service uptake. Facilitators repeatedly emphasized that community messaging must be reinforced by functional, welcoming health facilities: "Every community intervention must link with the health facility." Health workers corroborated the impact of this alignment, noting marked changes in service-seeking behaviour.

# :: Findings

Key findings indicate that the BCI approach effectively supported individual behaviour change and shifts in community attitudes. Notable results include increased ANC attendance, greater trust in the health system and higher motivation among frontline workers.

**SWODEN's engagement was reported to support individual behaviour changes, gradual shifts in earlier care-seeking and expanded space for women to negotiate their health needs.**

Across both states, men repeatedly described how outreach sessions and community dialogues reshaped their understanding of their responsibilities during pregnancy and early childhood. Men reported accompanying their wives to ANC, providing transport money when they could not go themselves, monitoring IFA intake, and taking on small household tasks when women were fatigued. As one man explained: "Before pregnancy, I used to decide things alone ... now I ask her what she wants to eat. I support her with cooking ... she gives instructions, and I follow. I also help with domestic chores like washing plates, because she is heavy and needs rest." His wife confirmed: "Yes, everything is joint now. The child is healthy. We follow ... all the guidance we received" (Couples meeting, Kudai, Jigawa). These statements illustrate emerging practices of shared decision making, a significant departure from norms that gave husbands sole authority.

Women similarly described a softening of household gatekeeping, with access to ANC becoming more collaborative as husbands and mothers-in-law were increasingly enlightened regularly on why women should go for ANC. While women still rarely travelled without informing household members, the nature of negotiation shifted from prohibition to consultation, expanding women's practical room to act even as male authority formally remained intact. As women in FGDs noted: "Husbands and mothers-in-law are more cooperative because they are being enlightened regularly on why women should go for antenatal care" (FGD, female community members, Kudai).



When discussing with male motivators, they shared their experiences and explained the changes regarding permission to seek antenatal care: "Previously, many women faced serious challenges in getting permission from their husbands to go for ANC or health services ... but with this project, things have improved significantly. Men now understand the benefits ... they realize that this reduces complications and costs at delivery."

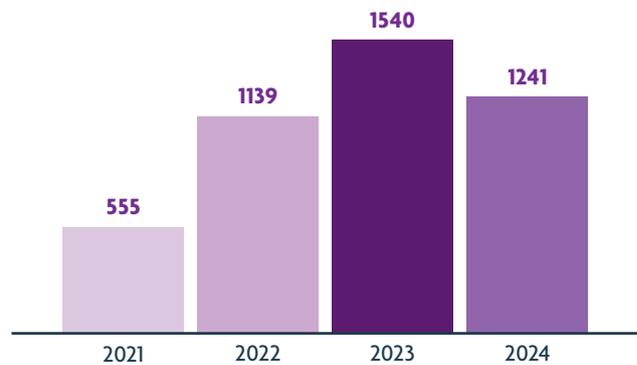


There are emerging forms of collective agency among women, particularly when navigating resistance within the household.<sup>iii</sup> In earlier phases, women rarely challenged a husband's refusal alone; over time, older women and peers increasingly intervened on one another's behalf, creating a shared buffer against gatekeeping. Furthermore, women's nutrition knowledge did not automatically translate into improved practices without collective support. Women's groups and informal networks played a critical role in strengthening shared negotiation power and reducing social risk when challenging household norms. "In emergencies, for example, when the husband is at the farm, and the woman enters labour, other women in the household accompany her to the hospital," explained a female community member. "When the husband returns, he is informed, and he accepts the explanation" (FGD, female community members, Kudai, Jigawa).

While still emerging, collective support among women was reported in multiple sites, suggesting early community-level shifts, from individual negotiation to collective endorsement of women's right to seek care.

**Ongoing community engagement and male involvement contributed to earlier ANC uptake and improved maternal and child nutrition practices by shifting local care-seeking norms.**

Across all study locations, health workers reported clear signs that women are seeking ANC earlier than in previous years. They attributed this shift to repeated community sensitization and the growing role men play in facilitating access to care. According to one provider in Kudai, "before, women waited until seven to nine months. Now they come at two or three months because outreach explains the importance of early attendance" (Health worker, Kudai, Jigawa).



**Figure 1: GAYA-Kano ANC attendance**

Figure 1 shows ANC attendance trends in Gaya, Kano, from 2021 to 2024, with a marked increase between 2021 and 2023, followed by stabilization in 2024. Attendance more than doubled between 2021 and 2023, reflecting earlier initiation and more consistent follow-up rather than changes in fertility patterns. The 2023 peak is linked to intensified community mobilization, male engagement and periods of incentive-linked service delivery from other organizations that temporarily increased uptake.

Although attendance in 2024 is slightly lower than in 2023, it remains well above the 2021 baseline. This suggests that changes in knowledge, male involvement and community norms are taking hold, though attendance remains sensitive to economic pressures and prevailing social norms.

<sup>iii</sup> Women's agency is the ability to make decisions regarding nutrition, household practices and mobility. Collective agency involves women's membership in groups and networks, highlighting that empowerment comes from both individual autonomy and collaborative efforts (Barak et al., 2023, pp. 231–32). Women's agency in nutrition-related decisions is assessed by their involvement in food choices, even within restrictive environments (Barak et al., 2023, pp. 231–32).



According to health facilitators, there is an improvement in IFA adherence, a longstanding challenge in maternal nutrition programming in northern Nigeria, recognized in the SGBA report. Previously, resistance to IFA was shaped by entrenched beliefs that supplements could harm the pregnancy or complicate childbirth. As one health facilitator explained, women associated ANC-provided supplements with negative outcomes, including fears that iron and folate would cause excessive fetal growth and obstruct delivery: “There were a lot of problems. Many pregnant mothers did not want the facility ... When they [pregnant women] came, they said the ANC attendant used to give them ANC drugs like iron and folate” (Health facilitator, Kiyawa).

The BCI provided frontline providers and community actors with consistent messaging on iron and folate. The program reduced misinformation and reframed IFA as a protective factor for maternal and newborn health: “When this program came, we were trained. They provided training on iron, folate and other interventions. We were equipped and passed the information to the ANC attendant and the community” (Health facilitator, Kiyawa).

Importantly, adherence was often narrated through visible outcomes, which reinforced acceptance within households. Male respondents emphasized experiential learning, observing improvements in maternal health and newborn outcomes when women followed ANC guidance, including IFA use. “From my own experience,” a community member in Kiyawa said, “I can testify that when a pregnant woman takes her iron folic acid and follows the food education provided through the program, her delivery is smoother and without complications. The babies born to such mothers are noticeably healthier.”

Changes were also reported in child nutrition and the management of childhood illnesses. Respondents noted increased awareness of the benefits of zinc and oral rehydration salts (ORS) for the treatment of diarrhea in infants and young children. These accounts reflect both perceptions and observed changes in practice: “We have seen a reduction in maternal and child mortality because women and now using the advice and support we give them” (Gender desk officer, Jigawa).



Male motivator Mohammed Sankira holds up one of the BCI materials encouraging pregnant women and their spouses to visit the nearest maternity care centre.

Beyond illness management, respondents reported broader shifts in nutrition-related practices affecting children (including breastfeeding) featured prominently, particularly in the work of male motivators. “I discuss maintaining young child nutrition,” said a male motivator from Gaya. “There are young children who are malnourished because breastfeeding practices have dropped ... I discuss with them the importance of maintaining breastfeeding and early initiation of breastfeeding.”

Respondents also highlighted the impact of food demonstrations and facility-based counselling on dietary habits, noting that women now better understand how to combine local foods. This approach was confirmed at the state level as essential.

Overall, the evidence suggests that improvements in ANC attendance, IFA adherence and child nutrition practices reflect emerging shifts in household support and shared knowledge. Engaging men, health workers and community actors can help reframe how these initiatives are viewed and implemented.

### **Trust emerged as a key mechanism enabling gender-responsive nutrition messages to gain legitimacy in the community.**

Nutrition International’s staff emphasized that effective community engagement required cultural fluency and relational sensitivity. The BCI approach relied on working with people (such as through community dialogue) who were already part of the social fabric, understood local norms and could communicate without triggering defensiveness. As one Nutrition International staff explained, “I will say the community dialogue has been very instrumental to get them to buy in, get them to accept and own it, because of the way we have structured the communication with the community themselves, working with SWODEN.”



Training is delivered to male motivators by Mercy Edmonds, a program officer with SWODEN. The session covers gender norms, the role of men and the role of mothers-in-law in supporting ANC attendance.

Community members reported that trust deepened when religious and traditional leaders echoed maternal health messages during Friday prayers and *majalisar* gatherings, as well as at shops and social events. One male motivator described that he regularly meets a man at the shop and uses these encounters to build rapport and encourage small improvements for the man's pregnant wife, even when he resisted what he called "western medicine." Evidence from comparable contexts shows that such socially legitimate spaces are critical entry points for engaging men in maternal health, particularly in settings where pregnancy and childbirth are normatively framed as women's responsibility.<sup>3</sup> Similarly, research demonstrates that men are more receptive to health messages delivered by trusted peers embedded within their communities, and that behaviour change often begins with incremental actions, such as approving care seeking or providing resources, before deeper normative shifts occur.<sup>4</sup>

**The partnership model was reported to add clear delivery value by extending reach through trusted local actors and strengthening community confidence in services.**

The partnership between Nutrition International and SWODEN was intended as a strategic mechanism to enable entry into social spaces and local systems that would have been difficult for an external actor or short-term extension worker to access independently.

The partnership enabled Nutrition International to mobilize and align a diverse network of frontline actors, including male motivators, health workers and community facilitators, who carried BCI messages into the everyday spaces where norms are negotiated. While they were often formally linked to the health system or community structures, their effectiveness depended on sustained credibility and coordination. SWODEN's role as a trusted intermediary allowed the technical messages to circulate repeatedly through familiar channels, delivered by individuals who communities already recognized and respected.



Health workers consistently noted that Nutrition International's collaboration with SWODEN strengthened community confidence in facility-based services. Outreach activities helped bridge historical mistrust between communities and the health system, reinforcing the perception that facilities were accessible, relevant and responsive. This relational bridge was critical to improving service uptake and was described as more effective than facility-based or externally driven outreach alone.

A further strength of the partnership was its role in sustaining the motivation of frontline community actors, particularly male motivators. Several described how working within the partnership renewed their sense of purpose and reinforced their accountability to the communities they serve. As one male motivator explained, "The next is the most important. I am saying this from my life. SWODEN renewed this gentleness in me. Even if they say we should stop, the community knows the importance of the work. Whenever they see me, they say, 'many days you did not come for enlightenment'. Without SWODEN this work will not stop, but with SWODEN this work improves" (Male motivator, Wudil, Kano).

### **Effective community-based models require strong co-ownership with state and LGA authorities for sustainability.**

Although the partnership successfully encouraged positive behavioural change at the community level, Nutrition International's role was often invisible, and in some contexts, there was a lack of awareness between actors at different levels of government. In the future, there is an opportunity to embed this partnership model within broader implementation plans so that gender-responsive approaches are not dependent on individual project funding.

These findings point to practical implications for how gender-responsive behaviour change strategies can be designed and sustained to translate normative shifts into durable improvements in women's nutrition, health-seeking and household decision making.

# ::: Conclusion

The northern Nigeria experience demonstrates that engaging local civil society organizations as key partners in behaviour change strategies can meaningfully shift household decision making, community acceptance and service uptake. Communities reported increased male support for ANC, earlier care seeking and greater confidence among women in navigating health decisions.

These gains show what is possible when behaviour change efforts intentionally address gender barriers. Moving forward, it is important to sustain investment in local civil society partners, meaningful engagement with men and the integration of gender-responsive strategies across both community and facility systems.

## RECOMMENDATIONS

- 1 Embed gendered power relations as a core design requirement**

This case study shows that nutrition practices in northern Nigeria improved when programs addressed gendered power relations, household gatekeeping and institutional legitimacy, rather than focusing only on individual behaviour change.
- 2 Engage respected local actors over the long term**

Norm change was most effective when programs worked through trusted local actors such as male motivators, community health agents and women leaders, supported by clear role definition, mentorship and recognition. Behaviour change efforts were more accepted and durable when delivered through trusted social, religious and community structures where norms are formed and reinforced.
- 3 Engage influential household actors**

Mothers-in-law and other senior family members significantly influence decisions about antenatal care, dietary practices and supplement adherence, and should be intentionally involved in behaviour change efforts.
- 4 Strengthen institutional credibility and sustainability through visible, system-aligned partnerships**

Joint visibility and structured engagement with local government nutrition platforms required careful coordination and adaptive relationship management. While initially challenging, these efforts ultimately improved alignment and reduced duplication.
- 5 Prioritize investment in gender-responsive and transformative programming**

Effective investments require funding for gender analysis and adaptive design, support for collective and community-based norm change mechanisms, inclusion of women's civil society organizations as strategic partners, and early planning for institutionalization within government systems.

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