

Navigating Social Norms and Community Narratives: A Thematic Analysis of Health
Communication Practices in Northern Nigeria.

by

Faridah Kwandala Abraham

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Approved by:

Major Professor
Dr Sean Eddington

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Abstract

Nigeria widely known as the giant of Africa, rich in abundant natural and human resources, and despite its abundant resources, continues to experience severe health inequities, reflected through high mortality rates in women and children and persistently low life expectancy (Matthew Ayodele et al., 2024) These disparities are most pronounced in Northern Nigeria, where factors like religious beliefs, gender norms, stigma, and reliance on spiritual beliefs strongly shape health behaviors and decision-making processes.

This study is a deep analysis of the disconnect that exist between dominant health communication strategies and the socio-cultural realities that influence health beliefs and practices in Northern Nigerian communities. Anchored on the Social Norms Theory (Bak et al., 2021) and the Culture-Centered Approach (Dutta, 2008), the research explored the various ways social norms influence health related beliefs and behaviors across maternal and infant health, infectious diseases, and noncommunicable conditions, while assessing the effectiveness of existing health communication practices.

Data was collected qualitatively through semi structured interviews and participant observation, and patterns on how health messages were interpreted, legitimized, and acted upon within sociocultural contexts were identified using thematic analysis.

Findings from the study reveals that health communication in Northern Nigeria continuously gets filtered through religious and cultural filters. Leaders of faith such as Imams and traditional leaders emerged as the central figures of medical authority, determining if medical information is accepted or dismissed, especially in the contexts where institutional trust in formal

health institutions remains fragile. In the same vein, traditional and biomedical knowledge systems coexist, gender hierarchies hindered the agency of women's health and yet community-trusted figures and culturally resonant communication strategies transformed social norms into facilitators of sustained health behavior change.

The findings show that strategically engaging with the culturally embedded norms can greatly improve health communication outcomes in complex sociocultural settings.

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Dedication

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Preface

This research investigates how social norms shape health communication practices in Northern Nigeria, with particular attention to maternal health, vaccination uptake, and mental health stigma. It aims to illuminate culturally grounded strategies for improving health literacy and outcomes in underserved communities.

My interest in this topic stems from the fact that from where I came from, girls are ordinarily not allowed to go to school, and from experience I witnessed firsthand how cultural narratives influence how health messages are received and interpreted.

As a researcher working within academic and community settings, I approach this study with humility and a commitment to amplifying local voices. I recognize the privilege of conducting research in communities where trust and cultural sensitivity are paramount.

I am deeply grateful to the community health workers, local leaders, and participants who generously shared their time and insights. Their contributions shaped the heart of this research.

The chapters that follow explore theoretical frameworks, fieldwork findings, and culturally adaptive recommendations for health communication strategies in Northern Nigeria.

Chapter 1 - Introduction

Background

The Northern Nigeria geopolitical zones continue to experience deep public health challenges characterized by high maternal and infant mortality rate, low immunization coverage, and limited access to reproductive health services (Matthew Ayodele et al., 2024). Maternal mortality ratios in the region range between 800 and 1,200 deaths per 100,000 live births, which is substantially more than the national average and among the highest globally (National Population Commission [NPC] & ICF, 2019; Adedokun & Uthman, 2019). These alarming figures are as a result of multiple intersecting factors such as limited access to skilled birth attendants, widespread reliance on traditional birthing practices, and male-dominated decision-making systems that restrict the agency of women in matters that concern their health (Matthew Ayodele et al., 2024; Doctor et al., 2018).

Disparities in this form negatively impact the health of children as well, with infant mortality rate disproportionately high in Northern Nigeria, exceeding 74 deaths per 1,000 live births in some Northern Nigerian states, which is almost double the rates in southern regions (Shobiye et al., 2022). It is noteworthy that infrastructural deficits alone cannot explain such health disparities as they also reflect complex sociocultural dynamics at play, that shape health-seeking behaviors and attitudes to how modern medicine is viewed (Weisner & Cameron, 2015). Factors like cultural practices, religious beliefs, and patriarchal social structures together create a complex context where biomedical recommendations frequently conflict with prevailing community values and norms (Shehu, 2015). Interpretations of health and illness by religious leaders, particularly within communities dominated by Muslims, show spiritual dimensions of well-being and positions health outcomes as expressions of divine will (Padela et al., 2011). Consequently, traditional

healing practices maintain strong legitimacy, rooted in centuries of indigenous knowledge and healing wisdom transmitted overtime from generation to generation (Janzen, 1978). Health behaviours are influenced by gender norms, as patriarchal family structures put so much decision-making powers in male household heads to the extent of limiting the independence of women's access to care (Ilyasu, Z., et al, 2012). These complex sociocultural dynamics become heightened with historically grounded mistrust of public health interventions alongside episodes of misinformation, persistent rumors connecting the polio vaccines to sterilization plots is rooted in broader mistrust of government and foreign-led initiatives, and leading to widespread apprehension towards programs related to immunization (Jegede, 2007). The 2003 polio vaccine boycott in Northern Nigeria, led by religious and traditional leaders, is a clear example of how the historical memory of past colonial medical exploitation and contemporary political marginalization negatively influenced collective resistance to public health interventions (Obadare, 2005).

Consequently, family planning and contraceptive use is usually resisted due to their religious interpretations and cultural ideologies that value large family size as signs of divine blessing and community strength (Akinyemi et al., 2020; Okonofua et al., 2018). The use of contraceptive is usually stigmatized among women who are unmarried and are rebuked morally for perceived sexual impropriety if they choose to seek reproductive health services (Balogun et al., 2021). These factors reveal the various ways social norms, which are the informal often unspoken rules guiding acceptable behavior within communities, play a significant role in shaping health decisions and outcomes (Eriksson, L. 2018). Even with these realities at play, dominant health communication approaches in this region have only achieved a little success. Conventional top-down, information-driven models operate on the assumption that individuals will adopt

healthier behaviors once adequately informed about health risks and protective practices (Airhihenbuwa & Obregon, 2000). Furthermore, these hierarchical models do not regard the relational and collective nature of health decision-making in norm-regulated communities (Dutta, 2008). Behavioral change in this context does not rely on the function of knowledge acquisition but is influenced by social expectations, communal validation, and moral judgments embedded in everyday life (Eriksson L 2018, Cislighi & Heise, 2019). Consequently, health interventions that fail to account for these normative dynamics often get resisted, misinterpreted, or selectively adapted in ways that disregard their intended effects (Airhihenbuwa & Obregon, 2000). In addressing these persistent gaps, this thesis argues that the persistent failure of health communication in Northern Nigeria is fundamentally a normative problem, and not informational and achieving meaningful health behavior change requires a drastic shift from the usual hierarchical ,biomedical messaging to a culturally grounded, participatory communication strategy that carries religious and traditional authority structures along, honoring existing knowledge systems, and pco-creating with co communities rather than perceiving them as passive recipients of health information.

Problem Statement

Persistent health disparities and the limited effectiveness of conventional interventions indicate critical gaps strategies used in public health and realities of these communities that demand systematic investigation. Theres been decades of sustained public health campaigns and substantial international interventions in health system strengthening, but nonetheless, Northern Nigeria remains one of the regions in sub-Saharan Africa with the most alarming, noteworthy health indicators (National Population Commission & ICF, 2019). Though several factors like weak healthcare infrastructure and inadequate workforce capacity contribute significantly to these

outcomes, structural deficits do not give adequate explanations to this persistent resistance to available health services (Weisner & Cameron, 2015). A critical but less talked about factor is the influence of social norms and cultural meanings which fundamentally shape the health behaviors of the people, their attitudes toward modern medicine, and their receptivity to health communication interventions.

These normative influences reveal themselves through different connecting pathways such as mistrust in governmental and foreign-led health initiatives, deeply rooted in the historical experiences of colonial exploitation and contemporary political marginalization, which over time creates unfathomable hindrances to acceptance of these interventions (Jegede, 2007; Obadare, 2005). At the household level, issues related to reproductive health are usually gender controlled, where the male household head exercises authority over the healthcare access of the women and children, constraining them from seeking the most needed health care even when these health services are available and accessible (Ilyasu Z, 2018; Sinai et al., 2024). Simultaneously, how religion interprets illness and healing demonstrates spiritual causation and divine will, and positions biomedical interventions as potentially incompatible with faith-based worldviews (Padela et al., 2011). Such intersecting factors collectively restrict the acceptance and adoption of relevant health interventions from routine immunization to maternal healthcare as well as family planning services.

Furthermore, even with the prominence of these sociocultural realities, these normative structures have always been overlooked by dominant health communication strategies, rather than giving more focus to disseminating information with limited meaningful community engagement (Airhihenbuwa & Obregon, 2000; Dutta, 2008). Health campaigns typically employ standardized messages developed by external experts, and delivered through mass media or outreach workers,

with minimal adaptation to local cultural contexts or participation from community members in message design (Kreps & Sparks, 2008). As a result of these minimal adaptations, public health efforts often appear disconnected from the local realities of these communities, and fail to resonate with their values, and lack the cultural legitimacy necessary to influence deeply entrenched behaviors (Adebayo, C.T et al. 2026).

The disconnect between health communication approaches and community sociocultural realities depicts a huge gap in scholarship and practice. Though so many literatures document health disparities in Northern Nigeria identifying cultural factors as barriers to the success of these interventions, very few among them systematically examine how social norms mediate the interpretation and founded communication strategies could be co-created with communities to enhance engagement and effectiveness. The aim of this study is to address this gap by examining the normative mechanisms through which health messages are filtered, negotiated, and accepted or rejected, and identifying community-based approaches which would be relevant to designing culturally resonant health messages.

Rationale

A clear understanding of the various ways social norms shape how effective health messages in Northern Nigeria, is necessary for developing interventions that can closet the persistent gap between the objectives of public health and the realities of these communities. The distinct sociocultural terrain of the region, influenced by powerful religious leadership, deeply embedded patriarchal structures, and traditional community governance systems, will require thinking in strategic ways on how public health messages are conceptualized, constructed, delivered, and received (Shehu, 2015). Health communication, as broadly described is the strategic use of communication to inform and influence individual and community decisions that enhance

health (Kreps, 2013); must be reconceptualized in this context to move beyond biomedical or Western-centric paradigms that dominate global health conversations.

In Northern Nigeria, as in many collectivist societies, health behaviors are rarely the result of autonomous individual choice (Paternotte, C. 2018). Instead, they are profoundly mediated by factors like collective beliefs, shared practices, religious teachings, and the opinions and endorsements of influential community actors which are not exclusive of leaders of faith, traditional healers, elders, and family heads (Shehu, 2015; Padela et al., 2011). Social norms, the informal and often unspoken rules that govern acceptable behavior within groups, play a pivotal role in shaping health-seeking behaviors, reproductive choices, disease prevention practices, and perceptions of health interventions (Paternotte, C. et al, 2018).; Cislighi & Heise, 2019).

Instances shown overtime through documented incidences depict the immense influence social norms has on health intervention outcomes; like the widespread resistance to polio immunization campaigns in the early 2000s which was less driven by ignorance of vaccine benefits and impacted more by lack of trust in the motives of the government, religious leaders' interpretations questioning vaccine safety, and the fear the community has about Western interference in Muslim communities (Jegede, 2007; Obadare, 2005). The research shows that endorsement or opposition from religious and traditional leaders influence how communities comply with patterns which are more powerful than mass media campaigns or health worker counseling (Kaufman et al., 2009; Ghinai et al., 2013).

Inspite of decades of funds spent on public health interventions in Northern Nigeria, the normative mechanisms through which communities filter, negotiate, and respond to health messages remains critically understudied. Previous Interventions have consistently failed to account for the deeply relational and culturally embedded nature of health decision-making in this

context, revealing an urgent need for research that goes beyond documenting constraint to understanding the various ways social norms actually function as forces that influence health communication. The autonomy of women in making health decisions is further constrained by gender norms that position husbands or male family elders as primary decision-makers even in matters directly concerning the health of women (Sinai et al., 2024), yet this dynamic is rarely centered in communication intervention design. This study is therefore crucial to develop empirically grounded, culturally responsive insights that can inform how health messages are negotiated, constructed, delivered, and received in ways that reflect the lived realities of Northern Nigerian communities.

Instances like this show that effective public health interventions require the same level of attention to local culture and community dynamics as to scientific evidence and clinical best practices. When Interventions are designed without considering the cultural contexts, dismissing traditional knowledge systems, or bypassing community authority structures consistently, they tend to encounter resistance, selective adaptation, or outright rejection even if they are biomedically valid (Airhihenbuwa & Obregon, 2000; Dutta, 2008).

The concept of health literacy makes it central to understanding why health communication fails in the Northern Nigerian region. Health literacy can be broadly described as the degree to which individuals can obtain, process, and understand basic health information and services which are necessary in making informed health decisions (Nutbeam, 2000; Selden et al., 2000). It encompasses the ability to read health materials with understanding and the capacity to effectively navigate health systems, critically analyzed health information, and apply that information to one's own circumstances (Nutbeam & Muscat, 2021). In the Northern Nigeria region, understanding

health literacy through individual cognitive capacity is almost impossible. Communities have their own deeply embedded health knowledge frameworks grounded in Islamic teachings, traditional healing practices, and collectively held understandings of illness and wellbeing that function as legitimate systems of health sense-making. When biomedical health communication fails to acknowledge or engage these frameworks, communities do not exhibit a deficit of health literacy; rather, interventions fail to meet communities where they are within the health literacy systems they already hold. Leaders of faith occupy a particularly significant position within this system, acting as authoritative interpreters of Islamic teachings. Imams and other faith leaders shape how communities understand health, illness, and the acceptability of health-seeking behaviors, functioning as both enablers of health literacy when they align religious guidance with health promotion, and as potential barriers when religious interpretations discourage biomedical care-seeking. An excellent understanding of the role of religious leaders in shaping community health literacy is therefore foundational to understanding why health communication in this region succeeds or fails.

This study responds to these challenges by examining how individuals in Northern Nigerian communities interpret, negotiate, and respond to health messages within their normative sociocultural contexts. Specifically, it examined how prevailing social norms facilitate or constrain the acceptance of health messages and how community narratives, values, beliefs and lived experiences can inform more effective communication strategies. The study employed a culturally responsive, participatory approach to health communication, grounded in Paulo Freire's (1970) dialogical model, which emphasizes co-creation of knowledge, recognition of local agency, and mutual learning between external health actors and community members.

This approach aligns with the Culture-Centered Approach to health communication, which critiques dominant biomedical paradigms for marginalizing local knowledge and voices, and advocates for participatory processes that situate communities as active agents in defining health priorities and designing health interventions that pertain to them rather than situating them as passive recipients of expert-designed programs (Dutta, 2008). Much attention is given to community perspectives, respecting local epistemologies, and engaging with normative structures rather than attempting to circumvent them. This study sought to identify pathways for health communication that achieve both cultural resonance and behavioral impact.

Study Objectives

The study is driven by three broad objectives that align directly with the gaps identified in the problem statement; First, community members lack of trust for government-led interventions, religious interpretation of illness and gender-controlled health decision making all work together to shape the receptivity of health messages and this study seeks to explore the various ways individuals in Northern Nigerian communities interpret and respond to health communication messages within the context of prevailing social norms and communal expectations. Secondly, understanding that dominant health communication strategies have consistently ignored normative structures through their dissemination channels over meaningful community engagement and this study aims to examine the various ways dominant and contested social norms facilitate or constrain the uptake of health-promoting behaviors communicated through public health campaigns. Lastly, in response to the critical gap in scholarship where very few studies systematically examined how communication strategies could be co-created with communities to improve engagement and effectiveness, this study seeks to have a better understanding of how community narratives and

culturally embedded meanings informs the co-creation of health communication strategies that reflect the lived experiences of marginalized communities. The three listed objectives shift the focus of the study toward understanding normative influence in health communication and documenting those health disparities, and the specific research questions that bring these objectives to life are presented in Chapter Two following the theoretical framework.

Theoretical and Methodological approach

The study is theoretically grounded in two complementary frameworks, the Social Norms theory (Patternotte, C. 2018) who provided the lens for better understanding of informal rules and collective expectations shape individual health behaviors, by differentiating the descriptive norms that describe what people perceive others to do and the injunctive norms which describes what people believe others approve or disapprove of.. The Culture Center Approach (Dutta, 2008) complement this by positioning community voices, local knowledge systems, and cultural agency in the design and reception of health communication. Collectively the SNT and CCA framework advances the analysis from an individualistic, information deficit model to a relational model of understanding how health messages are filtered, negotiated and acted upon within socio-culturally complex communities which is well detailed in chapter two.

The study employed a qualitative research design, appropriate for studying complex social processes, cultural meanings, and normative dynamics that cannot be adequately captured using a quantitative approach (Creswell J. W., 2000). The data for the study was collected across three Northern Nigerian states; Katsina state, Jigawa state and AMAC Abuja through semi-structured interviews, focus group discussions and participants observation, engaging twenty purposively selected participants drawn from community members, health workers and community leaders.

Thematic analysis, as articulated by Braun and Clarke (2006), was also employed to guide the analytical process, allowing for both inductive exploration of emergent themes and deductive engagement with the theoretical frameworks as presented in chapter three.

Significance of Study

This study advances theory, methodology, and practice in health communication meaningfully; Theoretically, it extends Social Norms Theory by showing how norms are influenced in deeply religious communities and how they operate through hierarchical authority systems, especially through faith leaders, depicting the hierarchical pathways of influence that standard peer-influence models do not account for (Patternotte, C. 2015). It also advances the Culture-Centered Approach by showing that Theo-cultural epistemologies; the way meanings are made through the integration of religious teachings, traditional knowledge, and cultural values which shapes the reception of health communication relevant for authentic community engagement rather than instrumental adaptation (Dutta, 2008).

Methodologically, the study shows the relevance of qualitative inquiry when conducted in local languages, across diverse stakeholder groups, and within sustained community engagement for producing contextually grounded insights in normatively complex settings. As an exploratory study, it seeks to generate findings that are statistically transferable; and also generates conceptual insights identifying normative mechanisms that future empirical research can build upon. Future studies are encouraged to develop quantitative or mixed methods approaches to measure the specific concepts proposed in this one, including the role of religious authority in shifting norm, the relationship between linguistic accessibility and message uptake, and the long-term impact of participatory communication strategies on health outcomes in Northern Nigeria.

Practically, the findings provide actionable steps for policymakers and health communication practitioners seeking culturally responsive strategies. The study identifies the ways in which religious framing, trust hierarchies, patriarchal gatekeeping, and epistemological pluralism function as factors that influence health communication and show how strategically collaborating with these structures can create more effective and sustainable pathways to change health behavior.

Research Questions

The study is guided by the Social Norms Theory (Patternotte, C 2018) and the Culture Centered Approach (Dutta, 2008) focused on responding to the questions; How did individuals in Northern Nigerian communities interpret and respond to health communication messages in relation to prevailing social norms and communal expectations? And in what ways do dominant and contested social norms facilitate or constrain the uptake of health-promoting behaviors communicated through public health campaigns? as well as how can community narratives and culturally embedded meanings inform the co-creation of health communication strategies that reflect the lived experiences of marginalized groups? This overarching research question recognized that how people receive health messages is not a one-way approach but largely influenced by social expectations and collective meaning making, and that social norms function as facilitator and constraint to health promoting behaviors and that communities are actively involved in how their meaning is made. The specific research questions that operationalize this broad inquiry are elaborated in chapter two after the theoretical frameworks relevant to engage with them fully.

Methodological Overview

This study adopted a qualitative research design approach supported by thematic analysis employed in exploring the lived experiences, values, beliefs and traditions of participants from Northern Nigeria as interpretive frameworks regarding health communication and social norms. A qualitative methodology was appropriate given that the aim of the study is to better understand complex social processes, cultural meanings, and normative influences that other research approaches could not adequately capture (Creswell J. W., & Whittaker, E. 2000). The data was collected between August and November 2025 using multiple complementary methods like in-depth interviews, focus group discussions, and observations conducted in selected Northern Nigerian communities across Jigawa State, Katsina State, and Abuja Municipal Area Council, engaging twenty purposively selected participants drawn from community members, health workers, and community leaders comprehensively presented in Chapter Three.

Two complementary theories drive this study, providing a robust lens for exploring health communication in normatively complex environments. The first theory, the Social Norms Theory (Patternotte, C 2018) provides a lens for understanding how perceived norms such as descriptive norms; the perception of what others do and the injunctive norm, the perception of what others approve or disapprove of, shape the health behavior of individuals and how they collectively make meaning within communities. The Culture-Centered Approach (Dutta, 2008) complements the SNT by situating community voices, local knowledge systems, and cultural agency in the design and reception of health communication, thereby challenging top-down biomedical models by placing community agency and dialogue as the center point for effective and ethical health communication.

Collectively, the two frameworks advance the analysis beyond individualistic, information-deficit models toward a relational understanding of how health messages are filtered,

negotiated, and acted upon within socio-culturally complex communities. Instead of social norms to be perceived as fixed barriers to health behavior change, these frameworks affirm that norms vary across different groups and contexts, but are contested and negotiated, with potential for change through strategic engagement with norm entrepreneurs and community advocates (Patternotte, C 2018; Cislighi & Heise, 2019). Detailed engagement with both frameworks is developed in Chapter Two.

Organization of the Thesis

This thesis is logically ordered in five well detailed chapters that systematically address the research problems, present empirical findings, and discuss theoretical and practical implications.

Chapter One establishes the contextual, theoretical, and empirical foundations of the study, documenting the crisis experienced in the Northern Nigerian public health system, identifying the gaps between conventional health communication approaches and the realities of the community socio-culturally and went further to articulate the research problem and questions thereby outlining the significance of the study. Chapter two then reviews the relevant literature on health communication, social norms, and participatory approaches, situating the study within broader scholarly debates and analyzing global perspectives on health communication, narrowing the focus to African and Nigerian contexts, while providing detailed information of the sociocultural landscape inherent in the Northern Nigerian focus region. The theoretical frameworks such as the Social Norms Theory and the Culture-Centered Approach that guides the study were then presented in detail showing how relevant and complementary it is to understand health communication in complex normative contexts.

Chapter Three provides an outline of the research design, elaborating how the data was collected, alongside its analytical framework; articulating the interpretivist philosophical orientation of the study and justifying the methodological choices made. It also describes the sampling strategy and participant recruitment process done, explaining the data collection methods in detail while outlining the thematic analysis process, addressing the ethical considerations, and discussing the strategies for ensuring trustworthiness. The chapter provides enough detail to enable the assessment of methodological rigor and potential replication or adaptation in similar contexts to Northern Nigeria.

Chapter Four presents and analyzes the findings in a sequential order around the three focus research questions; supporting the advancement of the analytical arguments of the research rather than just superficial description of themes on the various ways interpretation of health message functions as cultural translation, how social norms operate as both enablers and constraints, and how community narratives provide the blueprints for co-creating resonant communication. Each major section follows the pattern of restating the relevant research question, presenting a central claim responding to the question, and supporting that claim through thematic analysis grounded in participant narratives and theoretical frameworks.

Conclusively, chapter five interprets the findings through theoretical lenses, comparatively analyzing them alongside existing literature, exploring their unexpected patterns and conceptual tensions, as well as discussing the theoretical, methodological, and practical implications of the study. It translates the analytical insights generated into actionable recommendations for policymakers, practitioners, and researchers, thereby acknowledging the limitations of the study and identifying positive directions for future research. The chapter concludes with a synthesis of

the contributions of the study articulating a clear vision for health communication as relational practice grounded in cultural respect, community partnership, and dialogical engagement for better health receptivity and outcomes.

Collectively, these chapters provide a comprehensive examination of the various ways social norms mediate health communication in the Northern Nigeria region, generating insights which are significant for theory development, innovations in methodology, and practical effective design of intervention in Nigeria and globally.

Chapter 2 - Literature Review

Introduction

The challenges of Health communication in Northern Nigeria cannot be underestimated and understood by deficit information or individual decision-making models; but through scholarly literature revealing that communication is filtered through social norms, cultural paradigms and power relations that govern everyday life. This chapter is an exploration of the key scholarly conversations that inform this study, with keen focus on the various ways social norms shape the interpretation, negotiation, and uptake of health communication in normatively complex environments. To ensure deep focus is given to specific communication literature; the chapter pays much attention to four bodies of scholarship directly relevant to the research questions; global health communication paradigms and their limitations in culturally complex contexts; health communication dynamics within the African and Nigerian context; the intersection of social norms and health behaviors specifically in Northern Nigeria; and the two guided theoretical frameworks of the study, the Social Norms Theory and the Culture-Centered Approach.

This chapter analytically begins by examining global perspectives to an increasingly localized contexts, progressively showing that dominant health communication approaches fail constantly in contexts such as the area of focus due to the dominant normative influences and tensions existing between cultural beliefs and practices of modern medicine, while throughout each section, the study establishes clear explicit connections to the three research questions which captures the various ways in which communities interpret health messages, how social norms mediate the various ways messages are received and responded to, and how community-based interventions can be co-created to enhance the effectiveness of health communication strategies.

Global Health Communication paradigms and their limitations in culturally complex Contexts

On a global scale, maternal and infant health has always been one of the most critical public health challenges in the contemporary world. The World Health Organization (WHO, 2023) reported that approximately 287,000 women died from preventable causes related to pregnancy and childbirth in 2020, with over 94% of these deaths taking place in low and middle-income countries. Sub-Saharan Africa continues to be affected disproportionately, accounting for almost 70% of maternal deaths globally, while children under five consistently lose their lives at alarming rates from preventable conditions such as pneumonia, malaria, diarrhea, and vaccine-preventable diseases (WHO, 2023; UNICEF, 2022). These figures are not just statistics, but they reflect systemic failures in how health information reaches, resonates with, and is acted upon by communities whose cultural realities are rarely centered in intervention design.

In the African context, maternal mortality ratios remain among the highest globally, with the WHO (2022) estimating regional averages of 542 deaths per 100,000 live births, concealing major sub-regional disparities where countries like Nigeria, Chad, and South Sudan record rates which are twice higher. Infant mortality rates similarly reflect deep structural and sociocultural inequities, with immunization coverage declining in regions where community trust in external health actors remains unstable (UNICEF, 2022). These health disparities cannot be effectively accounted for by infrastructure deficits alone. Evidence consistently shows that sociocultural factors, like gender norms, religious beliefs, traditional healing preferences, and historically grounded mistrust of biomedical institutions, interact with structural barriers to shape health-seeking behaviors and the reception of health communication (Benova et al., 2018; Moyer & Mustafa, 2013).

Nigeria is a clear example of this worsening situation with its maternal mortality ratio at 1,047 deaths per 100,000 live births ranking among the third worst globally, while infant mortality stands at approximately 74 deaths per 1,000 live births (WHO, UNICEF, UNFPA & World Bank, 2023; World Bank, 2023). These figures show the inequities in the regions, with Northern Nigeria bearing the heaviest burden. On the other hand, maternal mortality ratios in Northern Nigeria states range between 800 and 1,200 deaths per 100,000 live births, infant mortality exceeds 74 deaths per 1,000 live births in some states which is nearly double the rates in the southern region and immunization coverage remains well below national targets (NPC & ICF, 2019; Shobiye et al., 2022). A better understanding of the reasons these disparities persist despite decades of sustained public health investment requires moving beyond infrastructural explanations to examine the cultural and normative mechanisms that fundamentally shape how health communication is received and acted upon in these communities.

Scholarships on health communication have long been dominated by cognitive-behavioral models that position individuals as rational actors who adopt healthier behaviors when adequately informed about the risks and protective practices, they take part in (Glanz et al., 2015). The Health Belief Model, for instance, posits that behavior change can occur when individuals perceive personal susceptibility to health threats, believe in the severity of those threats, recognize the benefits of partaking in recommended actions, and build confidence in their ability to carry out those actions (Rosenstock, 1974). Social Cognitive Theory similarly emphasizes individual self-efficacy, outcome expectations, and observational learning as primary determinants of health behaviors (Bandura, 1986). The Diffusion of Innovations theory (Rogers, 2003) describes how new health practices spread through social systems via early adopters and communication channels. Protection Motivation Theory (Floyd, D. L. 2000). Similarly centers individual cognitive appraisals of threat and coping capacity as the primary drivers of protective health behaviors. While these frameworks have generated valuable insights and guided successful interventions in contexts where individuals exercise autonomous decision-making and biomedical knowledge carries cultural legitimacy, their explanatory power falls short in collectivist societies where health decisions are embedded in social relationships, governed by communal norms, and interpreted through cultural epistemologies that diverge from biomedical paradigms (Airhihenbuwa & Obregon, 2000; Dutta, 2008). The Diffusion of Innovations theory (Rogers, 2003) explains how new health practices is translated through social systems via early adopters and communication

channels. Protection Motivation Theory (Floyd, D. L. 2000) similarly centers individual cognitive appraisals of threat and coping capacity as the primary drivers of protective health behaviors. While these frameworks have generated valuable insights and guided successful interventions in contexts where individuals exercise autonomous decision-making and biomedical knowledge carries cultural legitimacy, their descriptive power falls short in collectivist societies where health decisions are embedded in social relationships, governed by communal norms, and interpreted through cultural epistemologies that diverge from biomedical paradigms (Airhihenbuwa & Obregon, 2000; Dutta, 2008).

HBM and SCT have generated valuable insights and guided numerous successful interventions overtime especially in contexts where individuals have expansive rights over health decisions and where biomedical knowledge is backed up by cultural legitimacy (Glanz et al., 2015). With the value these frameworks bring, their capability to bring explanatory power falls short in collectivist societies where health decisions are embedded in social relationships, governed by communal norms, and interpreted through cultural epistemologies that may diverge from biomedical paradigms (Airhihenbuwa & Obregon, 2000). The COVID-19 pandemic exposed these limitations, even with the rich and robust global information campaigns grounded in behavioral science, people hesitated before taking these vaccines and some refused compliance with preventive measures which took a long time and effort for compliance across diverse populations, which was not driven by lack of information but by mistrust, cultural beliefs, and normative expectations that could not be adequately explained by cognitive models (Loomba et al., 2021).

Health literacy, broadly defined, refers to the degree to which individuals can obtain, process, and understand basic health information and services necessary to make appropriate health decisions (Ratzan & Parker, 2006). However, scholars have challenged this framing which is centered on the individual. Nutbeam (2021) provides an influential tiered model distinguishing functional, communicative/interactive, and critical health literacy, recognizing that competency extends beyond basic reading and understanding into the ability to engage with and act on health information in social contexts. In contemporary times, the field has advanced toward understanding health literacy as a relational and sociocultural phenomenon rather than a fixed

individual attribute. For this study, health literacy is understood as a cognitive skill set and as a dynamic capacity shaped by the interaction between individuals, their communities, and the health systems they navigate which is a definition that foregrounds systemic and cultural dimensions alongside individual ability.

These pitfalls were acknowledged by the World Health Organization, highlighting how health communication must go above and beyond before information is disseminated with the viewpoint that health literacy is a complex social practice shaped by cultural contexts, power dynamics, and structural inequities (WHO, 2020). Nutbeam and Muscat (2021) in their argument, pointed out the fact that health literacy goes beyond individual cognitive capacity but emphasizes a relational accomplishment which should be backed up by culturally appropriate communication, health systems which are easily accessible, and a clear understanding that there are diverse knowledge systems. This scholarship established that effective health communication in culturally complex contexts requires researchers to fundamentally reconceptualize their motives and procedures of engagement rather than paying all their attention to incremental refinement of existing models.

Consequently, as identified from the literature, three persistent limitations in global health communication directly led to the approach used in this study; first, dominant frameworks treated culture as an external factor that requires statistical adjustment rather than recognizing culture as an ontological context through which health epistemologies are constructed and communication is interpreted (Airhihenbuwa & Obregon, 2000).

Culture is perceived as the way people live their lives, and this leads to often reducing it to demographic categories or surface-level customs, rather than recognizing it as a comprehensive meaning system that shapes how illness is interpreted, healing preferences, and how message is

received. Secondly, communication is conceptualized as a means through which information is transmitted from experts in the field to lay audiences, reproducing power asymmetries and marginalizing local knowledge (Dutta, 2008). Thirdly, health behaviors are socially influenced and because of that influence, are primarily understood through the lens of individualistic peer pressure models that failed to capture how collective norms, religious authorities, and historical experiences shape health decision-making in communal societies (Cislaghi & Heise, 2019).

These limitations collectively identified a critical gap in the literature calling for theoretical frameworks that center culture in health understanding, recognize communities as legitimate knowledge producers, and examine how social norms shape health communication in complex environments.

Health Communication dynamics within Africa and Nigerian Context

Scholarship on African health communication identified and documented the gradual yet incomplete epistemological transition from top-down, expert-centered intervention models to engaged community-engaged approaches. Health communication interventions post-colonial era, were mainly focused on reproducing theoretical paradigms that were highly western, deploying mass media campaigns that were not targeted and disseminating standardized biomedical messages formulated by external technical experts without ethnocentric consultation, considerations or cultural contextualization (Kreps & Sparks, 2008). These interventions reveal limited efficacy as they experience frequent resistance from these communities or strategic adaptation as communities negotiated externally imposed messages through indigenous cultural interpretive frameworks that interventions that were neither expected nor substantively engaged.

With the growing visibility of these limitations, the HIV/AIDS pandemic precipitated new ways of carrying out research within African health communication scholarship. The South Africa's Soul City initiative is a clear example of how entertainment-education strategies get embedded into public health objectives within culturally resonant narratives shift behavioral intentions and collective social norms more effectively than conventional didactic approaches (Usdin et al., 2004). Its success stemmed from messages delivered through trusted media personalities, narratives reflecting community experiences and values rather than imposing foreign frameworks, and storylines addressing social norms and structural barriers rather than focusing solely on individual knowledge and attitudes.

Conversely, this growing recognition of cultural complexity kept becoming more visible, especially during the 2014-2016 Ebola outbreak in West Africa, where the limitations of these external factors resulted to international health organizations and national governments failing catastrophically, getting horrendous resistance from the community that made the epidemic spread even worse than before (Vinck et al., 2019). As a fight back mechanism, these communities demonstrated agency through three distinct forms of resistance; and the first was by rejecting health messages delivered by external actors that they perceived as not culturally sensitive or historically untrustworthy, and maintaining their traditional practices even if popular public health recommendations stated otherwise, and even going further to frame alternative etiological explanations for illness that made sense to them within their indigenous knowledge systems. The only reason why they chose to accept the message, improved and behaviorally complied was because the strategies used for communication shifted to engaging their leaders of culture and faith and community communicators (Vinck et al., 2019). This scenario is a clear case that exemplified

the focus point that effective health communication requires working through rather than around existing authority structures and cultural practices.

Despite these documented successes of participatory approaches, African health communication remains substantially influenced by donor-driven agendas that prioritize externally defined health targets over community-identified priorities (Adebayo, C. T. et al., 2026)). However, despite all identified and documented, health communication interventions still fall short when it comes to how they engage local epistemologies. Health communication interventions frequently bypassed community epistemologies, identifying traditional healing practices as stumbling blocks that should be identified and removed rather than legitimate epistemological frameworks requiring ethnography. Moreover, community participation was operationalized instrumentally to solicit ideas from the community members but failing to use the solicited ideas for predetermined interventions rather than facilitating authentic collaborative development of contextually appropriate solutions (Airhihenbuwa & Obregon, 2000).

These critiques have led to a growing body of decolonial scholarship that calls for fundamental mind shift of health communication practices especially in the African context. Recent scholarship advocated for decolonizing health communication by placing indigenous epistemologies at the helm of designing interventions; thereby, redistributing power from external experts to community members, acknowledging how colonial legacies and contemporary global health approaches brought about inequities, and elevating genuine co-creation processes that positioned communities as equal partners rather than targets of their interventions (Adebayo, C. T. et al., 2026). By extension, the body of decolonial scholarship provided critical theoretical justification for this study's adoption of the CCA as its primary analytical framework and informed

the methodological commitment to using participatory research methods that positioned the epistemology of the community as relevant and central to the research (Dutta, 2008).

From the exploration of African health communication, three main insights that specifically shaped this study's design emerged, the first is that the content of a health message had less relevance than the credibility of the messenger, as health information was evaluated based on the transmitter of the message and with the consideration that the messenger possessed cultural legitimacy within the community structures (Vinck et al., 2019). Secondly, for communication to be effective, it is required that there is some form of engagement with social norms and collective decision-making rather than placing too much attention on targeting the knowledge and attitudes of individuals (Kiburz, A. D. 1999). Additionally, participatory approaches that genuinely redistributed power across stakeholders achieved greater cultural appropriateness and superior behavioral outcomes compared to campaigns focused on hierarchical campaigns (Adebayo, C. T. et al., 2026). The identified insights are closely connected to the study's research questions about how individuals interpreted messages within normative contexts (RQ1), how norms facilitated or constrained message uptake (RQ2), and how community narratives could inform co-created communication strategies (RQ3).

Health Literacy and the Role of Religious Leaders in Northern Nigeria

Health literacy as a concept has evolved overtime since its initial formulation as a functional skill as early definitions, such as that of (Ratzan, & Parker 2006). conceptualized health literacy narrowly as the ability to read and understand health-related materials. Subsequent scholarships also broadened this definition. Nutbeam (2001) proposed a widely adopted three-tier model distinguishing functional health literacy described as the basic reading and numeracy skills

applied to health information, communicative or interactive health literacy which is the ability to get meaning from different forms of communication and apply new information to changing circumstances, and critical health literacy, the capacity to critically analyze health information and use it to exert greater control over personal and community health. The World Health Organization defines health literacy as the personal, cognitive, and social skills that determine the ability of individuals to access, understand, and use information in ways that promote and maintain good health (Speros, C. 2005). More recent scholarship has moved beyond purely individual cognitive models to recognize health literacy as a relational and structural achievement, shaped by the accessibility of health systems, the quality and cultural appropriateness of health communication, and the social contexts in which health decisions are made (Nutbeam & Muscat, 2021; Paasche-Orlow & Wolf, 2007).

Health literacy is typically measured through standardized instruments that assess reading comprehension, numeracy, and the ability to interpret health materials. The Rapid Estimate of Adult Literacy in Medicine (REALM; Murphy et al., 1993), the Test of Functional Health Literacy in Adults (TOFHLA; Parker et al., 1995), and the Newest Vital Sign (NVS; Weiss et al., 2005) are among the most widely used tools in clinical and research settings. However, these instruments were developed primarily in Western, high-income individualistic contexts and have significant limitations when applied in cultural, collectivist and linguistically diverse communities, like those in sub-Saharan Africa where health knowledge is embedded in oral traditions, religious frameworks, and collective meaning-making rather than individual textual comprehension (Kickbusch et al., 2007; Porr et al., 2006). In Northern Nigeria specifically, conventional health literacy measurement tools are ill-suited to capture the sophisticated health knowledge frameworks communities hold, frameworks that are articulate, internally coherent, and deeply functional within

their own epistemological terms, even when they diverge substantially from biomedical models. These limitations reinforce the argument that low health literacy scores in such contexts may reflect measurement failure and not genuine knowledge deficit.

Leaders of faith such as Imams take a structurally unique position in the health literacy climate of Northern Nigeria. Their role extends well beyond doctrinal instruction to encompass the interpretation of everyday life challenges, such as health and illness, through Islamic frameworks. Research across Muslim-majority communities in sub-Saharan Africa has consistently documented that religious leaders serve as primary sources of health information and guidance for large segments of the population, especially in contexts where trust in formal health institutions are fragile (Ghinai et al., 2013; Kaufman & Feldbaum, 2009; Obadare, 2005). Their influence on health literacy operates through two distinct but related mechanisms; the interpretation of Islamic texts and traditions in relation to health practices, and the modeling of health attitudes and behaviors that community members observe and internalize as normatively appropriate.

The positive contribution of religious leaders to community health literacy is richly documented as Imams frame health-seeking behaviors as consistent with Islamic obligations articulating, for instance, that when we seek medical care, we automatically honor the Quranic injunction to protect the life Allah has given, or that vaccination protects family members as an expression of Islamic duty, they effectively translate biomedical recommendations into the epistemological and moral register through which communities evaluate all health information (Campbell et al., 2007; Padela et al., 2012). This translation substantially increases the accessibility, credibility, and uptake of health messages. Studies of faith-based health interventions in Nigeria and across sub-Saharan Africa found that the involvement of leaders of faith,

significantly improves health-seeking behaviors across domains such as maternal health, vaccination uptake, HIV prevention, and family planning (DeHaven et al., 2004; Jenny T & Weinreb, 2013). In contexts where trust in government and external health institutions is low, the authority of a trusted Imam can confer legitimacy on health messages that formal health systems cannot independently achieve.

However, the influence of religious leaders on health literacy is not generally a positive, one and scholarship has documented significant instances where religious authority has constrained health-seeking behaviors and actively reduced effective health literacy within communities. The 2003 polio vaccine boycott in Northern Nigeria, where senior Islamic scholars declared the vaccine unsafe and contrary to Islamic values, is the most extensively documented instance where religious authority can mobilize community-level resistance to evidence-based public health interventions (Jegede, 2007; Obadare, 2005). More broadly, religious interpretations that frame illness as divine will, that position biomedical treatment as a demonstration of insufficient faith, or that identify specific health practices such as family planning or vaccination as incompatible with Islamic teaching, creates an extra layer of normative barriers to health-seeking that biomedical communication cannot overcome by providing more or better information alone (Padela et al., 2011; Shehu, 2015). In these cases, religious authority does not suppress health literacy in a simple sense; rather, it shapes what communities understand as legitimate health knowledge and which sources of health guidance are considered credible, effectively constructing a parallel health literacy framework whose criteria for acceptable health action diverge substantially from biomedical norms.

The dual role leaders of faith play, as enablers and potential constrainers of community health literacy has direct implications for the present study; as it emphasizes that health literacy in

Northern Nigeria cannot be improved through only the development of clearer, simpler, or more accessible biomedical information. It requires engaging with the religious epistemological frameworks through which communities filter what counts as credible health knowledge, and with the religious leaders who serve as the primary interpreters of those frameworks. Existing scholarship on religion and health communication has called for greater integration of faith-based actors into health programme design (Campbell et al., 2007; DeHaven et al., 2004) but has not fully theorized what competencies and ethical commitments are required for that integration to be genuine rather than instrumental. This gap is one that the present study directly addresses through its empirical findings and through the theoretical contributions developed in other chapters.

Religiosity and Health

Religiosity plays a dual role in shaping health outcomes, acting as a facilitator and a constraint reliant on how religious teachings are interpreted and who is interpreting it. Religious belief systems on a positive note, provides the psychological resilience, social support networks, and community solidarity that promote health-seeking behaviors (Koenig, 2012; Levin, 2010). In Northern Nigerian regions, the Muslim places of worship serve as communication platforms that can be trusted, where Imams can effectively deliver health messages with significant normative weight, and faith-based health interventions framed within Islamic teachings which have consistently achieved higher community acceptance than conventionally delivered biomedical interventions (Ghinai et al., 2013; Obadare, 2005). When religious leaders publicly endorse vaccination, antenatal care, or child nutrition, they transform individual health decisions into behaviors that are communally sanctioned, harnessing the power of collective norms to drive sustained behavior change (Bicchieri, 2006).

However, religiosity can equally constrain health outcomes with an instance of religious fatalism; where the belief that health outcomes are entirely subject to divine will has been connected to delayed care-seeking, rejection of family planning, and refusal of life-saving treatment in Northern Nigerian communities (Shehu, 2015; Jegede, 2007). Structures of religious authority have also reproduced gender inequalities that limit the health decision-making autonomy of women, through expectations of male escort, and deference to household male authority (Adjiwanou & LeGrand, 2014). The 2003 polio vaccination boycott in Kano State remains the most documented example of how religious framing can mobilize entire communities against biomedical interventions with devastating public health outcomes (Ghinai et al., 2013).

Literature gives clarity on the fact that religiosity is neither inherently facilitative nor obstructive, but a strong social force whose relationship with health depends entirely on how it is engaged. This insight is central to the argument of this study that effective health communication in Northern Nigeria must engage strategically and respectfully with the religious landscape rather than dismissing or uncritically deferring to it.

Health Communication in Nigeria: The intersection of social norms and health behaviors in Northern Nigeria

Health communication scholarship in Nigeria revealed substantial regional variations in the effectiveness of communication which is directly linked to socio-cultural contexts. For National campaigns that were successful in Southern regions, there is always a corresponding failed campaign in Northern regions, while for interventions designed for Northern contexts, they did not necessarily transfer to Southern settings (Obadare, 2005). These geographic disparities reflect the deep ethnic, linguistic, religious, and cultural diversity in Nigeria (a single nation

encompassing over 250 ethnic groups, three major languages and hundreds of minority languages, which in estimates equal Christian and Muslim populations with significant regional concentration, and diverse health beliefs and practices ranging from biomedical to traditional and spiritual healing systems.

The Kick Polio Out of Nigeria campaign reveals the gains and losses of the intervention initiated in 1996. The campaign employed the integration of mass media, celebrity endorsements, community mobilization, and sustained governmental commitment to promote polio vaccination (Obadare, 2005). In the Southern Nigeria region, there was a significant variance in vaccination coverage by state and type of vaccine, with some states in the southern region reporting over 65% coverage for full immunization which remained below the target Global Vaccine Action Plan. Significantly in Northern Nigeria, the campaign went through severe resistance escalating to the 2003 vaccine boycott where several Northern states suspended polio immunization based on the declaration of religious leaders who stated that the vaccines were unsafe and part of Western anti-Muslim plots as well as getting them sterile (Jegede, 2007).

Scholarly analysis of how the polio campaign was successful in some regions and unsuccessful in others identified significant critical factors directly relevant to this study. How the campaign messaging was drafted shows biomedical rationales and governmental authority sources of legitimacy in Southern regions but was deeply mistrusted in Northern contexts shaped by the historical experiences of colonial exploitation and contemporary political marginalization (Jegede, 2007). It also ignored the opinions of religious and traditional authorities in Northern Nigeria, failing to secure their endorsement or engage issues that are of concern to them, thereby positioning vaccination as conflicting with, rather than compatible with Islamic teachings (Obadare, 2005).

When they communicate, it was primarily in English or through formal Hausa which is different from the language they are used to, creating the wedge of linguistic barriers and signaling cultural distance (Adebayo et al., 2019). In addition, the campaign employed hierarchical implementation without involving the community in message design and delivery or program governance, reproducing power imbalance that reinforced mistrust (Jegede, 2007).

Immunization efforts that took place afterwards corrected these failures and showed significant effective improvement. Communication strategies that proactively involved Imams and leaders of culture in their message design, secured explicit religious endorsements, framing vaccination as compatible with Islamic teachings, employed trusted community members as vaccinators rather than getting external health workers involved, and employed conversational Hausa language in familiar community settings, leading to substantial improvement in vaccination acceptance (Obadare, 2005). Which is a clear indication that effective health communication does not depend so much on message sophistication but on cultural alignment and community buy ins.

Significantly, the COVID-19 pandemic exposed persistent challenges in the health communication in Nigeria, through scholarship that documented widespread misinformation as a factor and conspiracy theories about the origin of vaccine and purposes, denial of how severe the disease is, and promotion of unproven treatments (Abdulraheem et al., 2021). Misinformation spread rapidly, especially in contexts characterized by low trust in government, limited access to reliable information sources, and strong social media networks that amplified rather than downplay false claims (Melki J. et al., 2021). Several factors like engaging trusted community influencers, using local languages and culturally familiar communication formats, addressing underlying

mistrust rather than merely correcting factual errors, and demonstrating cultural respect and institutional transparency were required for effective counter-messaging (Adebayo et al., 2020).

Situated within this broader body of Nigerian scholarship, Northern Nigeria emerged as a particularly consequential site of analysis because of the distinctive sociocultural context of the region characterized by Islamic religious frameworks, patriarchal social structures, historical mistrust of governmental and external health initiatives, preference for traditional healing systems, and linguistic-cultural distance from dominant national communication approaches which created conditions that identified conventional health communication as consistently underperformed. Better understanding how health communication functioned in this context required examining the normative and cultural mechanisms that existing scholarship had identified as influential but not rigorously theorized.

Northern Nigeria: Socio-Cultural Context and Health Communication

Challenges

Northern Nigeria faces disproportionate health challenges characterized by maternal mortality ratios between 800-1,200 deaths per 100,000 live births among the world's highest rates, infant mortality exceeding 74 deaths per 1,000 live births, immunization coverage well below national targets, and limited utilization of reproductive health services despite availability (NPC & ICF, 2019; Adamu, 2011). These persistent disparities emphasize the lack of infrastructure as well as the complex socio-cultural dynamics that shape health seeking behaviors and reception of health communication.

Central to these socio-cultural dynamics is religiosity, usually confused with spirituality, but conceptually distinct. Spirituality refers to an individual's personal sense of connection to something greater than oneself, encompassing inner meaning, transcendence, and existential beliefs that may exist outside any formal religious structure (Koenig, 2012). Religiosity, by contrast, refers specifically to the degree of adherence to the beliefs, practices, and institutions of an organized religion (Abdel-Khalek, 2006). In Northern Nigeria, where Islam is deeply embedded in social life, religiosity shapes individual health beliefs and community-level norms around healthcare seeking, gender roles, and the perceived legitimacy of health interventions. Religious leaders function as trusted authority figures whose interpretations of health-related matters carry significant influence over community receptivity to health communication (Jegede, 2007). Any health communication framework operating in this context must therefore account for religiosity as a structural and normative force, different from personal spirituality, that influences how health messages are received, evaluated, and acted upon.

Several interconnected sociocultural factors distinguish the health communication environment in Northern Nigeria from other regions and informed the focus of this study through the Islamic religious frameworks which significantly had a huge part to play in shaping health beliefs, interpretations of illness, and preferred healing practices. Illnesses were often understood through spiritual lenses as expressions of divine will, a form of spiritual affliction, or a moral consequence thereby, necessitating religious and traditional healing responses alongside or in place of biomedical interventions (Padela et al., 2011). Religious leaders, such as Imams play the part of authoritative interpreters of health challenges, and their endorsement or rejection of health practices substantially influenced how the community complied (Obadare, 2005). Health

communication that constantly ignored religious dimensions or positioned biomedical approaches above spiritual interpretations, there was always consistent resistance.

Patriarchal family structures placed so much power to make health decisions on the male household heads, severely holding back the women from making decisions concerning their health and their children's health (Adjiwanou, V., & LeGrand, T. 2014). Permission was always required by the male heads before any female can access healthcare facilities, use contraceptives, or make significant health expenditures which created complex communication challenges. Health messages had to reach women, who are the primary caregivers, while also persuading those who held decision-making authority, all within the cultural norms that restricted their mobility and active participation in public discourse (Sinai et al., 2024). And with these identified gaps, health communication targeting women without engaging male gatekeepers routinely failed to translate information into behavioral change.

The historical experiences of colonial medical exploitation and contemporary political marginalization led to deep mistrust in institutions and to governmental and external health initiatives (Jegede, 2007). The medical experimentation on African population during the colonial-era without consent, more recent controversies around vaccine testing, and ongoing patterns of resource extraction by foreign entities contributed greatly as well to a collective memory that framed external health actors as potentially exploiters. This mistrust was not individual skepticism but rational historically grounded response to documented harm brought to them and passed down across generations through the narratives of the community (Obadare, 2005). As a result, health communication introduced by the government or international organizations face significant credibility backlash that technical improvements to messaging alone cannot resolve.

Traditional healing systems were identified as having strong legitimacy and for that reason, were often preferred to biomedical care (Janzen, 1978). Traditional healers were embedded in community life; having similar experiences as other community members, communicating in local languages, operating within shared cultural and spiritual frameworks, demanding less fees than the health centers, and providing clear explanations and treatments for health challenges are all norms that aligned closely with community worldviews. The knowledge of these traditional healers was regarded as ancestral wisdom and divine provision, giving it epistemological authority that biomedical expertise does not have (Mahapatra, 2023; Omonzejele & Maduka, 2011). Consequently, health communication that dismissed traditional medicine as ignorance or superstition did not only alienate communities but also reinforced perceptions of cultural disrespect.

The 2003 polio vaccine boycott is a significant example of how these factors intersect to shape health communication outcomes which was precipitated by the declarations of leaders of faith that polio vaccines were unsafe but are western impositions designed to bring sterility to the Muslim populations (Jegade, 2007). These claims gained traction because they resonated with existing mistrust rooted in historical colonial exploitation, as religious leaders possessed authority to interpret health challenges within Islamic frameworks, and because the immunization campaign had bypassed community authorities failing to show respect for their culture. The boycott was because of misinformation and rational response within a context where external health initiatives had previously caused harm and where religious authorities were losing trust in how complex issues were interpreted (Obadare, 2005).

Subsequent immunizations that were successful showed that meaningful cultural engagement could effectively curb resistance from these regions as interventions that collaborated

with Imams in message design and delivery, secured explicit religious endorsements that framed vaccination as Islamic responsibility, recruiting community members as vaccinators, used conversational Hausa, and addressed underlying mistrust through open dialogue, saw substantial increase in vaccination uptake (Nasir et al., 2014). On the other hand, maternal health initiatives achieved better results when they worked side by side women's informal networks, engaged male family heads as supportive partners, framed maternal care as essential to protecting family honor and ensuring healthy children, thereby incorporating traditional birth attendants as referral points rather than competitors. Such approaches outperformed campaigns that overlooked these sociocultural realities (Doctor et al., 2018). Existing scholarship on the health communication of Northern Nigeria, identified these sociocultural factors as influential but provided limited theoretical explanation of the mechanisms through which they operated. Studies documented that religious framing improved message acceptance but did not rigorously theorize how religious authority structured normative influence (Obadare, 2005). Research showed that community participation enhanced intervention effectiveness but did not systematically examine how participatory processes redistributed communicative power or how community narratives could guide message design (Adebayo, C. T. et al., 2026). Scholarship recognized gender dynamics as barriers but offered limited analysis of how patriarchal structures mediates the access women have to health information and how communication could simultaneously work within to gradually transform gender norms (Adjiwanou, V., & LeGrand, T. 2014).

This study examined these gaps employing the Social Norms Theory to describe the mechanisms through which normative influence and the Culture-Centered Approach guide participatory inquiry centered around community perspectives. This chapter established the theoretical and contextual foundation for the study, situating the research within existing

scholarship on health communication, normative influence, and culturally grounded inquiry in Northern Nigeria. The Social Norms Theory provided a framework for understanding how individuals interpret messages through normative lenses, while the Culture-Centered Approach guided participatory inquiry that provided the foundation for community perspectives and voices. Collectively, these frameworks oriented the study toward the unexplored dimensions of health communication in this context.

Theoretical Framework: Social Norms Theory and the Cultural-Centered Approach in Health Communication

Culture-Centered Approach (CCA)

The Culture-Centered Approach (CCA), developed by Dutta (2008), provides a fundamentally different perspective for health communication that challenges dominant biomedical and expert-driven models. These conventional approaches position external health professionals as sources of authoritative knowledge whose expertise should be disseminated to lay populations. The CCA criticized this model as reproducing colonial power relations, marginalizing local knowledge systems, and treating culture as an obstacle to overcome rather than a context to engage with (Dutta, 2008; Dutta & Basu, 2008). This shift is a fulcrum for conceptual orientation which brings change from communication delivered to communities, to communication developed with communities.

Building on this foundational critique, Culture-Centered Approach rests on three core commitments directly relevant to this study and the central commitment involves putting marginalized voices first by positioning communities particularly groups which were historically excluded from health discourse, including women, youth, ethnic minorities, and economically

disadvantaged populations as primary producers of knowledge. Their lived experiences, perspectives on matters that concern them, and priorities were understood as foundational for shaping health communication, rather than relying on the decisions defined exclusively by external experts (Dutta, 2008). This orientation required an acknowledgment of the fact that communities possess sophisticated and contextually grounded understanding of their own health realities, informed by lived experiences in ways that cannot be fully captured through brief assessments or standardized evaluative metrics.

The second major commitment expands this insight by treating culture as a structural system embedded in material conditions, historical contexts, and power relations and not as a set of cultural beliefs and practices that were individual preferences (Dutta & Basu, 2008).

The limited health decision-making authority women have is a clear example of how complex these issues really are. When women do not have control over the choices they make concerning their health, then this has gone beyond personal beliefs and cultural values and has extended to a web of interconnected structural issues negatively impacting them. These factors are much and not limited to economic dependence on the male family members which hinders them to seek for financial freedom to take care of their personal needs, legal frameworks that enable male authority figures to dominate in household decisions, the intentional exclusion of women from being educated and getting good jobs also weakens their ability to speak for themselves and the and community-enforced sanctions on women who dare go against these established gender norms.

As a result of these highlighted challenges women go through, effective health communication must by all means address these structural determinants like economic, legal

educational and social factors that facilitate and constrain what women are realistically able to do through persuasive messaging strategies and not just considering the issue as a matter of individual choice. The third commitment builds organically from the first two; health communication should not be designed without the focus community, but should grow out of ongoing, genuine conversations between the health practitioners and the members of community. This implies that communities must be active participants in shaping the messages and solutions that affect their lives and not just be recipients of information (Dutta, 2008). When there is authentic participation, power is distributed equally and communities get to exercise decision-making authority over communication priorities, message content, delivery channels, and program governance, and not just acting as providers of feedback after external actors have established the core parameters for them. This dialogical approach draws upon Paulo Freire's (1970) critical pedagogy, which conceptualized education and communication as liberatory practices. Through these processes, marginalized communities can clearly speak about their lived experiences, figure out the structural factors constraining their agency, and collectively envision pathways toward transformation.

Methodologically, these commitments translate into participatory action research where community members actively take part in defining research questions, collecting and analyzing data, and determining how the findings from the research should be translated into action (Dutta & Basu, 2008). Community storytelling, participatory media production, and culturally grounded communication formats such as drama, music, and visual arts were emphasized as methods that honored the local epistemologies and communication preferences of the people rather than showing down external formats on them. This methodological orientation creates a bridge between theory and practice, ensuring that research mirrors the cultural dynamics of the communities it seeks to support.

The fulcrum for these three commitments is the Culture-Centered approach which focuses on political economy; examining how broader historical and economic forces shape local health communication contexts (Dutta, 2008). Viewing things from a lens like this shows how past and present power structures continue to directly and indirectly influence health systems in present day. Four interconnected factors influence the health communication landscape in Northern Nigeria, specifically, first, the exploitation on the people during the colonial era led to community mistrust in external health interventions, secondly, structural adjustment programs that systematically weakened public health infrastructure, thirdly, donor-driven priorities that often overlook the health needs community members identify, and lastly the persistent global power imbalance that puts community epistemology in an inferior position compares to Western biomedical frameworks. This meant having deep understanding of how the colonial medical exploitation, led to mistrust in the system, how structural adjustment programs downplayed public health infrastructure, how donor-driven priorities marginalized community-identified health needs, and how global power imbalance placed African knowledge systems as inferior to Western biomedical knowledge.

Applying these to Northern Nigerian health communication, the Culture-Centered Approach necessitated a shift from the conventional practice. Health communication must emerge from sustained dialogue with community members about their lived experiences, their priorities, and their preferences, rather than being designed exclusively from biomedical evidence and expert opinion. Secondly, traditional healing systems should be integrated as legitimate epistemological frameworks with their own internal rationality and therapeutic claims, deserving respectful consideration even where they don't align with biomedical understandings rather than being dismissed as ignorance or superstition, Thirdly, there should be collaborative engagement between

religious beliefs and institutions; religious leaders should use their teachings to design communication interventions so health practices can align with faith commitments, rather than positioning religion as an barriers to work around. Fourthly, interventions must address structural barriers such as gender inequities, economic marginalization, and inadequate health infrastructure, which are factors that limit health agency even among individuals who possess both knowledge and motivation, rather than being focused on individual behavior change. However, the Culture-Centered Approach also faced significant limitations relevant to this study in areas like centering marginalized voices; it provided limited guidance on navigating situations that have to do with powerful actors whose perspectives dominated community voices by marginalizing others within the community. In patriarchal contexts, male elders and leaders of faith often spoke as community representatives, potentially silencing women and youth whose experiences and perspectives are different from theirs (Adjiwanou, V., & LeGrand, T. (2014). How could participatory approaches center marginalized voices when community structures systematically exclude those voices?

The Culture-Centered Approach values respecting local epistemologies, but the real challenge is from certain cultural practices which directly negatively impact the health of the people. The framework acknowledges the need to valorize indigenous epistemologies and fails to provide sufficient guidance for navigating situations where culturally informed decisions may result in preventable suffering or death. An instance is when families say no to modern medicine that can save the life of a family member, especially a child because the culture or religion says otherwise. This puts health practitioners in a difficult state where they begin to ask themselves if they should respect the cultural beliefs of the family or not, even when doing so means someone has to die; or do they have a duty to step in and take charge of the situation even when the cultural value says not to. There is no easy way to respond to these questions, and tensions like this between

valorizing cultural values and protecting lives remain one of the toughest in public health. While the Culture-Centered Approach recognizes these complexities, it offers limited operational guidance for practitioners confronting such situations, leaving the question of how health communication can simultaneously honor local epistemologies and fulfill ethical responsibilities to protect vulnerable populations from preventable harm unresolved.

Lastly, though, CCA highlights structural determinants of health, many communication practitioners do not have the authority or resources to alter those structures. Determinants like poverty, gender inequality and poor infrastructures go beyond the scope of communication intervention. This gap captures the need to integrate insights from CCA that explain the small, everyday behavioral patterns that drive people's actions which is exactly where social norms theory becomes relevant.

Despite these limitations, CCA provides an indispensable conceptual framework for this study's commitment to participatory methods such as respect for local knowledge and paying attention to structural power relations. Its integration with social norms theory offers a precise account of how collective expectations shape behavior creating a robust and complementary framework for understanding health communication in Northern Nigeria.

Integration of Social Norms Theory and the Culture-Centered Approach

Integrating SNT and CCA offers a robust and ethically responsible framework for understanding the challenges in this study and intervening in health communication in Northern Nigeria. Social Norms Theory and the Culture-Centered Approach emerged from different scholarly traditions and emphasized different dimensions of health communication, integrating

them provides an analytical and practical advantage for understanding the Northern Nigerian contexts. SNT provides a diagnostic lens to identify normative patterns, reference groups, and enforcement mechanisms that shape behaviours. CCA foregrounded cultural contexts, structural constraints, and community agency, but provided less systematic analysis of normative mechanisms through which cultural beliefs are translated into behavioral conformity.

The first advantage of integrating the application of both frameworks enabled several analytical moves central to this study and the first is examining how cultural epistemologies established guiding principles that influence how specific health norms were interpreted. An example is the religious principle that state "health is from God" function as a meta-norm in Northern Nigeria shaping whether biomedical or traditional healing was considered appropriate for specific illnesses (Padela et al., 2011). Having a clear understanding of this guiding principle was essential for explaining why communities might accept certain biomedical interventions and rejecting others, depending on how well interventions could be interpreted as compatible with divine will.

Secondly, analyzing how power dynamics shaped whose perspectives counted as normative; the focus of SNT on reference groups could be enriched by CCA's focus on structural hierarchies in patriarchal contexts where the behaviors and attitudes of male authority figures counted as more relevant than women in establishing norms even when women constituted the majority of relevant actors (Adjiwanou, V., & LeGrand, T. (2014). The interpretations of religious leaders superseded the influence of peers because hierarchical authority structures vested them with exceptional normative power. Recognizing these power dynamics is essential for understanding normative influence and for designing interventions that engaged rather than bypassed authority structures.

Thirdly, connecting normative mechanisms with participatory processes showed how community-led norm change is different from externally imposed behavior change. When communities themselves identify health practices as problematic and collectively decide to shift norms, change was more sustainable and culturally appropriate than when external actors attempted to persuade individuals to deviate from community expectations (Cislaghi & Heise, 2019). Participatory approaches that enable communities to examine their own norms, consider if those norms serve collective wellbeing, and deliberate about potential changes honored cultural autonomy and health improvement goals.

In addition, integrating frameworks such as CCA and SNT shows that for health communication to be effective, there has to be normative alignment and cultural resonance, which, if not integrated, could cause backlash. Health messages are required to align strongly with rather than against prevailing norms while also emerging from, rather than being imposed upon cultural contexts. For instance, messages on family planning endorsed by leaders of faith aligned perfectly with normative authority structures, while framing contraception through community narratives about maternal care and child wellbeing ensured cultural resonance. Both normative alignments and cultural resonance can work alone but for effective messaging, they must work together.

This integrated framework directly addressed the study's research questions by synthesizing SNT's normative mechanisms with CCA's attention to cultural meaning, power relations, and participatory methods ensuring that interpretation, message uptake, and co-creation were all examined within their proper community context.

Gaps in Existing Literature

Invaluable insights were gained from the scholarship reviewed in this chapter, but despite the insights, three significant gaps motivated this study. While existing research documented how cultural factors influence the effectiveness of health communication in Northern Nigeria, limited scholarship rigorously theorized the mechanisms by which this influence operated. Studies show that religious framing improved message acceptance, but those studies failed to systematically examine how religious authority structured normative influence or how theological interpretation processes shaped health decision-making (Obadare, 2005). Research demonstrated that community participation enhanced outcomes, but they did not analyze what made participation genuine and instrumental or how participatory processes could navigate power dynamics within communities (Adebayo, C. T., & Ambrose, O. E. 2026).

Existing literature did not adequately connect normative theory with cultural approaches as health communication scholarship tends to draw on either Social Norms Theory or cultural frameworks but rarely integrated them systematically. This disciplinary separation implies that normative analyses often lacked cultural depth while cultural analyses gave insufficient attention to normative mechanisms. The few studies that employed both frameworks did not fully explore how they complemented each other to resolve tensions between them. (Edberg & Krieger, 2020) Most existing research was conducted by external researchers using their language, questions, categories and interpretive frameworks, leaving a significant gap in understanding health communication from the perspective of the community, in their own language, and through their own ways of making sense of the world. Participatory research that genuinely centered community voices and honored local knowledge were difficult to find; especially research that engaged with

religious frameworks, traditional healing systems, and gendered experiences on their own terms rather than as obstacles to biomedical compliance.

This gaps were addressed in this study through the integration of SNT/CCA framework to analyze normative mechanisms within cultural contexts; conducting in-depth qualitative inquiry in the language the community understands (Hausa), that enabled the exploration of meanings within local frameworks rather than imposing external categories; and adopting participatory commitments that positioned community members as knowledge producers whose perspectives should guide data collection, interpretation and application of findings.

To systematically synthesize the insights and limitations identified in the reviewed scholarship, the following table summarizes the three major gaps that informed the direction of this study. These gaps highlight the need for deeper theorization of cultural mechanisms, stronger integration of normative and cultural frameworks, and research approaches that center community epistemologies.

Table 1:1 Summary of Gaps in Literature

Gap	Description	Key Issues Identified
Limited theorization of cultural mechanisms in Northern Nigeria	Existing studies acknowledge cultural influences on health communication but do not rigorously theorize <i>how</i> these mechanisms operate	Religious framing improves message acceptance, but mechanisms of religious authority and theological interpretation remain under-examined. Community participation is linked to improved outcomes, yet distinctions between genuine and instrumental participation are unclear. Limited analysis of how participatory processes navigate community power asymmetries
Weak integration of normative theory and cultural approaches	Scholarships often treat Social Norms Theory and cultural frameworks separately, resulting in incomplete analyses.	Normative analyses lack cultural depth. Cultural analyses overlook normative mechanisms. Few studies use both frameworks, and those that do rarely explore their complementarity or address tensions between them.
Limited research grounded in community epistemologies	Most studies rely on researcher-defined categories rather than community-generated meanings, leading to missed insights.	Limited use of participants' own language and interpretive frameworks. Researcher-imposed categories may obscure local meanings. Participatory approaches that center community voices are rare. Insufficient engagement with religious frameworks, traditional healing systems, and gendered experiences on their own terms

To support readability, the full table is placed in Appendix C, with a condensed version shown here

Conclusion

This literature review established the scholarly foundation for investigating how social norms mediated health communication in Northern Nigerian communities. Global health communication scholarship revealed the limitations of cognitive-behavioral models in culturally complex, collectivist contexts while the African health communication research documented shift toward participatory approaches but also persistent reproduction of donor-driven, top-down models. The Nigerian scholarship showed substantial regional variation in communication effectiveness connected to sociocultural factors. Northern Nigerian research identified religious authority, gender dynamics, institutional mistrust, and epistemological pluralism as influential but undertheorized.

Social Norms Theory provided analytical tools for better understanding of normative mechanisms, while the Culture-Centered Approach offered ethical and methodological guidance for participatory engagement with cultural contexts. Integrating these frameworks created a robust conceptual scaffolding for the study's three research questions about message interpretation, normative mediation, and community-based co-creation of health communication.

The identified gaps limited the theoretical explanation of normative mechanisms, inadequate integration of normative and cultural frameworks, and insufficient centering of community perspectives which systematically justified the approach and contributions of this study. The following chapter gives elaborate details of the qualitative methodology employed to address these gaps and respond to the research questions.

Chapter 3 - Methodology

Introduction

This chapter outlines the methodology employed to explore the intersection of health communication with social norms within Northern Nigerian communities. It is a qualitative design grounded in the constructivist epistemology guiding this inquiry and supported by Braun and Clarke's (2006) reflexive thematic analysis framework. This approach captures the richness of participants lived experiences and the sociocultural forces shaping their understanding of health, communication, and social norms. It also prioritizes interpretation, reflexivity, and meaning making, allowing for a deeper exploration of how decisions around maternal health, family planning, and immunization are negotiated within cultural and normative contexts.

Epistemological Stance

A constructivist epistemological stance was adopted in this study, asserting that knowledge is neither fixed or objective but co-created through human interaction and influenced by cultural and historical experiences (Creswell & Poth, 2018; Schwandt, 2000). Meaning, from this perspective, is continuously negotiated through dialogue, everyday practices, and power dynamics within communities. This stance is particularly well suited to analyzing health communication in Northern Nigeria, where beliefs and practices related to health are deeply rooted in religious teachings, gender dynamics, and traditional power structures. The approach aligns naturally with thematic analysis, which treats meanings as situated, socially produced, and context-dependent (Braun & Clarke, 2012; Nowell et al., 2017). It also acknowledges the researcher's active interpretive role in translating participants' narratives into themes, requiring continuous reflexive engagement throughout the research process.

Research Design

The research approach is a qualitative interpretive design, employing reflexive thematic analysis as its analytical method, because qualitative research interrogates the nature of a phenomenon and is particularly appropriate for answering questions of why and how (Bhattacharya, 2017; Merriam & Grenier, 2019; Creswell, 1998). Its design is rooted in the principles of cultural sensitivity and community-centered inquiry (Dutta, 2008). Instead of generalizing, it sought transferable insights into how health communication operates within the social worlds of Northern Nigerian communities.

Thematic analysis was chosen over other qualitative approaches such as grounded theory, phenomenology, or discourse analysis for several key reasons first, its theoretical flexibility allows for the systematic integration of inductive exploration of emergent themes and the deductive examination of concepts derived from Social Norms Theory and the Culture-Centered Approach (Braun & Clarke, 2012). Unlike the grounded theory, which requires the development of a new theory from data, or phenomenology, which focuses exclusively on the lived experiences of specific phenomena. Thematic analysis permitted the researcher to work within established theoretical frameworks while remaining open to unexpected insights (Braun & Clarke, 2006). Secondly, thematic analysis was particularly well-suited for examining patterns across diverse stakeholder groups, community members, health workers, and leaders without requiring the homogeneity of experience that phenomenological approaches typically demand. Thirdly, its emphasis on semantic and latent meaning-making aligned closely with the goal of the study to understand explicit statements about health communication and underlying cultural assumptions and normative structures. Lastly, thematic analysis provided the practical advantages for a study seeking to generate actionable insights for policy and practice, as its accessible, systematic

approach facilitated clear communication of findings to diverse audiences including policymakers, practitioners, and community stakeholders (Nowell et al., 2017).

The interpretation of data is guided by Braun and Clarke's six-phase framework of thematic analysis (2006), which provided a clear concise systematic process of analyzing data from its raw data form to meaningful findings; which was initiated with the researcher familiarizing with the data through intentional reading and re-reading of the transcripts and generating initial codes by identifying and labeling meaningful patterns across the dataset. Related codes were then grouped into themes which were reviewed, refined and later clearly defined to ensure the essence of participants' experiences were well captured. From the inception of this research, one central thing in this study is reflexive interpretation with the researcher continuously reflecting on the various ways in which their background, assumptions and position may have influenced how the data was read and themes constructed. This approach was selected for its flexibility to accommodate the richness and complexity of qualitative data while providing the rigour and structure necessary for credibility in analysis.

As an exploratory qualitative study, this research focused on the depth and contextual richness of the data, generating nuanced and contextualized insights on how health communication plays out within specific sociocultural contexts (Patton, 2015). The decision to employ qualitative inquiry was driven by the need to illuminate complex social processes and cultural meanings that statistical data cannot adequately capture (Creswell & Whittaker, 2000). The conceptual insights generated here provide a foundation for follow-up empirical research that can measure the specific normative mechanisms and communication concepts proposed in this study.

Research Site

A purposive sampling method was employed in identifying individuals with relevant experiences in health communication efforts within the three selected communities in Northern Nigeria like Jigawa, Katsina and (AMAC) in Abuja. The purposive sampling method is particularly appropriate in qualitative research where the goal is to gain deep, contextual insights from information-rich cases rather than achieve statistical generalizability (Patton, 2015). The communities were selected based on predefined criteria to strengthen the transparency and transferability of the findings (Lincoln & Guba, 1988). Specifically, communities were chosen if they have ever had any active maternal health programs, family planning interventions, or immunization initiatives. The second criteria captured the differences in how easily participants could access healthcare, depending on if they lived in rural or semi-urban areas. Thirdly, if they represent the religious, linguistic, and cultural diversity common across Northern Nigeria for a rich and diverse data.

These selection criteria were employed to ensure the study captured the various ways local norms, power structures, and health system dynamics in Northern Nigeria shaped communication behaviors and attitudes. Within each community, participants were drawn from key stakeholder groups within the age range(19-49), and that includes healthcare professionals, leaders of culture and faith, and community members (both male and female) who were directly working on issues that pertain to maternal and child health efforts; with perspectives and experiences relevant to having a clearer understanding of how health messages were received, adapted, and acted upon. The selected age range allowed the researcher to engage with individuals who were most likely decision-makers or direct beneficiaries of reproductive and child health services (National Population Commission [NPC] & ICF, 2019).

Sampling and Recruitment Procedures

A referral-based purposive chain sampling method, also known as snowball sampling, which is particularly effective in accessing hard-to-reach populations and identifying information-rich cases within closely-knit communities was employed in recruiting participants (Biernacki & Waldorf, 1981; Noy, 2008). This approach was especially appropriate for the contexts of Northern Nigeria, where trust, social networks, and hierarchical community structures significantly influences the willingness of individuals to take part in research that benefits their communities (Shehu, 2015). Purposive sampling is particularly appropriate in qualitative research where the goal is to gain deep, contextual insights from information-rich cases rather than achieve statistical generalizability (Patton, 2015).

Community Selection

Communities were purposively selected across three sites: Jigawa State, Katsina State, and Abuja Municipal Area Council based on predefined criteria to strengthen the transparency and transferability of the findings (Lincoln & Guba, 1988). Specifically, communities were selected if they had active maternal health programs, family planning interventions, or immunization initiatives; represented differences in healthcare accessibility between rural and semi-urban areas; and reflected the religious, linguistic, and cultural diversity common across Northern Nigeria. These selection criteria ensured the study captured the various ways local norms, power structures, and health system dynamics shaped communication behaviors and attitudes. The geographic diversity across the three sites allowed for the strategic capturing of variations in health communication experiences while maintaining focus on the shared sociocultural makeup of Northern Nigeria, enhancing the transferability of findings to similar settings characterized by

strong religious influence, patriarchal structures, and active health communication efforts (Malterud et al., 2016).

Inclusion Criteria and Exclusion Criteria

The inclusion criteria comprised of community members aged 19 and older, who are currently or previously involved in issues of maternal and child health, family planning, or immunization interventions, as well as healthcare providers such as nurses, doctors, community health workers and leaders of culture and faith whose influence over social and behavioral norms was visible and widely known in the chosen communities. The selected age range allowed the researcher to engage with individuals who were most likely decision-makers or direct beneficiaries of reproductive and child health services (National Population Commission [NPC] & ICF, 2019).

The exclusion criteria included individuals who live outside the selected communities and people without direct involvement or impactful knowledge of community health or communication efforts. These criteria were established to ensure the study recruited information-rich participants who could provide meaningful insights into health communication and social norm dynamics (Palinkas et al., 2015), and to prevent the dilution of the dataset with perspectives lacking sufficient depth or contextual grounding which is a major consideration in studies with limited sample sizes where each participant's contribution must be substantive (Malterud et al., 2016).

Recruitment Procedures

The researcher made initial contact through local health officers and community gatekeepers comprising ward heads, leaders of faith, and cultural leaders who served as cultural

brokers facilitating access to communities and helping build trust between the researcher and potential participants (Downey & Atkinson, 2012). This gatekeeping process was essential for ensuring cultural appropriateness and minimizing potential harm or misunderstanding in communities where external researchers might be viewed with suspicion due to historical experiences with colonial and foreign-led interventions (Obadare, 2005; Jegede, 2007).

Once potential participants were identified, the researcher made direct contact to provide full details of the study using information sheets, consent forms, and ethical assurances guaranteeing confidentiality, anonymity, and the right to withdraw at any time without consequence. All materials were provided in English, with accommodations made based on participant preference and literacy level. For participants with limited literacy, materials were read aloud and explained in detail, with comprehension verified through follow-up questions before proceeding. Participants were given 24 to 48 hours to consider their participation, ask questions, and consult with family members if desired, respecting the communal nature of decision-making in Northern Nigerian contexts (Emanuel et al., 2000).

Sample Size and Saturation

Twenty participants were recruited across the three locations, representing diverse roles within the health communication ecosystem: with eight community members comprising four women and four men involved in health decision-making, seven health workers including nurses, midwives, and community health extension workers, and five community leaders including Imams, traditional healers, and village elders. This distribution ensured representation across key stakeholder groups while allowing for saturation within each category (Palinkas et al., 2015).

The sample size was determined based on two complementary principles, first, the power of information and second, thematic saturation. Following Malterud, Siersma, and Guassora

(2016), studies with narrow aims, specific samples, established theoretical frameworks, strong interview quality, and in-depth analysis strategies require fewer participants to achieve robust findings. This study met all of those conditions through its focused research questions, purposively selected information-rich participants, and grounding in the Social Norms Theory and Culture-Centered Approach. Thematic saturation was reached at the point at which new interviews yielded no additional interpretive insights and was monitored throughout data collection (Guest, Bunce, & Johnson, 2006; Saunders et al., 2018). On the eighteenth interview, preliminary analysis indicated no new themes were emerging, and the final two interviews confirmed saturation by reinforcing existing patterns without introducing new insights. This approach aligns with established qualitative research practices that prioritize depth and quality of data over number of participants (Morse, 2015; Vasileiou et al., 2018).

Including diverse stakeholder groups enabled triangulation of perspectives, providing a comprehensive understanding of how health communication functions within Northern Nigerian sociocultural contexts (Patton, 2015; Creswell & Poth, 2018). This multi-stakeholder approach was particularly relevant given the hierarchical and relational nature of health decision-making in the region, where multiple actors influence how health messages are received, interpreted, and acted upon (Bicchieri, 2017; Dutta, 2008).

Data Collection

The data was collected between the months of August and November 2025, with a brief extension into December 2025 due to insecurity challenges that temporarily prevented the researcher from reaching selected participants in certain focus areas. Data collection was carried out through three complementary methods; semi structured in-depth interviews, focus group

discussions and observation for triangulation across purposively selected communities in Jigawa State, Katsina State and Abuja Municipal Area Council. These sites were strategically selected to represent the sociocultural characteristics central to the study while providing geographic and demographic diversity. Interviews were conducted through sessions held in community centers, primary healthcare facilities, and participants' homes, remotely via Zoom, with the mode determined by participant preference, geographic accessibility, and safety considerations.

Twenty participants were recruited through purposive sampling, a strategy appropriate for qualitative inquiry seeking information-rich data (Patton, 2015), drawn from three key stakeholder groups such as community members including men and women involved in health decision-making, health workers including nurses, midwives, and community health extension workers, and community leaders including leaders of faith, traditional healers, and elders to ensure diverse perspectives on health communication dynamics.

After ethical clearance was obtained from the Kansas State University Institutional Review Board (IRB), the interview guide was pretested with two participants from each stakeholder group, resulting in minor adjustments to phrasing and sequencing to enhance cultural sensitivity and clarity. Interviews were conducted in English or Hausa based on participant preference, and where interpretation was required, trusted interpreters familiar with the communities were engaged following established procedures for cross-language research (Temple & Young, 2004). Each interview, focus group discussion, and observational session was allotted 45 to 60 minutes, with some extending slightly when participants were comfortable elaborating on their experiences.

The interview guide explored key themes including experiences with health communication campaigns (Dutta, 2008), perceptions of social norms shaping health decisions (Bicchieri, 2006), cultural and religious narratives influencing health practices, gender dynamics

and authority structures, trust in health systems and traditional healing, and community storytelling traditions related to health and healing. With participant consent, all interviews were audio-recorded, and detailed field notes documented nonverbal cues, contextual factors, and communicative dynamics. Audio files were transcribed verbatim and stored on an encrypted drive under anonymized identifiers to ensure confidentiality, and NVivo software was employed to facilitate systematic coding, data management, and theme development.

Table 2.1: Participants Characteristics*For a complete list of participant demographics, refer to Appendix A*

Name	Role	Gender	Approx. Age	Location	Yrs in Role	Duties
Imam Tukur	Rel. Leader	Male	52	Katsina	18	Community health advocate; delivers health messages during Friday prayers
Mal. Umar	Rel. Teacher	Male	45	Jigawa	15	Teachers at Islamic school; involved in malaria prevention campaigns
Mal. Giwa	Community Head	Male	61	Katsina	25	Traditional ruler; decision maker on community health initiatives
Imam Mohammed	Rel. Leader	Male	48	Katsina	12	Advocates for family planning through religious framing
Elder Shehu	Community Elder	Male	67	Katsina	N/A	Custodian of traditional knowledge and cultural practices
Mallama Rabi'u	Female Religious Leader	Female	39	Jigawa	10	Teaches women and girls; observes gender dynamics in health decisions
Hajiya Ramatu	Midwife	Female	43	Abuja	16	Works in community health center; intermediary for women's informal health networks

Data Analysis

Data collection was done employing thematic analysis, a systematic qualitative method for identifying, analyzing and reporting patterns within data Braun and Clarke's (2006). This approach was chosen because of how it proved to be particularly valuable in exploring the rich complexity of participants' narratives while considering what participants said and the deeper undertones embedded within their statements. The analysis followed Braun and Clarke's (2006) six-phase framework, though the process was iterative rather than strictly linear, requiring movement back and forth between phases as understanding deepened.

Phase 1: Familiarization with the Data

The researcher began the process with a verbatim transcription of all audio-recorded interviews, a process which was singlehandedly carried out for the first several interviews to be deeply immersed in the language and expressions of the participants. During the transcription phase, the researcher noted pauses, laughter, and moments of hesitation that signaled emotional weight or cultural sensitivity around particular topics. Following the transcription, the researcher read each transcript multiple times while listening to the corresponding audio recordings, allowing reconnection with the tone, context, and nonverbal communication documented in the field notes. This repeated engagement revealed patterns that had not been previously identified in the course of the interview. A clear example is how different participants from other communities used metaphors that were strikingly similar when describing trust in health workers, giving us a better understanding of shared cultural frameworks. This provides clarity to how healthcare relationships are similar, and these initial observations were recorded in analytic memos, capturing preliminary connections and questions that would guide subsequent coding.

Phase 2: Generating Initial Codes

The researcher began the coding process with a line-by-line analysis of transcripts, systematically identifying meaningful segments relevant to the research questions. The initial generated codes were both descriptive, capturing the surface meanings such as., "prefers traditional birth attendant," "trusts Imam's advice", and interpretive, reflecting underlying concepts like., "religious authority supersedes medical authority," and "collective decision-making". A good example is in this young mothers' experience where she explained stating, "I cannot just decide to go to the hospital without asking my husband's mother first," this segment was coded as "hierarchical decision-making", "deference to older women," and "limited maternal autonomy." The codes emerged deductively from theoretical frameworks such as the social norms' theory and the culture-centered approach and inductively from the language and deep concerns of participants. Throughout this phase, the researcher was consistent with coding while remaining open to unexpected patterns, such as how male community leaders frequently invoked notions of "protection" when discussing restrictions on the areas of women healthcare access, a framing that appeared repeatedly across different interviews and locations.

To ensure intercoder reliability, the researcher worked alongside a mentor who engaged with the same transcripts and coding process simultaneously. Emerging codes and interpretations were discussed and reviewed together, and in areas of discrepancies, these were resolved through deliberation until consensus was reached. This process ensured that the coding was reliable and grounded in the data rather than reflecting the assumptions of a single interpreter.

Phase 3: Searching for Themes

At this third phase, the researcher organized the 88 initial codes into 18 potential themes by identifying patterns across coded segments. Using NVivo's visualization tools, the researcher created mind maps to explore relationships between codes and clustered them into coherent groupings. For instance, codes related to "husband's permission," "mother-in-law's approval,"

"male escort requirements," and "women's limited mobility" were grouped under a broader theme initially labeled "gendered control over healthcare access." Similarly, codes that capture participants' descriptions of "collective expectations," "community surveillance," and "fear of social judgment" were integrated into a theme that has to do with "social accountability mechanisms." This phase required constant comparison across participant groups such as community members, health workers, and leaders to identify where perspectives aligned and where they don't. Notably, while social pressure was emphasized to be a constraining factor, religious leaders often framed the same norms as protective, revealing how the same social mechanisms were understood differently depending on one's position within community hierarchies.

Phase 4: Reviewing Themes

The 18 participant themes were thoroughly reviewed to ensure each theme was internally coherent and distinct from the others; though some themes appeared to be too broad and were subdivided into other subthemes while others overlapped substantially and were merged. For example, initial separate themes concerning "religious interpretations of illness" and "spiritual explanations for disease" were combined into a single theme, "sacred narratives of health and illness," as the two captured how participants understood health conditions through religious and cosmological frameworks. Conversely, Initial themes that had to do with 'communication barriers' were broken down into three distinct themes when closer examination revealed fundamentally different issues such as linguistic barriers like health messages delivered only in English, cultural translation failures through biomedical concepts lacking cultural resonance, and gendered communication constraints, when women were unable to speak directly with male health workers. In this phase, the researcher referred frequently, back to the raw data extracts ensuring quotes clustered under each theme genuinely reflected a unified concept; and these led to the identification

of themes that could not be substantiated with sufficient data across multiple participants which were then either reconceptualized or set aside.

Phase 5: Defining and Naming Themes

Each theme was refined through detailed description that articulated its scope, boundaries, and relationship to the study's research questions. For instance, the theme "Collective Enforcement of Gender Norms in Healthcare Seeking" was defined as encompassing the various ways community members monitored, reinforced, or sanctioned adherence to gender-specific expectations around health behaviors. This theme captured formal and informal rules such as gossip networks, and the strategic deployment of religious or cultural narratives to legitimize gendered restrictions.

For complex themes with internal layers that warranted differentiation, subthemes were identified; for example, the theme concerning trust in health systems, was broken down to three subthemes that include institutional trust which considered participants' perceptions of healthcare facilities and government health interventions, interpersonal trust which includes the relationships with individual health workers, and epistemic trust which explored the level of confidence participants had in biomedical knowledge compared to traditional healing systems.

These themes were crafted to be analytically meaningful and accessible, preventing unnecessary theoretical sophistication with clarity while reflecting on the depth of the analysis. Each theme detailed analytic memos of its conceptual definition, core characteristics, boundaries, and illustrative participant quotes.

Phase 6: Writing the Report

The final phase which is placing the themes within a coherent analytical narrative addressed the research questions while recognizing the complexity and nuance of participants' experiences. Each theme was deeply and clearly illustrated with carefully selected quotations that

exemplified key points while representing the range of perspectives within the data. When the theme concerning religious authority in health decisions was presented, the researcher included the voices of community members who experienced this; creating a positive image about this theme, as they perceived religious leaders as trusted guides in the same vein as those who experienced tension between religious directives and biomedical recommendations. The narrative moved beyond descriptive to interpretation, depicting the ways in which the findings illuminated the intersection of social norms, cultural narratives, gender dynamics, and health communication within the Northern Nigerian communities. The relationships between themes were clearly pointed out, demonstrating how gendered mobility restrictions intersected with trust deficits in healthcare facilities to create compounding barriers to the access women have to healthcare. All through the report, the findings were situated within existing theoretical frameworks while also highlighting the areas where the lived experiences of participants escalated, challenged, or extended beyond existing scholarship. This final narrative was not focused solely on reporting the findings, but on making a clear argument for what the findings meant for a better understanding of health communication and social norm dynamics within this specific sociocultural context.

Ensuring Quality and Rigor

Establishing trustworthiness in this qualitative study requires moving beyond conventional notions of validity and reliability, which researchers use in quantitative research to apply the criteria that is more appropriate for the interpretive research. Following Lincoln and Guba's (1985) foundational framework, the study employed several interwoven strategies to ensure credibility of findings, that the findings are transferable, dependable, and confirmable throughout the analytical process.

To maintain credibility of data, the qualitative equivalent of internal validity was strengthened through sustained and meaningful engagement with participants and their communities. Consistent immersion with the participants, enabled the researcher to build genuine rapport and develop nuanced understanding of the sociocultural landscape, and have a better view beyond surface-level observations to deeper contextual insight. Staying consistent with the preliminary analysis, enabled member checking sessions where participants were invited to review the interpreted themes to assess if the findings authentically represented their lived experiences. Dialogues of this sort prompted minor but meaningful changes in how themes were articulated, ensuring the voices and agency of participants remained central rather than lost in academic interpretation. Additionally, triangulation across participant groups such as community members, health workers, leaders of culture and faith and their geographic locations within Jigawa, Katsina, and Abuja (AMAC) revealed consistent patterns and meaningful differences in the findings that emerged.

Transiting to transferability, the study provided a rich, elaborate description that systematically situated the findings within the specific sociocultural, political, and historical landscape of Northern Nigeria. It provided sufficient contextual detail of the community settings, participant characteristics, gender dynamics, religious practices, and the broader health communication environment to assess the degree to which the findings might resonate with or apply to other settings that share similar characteristics rather than making a generalized assumption when different regions have different perspectives and experiences. Dwelling on the fact that this is a qualitative study, statistical generalization was never intended or appropriate in this study; as in-depth detail provided throughout the study, makes it possible to draw broader

analytical insights and supported thoughtful consideration of how the findings might be theoretically transferred to other settings with similar characteristics.

To ensure dependability, the qualitative equivalent of reliability required transparency and traceability of research process, and a comprehensive audit trail was maintained throughout the study noting the major decisions which consists of participants selection, the process of developing the interview protocol, the coding iterations, how themes were refined, and reflexive memos taken through the process making it possible for others to follow the research process step by step and getting a better understanding of how the researcher reached the findings. This documentation will make it possible for external reviewers to trace the researcher's thought process and assess how the interpretive decisions made were consistent and coherent. Frequent debriefing sessions with peers, supervisors and colleagues further strengthened dependability, creating spaces to question the emerging patterns, challenge preliminary interpretations, and strengthen the analytical approaches through open and critical conversations.

To ensure confirmability, the study actively addressed the influence the researchers' background and assumptions have on the study through constant reflection. Through the data collection and analysis process, the researcher made use of a reflexive journal documenting personal reactions, cultural assumptions, moments of interpretive tensions, and evolving insights. This practice created the necessary separation between the researcher's perspectives and the narratives of the participants, to ensure the findings were genuinely grounded in the data rather than influenced by preexisting expectations. The researcher's positionality was a complex one as someone with deep familial and cultural ties to Northern Nigeria but educated and trained within Western academic traditions presenting benefits and potential blind spots. Instead of treating this as a problem to be eliminated, the researcher analyzed and reflected on the best ways this

positioning influenced the noticeable facts, subtle things that were heard and ultimately interpreted and taking this step made what would have been a source of bias, become an analytical strength through conscious examination.

Finally, triangulation was employed as a deliberate strategic to strengthen the depth and reliability of the findings through the systematic comparison of data across different participant groups and research sites. This comparative analysis made it possible for the identification of themes that came up frequently across contexts and the diverse perspectives that revealed very important variations in experience. Through the process of triangulation, the study achieved a richer, comprehensive understanding of how social norms and health communication works in a diverse context like that in Northern Nigeria.

In summary, these integrated strategies strengthened the trustworthiness of the study, ensuring that findings were credible, and solidly grounded in the experiences of the participants, methodologically sound, and sufficiently detailed to allow a meaningful engagement that goes beyond the immediate research setting

Reflexivity and Positionality

My positionality as a researcher with deep social, cultural and professional ties to Northern Nigeria was central to the epistemological grounding of this study. Having lived, worked, and collaborated extensively within the region's health and development sectors, I occupied an insider-outsider position that shaped how I engaged with participants, how I interpreted data, and also how I constructed meaning. This dual positionality provided the researcher a unique advantage such as linguistic fluency in Hausa, contextual sensitivity to cultural norms in the region, and relational trust built through community connections that may have been less accessible to researchers who

are not familiar with the sociocultural dynamics in the region (Chavez, 2008; Ganga & Scott, 2006). However, it also introduced potential biases that required critical assessment throughout the research process.

Reflexivity was therefore not an add-on, but a core part of how this study was conducted; as I was aware of how my social background, professional identity, and prior experiences could influence how participants perceived me and how comfortable they were with sharing their lived experiences with me, especially if they associated me with institutional health interventions or external organizations. This important perception could be a factor that makes participant hold back information that could richly shape the content, tone, and depth of information they are able to divulge, as well as the power relations embedded in the research encounter. To address this, I engaged in continuous reflexive practice through journaling, memo-writing, and peer debriefing sessions with peers, colleagues and research supervisors. These practices helped me continuously interrogate how my assumptions, values, and ways of interpreting the world may have shaped how I collected the data, developed the codes, and analyzed the findings (Berger, 2015).

Moreover, I also recognized that being too familiar with the field could sometimes be a hindrance to how I interpret information; as considering cultural factors rather than genuinely making inquiries. To avoid issues of this nature, I adopted a stance of epistemic humility, staying open to alternative interpretations and always prioritizing the voices of participants over my preexisting assumptions. During interview sessions, I practiced active listening and used follow-up questions to explore unexpected responses rather than assuming I already understood the perspectives of the participants based on my own cultural familiarity. In the analysis phase, I always referred back to the raw data to check that my interpretations were genuinely rooted in what participants were actually saying. Being transparent about these positional complexities was

essential for ensuring the trustworthiness and ethical rigor of the study (Lincoln & Guba, 1985; Holmes, 2020). Documenting my reflexive process throughout this thesis was intended to strengthen the credibility of the findings and demonstrate a sustained genuine commitment to ethical responsibility, cultural sensitivity, and methodological rigor.

Ethical Considerations

Research with human subjects demanded more than procedural compliance, it called for a principled, culturally sensitive commitment to safeguarding the dignity, autonomy, and well-being of participants who volunteered to generously share their experiences for meaningful contribution to the wellbeing of their community. Grounded in ethical rigour and relational care and guided by core principles such as informed consent, confidentiality, voluntary participation, data protection, and cultural sensitivity.

Before the data was collected, ethical clearance was obtained from the Institutional Review Board (IRB) of Kansas State University. This review was collected to ensure all research procedures were strategically aligned with established ethical standards and that potential risks from the research were deliberately and thoughtfully assessed and minimized (American Psychological Association, 2017).

Participant invitation to the study was drafted with full transparency in clear, jargon-free explanations of the purpose of study, study procedures, potential risks and benefits, and their rights as participants. Consent was documented either through written or electronic signatures, depending on the preference of the participant and their literacy levels. The researcher reminded the participants that taking part in the study was entirely voluntary and that they could withdraw at any time, without explanation or consequence (Beauchamp & Childress, 2019). The consent form

was read to participants with limited literacy in their preferred language, and their comprehension level was verified through follow-up questions before proceeding with the interview.

Participants were not just recruited as people to extract data from, but they were seen as individuals with lived experiences whose experiences and data should be respected and protected. Pseudonyms were used as means of identification to anonymize participant information in transcripts and in reporting. Audio recordings, transcripts, and related materials were stored in encrypted, password-protected files accessible only to the research team. When findings are shared publicly, no personal identifiers would be disclosed, preserving the privacy and trust of those involved (Wiles et al., 2008). Data will be securely stored for a minimum of five years as required by institutional policy, after which all identifiable materials will be permanently destroyed.

Participation in this study was purely voluntary, without coercion or expectations from participants, prioritizing the comfort and boundaries of the participants at every stage. Participants were informed that they could ignore any questions they found that makes them feel uncomfortable and could discontinue their involvement at any point, even after beginning the interview, without any negative consequences. This respect for autonomy was foundational to building authentic, ethical research relationships (Babbie, 2010).

Given the cultural sensitivities surrounding topics like reproductive health, family planning, and gender dynamics, particular care was taken to ensure respectful and contextually appropriate engagement was put into consideration. As necessary, interviews were conducted by deliberately gender-matched interviewers such as men interviewing men and women interviewing women to foster comfort and trust, especially when it had to do with sensitive issues like reproductive health topics. The researcher remained attentive to cultural norms and participant preferences, adapting methods to honour and respect diverse values and lived experiences; with

interviews conducted in private settings where participants were most comfortable to ensure confidentiality and comfort.

Embedding these ethical commitments into every phase of the research process, this study sought not only to meet regulatory standards but to model a research practice that was principled, inclusive and deeply respectful of those who participated.

Limitations of this Study

The thematic analysis employed in this study provided a rich and nuanced insight into the intersection of social norms and health communication, this study still acknowledged several limitations. First, based on a purposively selection of participants from specific communities in Northern Nigerian like Jigawa, Katsina, and AMAC, consistent with the exploratory nature of qualitative inquiry, the findings are not intended to be statistically generalizable but are designed to offer transferable insights to similar sociocultural contexts. which is consistent with the nature of qualitative research, which puts the depth of understanding above broad representation (Braun & Clarke, 2006). However, the detailed contextual descriptions provided throughout the study enable readers to assess the transferability of findings to similar settings.

Secondly, thematic analysis is designed to identify patterns in the qualitative data rather than measure or establish a cause-and-effect relationships, which implies the findings are interpretative in nature While the study exposed the various ways social norms shaped health communication, it could not quantify the strength of these relationships or predict how things might unfold in different contexts.

Third, as a result of the interpretive nature of thematic analysis, my positionality as a researcher could influence how the themes were developed. While reflexivity and systematic

analytical procedures supported the mitigation of this limitation, complete neutrality was neither possible nor expected in constructivist research (Braun & Clarke, 2013). The findings therefore represented one interpretation of the data, informed by the voices of participants and the researchers' theoretical knowledge and lived experiences.

Fourth, the study relied on self-reported data from interviews, which may have been subject to social desirability bias, particularly regarding sensitive topics such as family planning, traditional practices, or critiques of health systems. While efforts were made to build rapport and create comfortable interview environments, some participants may have presented idealized versions of their beliefs or behaviors.

Expected Outcomes and Contributions

The study developed a deeper more grounded understanding of how health communication and social norms intersect in Northern Nigerian regions to shape health behaviors. The findings provide academic insights and practical guidance for those designing health interventions and communication strategies that are culturally sensitive and effective. Additionally, the research also informs broader public health policies in ways that better reflect the lived realities and needs of the communities being served. While the focus of the study was on Northern Nigeria communities, the insights proved relevant to other settings facing similar challenges, especially across Sub-Saharan Africa. The key contributions of the study are summarized as follows:

The study contributes great insights into the effectiveness of health communication; by documenting how health communication messages were received, interpreted, and acted upon by community members, revealing the local nuances around maternal health, family planning, and immunization, that provides actionable guidance for public health practitioners seeking to design targeted and culturally appropriate interventions (Rogers, 2003; Kincaid, 2000).

Also, the study identified key social norms that influenced health behaviors such as religious framing, gendered decision-making hierarchies, and expectations of communal conformity which shows how cultural and religious beliefs impacted individual acceptance or rejection of health messages and how social expectations either facilitated or constrained the adoption of health behaviors (Sheridan S L. et al., 2011). Having a clear understanding of this interaction helped demonstrate how health interventions could be better adapted to local contexts to achieve greater success (Marmot, 2005).

It exposed the barriers to health behaviour change that hindered people from adopting the recommended health behaviors, by exploring the various ways health communication and social norms interact. It also revealed how cultural values, religious beliefs, and societal expectations limit the effectiveness of health interventions (Eisenberg et al., 2003).

The recommendations for tailored health communication strategies based on the findings from this study include proposing practical recommendations for designing culturally sensitive and contextually relevant health communication strategies (Kincaid, 2000). These are strategies that emphasized the need to close the gap between evidence-based health recommendations and local practices, to ensure greater acceptance and action upon health messages (Vaughan & Rogers, 2000).

The study contributes to health policy and community health initiatives by providing valuable data that could inform policymakers, public health organizations, and community health workers on the benefits of aligning health interventions with local cultural contexts (Sheridan S. L. et al., 2011). It supported the revision of health campaigns, increasing community engagement, and fostering structured meaningful collaborations between health authorities and community leaders (Marmot, 2005).

The study also advances an integrative conceptual framework that connects health communication, social norms, and health behavior in a coherent, structured and strategic way which is relevant for getting a better understanding of the findings of the study and also serve as a foundation for future studies exploring similar topics or challenges in other cultural contexts or regions. (Berkman et al., 2011; Rogers, 2003)

Chapter 4 - Data Analysis

Introduction

This chapter focuses on presentation of the data, analysis and interpretation of the findings informed by the Social Norms Theory thematic analysis of semi-structured interviews conducted with 20 participants across three locations in the Northern part of Nigeria as follows: Jigawa State, Katsina State, and Abuja Municipal Area Council (AMAC). Braun and Clarke's (2006) six-phase approach to thematic analysis was employed to explore the various ways individuals in Northern Nigerian communities interpret, negotiate, and respond to health communication within their normative sociocultural contexts.

The analysis addresses three research questions that guiding this investigation:

1. How do individuals in Northern Nigerian communities interpret and negotiate health communication messages within prevailing sociocultural norms and communal expectations?
2. In what ways do dominant and contested social norms facilitate or constrain the reception and adoption of health-promoting behaviors communicated through public health campaigns?
3. How can community narratives and culturally embedded meanings inform the co-creation of health communication strategies that reflect the lived experiences of marginalized groups?

Chapter four organizes the findings that answer each research question in a coherent way; beginning with the research question restated, advancing a clear statement that answers it, and presenting the thematic evidence through the narratives of participant and analytical interpretation. This structure puts research questions in perspective and the themes as evidence that depict how health communication, social norms, and community behaviors are all connected.

The analysis is informed by Social Norms Theory (Paternotte, C. 2018). and the Culture-Centered Approach (Dutta, 2008), which provides a theoretical lens to better understand how health messages are filtered through religious authority, gender hierarchies, trust networks, and epistemological preferences. Following presentation and discussion of findings for each research question.

The three research questions addressed in this chapter are connected and built on each other rather than operating as three separate inquiries (see Table 4.2). RQ1 establishes the interpretive approach through which communities evaluate health messages; the structured epistemological system that determines what counts as credible knowledge and who counts as a legitimate authority. RQ2 goes further from interpretation to action, examining how the normative expressions of that approach facilitate or constrain the adoption of health behaviors, and what conditions create lasting versus temporary shifts in accepted behavior. RQ3 captures the practical implications depicting how communities interpret messages and how norms shape behaviors, how effective co-creation of health communication looks like, and what it demands of health systems. Each gives a clear response to what the previous question ignores. All three come together to make a single argument that health communication in Northern Nigeria does not fail because communities lack knowledge, but they fail because interventions lack epistemological credibility

and building that credibility requires capacity, partnerships, and institutional commitments that dominant health communication models fail to address.

Table 3.1: Summary of Themes, Subthemes and Key Patterns

Research Question	Themes	Sub-theme	Key Patterns
RQ1: How do individuals interpret and negotiate health messages within sociocultural norms?	Theme 1: Religious Authority, Gender Hierarchies, and Epistemological Filters as Mechanisms of Message Interpretation	1.1 Religious Authority as Moral Legitim�izer and Spiritual Gatekeeper 1.2 Gender Hierarchies as Access Mediators and Decision-Making Gatekeepers 1.3 Trust Networks as Credibility Determiners and Historical Memory Keepers 1.4 Traditional and Biomedical Epistemologies as Competing yet Coexisting Knowledge Validators	- Religious texts and imams legitimize health messages - Male authority mediates women's health access - Trust high for local actors, low for institutions - Traditional and biomedical systems coexist - Historical memories shape institutional mistrust
RQ2: How do social norms facilitate or constrain health message uptake?	Theme 2: Social Norms as Dual Forces of Constraint and Facilitation	2.1 Cultural Alignment as Message Resonance Mechanism and Normative Filter 2.2 Leadership Networks as Norm Entrepreneurship Platforms and Institutional Amplifiers 2.3 Community-Driven Normative Shifts as Grassroots Transformation Mechanisms 2.4 Traditional Medicine Preference as Normatively Entrenched Resistance Mechanism	- Messages aligned with faith, family, culture succeed - Local leaders function as norm entrepreneurs - Grassroots advocacy shifts norms sustainably - Traditional medicine remains normatively preferred - Norms are context-dependent and negotiable
RQ3: How can community narratives inform co-creation of health communication?	Theme 3: Community Narratives as Co-Creation Foundations	3.1 Grassroots Mobilization as Ownership Mechanism and Sustainability Platform 3.2 Language as Cultural Bridge, Trust Mechanism, and Comprehension Enabler 3.3 Narrative Power as Emotional Connection Generator and Social Proofrecipients Mechanism 3.4 Spiritual Messaging as Religious Legitim�izer and Moral Affirmer	- Participatory design fosters ownership - Hausa essential for trust and comprehension - Storytelling creates emotional connection and social proof - Religious framing transforms practices into spiritual duties - Communities are knowledge producers, not recipients

This table summarizes the analytical themes emerging from the thematic analysis, organized by research questions. Each sub-theme represents a distinct mechanism through which health communication is interpreted, facilitated, constrained, or co-created within Northern Nigerian communities.

Message Interpretation - RQ1

The first research question sought to understand how individuals interpreted message within normative context. Based on the information, four key themes emerged that included religious authority, gender hierarchies, trust networks, and epistemological filters as mechanisms of message interpretation.

Research Question 1 asked how individuals in Northern Nigeria regions interpret health communication messages through normative lenses and the findings reveal that participants actively provide a distinct interpretation of health messages through four primary filtering lenses which include religious authority as moral legitimizers, gender hierarchies as access mediators, trust networks as credibility determinants, and epistemological preferences as knowledge validators. These listed filters do not work alone, but simultaneously, creating a complex interpretive foundation where health communication functions as culturally understandable rather than biomedically transmitted. Significantly, these filters are not barriers to be overlooked but they constitute what this study terms a community-level epistemological architecture; the structured, collectively maintained frameworks through which Northern Nigerian communities construct health meaning, assign credibility, and determine which knowledge claims deserve acceptance. All four mechanisms share the same epistemological agency; comparing different information,

deciding when external ideas can be trusted, and protecting the various ways these communities have understood things for a long time now.

Health communication in Northern Nigeria is not a straightforward information transfer process. Instead, it goes through systematic cultural translation through deeply embedded social structures and collective memories. The findings reveal that message interpretation is facilitated by Islamic structures that evaluate health advice for spiritual compatibility, patriarchal family structures that determine who receive and acts on information, historical memories of medical exploitation that shape institutional trust, and traditional knowledge systems that compete with biomedical paradigms for epistemic authority. Having a clear understanding of these interpretive mechanisms is relevant for understanding the reason why certain messages gain traction while others face resistance or rejection. Significantly, each mechanism does not function in isolation, they converge simultaneously on individual health communication encounters, producing outcomes that no single mechanism can explain alone. This convergence is demonstrated throughout the analysis that follows and summarized at the end of this section.

Religious Authority as Moral Legitim�er and Spiritual Gatekeeper

In Northern Nigeria, religious authority functions as the primary lens through which individuals interpret whether health messages are morally and spiritually acceptable, directly shaping how normative frameworks mediate message reception. These findings challenge conventional health communication models that place scientific evidence over religious legitimacy. In Northern Nigerian communities, getting the facts straight in a health message does not matter as much as its alignment with Qur'anic teachings and its endorsement by trusted religious authorities. These findings align with Dutta's (2008) Culture-Centered Approach, which

emphasizes that health meanings are constructed within cultural contexts rather than universally understood. Religious authorities operate as what Paternotte, C. (2018) terms "norm entrepreneurs", the influential actors whose endorsement shifts collective expectations about appropriate behavior. The Imam's validation transforms health advice from what is medically recommended to what is morally right, effectively moving the credibility of a health message from healthcare providers to the religious institution that endorses it.

However, these religious filters also constrain health communication, when messages perceived as secular, atheistic, or culturally foreign face immediate rejection regardless of scientific validity. This creates tension when religious framing makes health messages easier to accept but restricts what topics and approaches are allowed. Health communicators must possess theological literacy and genuine respect for Islamic teachings to navigate this area effectively.

Mal. Umar, a religious teacher from Jigawa, directly shows us how the source of a message shapes its reception, through his explanation:

In our community, who speaks is more important than what is spoken. If a government health worker comes wearing a uniform and speaking English, people will listen, but they will not act. But when I explain the same thing in Hausa, using examples from the life of the Prophet, peace be upon him, and connect it to what a good Muslim should do for their family, that message goes deep inside a person. It becomes part of how they see themselves, not just information they heard once.

A simple statement like this, says a lot as it reveals that the interpretive process in Northern Nigerian health communication is fundamentally messenger dependent. The same health message

delivered by a government health worker in uniform carries far less interpretive authority than when delivered by a locally embedded religious figure speaking in Hausa and making reference to Islamic texts. How credible a source is, determines whether a health message is taken seriously or ignored. Consequently, relying on the messenger is a rational epistemological response because in communities where external institutions have historically exploited trust, the identity and embeddedness of the messenger functions as the first and most reliable validity check available.

Imam Mohammed from Katsina further expressed this dynamic where he addressed family planning as a practice widely perceived as culturally inappropriate or religiously forbidden. He explained that:

Family planning is a topic many Imams avoid because they fear being misunderstood or accused of promoting something forbidden. But I studied the text carefully. Spacing children is not haram¹ but Islamic, that is, if it protects the health of the mother and the child. The Prophet, peace be upon him, said that a believer should not harm themselves or others. What harm could come from allowing a mother to rest and recover before carrying another child? This is mercy, not sin.

By framing child spacing as a religiously approved practice grounded in the Islamic principle of protecting life, Imam Mohammed dismantles normative barriers without challenging the religious structure itself.

¹ In Islamic Law, Haram refers to anything forbidden or prohibited examples: pork and its by-products, intoxicants gambling etc.

This shows how religious authority function as a norm entrepreneur to drive behavior change when health practices are aligned with Islamic values of care and mercy. The Imam does not introduce new values but shows how contested health behavior fulfills deeply held traditional and religious ones. This interpretive move from forbidden to faithful is only possible because the message comes from within the religious structure rather than against it, illustrating precisely why Bicchieri's (2017) norm entrepreneur concept applies with particular force in this context: it is not the content of the message that shifts community norms but the authority of the figure who reframes it.

The interpretive power of faith-based framing was equally evident when Hajiya Safiya, a midwife in Abuja, reflected on how she learned to connect modern medicine to traditional knowledge systems:

When health workers calmly explained exclusive breastfeeding and related it to Islamic teachings, many mothers started following these teachings. I learned this early in my career; the information itself is not enough. The framing matters enormously. Now when I discuss any health practice with a mother, I first ask her what she already knows, what her mother did, what her community believes. Then I find the connection between that knowledge and what the medical evidence shows. Rarely are they completely opposed.

This account reveals a thoughtful interpretive process at work. Mothers do not simply receive health information against what they already know but filter it through their religious and cultural knowledge. When modern medicine recommendations align with Islamic teachings, they are just accepted as medically correct but reinterpreted as spiritually appropriate. Hajiya Safiya's practice of beginning with what a mother already knows before introducing medical evidence

reflects a culturally grounded approach to health communication; one that works through existing interpretive structures rather than against them. Her observation that biomedical and traditional knowledge are rarely completely opposed is analytically significant suggesting that the apparent conflict between these systems is frequently a product of communication failure rather than genuine incompatibility, and that skilled mediators can spot connections that neither system alone makes visible.

Gender Hierarchies as Access Mediators and Decision-Making Gatekeepers

In the Northern Nigerian region, gender hierarchies constitute a primary normative mechanism through which health messages are filtered, determining who receives health information, who holds health-related decision authority, and whose voices are included or excluded from health-related conversations. From the perspective of Social Norms Theory, patriarchal family structures function as deeply entrenched injunctive norms; shared beliefs about what ought to happen that are socially enforced through family expectations and community monitoring (Bicchieri, 2017). These norms position men as final decision-makers on health issues affecting women and children and creating multi-layered communication pathways where messages must navigate spousal approval, family consultation, and community expectations before reaching intended recipients. Notably, gender hierarchies do not operate as independent of the religious authority described in response to RQ1, they are frequently reinforced through Islamic interpretations that assign men spiritual responsibility for family welfare, making religious and patriarchal authority overlapping filters that health messages must pass through simultaneously.

Mallama Rabiū, a female religious teacher from Jigawa, described this hierarchical decision-making structure:

In most houses, men make the final decisions, including those that concern women and their health. A woman may feel pain in her body for weeks, but she will not go to the clinic until her husband agrees. And if the husband is not convinced, or if he does not want to spend money on her care, she waits. Sometimes she waits too long. I have seen women lose children because of this waiting. It breaks my heart.

This pattern creates what we understood as the challenge of dual-audience communication (Bicchieri, 2017) as health messages focused on maternal or reproductive health must carry everyone along; capturing the women who most directly are affected but also their male gatekeepers who control access to resources, healthcare facilities, and permission to adopt health behaviors. Mallama Rabiū's experience paints this scenario in a very vivid way and not as an abstract structural observation but a sensitive communication failure where women die, and children are lost due to the absence of health information and because the gender hierarchy through which that information is transmitted is delayed, distorted, or entirely obstructing its translation into action. Women's choices on their health are structurally constrained, requiring health communication strategies that engage men as partners while simultaneously empowering women within the spaces available to them.

The most marginalized voices in health conversations belong to adolescent girls, who face extreme exclusion based on their age and gender. Mal. Rabo, a community leader in Katsina, acknowledged this critical gap:

Young girls, especially teenagers, are left out of these conversations. Their perspectives are usually never heard. When health organizations come, they speak to the elders, to the Imams, to the community heads. But the young people, who are the ones who will carry the future; they are invisible. This is a serious problem. How can you design a health program for young people without listening to young people?

Dutta's (2008) emphasis on listening to marginalized voices takes on particular urgency; where the systematic exclusion of adolescent girls reveals how marginalization operates through active silencing and through structural absence from communication processes entirely. Cultural taboos around discussing sexuality with young, unmarried community members, combined with patriarchal norms that devalue the voices of young women, create information gaps that are frequently filled with misinformation. Reaching the right audience goes beyond women and their male counterpart who control them to include young and excluded community members who are left out even within the women's own spaces. The interaction between gender hierarchy and religious authority is again visible here; as it is as a result of religious and community leaders that male community members function as the primary gatekeepers of health communication that adolescent girls, who have no recognized access to these authority structures, are overlooked twice over.

Trust Networks as Credibility Determinants and Historical Memory Keepers

Trust networks operate as a normative lens through which individuals in Northern Nigeria evaluate the credibility of health messages, with historical memory of medical exploitation shaping which messengers are deemed legitimate and which institutions face resistance. A clear understanding of trust in health systems within Northern Nigerian communities means recognizing

that multiple knowledge systems exist side by side, shaping how communities assess credibility, assign authority, and respond to external interventions. Trust differs from person to person and is shaped by context, shaped by the perceived legitimacy of messengers, historical experiences of medical exploitation, and the degree to which health systems recognize or suppress local knowledge traditions. This hierarchy produces a clear and consistent pattern across participants through deep trust in locally embedded actors whose credibility is grounded in cultural familiarity, linguistic accessibility, and relational continuity, and profound mistrust of external institutions whose historical conduct has repeatedly confirmed community suspicions about their intentions.

Imam Mahmud from Katsina articulated this trust hierarchy directly, explaining what makes locally embedded actors trustworthy where government institutions are not:

We trust the village healer more than the hospital, he knows our ways and does not ask for money first. The government sends health workers who do not know our language, do not know our customs, and then they are surprised when we do not trust them. Trust must be earned. It is not given automatically because someone is wearing a uniform.

This finding suggests that trust in a diverse knowledge setting; where cultural familiarity (knowing local customs), language accessibility (speaking Hausa), ongoing relationships (long-term community presence), and economic accessibility (no upfront payment required) all play a role as central factors to how communities evaluate health messages. Each dimension maps onto a corresponding failure of government health institutions, making the contrast between trusted and distrusted actors structurally produced rather than arbitrary. The uniform symbol of institutional authority is explicitly identified as insufficient and even counterproductive because, in this context, it carries the weight of historical exploitation rather than legitimate expertise. This connects

directly to the norm entrepreneur dynamic identified in Theme 1.1 where the same endorsement that gains force when it comes from a trusted Imam loses all force when it comes from a uniformed outsider, regardless of the content being communicated.

Elder Dantijoe Tijani from Katsina gave voice to the collective memory that underpins this institutional mistrust:

They used our people for experiments. We will not forget that. I was a young man during those times; I saw things that I cannot unsee. Medicines given without explanation, injections without consent, children taken for 'examination' and returned changed. The scars from those times are still in this community, passed down through the stories our parents told us and that we tell our children. History does not disappear; it lives in memory and in the body.

This invokes both colonial-era medical exploitation and more recent vaccine controversies, particularly the 2003 polio vaccine boycott in Northern Nigeria. These historical wounds are not personal but shared, transmitted across generation to generation through communal narratives that frame external health interventions as potentially harmful. Bicchieri's (2017) Social Norms Theory illuminates how collective memories of exploitation become embedded in shared expectations. Mistrust functions as a protective social norm, reproduced and reinforced through intergenerational storytelling. Elder Tijani's testimony is not a personal account but a communal narrative, the very mechanism by which the norm of institutional skepticism is sustained and passed on. The phrase "history does not disappear, it lives in the memory and in the body" is analytically precise, as it positions mistrust as irrational resistance and as embodied, socially

transmitted knowledge that communities have valid and rational reasons to maintain, protect, and pass on to their children.

The interaction between trust networks and the religious authority described in RQ1 is structurally significant here because the reason Imams function so effectively as norm entrepreneurs is not just because of their religious authority but because of their position within trust networks built on exactly the qualities government health workers lack, such as cultural embeddedness, linguistic familiarity, and long-term relational continuity. Trust and religious authority are therefore not parallel but mutually reinforcing filters as religious framing gains persuasive force precisely because it is delivered through figures who already occupy the highest positions in community trust hierarchies.

Traditional and Biomedical Epistemologies as Competing yet Coexisting Knowledge Validators

Individuals in Northern Nigeria interpret health messages through the normative lens of competing epistemological systems, actively negotiating between traditional and biomedical knowledge frameworks to determine which holds authority over their health decisions. Traditional epistemology, rooted in spiritual causation, generational wisdom, and religious structures, and biomedical epistemology, grounded in empirical observation, physiological mechanisms, and clinical evidence each maintain distinct criteria for what counts as legitimate knowledge about illness and healing. Rather than one system displacing the other, participants demonstrate sophisticated epistemological agency which encapsulates active, reasoned judgment about which knowledge validators to recognize as authoritative, under what conditions, and for which dimensions of health experience. This agency introduced earlier in the section, is the key idea that

connects all four subsections that follow and returns as the conceptual conclusion of the entire RQ1 analysis.

Traditional Epistemology as Knowledge Validator

Traditional epistemology validates health knowledge through the integration of spiritual authority, generational transmission, and observed natural patterns. Elder Shehu from Katsina articulated the relevance of traditional epistemology in everyday health interpretation:

Prayer comes first always, then we consult the healer, then, if needed and if Allah wills, we go to the hospital. But prayer is not separate from healing, it is the foundation of healing. When I am sick, the first thing I do is make wudu [ritual ablution] and pray two rakats [units of prayer]. Then I recite Ayat al-Kursi [a verse from the Quran known for protection]. After this, my mind is calm, and my body is ready to receive whatever treatment comes. Without this spiritual preparation, medicine is just chemicals.

This sequencing is worth noting as it reveals a hierarchical validation process in which spiritual preparation precedes and legitimizes biomedical treatment. The idea of visiting the hospital is not rejected but is assigned a subordinate epistemic position. The only time biomedical medicine is accepted is when it has been spiritual prepared and framed within a religiously coherent understanding of healing. Elder Shehu's description of medicine as "just chemicals" without spiritual preparation is particularly revealing as it positions biomedical knowledge as invalid and incomplete, requiring spiritual legitimation before it can function as genuine healing. This is epistemological agency in its clearest form, not blindly following tradition but actively deciding when and how biomedicine fits within an existing belief system.

Biomedical Epistemology as Knowledge Validator

The tension between competing knowledge systems becomes most visible when biomedical knowledge successfully earns validation by demonstrating compatibility with traditional epistemological criteria. Alh. Shuaibu, a community head from Jigawa, shed more light on the epistemological labor this requires: "A word-for-word translation is not enough. I have to find the equivalent concept in our culture, the story or saying that carries the same wisdom." This statement captures a much deeper issue than linguistic translation. Cultural translation is fundamentally an epistemological act that requires mediators who can locate biomedical concepts within the interpretive structures communities already use to make sense of health and illness. When this translation fails, health messages remain epistemologically foreign regardless of linguistic accuracy. When it succeeds, biomedical knowledge becomes legible within traditional frameworks and gains genuine community acceptance.

Alh. Shuaibu does not only position himself as a translator of words but as a translator of ways of knowing, a role that requires simultaneous fluency in both epistemological systems. Consequently, this figure functions as what Bicchieri (2017) would call an epistemological norm entrepreneur, as it does not simply convey existing norms but actively shifts community epistemological expectations about which knowledge systems can be trusted and under what conditions biomedical knowledge earns legitimate standing within traditional structures. Applying Bicchieri's concept beyond religious authority into epistemological mediation more broadly reflects one of the distinctive contributions of this study's findings.

Pragmatic Navigation Between Competing Validators

Participants described how community members literally deploy different epistemological validators depending on the nature, severity, and cultural meaning of a given health situation. This pragmatic navigation reflects sophisticated epistemological judgment rather than inconsistency or confusion. Hajiya Safiya demonstrated this precisely through her practice of reframing biomedical postnatal care within the culturally recognized framework of the *kwance* (lying-in period):

One example is postnatal care, many women here believe that after birth, a mother should remain inside for forty days what we call *kwance* (lying-in period). Biomedically, some elements of this practice are actually beneficial as rest, social support, protected bonding time with the baby. When I explain postnatal visits within this context as part of your *kwance*, this visit protects you during this sacred period; women are much more receptive than if I simply say: you must come to the clinic on day three.

An instance like this illustrates pragmatic epistemological navigation with precision. Framing a biomedical recommendation within a traditional cultural practice, Hajiya Safiya submits biomedical knowledge to traditional epistemological validation criteria demonstrating that clinic visits fulfill rather than disrupt the community's existing understanding of appropriate postpartum care. The biomedical recommendation does not replace the *kwance* context, but is incorporated within it, gaining legitimacy precisely because it is shown to honor rather than challenge traditional epistemological authority. Competing knowledge systems do not coexist because one defeats the other but because skilled translators show they are genuinely compatible. Also, this same encounter simultaneously engages three of the four filtering mechanisms identified across this section; it works through trust networks (Hajiya Safiya as a trusted female mediator), navigates gender hierarchies (by reaching women through a female practitioner in a culturally safe space),

and resolves epistemological tension (by locating biomedical practice within traditional knowledge). This overlap illustrates the interdependence of the four mechanisms that the summary ties together.

Conditions for Epistemological Authority

Mal. Shettima, a traditional healer in Abuja, articulated the gatekeeping conditions under which external knowledge claims gain validation within traditional epistemological frameworks:

If we feel your good message disrespects our culture, your message will not be accepted. But if it honors Allah, our culture, and tradition, then it will grow roots. This is not a small thing; this is the foundation of everything. You can have the best medicine in the world, the best evidence, the most talented doctors and it will all be worthless if you approach this community with arrogance or ignorance. Respect is the gateway to everything here.

Mal. Shettima's statement is a clear indication of the gatekeeping work of traditional epistemology around clarity: For biomedical knowledge to be validated as true within this community, it must meet traditional epistemological criteria, asking questions like, "Does it honor Allah?" "Does it respect cultural values?" or "Does it align with tradition?" These questions depict traditional epistemology as the overarching standard that determines which knowledge claims from competing systems deserve acceptance.

The metaphor "grow roots" is analytically significant as it distinguishes between superficial adoption and genuine epistemological integration. Messages that only translate biomedical concepts into local language without satisfying traditional epistemological validation criteria remain foreign impositions adopted temporarily under external pressure but never truly legitimated

within community knowledge systems. In contrast, messages that demonstrate genuine alignment with traditional validators become embedded in community practice because they have been authenticated as true according to locally authoritative criteria. Growing roots captures the idea of acceptance but also incorporates the knowledge that becomes part of the community's own epistemological structure, which are not very different from knowledge that originated within it. Behavior change during a health intervention is not enough proof of real adoption, but true success requires new knowledge to be genuinely integrated into existing cultural beliefs.

Epistemological Violence and the Refusal of Competing Validators

When biomedical epistemology fails to engage with traditional validation processes, the consequences extend beyond communication failure into what is termed epistemological violence. This concept names something that softer framings like "cultural sensitivity" or "health communication barriers" cannot. Those terms locate the problem in individual attitudes or messaging skill problems that can be solved through better training or clearer pamphlets. Epistemological violence, in contrast, names the structural power relations that determine which knowledge systems are granted institutional authority, funding, recognition, and the presumption of validity and which are systematically denied these. It clearly shows how global health systems position biomedical epistemology as universally valid while overlooking traditional epistemological structures, not because biomedical knowledge has proven universally superior but because it is backed by colonial legacies, economic power, and institutional structures that traditional knowledge systems cannot access on equal terms.

Participants described experiencing this violence directly as Mal. Inusa, a traditional healer from Katsina, articulated the dismissiveness with which biomedical practitioners frequently treat

traditional knowledge, “They look at what I do as primitive, as superstition. This arrogance closes doors. We could work together more if there was more respect on both sides.” The word "arrogance" is analytically precise here. It not only names rudeness but the structural presumption that biomedical epistemology requires no authentication through local validation structures, that its validity is self-evident, while traditional knowledge must justify itself according to biomedical standards. This imbalance manifests not only in a lack of communication but also in refusing to recognize the other knowledge system as valid. Consequently, Mal. Inusa's statement also expresses epistemological agency: the recognition that collaboration is possible and that its absence is a choice made by those with institutional power, rather than an inevitable feature of the relationship between the two knowledge systems.

Imam Mahmud, a religious leader from Katsina whose deep mistrust of external health programs is among the most explicitly articulated in the dataset, nonetheless identified the precise communicative conditions under which he became willing to carry an external health message

When someone came to speak about malaria prevention and explained it in terms of Islamic principles of cleanliness and protection of family, I agreed to mention it at the mosque. Because the message was not presented as something foreign it was presented as something already within us, just needing to be activated. That is the right approach.

I believe the phrase "already within us, just needing to be activated" excellently captures the epistemological significance as it describes the pattern of communication that external health messages are not introduced to invalidate and replace already existing epistemological framework but would rather be more receptive to the current framework as an add-on rather than a replacement of what the community is used to. This is a direct opposite of the deficit model that

Dutta (2008) critiques as a feature of hierarchical health communication model which identifies the problem concerning community ignorance and proffers a solution in the delivery of expert knowledge. In Imam Mahmud's account, the approach operates in a different way as the existing community knowledge is perceived as the foundation of all other knowledge and the external knowledge must be validated by the community to take root rather than be presented as superior to the community's knowledge and its significance made visible by its outcome

Imam Mahmud whose account is marked by deep institutional suspicion, became a mouthpiece for health communication once the epistemological framework of the community was validated from its point of entry instead of an obstacle to be rejected. When communication approach changes, it strategically improves the reception of the message as well as transforms the relational structure of the encounter from one of imposition to collaboration and partnership which is the point at which religious authorities become a tool for health communication and not a source of resistance to it. For humility and credibility to reflect in cross cultural health communication matters, the tone of the health message and its cultural sensitivity training should be considered. It operates as an epistemological requirement with the precondition in which knowledge claims can be delivered to traditional validation processes and if lacking, the gatekeeping conditions that Mal. Shettima identified, in the areas of honoring Allah, respecting the culture of the people, and aligning with tradition are never reached, because the dialogue that would allow them to be meaningfully assessed never begins.

Epistemological violence subtly takes precedence through different platforms such as; how it shows up in overt dismissal of traditional practices and in subtler structural processes like educational systems that teach biomedical structures as objective truth while treating traditional

knowledge as cultural belief, healthcare systems that recognize modern medical practitioners while neglecting traditional healers; research structures that measure if community members understand health by their knowledge of modern medicine concepts, rather than by how effectively they navigate the set down knowledge systems used by their community. These structural dimensions ensure that epistemological violence is not resolved by training individual health workers to be more respectful though that matters but requires systemic recognition of traditional epistemology as a legitimate and equal validator of health knowledge.

Furthermore, recognizing epistemological violence as structural rather than attitudinal reframes the meaning of community resistance to health programs. When communities reject vaccination campaigns, decline antenatal care, or continue consulting traditional healers after biomedical consultation, these behaviors are not evidence of ignorance or irrationality. They are expressions of epistemological agency: communities exercising their authority to determine which knowledge claims meet their validation criteria and to protect the epistemological structures that have sustained them. This reframing does not romanticize traditional knowledge or suggest that biomedical interventions are unwelcome but insists that their welcome must be earned through genuine epistemological engagement rather than assumed based on biomedical authority alone.

Integrative Analysis: The Convergence of Four Mechanisms

Throughout this section, each addressed theme has been analyzed with rapt attention to its internal logic and empirical grounding. However, the most important analytical insight of RQ1 is not what each mechanism does individually, but how they work together within the same health communication encounter, producing outcomes that no single mechanism can explain alone. This

is clearly seen in Hajiya Safiya's account of her postnatal care practice, analyzed in RQ1, but would need a little more integrative attention.

When Hajiya Safiya frames a clinic visit as part of the kwance period, she is not just deploying a clever cultural metaphor but also navigating all four filtering mechanisms simultaneously. She draws on religious authority by framing the visit as honoring a spiritually sanctioned recovery practice; she works within gender hierarchies by reaching women through a trusted female practitioner in a culturally safe space rather than through formal channels controlled by male gatekeepers; she activates trust networks by positioning herself as a locally embedded, Hausa-speaking woman whose credibility is relational rather than institutional; and she resolves epistemological tension by demonstrating that biomedical knowledge is compatible with rather than threatening to traditional epistemological validators. The success of her communication is not attributable to any single mechanism but to her capacity to engage all four simultaneously and her failure to do so in any one dimension would likely compromise the others.

An integrative moment like this one reveals the deepest implication of RQ1's findings which implies that the community-level epistemological architecture this study identifies is not a checklist of separate cultural considerations but an integrated system in which each mechanism reinforces and is reinforced by the others. Health communication that engages religious authority but ignores gender hierarchies will reach men but not women. Communication that builds trust without addressing epistemological compatibility may be accepted but not adopted. Communication that achieves epistemological integration without working through trusted networks may be intellectually accepted but socially unsanctioned. Only communication that engages the full architecture simultaneously and with genuine cultural fluency has the conditions necessary for genuine and lasting behavior change.

Summary of Findings from Research Question 1

It is glaringly clear in Research Question 1 findings that health messages in Northern Nigerian communities do not travel on a lateral line from sender to recipient but goes through four filters that communities use to decide if a message is worth accepting or not.

Filter one is religious authority, where Imams and Islamic texts function are the main point of contact for health guidance as messages endorsed by trusted religious figures gained community acceptance; and messages that are not endorsed by these people of authority, or that appeared to conflict with Islamic teachings, were down right rejected regardless of their medical accuracy. The same health information, delivered by a government health worker in uniform and by a locally embedded Imam drawing on Koranic texts, produced entirely different results.

The second filter, which is gender, is demonstrated through patriarchal family structures that determine who receives health information and who made decisions about acting on it. Women and adolescent girls were systematically left out from such health conversations, not by incident but as a result of structures/powers that be. The same religious authority structures that granted legitimacy to health messages for some community members actively restricted access for others.

Filter three is trust in the system which can be questionable when communities fail to distinguish between locally embedded messengers, healers, religious teachers, community leaders who speak their language, culture, and history and external institutional actors whose credibility were undermined by historical memories of medical exploitation. The same message carried different persuasive forces solely depending entirely on who delivered it.

The fourth filter, which is epistemological preference, demonstrates as communities navigated pragmatically between traditional and biomedical knowledge systems, accepting

biomedical advice when it demonstrated compatibility with existing structures and rejecting it when it challenges or displaces them. Traditional medicine was not initially seen as habit or ignorance, but as coherent and internally consistent framework for understanding illness and healing that biomedical communication had not replaced but only challenged from outside.

These described filters did not operate independently, they reinforced one another as religious framing gained persuasive force when delivered through trusted community figures; gender hierarchies were sustained through religious interpretations of family authority; trust was built through the same cultural familiarity and respect that epistemological compatibility required and made it clear that health communication that engaged one filter while ignoring another consistently always fell short.

The main idea of these findings is that health messages did not fail because communities could not understand them but because they did not align with frameworks such as religious, relational, historical, and epistemological lenses that communities had sound reasons to protect. I deduced from them that the problem was not information scarcity but incompatibility between the assumptions of health messages and the knowledge of these communities.

Message Interpretation - RQ2

Having established how individuals interpreted health messages through normative lenses in RQ1, Research Question 2 sought to understand the various ways dominant and contested social norms facilitate or constrain the reception and adoption of health-promoting behaviors communicated through public health campaigns. Social norms operate as context-dependent mechanisms that act as enabler and an obstructor to health message uptake through four

interrelated processes; cultural alignment filters messages for moral compatibility, leadership networks transform recommendations into collectively enforced expectations, grassroots advocacy demonstrates that new behaviors can fulfill rather than threaten cultural identity, and entrenched traditional preferences sustain normative resistance rooted in epistemological coherence. The relationship between these four mechanisms is neither additive nor sequential; they constitute a dynamic system in which the same normative structure can facilitate or constrain specific health behaviors depending on how messages are framed, who endorses them, and whether communities retain genuine agency in determining their own normative evolution.

Understanding this system requires attention to two tensions simultaneously: between rapid behavioral change achieved through elite institutional authority and slower, community-led transformation that preserves deliberative space; and between accommodating existing norms as a condition for message acceptance and contesting norms that, however culturally embedded, produce demonstrable health harm. Unlike RQ1, which established that these tensions exist within the interpretive structure, RQ2 shifts to practice-level evidence, examining how the normative expressions of that structure facilitate or constrain health behavior adoption, and how the data itself provides partial empirical evidence of how communities navigate these tensions from within their own structures.

The analysis builds directly on the findings of RQ1 that health message interpretation operates through community-level epistemological structure comprising religious authority, gender hierarchies, trust networks, and epistemological preferences. The expectation generated by RQ1 that facilitating and constraining norms would not only appear as isolated variables but as expressions of the same integrated system are confirmed, complicated, and extended by the findings that follow. Consequently, the data also reveals relevant limitations and extensions of the

theoretical structures employed, which are captured in the summary were warranted by the findings.

Gender operates as a cross-cutting analytical dimension throughout this section rather than as a periodic concern. Each of the four normative mechanisms documented below operates differently across gender lines in analytically significant ways. The norms that messages must align with are themselves gendered; leadership networks are structurally male dominated; women's informal networks carry normative authority that formal health programs systematically overlook; and the preference for traditional medicine intersects with women's role as primary practitioners and transmitters of traditional health knowledge. These gendered dimensions are woven into the analysis of each theme rather than treated as supplementary observations.

Cultural Alignment as Message Resonance Mechanism and Normative Filter

Social norms facilitate health message uptake when communication aligns with the cultural, religious, and linguistic frameworks communities already recognize as legitimate, and constrain it when messages are perceived as foreign or disrespectful to those frameworks. Messages that align with cultural values, religious teachings, linguistic preferences, and family structures gain normative support and collective endorsement. Significantly, messages perceived as culturally disrespectful or foreign face normative rejection regardless of their potential health benefits. Cultural alignment functions as a filtering mechanism that determines whether health advice resonates as internally affirmed wisdom or external imposition; and that filtering operates primarily at the level of moral approval rather than factual persuasion.

Alhaji Shuaibu, a community head from Jigawa whose bilingual capacity and role as cultural mediator positioned him at the precise interface between external health systems and community reception, articulated the foundational conditions for message acceptance:

Any health message must take into perspective three pillars: Family, Faith, Tradition & Culture. My role is to make sure that when health messages come from outside, often in English, often using technical language, they are not only translated into Hausa words but into Hausa meaning. This is different as a word-for-word translation is not enough. I have to find the equivalent concept in our culture, the story or saying that carries the same wisdom.

This statement reframes health communication as a moral evaluation. Messages are not assessed merely for factual accuracy but for their compatibility with the relational, spiritual, and cultural frameworks through which community members construct meaning and identity. Health communication that fails to engage these three pillars is not just seen as simply ineffective, it is perceived as a form of cultural disrespect, which actively forecloses the possibility of acceptance. Alh. Shuaibu's distinction between translating words and translating meaning is analytically precise as it captures the difference between linguistic accessibility and genuine epistemological alignment, the latter requiring mediators with deep cultural fluency rather than mere bilingual competence.

The gendered dimension of the three pillars deserves explicit analytical attention. Family, faith, and tradition are not gender-neutral; family structures within Northern Nigerian communities assign women subordinate decision-making roles; faith structures confer gatekeeping authority on male religious figures; tradition frequently encodes gender-based health restrictions that limit women's autonomous care-seeking. Cultural alignment as a facilitation mechanism therefore

operates with greater reliability for health messages targeting male decision-makers than for those targeting women, because the normative structured messages must align with and are themselves organized around male authority. This does not render cultural alignment ineffective for women's health communication, but it implies that alignment strategies designed without explicit attention to gendered power dynamics within the three pillars will systematically reproduce rather than challenge the structural barriers to women's access to health.

The significant point here is that Mal. Giwa, a community head from Katsina, occupies a different institutional role and located in a different region from Alh. Shuaibu, articulates an almost identical normative structure using near-identical language:

In the North, you are to always reference the Hadith so that the messages can feel right to the people. It is not enough to tell someone that a thing is good for their body. You must show them it is also good for their soul, their family, their community. Any health message must take into perspective three pillars: Family, Faith, Tradition and Culture. If you ignore these, your message is already dead before it is spoken.

The analytical significance of this convergence is not in its redundancy, but in what it reveals about the normative structure itself. When two participants from different roles, locations, and linguistic backgrounds independently articulate the same three-pillar template using near-identical formulations, this convergence is evidence that the structure is not a personal preference or individual heuristic but a collectively shared, deeply embedded normative architecture, one that has been internalized across community positions to the point where it is articulated as self-evident rather than argued for. This is precisely what Bicchieri (2017) means by an injunctive norm: a shared expectation so thoroughly internalized that community members across different positions

reproduce it without coordination, as though describing an obvious feature of their social world rather than a contested normative position. The three-pillar structure is not one community leader's theory of health communication; it is the community's collectively held standard against which all health messages are evaluated, regardless of who is doing the evaluation.

The phrase "feel right" in Mal. Giwa's account signals the affective dimension of this normative evaluation that purely informational models of health communication cannot account for. Messages anchored in sacred texts gain moral authority that secular health education cannot achieve, because they do not only engage cognitive understanding but emotional and spiritual resonance. Religious framing transforms health advice from external recommendation to spiritual obligation shifting the message from "you should do this for medical reasons" to "this is what Allah commands for your wellbeing." The phrase "dead before it is spoken" is analytically significant as it positions cultural misalignment not as a something to correct communication flaw with but as a structural condition that determines whether a message enters community consciousness at all confirming that the three-pillar structure operates as a gatekeeping system rather than simply a preference, and that its collective embeddedness, evidenced by its independent reproduction across participants, makes it structurally unavoidable for any health communication operating in this context.

The practical mechanism of cultural misalignment triggers normative rejection with a force that neither scientific validity nor repeated messaging can overcome. Mal. Shettima, a traditional healer in Abuja, articulated the conditional logic of acceptance and rejection through his account of a conflict between an incoming health message and cultural practice:

It depends on who carries the conflict and how; if an outsider comes and says, your practice is wrong, you must stop; there will be resistance. Always. But if a respected elder or imam opens a dialogue and says, let us think together about this practice and what our faith and wisdom teach us, then there is room for change. Change imposed from outside is resisted. Change that comes from within, through honest reflection and trusted voices can take hold.

This account reveals the normative structures of cultural alignment at its most precise. The difference between the changes imposed from outside the community and the change that comes from within is a preference for tone or approach as it describes fundamentally different epistemological processes. When imposition comes from external forces, it bypasses the validation conditions that make new knowledge acceptable within the structure of the community. In contrast, dialogue from within the community introduces new ideas to the gatekeeping processes that the three-pillar structure requires, creating the conditions under which new knowledge can genuinely take root. These findings align with Bicchieri's (2017) distinction between descriptive norms and injunctive norms as cultural alignment operates primarily at the injunctive level as messages must be morally approved before change in behavior can take place. In situations where there is a contrast between health messages and injunctive norms centered around family, faith, or tradition, individuals may have a clear understanding of the biomedical rationale but still reject the practice as morally inappropriate, and this rejection does not emerge from ignorance but from normative coherence.

While cultural alignment consistently emerges as a key facilitator, the data reveals a structural limitation that the analysis must address directly. Accommodating existing norms as a condition for acceptance cannot work when those norms are harmful to health and deeply rooted. This tension is not just in theory but evident in the data itself. Alh. Shuaibu's account reveals the

limit of alignment from within, when he describes assessing health messages against community values and refusing to support those that "go against core values," he is clearly describing a gatekeeping function that enables culturally compatible health messages and simultaneously blocks those that would challenge harmful normative practices including the patriarchal family structures his three-pillar framework notes as foundational. The same mechanism that facilitates breastfeeding adoption through Islamic framing is structurally capable of obstructing messages that challenge gender-based restrictions on the autonomy of women's health, because those restrictions are encoded within the "family" and "tradition" pillars that cultural alignment requires.

This structural limitation does not make cultural alignment ineffective as a facilitation strategy; it simply defines its scope. Alignment enables the facilitation of health messages that are genuinely compatible with existing normative structures. It cannot, by its nature, support messages that require those structures to be changed. The data does not offer a simple resolution to this tension within RQ2, but it does, as the integrative analysis will demonstrate, provide empirical evidence of communities navigating this limit from within their own structures in ways that create space for critical normative reflection without external imposition.

Leadership Networks as Norm Entrepreneurship Platforms and Institutional Amplifiers

Leadership networks constitute a primary mechanism through which social norms either facilitate or constrain health message uptake, as the endorsement of trusted community figures transforms individual health recommendations into collectively enforced normative expectations. Social norms are maintained and transformed through influential community actors; "norm entrepreneurs" whose endorsement legitimizes behaviors and ideas (Bicchieri, 2017). In Northern

Nigerian communities, cultural and faith leaders serve this function, wielding institutional platforms that transform individual health recommendations into collectively endorsed expectations. This theme does not simply document that leadership endorsement facilitates health communication, which is already known, but examines what kind of change institutional endorsement produces, whether that change supports the community agency that the Culture-Centered Approach positions as ethically foundational, and what the data reveals about the limits of Bicchieri's norm entrepreneur concept as applied in this context.

Leadership networks in Northern Nigeria are structurally male dominated. This gendered dimension is not incidental to the analysis of how they operate as facilitation or constraint mechanisms which it is constitutive of. The Imams, community heads, and traditional rulers who function as norm entrepreneurs are overwhelmingly men whose institutional authority is itself sustained by the patriarchal normative structures that simultaneously constrain women's health autonomy. This simply implies that health communication programs that rely primarily on leadership network endorsement as their facilitation strategy are structurally dependent on the very normative architecture that produces some of the most significant barriers to women's health creating an inherent tension between the efficiency of institutional endorsement and the equity implications of the gendered power structures through which that endorsement operates.

Mal Umar (Jigawa) explained the amplification effect of religious institutional endorsement in his words, stating:

I teach at the Islamic school, we call it *makaranta* (school) and I have been working with the malaria prevention campaign for the past three years. My work is to take the health messages and translate them into Hausa and into the language of our faith. If an imam

explains the importance of mosquito nets at Friday Tafsir (Quranic Interpretation) prayers, it will make a stronger impact than when heard on the radio or from outsiders.

Friday prayers provide religious gathering of religious authority, a social gathering, and moral instruction. Messages delivered in this context gain triple legitimacy as spiritual (endorsed by religious authority), social (witnessed by the gathered community), and institutional (sanctioned by the mosque as an organization). This institutional platform transforms health messages from individual recommendation to collective norms, shifting from "the health worker suggests" to "our Imam teaches." The distinction is not only rhetorical; it also changes the social stakes of non-compliance, attaching moral and communal weight to what was previously an optional personal choice.

The trust hierarchy positioning local leaders above external authorities was articulated by Elder Dantijoe Tijani from Katsina, whose account of historical exploitation in RQ1 established the structural basis for this differential, emphasizing:

Our people believe in and listen more to the elders and the Imams, and the community leaders than to what outsiders come to tell us. This is not stubbornness; it is wisdom accumulated over many generations. We have seen what happens when you trust those who do not know you.

The phrase "wisdom accumulated over many generations" shows that the trust gap is not cultural closed mindedness but as a rational response based on historical experience. The community members trust local leaders because of institutional position and because they are embedded in community life, share linguistic and cultural structures, and maintain long-term accountability relationships with the people they serve. External actors lack this embedded

legitimacy and must work through local intermediaries to gain credibility, a structural reality that health communication programs frequently underestimate.

Institutional endorsement creates successive normative effects that extend well beyond the initial communication event. Hajiya Ramatu, a midwife in Abuja, described this process, stating, "Once our Imam spoke about breastfeeding during the Friday sermon, everyone believed it must be a good thing. No one questioned it afterward. This shows you the power of the religious channel." The observation "no one questioned it afterward" warrants sustained analytical attention rather than simple celebration. The Culture-Centered Approach positions genuine community agency as the capacity of communities to deliberate, contest, and determine their own normative evolution, not as strategically beneficial but ethically foundational to health communication (Dutta, 2008). What Hajiya Ramatu describes is structurally the opposite of health behavior becoming socially enforced precisely through the elimination of questioning. People complied, but the discussion was shut down rather than encouraged. This is not an exceptional case; it is a situation that institutional norm entrepreneurship tends to produce by design. When a single authoritative voice delivers a health recommendation in a sacred setting before a gathered community, the social conditions for disagreement collapses. Individuals who disagree privately face religious, institutional, and social sanctions if they dissent publicly. The behavior spreads rapidly, but the community has not reasoned its way to adopting it but has been organized into it.

The gendered implications of this foreclosure are structurally significant; when health communication depends entirely on endorsement by male religious authorities, the normative changes it achieves are filtered through patriarchal institutional structures. Women whose experiences, knowledge, or preferences contradict the endorsed position have no legitimate

channel through which to raise them once institutional pronouncement has closed the space for questioning. Imam Mohammed from Katsina, whose advocacy for family planning through religious reframing was documented in RQ1, illustrating this tension with analytical precision:

The biggest barrier is that women are not allowed to make their own decisions. A woman may know very well that she needs to go to the clinic, but her husband or mother-in-law will say no. So, the clinic visit never happens, and if something goes wrong, we weep but we do not understand why. I work to change this by speaking directly to men telling them that allowing your wife access to health care is not weakness, it is care [kulawa], it is what Allah asks of us as husbands and fathers.

Imam Mohammed's advocacy for women's access to health care is genuine and consequential. Yet the mechanism through which he advances it, persuading men to grant their wives permission, simultaneously reinforces the patriarchal authority structure that produced the barrier in the first instance. Change is achieved not by consolidating male gatekeeping, but by expanding women's autonomous decision-making. This internal contradiction within a single participant's account is not a flaw in the data but a finding of considerable analytical importance, revealing how institutional norm entrepreneurship can simultaneously facilitate health outcomes and reproduce the structural inequities that constrain them. Dutta's (2008) Culture-Centered Approach cautions against instrumentalizing community leaders as communication channels without engaging their substantive concerns and granting genuine decision-making power, but Imam Mohammed's account suggests the problem is deeper than instrumentalization. Even well-intentioned, genuinely committed norm entrepreneurs operating within patriarchal institutional

structures may be structurally incapable of challenging those structures from within, because their authority is itself constituted by the power relations they need to contest.

Negative Case: Leadership Endorsement as a Contested Rather Than Uniform Force

Leadership endorsement is important but is not always effective and the data reveals a significant limitation in Bicchieri's (2017) norm entrepreneur concept that the analysis must name explicitly. Bicchieri's framework describes norm entrepreneurs as actors who shift collective expectations toward adoption of beneficial norms. What the data demonstrates is that norm entrepreneurship is direction-dependent: the same institutional authority that Imam Mohammed deploys to facilitate family planning adoption, Imam Mahmud deploys with equal structural force to sustain communal vaccine resistance:

Last time they said the vaccine was safe, but people got sick. We do not believe them anymore. There is a history here going back many years of outside organizations using our people for experiments. We will not forget that. When they come with vaccines and speak in English and refuse to answer our questions clearly, our suspicion grows. I am not against medicine. I am against being treated as if our questions do not matter.

Bicchieri's concept, as originally formulated, does not adequately account for norm entrepreneurs who operate in constraining directions amplifying resistance rather than enabling adoption. The data suggests that norm entrepreneurship requires a directional qualifier absent from the original approach as the same institutional mechanism that produces normative facilitation under conditions of trust and cultural alignment, produces normative constraint under conditions of historical mistrust and cultural dissonance. This is not a criticism of Bicchieri's approach but an extension that the Northern Nigerian health communication context makes analytically necessary,

and that has practical implications as health communication programs that treat religious leader engagement as a reliable facilitation strategy without attending to the specific directional orientations of specific leaders' risk institutional amplification of resistance rather than adoption.

Community-Driven Normative Shifts as Grassroots Transformation Mechanisms

While dominant norms can constrain health message uptake, the findings reveal that community-driven grassroots processes constitute a facilitative counter-mechanism capable of transforming normative resistance into collective endorsement from within. Dominant norms can obstruct health communication, even in situations where norms are not static. Participants described how grassroots advocacy, visible role models, peer success stories, and community driven mobilization facilitate normative shifts that external campaigns and institutional endorsement alone cannot achieve. These are shifts that operate through the lens of descriptive norms (what people observe others doing) and injunctive norms (what people come to morally approve of), revealing a fundamentally different model of norm change than the elite institutional endorsement examined in RQ2; one with different patterns of change over time, different relationships to community agency, and critically different implications for whether normative change addresses or reproduces structural gender inequity.

Haj Binta, a midwife in Katsina whose fourteen years of practice gave her long term access to normative change in action, described the mechanism of descriptive norm shift through visible peer example:

When I started working here fourteen years ago, almost no one came to the clinic to deliver.

It was seen as shameful, as abandoning tradition, as lacking faith in Allah's provision.

Slowly, as a few brave women began delivering at the facility and shared their experiences, others followed. The gossip shifted from 'why is she going to the hospital?' to 'how did she do it and where did she go?' That shift in the questions people ask is everything.

The long-term observational framing of this account is analytically valuable as it documents normative change as a moment and as a process, unfolding across years through the accumulated weight of positive examples. Shift from "why is she going?" to "how did she do it?" marks the precise point at which a contested behavior crosses from deviant to normal within community perception. This is descriptive norm change in its clearest form as the behavior becomes normalized through pronouncement and visible accumulated evidence that people like us successfully adopt it without suffering social penalty. The word "slowly" is analytically significant and will be explored further in the temporal analysis that follows.

The gendered dimension of this peer-example approach deserves explicit analytical attention. The "brave women" Haj Binta describes are navigating health system unfamiliarity as well as active social surveillance and potential community judgment. Their willingness to adopt hospital delivery and share their experiences publicly constitutes a form of normative agency that operates directly within and against the patriarchal norms that have historically constrained women's health-seeking behavior. These women are not just early adopters in a diffusion-of-innovation model, they are active normative change agents whose public sharing of positive experiences, creates the descriptive norm evidence that gradually shifts community injunctive norms around facility delivery. The fact that this normative agency is exercised within the constrained space that patriarchal structures permit, does not diminish its analytical significance

but reveals how women exercise epistemological and normative agency even within structural conditions designed to limit it.

The power of informal peer networks as vehicles for normative transmission was articulated by Haj Binta with equal precision when she stated that:

They are the invisible backbone of health communication in this community, for before any woman makes a major health decision, she has to consult her network (her mother, her sister, her neighbor, her midwife). These conversations happen quietly, at home, at the water point, after prayer and if her network supports the decision, she will proceed but if her network is uncertain or opposed, she will hesitate.

The phrase "invisible backbone" is analytically rich as it identifies women's informal networks not as supplementary channels to formal health communication but as the primary infrastructure through which health decisions are made invisible to health programs that engage only formal institutional actors, yet structurally more influential than any campaign or endorsement. The network functions as a distributed normative system as each member's experience and opinion contribute to the collective assessment that precedes individual decision-making. This distributed structure makes women's networks simultaneously more resilient and more difficult to engage than centralized institutional platforms. Resilient because no single intervention can shift the entire network; difficult because engagement requires sustained, relationship-based presence rather than episodic campaign activity.

The gendered implications extend further as informal women's network operate in the spaces that patriarchal authority does not surveil at the water point, after prayers, within domestic

settings. These are precisely the spaces where normative change generated by institutional endorsement cannot reach, because institutional endorsement operates through formal public channels that have systematically excluded women's voices. This implies that for health behaviors primarily affecting women, grassroots network-based facilitation is not only an alternative to institutional endorsement but also the only mechanism capable of reaching the primary normative decision-making infrastructure through which women's health behaviors are actually shaped.

Advocacy groups by women show the capacity for strategic grassroots reframing of contested health practices. Haj Ramatu, a women's association leader in (AMAC) Abuja, described the reframing of child spacing as:

When the women's association started saying that spacing births is a way of showing love and care, more families began to agree. It became something respected. We did not call it family planning, we called it responsible motherhood, caring motherhood. We showed women who had spaced their births that their children were healthier, they themselves were healthier, their families were more stable. The evidence was right there in our community, not in a foreign research paper, but in the lives of women that people knew.

Instances like this reveal strategic injunctive norm reframing that embedding child spacing within culturally valued narratives of love, care, and maternal responsibility transforms the moral register of a contested practice from morally wrong (associated with forbidden contraception) to morally right (demonstrating responsible family care). The normative shift was achieved not only by replacing community values but also by reinterpreting which practices best expressed them. The phrase "evidence right there in our community, not in a foreign research paper" identifies the epistemic form that persuasion must take through lived, visible, locally embodied evidence with

normative authority that external scientific evidence cannot, which connects directly to RQ1's finding about traditional epistemological validators valorizing observed community experience over clinical and statistical evidence.

Haj Ramatu further described the deliberative process through which this reframing was developed:

It came from listening to our members; we asked, what does a good mother mean to you? What does loving your children look like? What does caring for your family look like?' And the answers that came back were about health, about wellbeing, about giving each child what they need. We simply showed them that spacing births was a path to achieving what they already valued. We did not introduce new values; we showed them a new way to live their existing values.

This describes a genuinely community-centered process where the reframing emerged from listening to community members articulating their own values, then demonstrating how health practice fulfills those values. It contrasts structurally with the top-down institutional model in a way that is strategic and ethical; where institutional endorsement produces normative change by foreclosing deliberation, grassroots advocacy produces it by encouraging deeper discussion creating conditions for communities to reason their way to adoption rather than being organized into it. The Culture-Centered Approach identifies this deliberative dimension as ethically non-negotiable as health communication that achieves behavior change by bypassing community reasoning, however efficient, reproduces a relationship of dependence and compliance rather than building the community's ability to drive its normative change (Dutta, 2008).

Haj Ramatu's account also provides the first empirical evidence of communities navigating the harmful norms problem from within their own frameworks; a dimension whose full analytical significance is developed in the integrative analysis that follows. The resistance she describes from religious leaders who initially opposed the advocacy of women's association was overcome through external pressure or value imposition and through alliance-building with Imams and sustained demonstration of benefit visible within the community itself. It is critical normative reflection initiated and led by community members, contesting a health-damaging norm through the community's relational and religious approach rather than against them.

Mal. Mustapha, a community head from Jigawa, described the multi-causal contributing factors that accelerated normative change toward facility-based delivery:

Partly the deaths, which I mentioned., partly the role of women who shared their positive experiences at the clinic they were like ambassadors, partly the work of health workers who came to us with respect and patience instead of authority and judgment. And partly the Imam, who began to speak about protecting maternal health as a religious duty. When all these things came together at the same time, the change accelerated.

Mal. Mustapha's statement resists single cause explanation with analytical depth; as normative change was not produced by any single mechanism, but by the synthesis of peer example, respectful health worker engagement, Imam endorsement, and the visible evidence of preventable deaths simultaneously activating community reflection. This synthesis serves as the empirical anchor for the integrative analysis that follows.

Negative Case: The Temporal Tension Between Grassroots Change and Public Health Timelines

Grassroot mechanisms documented in this theme carry a structural issue that the data makes explicit. The word "slowly" in Haj Binta's account and Mal. Mustapha's observation that "times are moving" both reflect a temporal feature of bottom-up normative transformation that sits in direct tension with public health programs designed for short-term measurable outcomes and episodic campaign cycles. Genuine community-led normative change unfolds across years and generations, not within a six-month project cycle.

This is not a flaw in grassroots approaches but an inherent part of how community deliberation produces deep and lasting normative change rather than superficial change. Public health interventions that consistently prioritize rapid normative change through institutional platforms over slower grassroots mobilization are making an ethical choice sacrificing the deliberative community participation the Culture-Centered Approach positions as non-negotiable in favor of efficiency metrics that institutional funders reward. Being honest about this trade-off, rather than treating it as a logistical problem to be solved, is a condition for true community partnership.

Traditional Medicine Preference as Normatively Entrenched Resistance Mechanism

Traditional medicine preference represents one of the most deeply entrenched normative constraints on biomedical health message uptake, operating not as mere cultural habit but as a coherent epistemological system that communities actively defend against perceived external imposition. Even with opportunities for change, many communities still strongly prefer traditional medicine and remain skeptical of modern medicine, driven by deeply entrenched religious beliefs, cultural traditions, ancestral knowledge, and mistrust of external institutions. They function as normative resistance mechanisms that filter and often reject biomedical health messages. However,

framing them primarily as resistance misrepresents their epistemological character. Health communication that approaches traditional medicine preference as a barrier to overcome rather than as a coherent knowledge system to engage, reproduces the dynamic that the Culture-Centered Approach identifies as one of the foundational failures of conventional public health communication.

The gendered dimension of traditional medicine preference is analytically significant and has been largely missing from health communication literatures. Women in Northern Nigerian communities are not only consumers of traditional medicine but are its primary practitioners and transmitters within domestic and community settings. Mothers, grandmothers, and female elders carry and transmit traditional health knowledge across generations through the informal networks that Haj Binta identified as the invisible backbone of health communication. This simply implies that traditional medicine preference is not simply a normative obstacle to biomedical uptake but a domain of female knowledge authority which is one of the few spaces within the patriarchal normative structure where women hold recognized epistemic power. Health communication programs that dismiss traditional medicine preference as ignorance are therefore epistemologically dismissive and are simultaneously delegitimizing one of the primary sites of women's knowledge authority within communities where such authority is already severely constrained.

Mal. Inusa, a traditional healer from Katsina with thirty years of practice, framed traditional medicine as cultural inheritance:

Maganin gargaji ya shi ne gatanmu (traditional medicine and remedies are our inheritance). This knowledge was given to us by our ancestors, refined over hundreds of years of observation, prayer, and experience. It is not guesswork; it is a system; I know

which root treats fever, which leaf calms a troubled stomach, which combination of plants supports a woman through pregnancy. My patients come to me because they trust this knowledge, and because I am one of them.

The term "inheritance" positions traditional healing as ancestral knowledge transmitted across generations rather than as a preference that might be updated in response to new information. It represents cultural continuity, collective identity, and considered resistance to external influence. Practicing traditional medicine is a healthcare choice and an act of cultural preservation which shows that framing biomedical care as the rational alternative implicitly positions traditional practice as irrational, and traditional practitioners as people who have failed to modernize. This is an ineffective framing from the perspective of those on the receiving end, and a form of cultural disrespect that confirms rather than counters their reasons for skepticism. The final phrase "because I am one of them" identifies the relational basis of trust in traditional healers and not institutional credibility or clinical qualification but community membership, shared identity, and long-term relational presence. These are precisely the trust qualities that RQ2 identified as absent in government health workers and their presence in traditional healers, describes why biomedical systems cannot simply replace traditional ones without rebuilding the relational infrastructure that gives traditional medicine its normative authority.

Elder Shehu from Katsina articulated the spiritual dimension of traditional healing preferences stating that:

Health is from God (*laftiya daga Allah*), and so when we fall sick, we pray, we recite the Koran², and we do not run to the hospitals like the new age children do. This impatience, I do not understand it.

The statement reflects a complete normative framework for understanding illness and recovery, one in which divine providence is the primary agency, prayer and scriptural recitation are the appropriate interventions, and biomedical care-seeking represents a loss of faith rather than simply a different healthcare preference. The dismissive reference to "new age children" frames hospital attendance as cultural dilution and generational decline. From within this approach, preference for traditional and spiritual healing is an injunctive norm, adhering to the demonstration of correct values in the face of external pressure to abandon them. Health communication that treats this approach as a misconception to be corrected rather than a coherent worldview to be understood will reliably produce the resistance it diagnoses.

Mal. Bitrus, a traditional healer from Jigawa who integrates Koranic healing with herbal remedies, articulated the epistemological basis of the relationship between traditional and biomedical systems saying:

Separating spiritual from physical is a Western concept in our tradition, these cannot be separated. When someone is sick, we ask: what is the spiritual dimension? What is the physical dimension? How do they interact? A healer who addresses both dimensions provides complete care. A doctor who only addresses the body is providing incomplete care, in our understanding.

² Koran: The central religious text of Islam, which Muslims believe to be a revelation from God (Allah).

A statement like this does not position traditional medicine as superior to biomedical care but as addressing dimensions of health that biomedical care systematically ignores. The traditional healer provides "complete care" not because herbal remedies are clinically more effective but because the integrated approach addresses the whole person in a way that biomedical epistemology, which separates physical dysfunction from spiritual meaning, structurally cannot. This connects to RQ1's analysis of epistemological coexistence, where communities navigate traditional and biomedical care as complementary validators addressing different dimensions of health experience rather than as competing alternatives.

Mal. Umar from Jigawa identified the structural distance embedded in externally designed health programs as a compounding resistance mechanism:

The biggest challenge is that some of the health programs are designed in Abuja or Lagos or even overseas, by people who have never visited a community like this. Their messages assume everyone can read, can afford medicine, can get to a clinic. They do not understand our lives here. So even if the message is correct in terms of medical facts, it does not connect to our reality. We need messages that start from where we are, not where they wish we were.

This goes beyond language barrier to reveal a deeper gap between what health messages assume and the realities of community life. When messages assume literacy, financial access and geographic mobility, communities recognize that the designers do not understand their lives, which undermines credibility before the biomedical content is even engaged with; and this is the gap between the assumptions embedded in externally designed health messages and lived realities. Language in this case, operates as an identity marker where messages in Hausa, grounded in

community reality, signal belonging; and messages in English, grounded in assumptions that do not reflect community experience, signal foreign imposition.

The Culture-Centered Approach is unambiguous on the epistemological basis of traditional medicine preference as communities' engagement with traditional healing reflects rational responses to biomedical systems that have been economically inaccessible, culturally alienating, and historically epistemologically violent; systems that dismissed local knowledge as superstition while claiming universal authority (Dutta, 2008). If preference for traditional medicine is a rational response to institutional failure rather than a lack of knowledge, then the appropriate intervention is structural transformation rather than persuasion as rebuilding biomedical systems to be linguistically accessible, culturally competent, and genuinely accountable to the communities they serve.

Mal. Inusa demonstrated that traditional healers are not straight out resistant to biomedical collaboration stating that:

They are not enemies, or they should not be. I referred patients to the hospital when I recognized something beyond my capacity to treat. And I have had patients come to me after the hospital failed them, and together we found a path. The problem is the attitude of some hospital workers, they look at what I do as old school, as superstition. This arrogance closes doors. We could work together more if there was more respect on both sides.

This is a clear indication of how existing bidirectional referral relationships already operate between traditional and biomedical systems. The barrier is not epistemological incompatibility, but attitudinal imbalance and the goal is normative integration; demonstrating through structural

transformation and respectful practice that biomedical and traditional approaches can operate as collaborative partners rather than as competitors in a hierarchy that has already declared its winner.

Negative Case: Generational Evolution of Traditional Medicine Preference

Traditional medicine preference appears as a deeply entrenched norm among older participants, as Mallama Aisha, the youngest participant at 28, offered a perspective that questions a one-dimensional view:

The older generation sees health through the lens of faith and tradition, and I respect that completely. But our generation also has access to different kinds of information. We have phones, we have education, we have friends in other communities. I think the best approach combines both the wisdom of the elderly with the knowledge that our generation has access to. Neither alone is complete.

This young participants' account does not reject traditional epistemology but resists limiting it to one system, describing a genuinely integrative approach in which both systems carry complementary authority. A generational perspective like this suggests that traditional medicine preference is not being reproduced identically among younger community members who navigate between multiple information sources. The normative structure documented in this study, reflects primarily older, more traditionally embedded community members, and its evolution among younger generations represents emerging opportunity for health communication strategies designed with long-term normative transformation in mind. Notably, Mallama Aisha's framing "neither alone is complete" echoes the integration argument that Mal. Inusa from the traditional side and Hajiya Safiya from the biomedical side. This convergence across age, gender, and professional role positions is analytically significant as it suggests that the epistemological

integration the Culture-Centered Approach calls for is not simply an external academic prescription but a position that community members across multiple positions are independently arriving at through their own reasoning.

Integrative Analysis: The Convergence of Facilitation and Constraint and the Empirical Basis for Normative Contestation

The four themes developed above constitute four dimensions of a single integrative system, the same system whose interpretive structure was documented in RQ1. Their convergence points to a central finding that the same normative framework can either help or hinder specific health behaviors depending on how messages are framed, who endorses them, and whether communities retain genuine agency in shaping their own normative change. It is the distribution of that agency not the content of the health message that determines whether normative change is experienced as empowerment or compliance.

This convergence is most clearly demonstrated through Alh, Shuaibu's account of how community gatekeeping operates as resistance to health communication and as the normative infrastructure through which it must pass to succeed in this context:

I assess them against what I know about my community. If a message goes against our core values, our faith, our family structures, our traditional wisdom, I will not support it, or I will advocate for it to be redesigned. I am not an obstacle to health programs. I am a quality check. If you pass my test, your message will reach the people. If you do not, I am doing you a favor by telling you now rather than letting you waste your resources on something that will fail.

From Alh Shuaibus' account, he is not simply reframing the entire relationship between external health interventions and community authority structures, but what biomedical institutions always experience as resistance from communities is revealed here as a structural validation process which is a parallel set of conditions that newly introduced knowledge claims must satisfy simultaneously before being accepted into the community's normative system. Consequently, Mal Shuaibu describes the 'test' not as a single criterion but as a multi-dimensional threshold that maps precisely into the thematic structure this analysis has documented across all three research questions. For health messages to be accepted, there are trust conditions it must satisfy as identified in RQ1, which reveals that when engagements are sustained respectfully instead of assertion, that external actors are genuinely committed to the wellbeing of the community rather than extracting compliance from it. It must satisfy the religious legitimization conditions identified in RQ2, which shows that the health practice is compatible with Islamic injunctive norms and can therefore be endorsed by the religious authority structures through which moral permissibility is established. Also, it must satisfy the conditions of the peer network identified in RQ2, providing the kind of community-embedded descriptive norm evidence that allows women and families to perceive the practice as a socially accepted norm and experientially validated rather than just institutionally approved. These conditions are not sequential obstacles but are conditions that must all be met simultaneously as when one fails, the other gets invalidated as the normative system operates as an integrated whole. No single condition is sufficient on its own it is only when all conditions align that acceleration of change takes place.

Mal. Shuaibu's account about the direction of causality in normative change reveals what every external health intervention fundamentally does wrong as most health interventions perceive community gatekeepers to be managed, because they will always obstruct new interventions and

as people whose reluctance must be overcome through better health messaging or more persistent effort. From Mal. Shuaibu's viewpoint, this assumption is wrong as the gatekeepers do not resist health interventions that are for the wellbeing of their community, but they are only playing their role as the gate through which the health message must access. When a message is endorsed by the head of the community, it gets heard and also gains the authority of the community that makes trust networks available and gives access to religious legitimization channels which then generates the conditions where peer example mechanism begins to operate. The function of gatekeeping in this situation is therefore not a barrier that stands before normative change but the first and necessary strategy that the whole system sets in motion.

The gendered dimension of this gatekeeping structure needs to be analytically recognized; Mal Shuaibu's account describes a quality check that is institutionally visible and formally authorized. The community gatekeeper is an authority figure whose must endorse external interventions and messages, yet this thematic analysis has consistently documented a parallel gatekeeping structure that operates alongside the gatekeeping structures through women's informal networks, which is not institutionally visible but as effective and efficient as in determining if health messages really do reach and influence the behavior of women. Women do not decide to change their behaviors just because a man says so and approves a message that has been institutionally endorsed, but they intentionally decide to change because other women who share their lived experiences, their constraints and social positions encourage them that it is safe, acceptable and worth the change. This simply implies that gender equity in health communication outcomes requires passing two tests simultaneously and the first is the formal institutional gatekeeping test that Mal. Shuaibu articulates, and the second are the informal network test women exercise through the community-embedded everyday conversations that determine what other

women understand to be normal, possible, and safe. A message that secures institutional authorization without generating positive experiential evidence through the women's networks remains normatively incomplete allowed in principle but not yet socially imaginable in practice. It is when these two gatekeeping conditions are met simultaneous, formal and informal, institutional and experiential, male-authorized and women-validated, that they begin to experience durable community-wide norm shift that leads to effective maternal health communication.

The number of deaths in this context led to the communities reflecting on the consequences of existing norms, creating the cognitive and emotional transparency within which other mechanisms could operate. The women ambassadors started off by providing visible evidence through their positive experiences of facility delivery, which was compatible with community identity thereby, engaging RQ2's Theme on peer example mechanism which the was identified as central to descriptive norm change. Respectful health workers reinforced this shift by rebuilding trust deficit that RQ1's theme identified as documented, revealing that building trust goes beyond making promises but demonstrating in practice how the behavior that external actors portray can genuinely engage the community knowledge with deep authentic respect rather than being dismissive. Imam Shuaibu's endorsement provided the institutional religious authorization identified in RQ2's Theme placing facility delivery within the framework of Islamic obligation and removing the injunctive normative structural barriers that had made the practice feel religiously suspicious. No single mechanism brought about acceleration; but their simultaneous activation that made change happen. This is not an incidental convergence but a structural reflection of how normative change in this context requires the simultaneous engagement of religious authority, trust networks, peer example, and epistemological alignment because these are not four separate systems but four dimensions of a single integrated system.

The gendered dimension of this convergence deserves explicit analytical recognition, as the "women ambassadors" in Mal. Mustapha's depict women who shared positive facility delivery experiences publicly were exercising normative agency within and against the patriarchal constraints that RQ2's Theme documented as the primary structural barrier to women's health autonomy. Their public testimony created the descriptive norm evidence that no institutional endorsement could produce, because descriptive norm change for women's health behaviors requires evidence from women who are perceived as "people like us" rather than from male authorities speaking on their behalf. The Imam's endorsement provided institutional legitimation, while the women ambassadors provided the lived epistemological evidence. Which were necessary as neither was sufficient alone. This interaction reveals that gender equity in health communication outcomes requires engaging male institutional structures but actively creating conditions for normative agency in women to be exercised and publicly visible.

Analytical Engagement with the Problem of Harmful Norms

Challenges like harmful norms, the tension between cultural alignment as a facilitation strategy and the ethical imperative to address norms that produce health harm, were identified across all four themes and this analysis is committed to engaging it empirically with the collected data providing the basis for doing so.

Harmful norm challenge is a theoretical tension and a practical challenge that the chosen participants in this study are already navigating from within their communities. Haj Ramatu's account of the women's association's advocacy for child spacing gives us direct empirical evidence of how communities can engage in critical normative reflection without external value imposing on it, stating,

From some religious leaders who initially said we were promoting something forbidden. From some older women who felt we were changing traditions that had served the community for generations. From some men who felt we were encouraging women to be disobedient. But over time, as the benefits became visible in our members' lives, and as we were careful to always frame our work within Islamic and cultural values, the resistance decreased. We also brought Imams on board early that was critical.

This describes how the community navigated health-damaging norms against child spacing, which carried demonstrable maternal and child health costs from within the community's relational and religious structures. The women's association did not challenge Islamic values to advance child spacing; rather, they demonstrated that child spacing upheld them. They did not bypass male religious authority but brought Imams on board as genuine partners. They did not impose change on a fixed timeline; they waited for visible evidence to accumulate in community members' lives. The resistance they encountered from religious leaders, older women, and men is analytically significant as it shows that normative contestation generates conflict even when pursued through entirely community-centered methods. There is no path that is without friction to challenging health-damaging norms. But the mechanism through which the women's association navigated that friction demonstrates benefit through community-visible evidence, building alliances within existing authority structures, framing change as fulfillment of existing values rather than their replacement provides an empirically grounded model for respectful normative contestation that neither abandons cultural respect nor accommodates norms that harm health.

Imam Mohammed's advocacy for women's health autonomy provides a second empirical data point. His strategy of addressing men directly while reframing women's healthcare access as

an expression of Islamic male duty rather than as women's independent right is the same mechanism the women's association used with contesting a health-damaging norm by demonstrating its incompatibility with values the community already holds. The fact that this mechanism works through patriarchal rather than feminist logic does not diminish its effectiveness in reducing health harm though it does, as RQ2's Theme analysis established, reproducing the structural power relation it is ostensibly challenging. This is the irreducible tension that the data reveals as community-centered normative contestation is both the most ethically appropriate and the most structurally constrained mechanism for addressing harmful norms, because it must operate within the very normative structure it seeks to change.

What the data does not support is the idea that harmful norms can be effectively addressed by imposing external values on communities. Every account of external intervention that bypassed community structures, the uniformed health workers Elder Tijani described, the English-language vaccine campaigns Imam Mahmud resisted, the externally designed programs Mal. Umar identified as structurally disconnected from community reality; produced resistance rather than adoption. The data consistently points to the same conclusion that lasting normative change, including change that challenges harmful norms, requires communities to be the primary drivers of their own normative change. What external actors can contribute is not the direction of that change but the conditions, the resources, respect, long-term presence, and genuine partnership that allow community-led normative change to take place.

This conclusion has a direct implication for Dutta's (2008) Culture-Centered Approach as the approach positions community agency as ethically foundational and structural transformation as the appropriate goal of health communication. The data supports this but highlights a

qualification that Dutta's approach does not fully address; the community agency in normative contestation is not only constrained by external health institutions but also by internal community power structures particularly the patriarchal authority structures that simultaneously create major barriers to women's health and serves as the structure which progressive community actors must work. A fully realized Culture-Centered Approach in this context must therefore address the relationship between external institutions and communities and the internal power relations within communities that determine whose voices are included in normative deliberation and whose agency is exercised or constrained. This is an extension of Dutta's approach that the Northern Nigerian data makes analytically necessary.

Summary of Research Question 2 Findings

The findings for Research Question 2 show that social norms in Northern Nigerian communities are not fixed forces that simply help or block health communication. Instead, they operate through four interrelated mechanisms whose effects depend on context, direction, and community agency.

Cultural alignment emerged as the foundational filtering mechanism through which all health messages must pass. Messages that honored family, faith, and tradition gained community support because they felt morally compatible with community identity. Messages perceived as disrespectful faced rejection regardless of their medical value. Communities described cultural alignment as working more reliably for messages targeting male decision-makers than for those requiring independent health-seeking behavior for women.

Leadership networks function as platforms through which religious leaders, traditional rulers, and community leaders transformed individual health recommendations into collectively

endorsed expectations. The data revealed that the same institutional mechanism produced different outcomes depending on direction. Imam Mohammed used religious authority to advance women's health access. Imam Mahmud used the same authority to sustain vaccine resistance. Community members described how institutional endorsement often shuts down discussion rather than encouraging it, producing rapid behavior change but limiting community deliberation.

Grassroots advocacy drove bottom-up normative shifts through peer example, women's informal networks, and strategic reframing. Women's informal networks emerged as a critical but largely invisible channel for health communication, operating in domestic and community spaces that formal health programs rarely reached. Haj Ramatu described how the women's association reframed child spacing as responsible motherhood by first listening to what community members valued, then demonstrating how the health practice fulfilled those values, and allowing visible community evidence to accumulate over time. Community members consistently described this process as slow, emphasizing that meaningful change could not be rushed.

Traditional medicine preference persisted as a deeply rooted resistance to biomedical health communication, sustained by religious beliefs, cultural continuity, and mistrust of outside health institutions. Community members did not describe this preference as a lack of knowledge but as a rational response to health systems they experienced as culturally alienating and historically exploitative. A generational pattern emerged in the data as younger community members such as Mallama Aisha described both traditional and modern medicine as incomplete on their own, a position independently shared by both traditional practitioners like Mal. Inusa and biomedical health workers like Hajiya Safiya, suggesting that integrative orientations are

developing organically within the community across different professional and generational positions.

Collectively, the findings show that health communication in Northern Nigerian communities is most effective when it begins with community values, works through trusted community relationships, and allows communities to lead their own processes of change. Every account of external intervention that bypassed community structures produced resistance rather than adoption. Every account of lasting change described a process rooted in community relationships, driven by community members, and moving at a pace determined by community deliberation rather than program timelines.

The findings also consistently highlight the gendered dimensions of how community agencies are distributed. Women's health decision-making is not only shaped by outside health institutions but by internal community power structures that limit women's autonomous health-seeking behavior. Informal networks for women emerged as the primary mechanism through which health communication reached women directly, operating outside the male gatekeeping structures that formal health programs typically navigate through.

Research Question 3 examines how communities, when genuinely engaged, draw on their own narratives, languages, and spiritual frameworks to co-create health communication that is both culturally grounded and health-promoting.

Message interpretation – RQ3

Having established how individuals interpreted health messages through normative lenses in RQ1, and how dominant and contested social norms facilitate or constrain health message

uptake in RQ2, Research Question 3 sought to understand how community narratives and culturally embedded meanings can inform the co-creation of health communication strategies that reflect the lived experiences of marginalized groups. Culturally resonant health communication emerges not just from top-down message dissemination but from participatory co-creation grounded in four community-based mechanisms: grassroots mobilization that fosters ownership and sustainability, linguistic accessibility that builds trust and comprehension, narrative power that creates emotional connection and social proof, and spiritual messaging that transforms health practices into religiously affirmed duties. These mechanisms do not operate in isolation. They constitute an interdependent system in which each mechanism enables and amplifies the others: linguistic accessibility makes grassroots mobilization credible; narrative power makes spiritual messaging personally resonant; spiritual messaging makes grassroots advocacy normatively legitimate; and grassroots mobilization creates the relational conditions within which narrative and spiritual mechanisms can operate with genuine rather than performed community ownership.

The Culture-Centered Approach fundamentally challenges conventional health communication models that position experts as knowledge holders and communities as empty vessels requiring education (Dutta, 2008). Instead, communities possess sophisticated understandings of health rooted in lived experiences, cultural meanings, and collective wisdom. Effective communication emerges through dialogue rather than instruction, co-creation rather than delivery, and cultural translation rather than simple transmission. Understanding how community narratives inform health communication requires examining the mechanisms through which local knowledge, languages, stories, and spiritual frameworks shape health meanings and practices and then asking what those mechanisms, taken together, demand of health communication as a discipline and as an institutional practice.

Gender operates as a cross-cutting analytical dimension throughout this section as it did in RQ2. The four co-creation mechanisms documented below operate differently across gender lines in ways that are analytically significant: grassroots mobilization through women's associations creates co-creation spaces that formal institutional channels structurally exclude women from; linguistic accessibility in Hausa is particularly critical for women whose formal educational opportunities have historically been more restricted than men's; narrative power operates primarily through women's informal networks that are invisible to health programs engaging only formal institutional actors; and spiritual messaging must navigate the patriarchal authority structures that determine whose religious voice is amplified and whose remains structurally inaudible. These gendered dimensions are woven into the analysis of each theme rather than treated as supplementary observations.

The analysis across these four mechanisms generates three new conceptual contributions; theological health literacy, progressive religious engagement, and respectful norm contestation, that are introduced within the themes where the data warrants them.

Grassroots Mobilization as Ownership Mechanism and Sustainability Platform

Community narratives reveal that grassroots mobilization constitutes a foundational co-creation mechanism, as health interventions achieve their most durable results when communities are active participants in message design, delivery, and evaluation rather than passive recipients of externally developed campaigns. Participants consistently emphasized that health interventions achieve their most durable results when communities take part in message design, delivery, and evaluation. This participatory approach fosters community ownership, builds trust through recognition and respect, and creates sustainability by embedding health communication within

existing social structures rather than establishing parallel external systems that dissolve when project funding ends. It also raises questions about the difference between authentic co-creation and consultative tokenism that the data makes analytically necessary to engage with directly.

Mal. Inusa, a traditional healer from Katsina whose thirty years of practice gave him a long-term perspective on the conditions under which communities open up to external health engagement, articulated the foundational principle of genuine co-creation when he stated:

When they came to our village and asked what we needed, we felt seen, and that is when we started going to the clinic, not because they told us to, but because they asked us. That question, what do you need? is a very powerful question. It says, we see you as people with wisdom, not just as a problem to be solved. When you feel seen, you open up. When you are told what to do, without being consulted, you close.

The phrase "felt seen" is analytically precise; as increase in behavioral change through clinic attendance was not driven by better information about what clinics offer, or by the removal of structural barriers to access. It came from an emotional shift as people felt respected. They had been consulted rather than lectured, and their local priorities were treated as genuinely important rather than as an afterthought to someone else's agenda. This observation aligns closely with the Culture-Centered Approach's argument that communities' resistance to health interventions is often not due to ignorance but to a rational response to systems that have historically treated their knowledge as irrelevant (Dutta, 2008). Recognition changes that dynamic as it does not only improve message reception, but it alters the fundamental relationship within which messages are received, transforming communities from objects of intervention to subjects of dialogue. The contrast Mal. Inusa draws from "when you feel seen, you open up; when you are told what to do

without being consulted, you close up" maps precisely onto the distinction between community deliberation and norm-alignment that RQ2 established as the analytical focus of this thesis; one model opens the relational space for genuine co-creation; while the other forecloses it before co-creation can begin.

Mal. Inusa extended this argument beyond the individual encounter, to the systemic conditions that genuine co-creation requires thus:

The best programs are those that build on what already exists, the knowledge of the healers, the networks of the women, the authority of the religious leaders, the trust of the community heads. These things are already here. Outsiders do not need to build them from scratch. They need to recognize them, work with them, resource them.

This statement carries profound implications for how health communication programs conceptualize their relationship to community infrastructure. It positions community knowledge systems, traditional healing, women's networks, religious authority, community leadership as cultural context to be navigated but as the primary architecture within which health communication must be built. The phrase "resource them" is analytically significant as it moves beyond recognition and respect into structural investment, identifying the material dimension of genuine co-creation that rhetorical commitment to community partnership consistently fails to address.

The gendered dimension of this dynamic recognition requires explicit analytical engagement. When external health organizations ask, "what do you need?" and direct that question primarily to male community leaders, elders, and Imams, the recognition they offer is real but structurally partial. Mal. Rabo, a community leader from Katsina, articulated the consequence of

this partial recognition for youth participation stating a dynamic that mirrors and intensifies the exclusion of women:

When they came and asked young people directly, not through the elders, not through the Imam, but directly; the response was remarkable. Young people had so much to say. They had questions that had never been asked before. They had knowledge that had never been recognized. That consultation changed everything, it made them feel like they belonged to the process.

The simple phrase "belonged to the process" adds a dimension to Mal. Inusa's "felt seen" that is analytically relevant as it is not only recognition of existing knowledge that produces the affective shift enabling genuine co-creation but the experience of inclusion in the process of knowledge production itself. Young people and by extension women, whose systematic exclusion from formal consultation processes has been documented across both RQ1 and RQ2 do not only want their existing knowledge acknowledged. They want to be recognized as legitimate participants in the ongoing production of community health knowledge. This is the distinction between consultation and conscientization that Freire (1970) identified as foundational; the former acknowledges what communities already know; the latter invites them into the process of collectively producing new knowledge from their own experiences and priorities.

Imam Tukur from Katsina, whose eighteen years of community religious leadership gave him sustained perspective on how health communication succeeds and fails, described his role as community-embedded health advocate stating:

I am the Imam of the central mosque in Katsina, and I have been leading this community for eighteen years now. People have come to me not just for prayers and religious advice but also for advice on family and health matters. They trust me because I am always here and because I am not an outsider who comes and goes. When someone is sick, their family will come to me first before they go anywhere else. This is how it has always been.

This quote illustrates how effective grassroots mobilization operates through existing trust networks rather than creating new institutional channels. The Imam functions as a cultural broker, because his authority comes from being part of the community, not from outside certificates or official titles. He is not just a communication channel grafted onto existing community structures, but he is those structures. The phrase "I am always here" identifies permanence and relational continuity as the foundational qualities that make his authority credible in ways that episodic external interventions structurally cannot replicate. Imam Tukur's account also reveals the co-creation implication of this embeddedness as health communication that works through existing trust networks does not only gain a more effective delivery mechanism but gains the normative legitimacy that only long-term relational presence can confer.

Negative Case: The Difference Between Authentic Co-Creation and Consultative Tokenism

While grassroots mobilization emerges consistently as a co-creation mechanism in this study, the data introduces a structural tension that cannot be resolved through a design process that is better. Mal. Giwa, a community head from Katsina, identified this tension with analytical precision when he said:

Come to us as partners, not as teachers, we have our own knowledge, our own systems, our own ways of caring for each other. Respect us, involve us, and we will open our doors. But

if you come with a program already designed, already funded, already evaluated and you ask us to participate in what is already decided that is not partnership. That is performance. And we can tell the difference.

The distinction between partnership and performance is analytically central to the co-creation argument. When people pretend to ask the community for ideas but still make all the decisions themselves, it only looks like teamwork while preserving the epistemological hierarchy that genuine co-creation requires dismantling. Mal. Giwa's identification of the "program already designed, already funded, already evaluated" as the structural signature of performed participation is analytically precise as it locates the failure of tokenism in the attitudes of individual health workers and in the institutional structure of project-cycle health programs, which determine outcomes before community consultation begins and then engage communities in a process meant to look legitimate, but is not genuine co-design. Mal. Giwa extended this critique to its structural conclusion when he articulated this:

There was a program on maternal health about why women should go to the clinic for antenatal care. At first, people were suspicious, but the organization came to me, explained everything, asked for my blessing, and agreed to involve our Imam and our women leaders. They used Hausa throughout and they showed how the care was consistent with Islamic teachings about protecting mothers and children. After two years, the number of women going for antenatal visits increased very much. That is a success, but I have seen ten programs fail for everyone that succeeded. The difference was always the same whether they came as partners or as teachers.

This is analytically significant for its description and for the evaluative standard it articulates. Mal. Giwa identifies the conditions for the successful program with precision through community head consultation before design, Imam and women's leader involvement, Hausa-language delivery, and Islamic framing. Each condition corresponds to a mechanism this analysis identified across the four themes. His observation that "ten programs fail for every one that succeeded" and that "the difference was always the same" positions the partner-versus-teacher distinction as an ethical aspiration and as a practical determinant of program effectiveness grounding the co-creation argument in outcome evidence rather than only in normative principle.

Language as Cultural Bridge, Trust Mechanism, and Comprehension Enabler

Community narratives consistently identify linguistic accessibility as a critical co-creation imperative, revealing that health communication delivered in locally spoken language is not a logistical preference but a foundational condition for credibility, comprehension, and cultural resonance. Language emerged across the data as a communication tool as well as a cultural bridge that determines whether messages are understood, trusted, and acted upon. Health communication in Hausa rather than English is neither a logistical preference nor is it a condition for credibility, comprehension, and cultural resonance and the reasons, extend beyond linguistic accessibility into the historical and social meanings that language carries as a marker of cultural belonging, institutional distance, and epistemic proximity.

Hajiya Safiya, a midwife from Abuja whose professional position between biomedical training and community practice gave her direct observational access to the conditions under which health messages succeed and fail, articulated the co-creation competency that genuine linguistic accessibility requires stating:

Sometimes I am caught between two worlds, as the biomedical colleagues see me as too accommodating of traditional practices. Community members sometimes see me as too modern, too educated, not enough like them. But I have come to believe that this in-between position is exactly where the most valuable work happens. Being trusted by both sides means I can translate between them and translation in this case means more than language. It means translating ways of understanding health itself.

Her testament identifies the "in-between position" as the site of genuine linguistic and cultural co-creation, a formulation more analytically sophisticated than the simple messenger-dependence argument, because it specifies that trusted messengers are more effective because they possess the dual epistemological fluency that translation between health knowledge systems requires. Hajiya Safiya's formulation that translation means "translating ways of understanding health itself" is analytically accurate as it captures the difference between linguistic conversion (finding Hausa equivalents for English biomedical terms) and genuine cultural translation (locating the conceptual frameworks within which biomedical recommendations make sense to someone whose health knowledge is organized around Islamic teachings, ancestral wisdom, and community experience). The latter constitutes genuine linguistic co-creation, and only practitioners who inhabit both epistemological worlds simultaneously can perform it.

Hajiya Ramatu, a midwife from Abuja, articulated the structural conditions that make linguistic co-creation succeed or fail with a precision that extends beyond individual communicator competency saying, "Right messengers, right language, right setting, and consistency. If you have all four, the message will reach people. If you are missing even one, the message will fall short."

The four-condition formula is analytically significant as it reveals that language alone even when accurately translated, however fluently delivered is still not enough for genuine communicative reach. The right language must be combined with the right messenger who is someone whose identity and institutional position signal cultural belonging rather than distance, the right setting which is a space where communities experience as their own rather than as an institutional imposition, and consistency which is sustained through relational presence rather than episodic campaign activity. Collectively, these four conditions constitute the communicative infrastructure of genuine co-creation, and their combination requirement means that improving any single condition without the others produces only partial gains. This account extends the linguistic co-creation argument beyond the competency of individual practitioners into the structural dimensions of health communication design; right messengers, language, setting, and consistency which are not individual capacities but institutional commitments that require systemic investment to be sustained.

The structural dimension of this argument was developed by Hajiya Safiya in her account of what genuine linguistic co-creation demands of health systems rather than only of individual practitioners when she said, "More health workers like me; women who are from here, trained here, who understand both the medical knowledge and the cultural context. And more programs that genuinely integrate traditional and modern practices instead of treating them as opposites." A statement of this magnitude grounds the professional training argument in participant testimony rather than analytical assertion. The phrase "from here, trained here" identifies local embeddedness as a professional competency requirement and not a characteristic that some health workers happen to possess but a qualification that health systems must actively develop through their training and hiring practices. The call for programs that "genuinely integrate traditional and modern practices"

extends the linguistic argument into epistemological integration as genuine linguistic co-creation is not achieved by training practitioners to speak Hausa, but by designing programs whose epistemological architecture treats traditional and biomedical knowledge as complementary rather than hierarchically ordered.

The gendered dimension of linguistic accessibility requires explicit analytical engagement. Mallama Aisha, a community health worker from Jigawa at 28 years old, articulated the generational communicative register that health programs relying on traditional formal channels consistently fail to reach:

Young people are quite open to health information than is sometimes assumed. The problem is that most health messages are not designed for us, they use formal language, they go through channels that our grandparents use such as the mosque, the community head; but they do not reach us where we are. Social media, peer groups, and youth networks are where young people get their information from, and health programs need to meet us there.

This extends the linguistic co-creation analysis beyond the Hausa English binary to encompass generational communicative registers. For younger community members navigating between traditional and digital information environments, linguistic accessibility does not only require Hausa fluency but is facilitated by the informal communicative registers like social media, peer dialogue, and youth networks through which younger generations construct and validate health knowledge. The phrase "meet us there" is the co-creation formulation of the linguistic argument as genuine linguistic accessibility requires, meeting communities where they are, not designing channels they are expected to follow.

The gendered and generational dimensions of linguistic access rests in Mallama Aisha's account of the health information gaps that formal language channels leave unaddressed:

Reproductive health, the information that most young women have never been given clearly and safely. Mental health, which is almost completely invisible in the conversation in this community. Young women carry enormous burdens and the pressure of early marriage, of not having choices about their education or their lives and there is nowhere to talk about how that feels.

This identifies a category of health information such as reproductive health, mental health, the emotional dimensions of constrained life choices that formal Hausa-language channels through mosques and community heads structurally cannot deliver, because these channels are governed by the same patriarchal norms that make these topics unspeakable within them. Genuine linguistic co-creation for young women requires Hausa fluency but also communicative spaces outside the formal channels dominated by male religious and community authority, which are spaces where the full range of women's health experiences can be articulated, not only the dimensions that patriarchal institutional structures permit to be named.

Negative Case: The Structural Limitation of Individual Linguistic Competency

While linguistic accessibility emerges consistently as a co-creation mechanism, the data surfaces a structural limitation that individual practitioner competency cannot resolve. Mal. Bitrus, a traditional healer from Jigawa, identified the generational communication gap from the perspective of a practitioner watching communities navigate between knowledge systems:

The young ones are caught between two worlds: the old ways of their grandparents and the new ideas from their phones and their schools. Some have lost confidence in traditional knowledge. They think old means wrong, and new means right. This is a mistake. Other young people are finding their way back to traditional knowledge, especially after the hospital failed to help someone they loved.

This clearly indicates a structural tension within linguistic co-creation that neither Hausa fluency nor digital literacy alone can resolve. The epistemological fragmentation of communities whose younger members are navigating competing knowledge systems with unequal institutional support. Traditional knowledge is transmitted through informal intergenerational channels that formal health programs do not resource; digital health information circulates through platforms that community elders cannot access or evaluate. Linguistic co-creation that addresses this fragmentation does not only require meeting communities in the communicative spaces they inhabit but actively creates bridging spaces where traditional and digital knowledge systems can be engaged simultaneously as structural requirement that goes beyond individual practitioner competency into program design and institutional investment.

Narrative Power as Emotional Connection Generator and Social Proof Mechanism

Storytelling through lived experiences, success stories, and peer testimonials emerged as a powerful mechanism for shaping health behaviors. Community narratives humanize abstract health recommendations, build emotional connection, provide relatable examples, and create social proof that change is possible and culturally acceptable. They also raise ethical questions about whose stories are told, how they are selected, and what is suppressed in the construction of

a health communication narrative, questions the section addresses directly rather than as a closing caveat.

Mallama Rabiū, a female religious teacher from Jigawa whose unique institutional position gave her observational access to the informal networks through which women's health knowledge circulates, described the primary infrastructure through which narrative power operates stating:

Women have created their own networks because they cannot always ask their husbands for permission to seek information. They whisper to each other saying this midwife is good, this clinic is safe, this remedy works. These networks are very strong, but they operate quietly, in the background, where men do not see.

The phrase "whisper to each other" is analytically rich for how it identifies women's informal health knowledge sharing as a communication channel and as a form of epistemic resistance, a collective practice of knowledge production and validation that operates precisely in the spaces that patriarchal surveillance does not reach, because those spaces are the only ones where women can speak freely about health experiences that formal channels render unspeakable. These whispered networks constitute what Mallama Rabiū identifies as the actual infrastructure of women's health decision-making and not the formal channels through which health programs attempt to reach women, but the informal relational spaces where health knowledge is produced, evaluated, and validated through the accumulated testimony of trusted peers. This connects directly to the Culture-Centered Approach's positioning of community knowledge as legitimate expertise systematically excluded from formal health discourse (Dutta, 2008); women's whisper networks are not communication gaps to be filled but knowledge systems to be recognized and built upon.

The social proof mechanism through which peer narrative produces normative change was articulated by Hajiya Ramatu from Abuja, whose account captures both the mechanism and its conditions:

If a message comes through a woman they trust, in their own language, in a space where they feel safe, they will listen. But if it comes from a stranger, in a language they do not understand, in a setting that feels foreign, they will nod and then go back to what they know.

This shows the tripartite conditions, trusted messenger, appropriate language, and safe space that transform narrative from information delivery into genuine social proof. When all three conditions are met, community members do not only receive information but recognize themselves in the story being told as they hear their own experiences, values, and social world reflected back to them through the testimony of someone whose life resembles their own. When any condition is absent, the narrative encounter produces the performance of reception, such as nodding, apparent agreement, while leaving the normative framework intact. Bicchieri's (2017) Social Norms Theory identifies descriptive norms as a primary driver of behavior change; seeing people like us successfully adopt a behavior is more persuasive than any external recommendation. Peer narrative in trusted, linguistically accessible, safe spaces provides descriptive-norm evidence (the lived, locally embodied proof that change is socially possible, medically advisable).

Haj Ramatu, a women's association leader in Abuja, described the deliberate narrative strategy through which the women's association produced injunctive as well as descriptive norm change:

Start from within the community's values, not from outside them, find the connection between what you want to promote and what the community already believes and loves. Build alliances with religious and community leaders not as a tactic, but as genuine partners. Be patient when change does not come quickly, but when it comes, it is deep and lasting.

This describes a narrative co-creation strategy that is simultaneously, epistemologically correct and practically grounded. Starting from within community values rather than from outside them is a communication technique and it is also an epistemological commitment to treating community knowledge as the legitimate foundation from which health communication must begin. The phrase "not as a tactic, but as genuine partners" draws the critical distinction between instrumentalizing community relationships for communication objectives and investing in the long-term relational infrastructure that durable normative change requires. The temporal dimension: "change does not come quickly here, but when it comes, it is deep and lasting" connects the narrative power argument directly to the sustainability argument in RQ3's theme that narrative-driven normative change built on genuine community partnership produces the depth and durability that episodic campaign-driven change cannot achieve.

The narrative dimensions of health communication specifically affecting younger women were articulated by Mallama Aisha, whose account identifies the gaps in content and the structural absence of safe narrative spaces within existing health communication interventions. She describes reproductive health, mental health, and the pressures of early marriage as topics that are almost completely invisible in the conversation and for which there is nowhere to talk about how that feels captures a category of community narrative that health programs and interventions

consistently overlook. throughout the dataset, younger women and girls emerged as a constituency whose lived experiences were systematically filtered through normative structures that has kept them silent for a long time in formal communication channels, without addressing their most pressing health concerns by the very interventions designed to serve them. This pattern of exclusion was not incidental but reflected the broader structural dynamic documented throughout this study, where health communication is designed around externally determined priorities rather than the topics communities identify as urgent and meaningful.

Negative Case: The Ethics of Narrative Selection and the Risk of Instrumentalization

While narrative power emerges consistently as a co-creation mechanism, the data surfaces an ethical tension that requires direct engagement. Mal. Shettima, a traditional healer from Abuja, identified the attitudinal imbalance that transforms narrative co-creation into narrative instrumentalization:

I am cautiously hopeful as I see more health workers who are willing to listen, and I see programs that use local languages and involve community leaders from the beginning. But progress is slow, and there are still many organizations that come with the old attitude; we know best, you just need to comply. Until that attitude changes completely, we will continue to have communities that resist programs that could genuinely help them. The responsibility is on both sides but those with the power have more responsibility to change first.

"We know best, you just need to comply" identifies the narrative posture that transforms health communication from co-creation into imposition, a posture that remains structurally

dominant even in programs that adopt participatory language, because the institutional power relations that produce it have not changed. Mal. Shettima's observation that "those with the power have more responsibility to change first" locates the ethical burden of narrative co-creation not in a balanced way between communities and health systems but in an imbalanced way on the side of those whose institutional power determines the conditions within which community narratives are or are not given genuine space. Ethical narrative co-creation requires health communicators to create space for community stories, but they cede the power to determine which stories matter by accepting that communities' own narrative priorities may diverge substantially from the outcomes that health programs have been designed to achieve.

Spiritual Messaging as Religious Legitim�er and Moral Affirmer

Community narratives reveal that spiritual messaging constitutes an indispensable co-creation resource, as health messages achieve their greatest persuasive power when embedded within religious frameworks that communities already recognize as morally authoritative. Health messages achieve the greatest persuasive power when embedded within spiritual narratives, grounded in religious teachings, and delivered by or endorsed through religious authorities. Participants emphasized that referencing the Koran and Hadith, invoking divine will, and framing health practices as spiritual duties are not optional enhancements to health communication but essential conditions for message acceptance. This theme also introduces two of the three original concepts that the discussion chapter claims as an approach such as theological health literacy and progressive religious engagement.

Imam Tukur from Katsina, whose eighteen years of community religious leadership gave him sustained observational access to the conditions under which spiritual messaging produces

genuine normative change, described the transformative effect of framing health practices within Islamic duty:

When I speak about something at Friday prayers, even about health, people listen with both their ears and their hearts. They know it is not just me talking; it is knowledge grounded in our faith. I once spoke about the importance of clean water and how this aligns with the Islamic principle of taharah [purification], and people began acting on it immediately. But if a stranger comes with a pamphlet in English, they will smile politely and throw it away.

The contrast between listening "with both their ears and their hearts" and smiling politely before discarding the pamphlet captures the difference between spiritual messaging and secular health communication with analytical precision. The pamphlet is received cognitively as its content may be understood; but it does not enter the affective and moral register through which behavior-shaping normative commitment is formed. The Imam's health message achieves what the pamphlet cannot, as it transforms health recommendation into a religious obligation, engaging rational evaluation and moral identity. The taharah example is analytically instructive of the connection between water purification and Islamic principles of ritual cleanliness which is not a communication tactic but a genuine theological alignment, demonstrating that health practices and Islamic values are not competing frameworks but dimensions of a single integrated understanding of how to live well before Allah. This theological alignment is only visible to communicators with genuine Islamic knowledge which is precisely what the concept of theological health literacy names.

Imam Tukur articulated the scope of spiritual messaging across health domains, demonstrating theological health literacy in practice:

I have spoken about maternal health, the importance of going to the clinic during pregnancy, child spacing. which many people used to fear was *haram* (forbidden) and also about malaria prevention. Each time I frame it in terms of our duty to protect the lives Allah has given us. The Koran says, 'Do not kill yourselves, for Allah is merciful to you.' I use this to explain why seeking medical care is not abandoning faith, it is honoring it.

The use of Koranic text to reframe medical care-seeking as an act of faith rather than a departure from it demonstrates theological health literacy in its most developed form. The Imam is not only translating a biomedical message into religious language but also conducting a theological argument, drawing on scriptural authority to reorient the community's understanding of what their faith requires of them regarding health. Health communicators without this competency cannot replicate this effect, regardless of how respectfully they engage with religious communities, because they are operating in an epistemological register that differs from the community's. Their arguments often lack the theological grounding and specialist knowledge required to be taken with credibility.

Imam Tukur's account of how this theological reorientation produces normative change captures the temporal and depth dimensions that institutional endorsement alone cannot achieve: "When people understand that protecting your health is an act of worship [ibadah], their resistance softens. Not everyone accepts immediately, but slowly, people begin to follow. Change here is not fast. it is like water wearing down stone." The metaphor "water wearing down stone" is analytically precise in a way that enriches the sustainability argument running through all four themes. Spiritual messaging that achieves genuine theological alignment does not produce sudden conversion, but it produces incremental, cumulative normative reorientation that eventually transforms the stone

of entrenched resistance into the yielding terrain of normative acceptance. This temporal dynamic is the spiritual messaging equivalent of the grassroots advocacy dynamic documented in RQ3's theme where both operate slowly, both require sustained commitment rather than episodic intervention, and both produce a depth of normative change that faster institutional mechanisms cannot replicate.

Theological health literacy as a competency framework raises a structural question that the data makes analytically unavoidable. Mal. Umar, a religious teacher from Jigawa whose three years of working on malaria prevention campaigns gave him practical perspective on the communicative precision theological health literacy requires, articulated the specific linguistic and conceptual care it demands:

With great care and patience, I do not use the words 'family planning' or 'birth control' because these words carry suspicion. Instead, I talk about the health of the mother, the welfare of children, and the wisdom of spacing births so that each child can be nursed properly. The Prophet Mohammad himself approved of this, when you frame it this way, people nod in understanding. But it takes time, you cannot say it once and expect change. You must say it many times, in many ways.

Mal Umar shows theological health literacy at the level of individual lexical choice through his account. The deliberate avoidance of "family planning" and words like "birth control" carry the accumulated suspicion of foreign imposition and their replacement with Islamic framings of maternal welfare and child nurturing which reflects the depth of cultural and theological knowledge that genuine theological health literacy requires. The phrase *hakuri* (patience) adds the temporal dimension to this discussion through theological health literacy not being a one-time

framing intervention but a sustained communicative practice that must be repeated across multiple encounters, in multiple registers, before the theological reorientation it aims to achieve takes hold. This is the communicator-level expression of Imam Tukur's water-wearing-stone metaphor with the same temporal logic operating at the scale of individual health communication practice.

Structurally, the implications of theological health literacy as a competency requirement was articulated by Mal. Bitrus, a traditional healer from Jigawa who integrates Koranic healing with herbal remedies stating:

They accept it completely, because it makes sense within their worldview. Separating spiritual from physical is a Western concept in our tradition, these cannot be separated. When someone is sick, we ask what is the spiritual dimension? What is the physical dimension? How do they interact? A healer who addresses both dimensions provides complete care. A doctor who only addresses the body is providing incomplete care, in our understanding.

This statement positions traditional medicine as superior to biomedical care and addresses dimensions of health that biomedical care systematically ignores. The traditional healer provides "complete care" not because herbal remedies are clinically more effective but because the integrated framework addresses the whole person in a way that biomedical epistemology which separates physical dysfunction from spiritual meaning structurally cannot. Theological health literacy is the competency that allows health communicators to bridge this epistemological divide in order to present biomedical interventions as addressing the physical dimension of what traditional epistemology already understands as an integrated spiritual-physical health experience, rather than as replacing a spiritual structure with a secular one.

Theological health literacy opens onto the second original concept this theme introduces; the progressive religious engagement. The data reveals that religious traditions do not speak with a single voice on health practices. Imam Tukur's facilitative reframing of maternal health care as Islamic duty and Mal. Umar's careful theological navigation around family planning terminology both reflect a specific interpretive orientation toward Islamic teachings, which is one that emphasizes protection of life, maternal welfare, and collective responsibility for health as religious obligations. Theological health literacy alone is insufficient because Islamic teaching admits multiple interpretations, health communicators who develop genuine religious knowledge must inevitably choose which interpretations to amplify, and progressive religious engagement names that choice explicitly rather than leaving it buried in practice.

Mallama Rabi'u, a female religious teacher from Jigawa, articulated the potential and the structural limitation of progressive religious engagement from her unique dual perspective as religious authority and woman:

As a female religious teacher, I hold a unique position which makes women trust me because I am one of them and I speak the language of faith. I can say things that a male Imam cannot say to women, things about their bodies, their pregnancies, their fears. I teach them that seeking health care is not shameful, it is not against Islam. Islam asks us to care for the body Allah gave us. I also speak with husbands, I tell them: your wife's health is your responsibility before Allah. This message reaches them.

This quote reveals a dimension of spiritual messaging that the dominant focus on male religious authority obscures. Mallama Rabi'u's effectiveness derives from a combination of religious authority, gender identification, and cultural trust that no male Imam can replicate for

women's health communication. Her simultaneous capacity to address women's bodies within a religious framework and to address husbands through the language of Islamic male responsibility creates a dual-audience spiritual messaging capacity that individually neither a male Imam nor a female health worker possesses. This in turn, directly challenges the implicit assumption in health communication programs that religious engagement implies engaging male religious authority; revealing that the most effective spiritual co-creation requires female religious voices whose authority is both theologically grounded and gender specific.

Imam Mohammed from Katsina demonstrated progressive religious engagement operating through the patriarchal institutional structure rather than against it which is an approach whose effectiveness and structural limitations are simultaneously visible:

There is always some resistance at first, the people say you are talking like those people from the government, but I show them the evidence in the Quran and in the Hadith; I read from the texts directly. When people hear these words coming from our own holy sources, not from a government leaflet, something shifts inside them. Some men have come to me privately afterward and asked me to explain more. Their wives are grateful, and this is how change happens quietly, person by person, heart by heart.

His statement reflects the exact mechanism through which progressive religious engagement creates normative shift in this context; as the initial resistance Imam Mohammed articulated describes how he was suspected of introducing government messages to the community reflecting how deep the institutional trust deficit is as shown in RQ1, where external health actors are perceived as officials who want to get information from them and not invest genuinely in their wellbeing. Rather than being defensive of external interventions, or even appealing to evidences

of modern medicine, his response to this resistance is analytically significant as he redirects the epistemic attention of the community to internal religious sources, using Quranic injunctions and Hadith to establish the fact that there is nothing strange about the health practice in question emphasizing the fact that it is already embedded within the community's normative framework. With a move such as this, two things happen simultaneously; first, it bypasses the trust deficit associated with external institutional actors by validating the message with sources whose authority is beyond communal dispute, and it also satisfies the injunctive norm conditions identified in RQ2's theme by framing the health practice within the religious obligatory structure and not in tension with it. The outcome is not compliance but genuine internal shift as in, "something shifts inside them" which is the exact distinction between surface level behavioral change and the deeper normative re-orientation that Bicchieri (2017) identifies as the condition for long term norm change.

The limit of this approach gets analytically visible when the men in the community, came to Imam Mohammed privately afterward requesting for more information, and that their wives are grateful. The progression from resisting public sermon, to private male inquiry sessions, to wives' gratitude; reflects the patriarchal authority structural pathway for norm change; as the Imam speaks, men get persuaded, and the access women get to healthcare increases as an implication of the shift in male attitude rather than as an expression of women's agency and decision-making.

As an effective normative intervention, the gratitude of the wives is confirmation that there is an improvement in health outcomes, but the mechanism through which it functions simultaneously reinforces the gatekeeping structure it is utilizing for beneficial purposes. Women remain positioned as the key beneficiaries of the change process in which male religious authority

and male household decision-making are the active normative agents. This shows there is a persistent tension at the heart of progressive religious engagement in this context as it must work within existing patriarchal authority structures to achieve meaningful change, and while doing that reproduces dimensions of those structures even as it contests others. The most that can be said is that this approach shifts what the patriarchal structure is used for from obstructing healthcare access of women to enabling it without shifting the underlying condition that women's access remains structurally dependent on male authorization in the first place.

Negative Case: The Ethical Tension Within Progressive Religious Engagement

Progressive religious engagement involves deliberate intervention in an ongoing interpretive contest within religious communities choosing to amplify health-facilitative interpretations while refusing to amplify health-constraining ones. The ethical question is not whether to engage with religious authority, but the data makes clear that health communication without it is effectively inactive in this context. The question is whether the engagement is transparent about its own values, genuinely accountable to the communities it claims to serve, and open to interpretive outcomes it did not predetermine.

Mallama Rabiū articulated the structural transformation that genuine progressive religious engagement ultimately requires saying:

More female health worker, more clinics run by women, for women and more education for girls not just Koranic education, but education that includes knowledge about their bodies and their rights. But also, we must engage the men, as you cannot improve women's health without changing how men think about women, the two must happen together as one without the other will not last.

This statement identifies the structural dimension of progressive religious engagement that theological reframing alone cannot address. The simultaneous requirement for engaging women directly while changing how men think about women specifies that progressive religious engagement must operate on two fronts; building the epistemic and health agency of women from within the spaces available to them while contesting from within Islamic structures the patriarchal authority structures that constrain those spaces. The phrase "one without the other will not last" is analytically correct as spiritual messaging that changes women's health behaviors without changing the normative structures that constrain their autonomy produces change that is fragile and reversible. Structural transformation without community-grounded spiritual reframing produces external imposition that communities resist and reject. Only the simultaneous operation of both constitutes the genuine progressive religious engagement that sustainable health equity requires.

Integrative Thematic Synthesis of Cross-Cutting Patterns

The three research questions address distinct dimensions of health communication, but several patterns emerged across all findings that reveal the fundamental dynamics shaping how health meanings are constructed, contested, and enacted in Northern Nigerian communities. These patterns are not eight parallel observations of equal analytical weight; they are organized around one central insight which is epistemological plurality as the foundational condition of health communication in this context; from which the other patterns radiate and to which they return. Sequencing them otherwise would misrepresent the structure of the argument the findings have built.

The most analytically generative insight across all three research questions is, communities in Northern Nigeria do not choose between biomedical and traditional knowledge systems, but

they inhabit both simultaneously, navigating between them with pragmatic sophistication according to perceived illness causation, treatment efficacy, cultural compatibility, and resource availability. This is not epistemological confusion or transitional ignorance on the path to biomedical adoption but a durable, rational, and culturally coherent condition that linear health communication models designed on the assumption that accurate information will progressively displace traditional belief, are structurally incapable of engaging.

Epistemological plurality organizes the thesis's most sophisticated thinking across all three RQs because it is the condition that explains the other patterns rather than simply accompanying them. Religious authority is foundational rather than peripheral because Islamic epistemology is one of the knowledge systems communities are navigating and not a communication barrier as it concerns biomedical truth. Traditional medicine preference reflects epistemological coherence rather than knowledge deficit because it draws on a complete and internally consistent framework for understanding illness and recovery. Grassroots co-creation produces more durable outcomes than expert-driven dissemination because communities are the drivers of local epistemological knowledge that health systems lack. Language carries cultural identity rather than merely conveying information because language is the medium through which epistemological frameworks are transmitted, validated, and reproduced.

The practical implication is that, effective health communication cannot be designed as a strategy for replacing one knowledge system with another but it must be designed as a strategy for working within a landscape of legitimate, coexisting epistemologies while framing biomedical advice as complementing rather than superseding traditional and religious knowledge, demonstrating through practice rather than assertion that different knowledge systems can serve community wellbeing together. This requires health communicators to abandon the

epistemological hierarchy that positions biomedical knowledge as the destination and traditional knowledge as the obstacle, and to develop what this thesis conceptualizes as a genuinely pluralist communication practice. A practice that the three original conceptual contributions of this thesis captures; theological health literacy, progressive religious engagement, and respectful norm contestation designed to enable. They are introduced across the RQ analyses and claimed as a framework in the discussion chapter; their relationship to epistemological plurality as the foundational condition is what gives them their coherence as a framework rather than as three separate observations.

Chapter 5 - Discussion, Implications, and Conclusions

Introduction

This chapter interprets and extends the theoretical significance of the findings presented in Chapter 4, situating them within existing scholarship, deriving their theoretical, methodological and practical significance. The chapter is structured around five key sections, with the first section discussing the findings from each of the three research questions in turn, examining what the data reveals, how they align with or diverge from previous research, and where they identify gaps that have not been addressed adequately by the existing literature. The second section develops the study's core theoretical contribution which is the Culturally Embedded Norms Model that synthesizes the Social Norms Theory and the Culture-Centered Approach and introduces three original concepts: theological health literacy, progressive religious engagement, and respectful norm contestation, as its operational framework. The third section addresses the methodological contributions and the fourth derives evidence-based practical recommendations for policymakers, practitioners and researchers. The fifth and final section presents the conclusions that directly align with the study's purpose and core objectives, as established in chapter one to examine the role of religious and cultural authorities in influencing health messages, to identify structural barriers and enablers to effective communications, and to contribute theoretical and practical frameworks that are grounded in empirical evidence and actionable in complex sociocultural contexts.

Discussion of Findings by Research Questions

Research Question 1: How Did Individuals in Northern Nigerian Communities Interpret and Respond to Health Communication Messages in Relation to Prevailing Social Norms and Communal Expectations?

Findings from RQ1 established that health message interpretation in Northern Nigeria communities is not a cognitive process of receiving and analyzing biomedical content. It is a culturally structured process of evaluation in which messages are filtered through four interconnected mechanisms: religious authority, gender hierarchies, trust networks, and epistemological preferences. These mechanisms do not operate sequentially or independently; they form what Chapter 4 describes as a community-level epistemological architecture through which all health claims are assessed before their biomedical content is considered. This architecture, and the participant accounts that illuminate it, represents the most foundational contribution of the RQ1 findings to health communication scholarship.

The central finding aligns with and substantially extends the Culture-Centered Approach (Dutta, 2008), which argues that health meanings are produced within cultural contexts rather than universally understood. The study confirms this claim while specifying the mechanisms through which it operates in practice. Mal. Umar's account from Jigawa, that who speaks is more important than what is spoken, and that the same health message delivered by a uniformed government worker in English carries far less interpretive weight than when delivered in Hausa by a locally embedded religious teacher drawing on the Prophet's example, names something that existing scholarship has documented in general terms but not analyzed in structural detail. What the data reveal is not simply that source credibility matters but that credibility in this context is epistemologically constituted: it is granted to messengers whose authority is grounded in Islamic

knowledge and communal embeddedness, not to those whose authority derives from institutional or biomedical credentials.

This finding extends Social Norms Theory (Bicchieri, 2017; Cialdini & Goldstein, 2004) in a significant direction. SNT's standard account of normative influence assumes a relatively flat, peer-to-peer model in which descriptive and injunctive norms operate within shared epistemological frameworks. The data reveal a strongly hierarchical model: normative influence flows from Imams downward through community and traditional leaders to individual community members, and this hierarchy is epistemological as well as social. Religious leaders do not simply endorse health behaviors, they determine what community members understand as theologically permissible, morally obligatory, or spiritually suspect. Bicchieri's concept of norm entrepreneurs is applicable here, but requires modification: in religiously grounded communities, effective norm entrepreneurs must be religiously credible in ways that no amount of biomedical expertise can replicate. As Imam Mohammed's account of child spacing demonstrates his reframing of the practice as Islamic stewardship grounded in the obligation to protect mothers and children, not as a compromise of religious injunction normative shift occurs when health practices are shown to fulfill rather than challenge Islamic values, and this demonstration can only be made by someone with the theological authority to make it.

Collectively, the findings from RQ1 mounts a sustained challenge to deficit models of health communication, which attribute poor health outcomes to inadequate community knowledge (Airhihenbuwa & Obregon, 2000). The analysis in chapter 4 of Imam Mahmud's account of how his willingness to carry a health message only once it was framed as already within Islamic frameworks establishes that the problem is not information scarcity but epistemological incompatibility. This distinction matters significantly for programme design: where deficit models

call for better health education, the findings call for structural transformation in how health systems establish epistemological credibility within the frameworks communities already hold (Vaughan et al., 2000; Waisbord, 2014). Communities are not resistant to information; they are applying their own well-developed criteria for what counts as trustworthy and relevant knowledge, and health interventions that do not meet those criteria will be filtered out regardless of their biomedical validity.

The fourth theme responding to RQ1 extends this insight with the concept of epistemological violence, introduced in Chapter 4 to name the structural process by which biomedical systems claim universal validity while dismissing traditional knowledge as superstition. Mal. Inusa's account that health workers' arrogance in dismissing traditional healing closes doors that could otherwise be open captures this dynamic at the practitioner level, while Elder Dantijoe Tijani's testimony about the colonial era medical exploitation that lives in community memory and is transmitted intergenerationally through communal narratives captures its historical and structural dimensions. This concept addresses a gap that existing scholarships have approached through documentation of cultural barriers without adequately theorizing their epistemological character. The implication for health communication practice is direct: the problem is not communities' resistance to information but the epistemological disrespect that interventions communicate when they treat local knowledge as an obstacle to overcome rather than a framework to engage.

The gender dimensions of RQ1's findings deserve particular attention. Mallama Rabi'u's account of women who wait weeks in pain before seeking care because male household members have not given permission is not a peripheral observation but a structural one: gender hierarchies do not merely create individual barriers to care access, they determine who participates in health

communication in the first place. Adolescent girls, as Mal. Rabo identifies, are rendered invisible in formal health dialogues excluded not only from decision-making but from the consultation processes through which health programs are designed and delivered. This finding expands on Adjikanou, V., & LeGrand, T. (2014). documentation of patriarchal gatekeeping in Northern Nigerian health decision-making by demonstrating that exclusion operates through the same authority structures that health communication programs depend on for legitimacy, creating a structural contradiction that conventional participatory models cannot resolve.

Research Question 2: In what ways do dominant and contested social norms facilitate or constrain the uptake of health-promoting behaviors communicated through public health campaigns?

The findings from RQ2 reveal that social norms operate as context-dependent mechanisms whose facilitative or constraining effects are determined by their content and how messages are framed, who endorses them, and whether communities retain genuine agency in their own normative evolution. The four mechanisms identified cultural alignment, leadership networks, grassroots advocacy and traditional medicine preference are not independent variables but dimensions of a single integrated normative system whose operation is consistent with the epistemological structures documented in RQ1.

The combination of Alhaji Shuaibu's account from Jigawa and Mal. Giwa's account from Katsina who are two participants in different roles, geographic locations, and institutional positions independently articulating the same three-pillar normative standard (family, faith, tradition and culture) with almost identical phrasing is analytically significant for what it reveals about the

normative structure itself. When community members across different positions produce identical framework without coordination, this intersection reveals a collectively embedded injunctive norm in Bicchieri's (2017) sense; a shared expectation internalized that it is articulated as obvious rather than as a contested position. The practical implication is direct as health messages that fail to go through this three-pillar test are not only ineffective, but are, as Mal. Giwa observes, dead before they arrive. Cultural alignment is therefore not an optional consideration for health communication design in Northern Nigeria but a foundational structural requirement.

However, the data also reveal a structural limitation in cultural alignment as a facilitation strategy that existing scholarships have not adequately named. Alh. Shuaibu describes his role as a quality check that assesses health messages against community values and refuses to support those that go against core values, including the patriarchal family structures that his three-pillar framework treats as foundational. The same mechanism that facilitates breastfeeding adoption through Islamic framing is structurally capable of obstructing messages that challenge gender-based restrictions on women's health autonomy, because those restrictions are encoded within the family and tradition pillars that cultural alignment requires. This identifies a gap that the CCA (Dutta, 2008) does not fully address which is the framework's commitment to cultural respect that does not adequately specify what health communicators are obligated to do when the cultural structures they are asked to respect are producing demonstrable harm.

The leadership network findings extend Bicchieri's (2017) norm entrepreneur concept while also revealing an important limitation. Imam Mohammed's facilitative reframing of women's healthcare access as an expression of Islamic male duty, and Imam Mahmud's institutional amplification of vaccine resistance based on historical community mistrust, reveals that the same normative mechanism operates in constraining as well as facilitating directions depending on the

theological orientation and trust dynamics of the specific leader involved. This directional variability is absent from Bicchieri's original formulation and constitutes an extension the Northern Nigerian data makes analytically necessary: health communication programs that treat religious leader engagement as a reliably facilitative strategy without attending to the specific directional orientations of specific leaders' risk institutional amplification of resistance rather than adoption.

Hajiya Ramatu's observation that once an Imam spoke about breastfeeding during the Friday sermon, no one questioned it afterward, captures a structural consequence of institutional norm entrepreneurship that the CCA's participatory principles require engaging critically. Institutional endorsement can produce rapid behavior change precisely by foreclosing deliberation: when a single authoritative figure delivers a health recommendation in a sacred communal setting, the social conditions for disagreement collapse. Communities comply, but they have not reasoned their way to adoption they have been organized into it. For women whose experiences may diverge from the endorsed position, the absence of deliberative space means the absence of any legitimate channel through which to raise concerns. This is not an incidental limitation of leadership network strategies but a structural feature that health communication programs must directly address.

The grassroots advocacy findings provide the study's most direct empirical evidence of what durable community-led normative change looks like and demands. Haj Binta's account of how facility-based delivery shifted from shameful to normal in Katsina over fourteen years not through institutional pronouncement but through the accumulated weight of positive peer examples documents descriptive norm change as a temporal process rather than a communication event. Haj Ramatu's account of the women's association's strategic reframing of child spacing as responsible motherhood, developed by first asking community members what a good mother looks like and then demonstrating how birth spacing fulfills those values, provides empirical illustration

of what the CCA calls genuine co-creation: community members leading their own normative change, drawing on their own values, at their own pace. This community-led process reflects what Ari and Kliwer (2022) identify as intentional dialogic interaction that "cultivates agency for marginalized groups, particularly women, to defy norms, and engage in leadership activity" (p. 29), reinforcing that durable normative change in Nigerian communities is not delivered through institutional pronouncement but built through sustained, participatory, ground-level engagement. The phrase evidence right there in our community, not in a foreign research paper captures the epistemological authority of locally embodied evidence that the RQ1 analysis identifies as a foundational condition for normative acceptance.

The traditional medicine preference findings address a gap in existing scholarship that documents the prevalence of traditional medicine use in sub-Saharan Africa (Janzen, 1978; WHO, 2019) without adequately theorizing why it persists in communities that have access to biomedical alternatives. Mal. Inusa's framing of traditional medicine as *maganin gargaji ya shi ne gatanmu* ancestral inheritance refined over centuries positions traditional healing not as a knowledge deficit but as a domain of cultural identity, epistemological authority, and community trust that biomedical systems have not displaced because they have not earned the relational credentials required to replace it. The phrase because I am one of them identifies the trust basis of traditional healing with analytical precision: it is not clinical expertise but community membership, shared identity, and long-term relational presence that confers therapeutic authority in this context. Mallama Aisha's generational perspective that neither traditional nor modern medicine alone is complete, a position independently shared by Hajiya Safiya from a biomedical position and Mal. Inusa from a traditional one suggests that the integrative epistemological orientation the CCA calls

for is not merely an external prescription but a position that community members across positions are arriving at through their own reasoning.

Cultural alignment functions as a resonance mechanism, with messages that embed within Islamic values, family structures, and local languages getting normative support while culturally dissonant messages face rejection regardless of their biomedical validity. Leadership networks amplify or suppress health behaviors through norm entrepreneurship, as faith and cultural leaders transform individual recommendations into collectively enforced expectations. Community-driven grassroots advocacy demonstrates that normative shifts are most durable when they emerge from within communities through peer instances and visible role models rather than only through elite institutional endorsement. Traditional medicine preference depicts a coherent epistemological system that communities actively defend, and health communication that fails to engage it on its own terms will consistently encounter resistance.

Research Question 3: How can Community narratives and culturally embedded meanings inform the co-creation of health communication strategies that reflect the lived experiences of marginalized groups?

The findings from RQ3 provide the most direct answer to the study's practical problem and the most explicit empirical foundation for the study's three original theoretical concepts. Across all four themes, grassroots mobilization, linguistic accessibility, narrative power and spiritual messaging and the findings consistently reveal that health communication achieves durable outcomes when communities are engaged as knowledge producers and not as target

audiences. The RQ3 findings also consistently show what genuine co-creation demands of health systems structurally, not just what it asks of individual practitioners attitudinally.

The most analytically precise formulation of what co-creation requires comes from Chapter 4's analysis of Mal. Inusa's account of communities opening up to clinic attendance only after being asked what they needed rather than being told what to do establishes that the precondition for genuine engagement is recognition, not information delivery. This extends the CCA's argument that community resistance reflects rational responses to systems that have treated local knowledge as irrelevant (Dutta, 2008) by specifying the relational mechanism through which that dynamic changes. Mal. Giwa's account of the difference between programmes that arrive as partners and those that arrive as teachers with design, funding, and evaluation already complete names the structural failure mode that the CCA critiques in principle but does not operationalize. Together, these accounts identify a gap in how participation is defined in both scholarship and practice: genuine co-creation requires redistributing decision-making authority from the design stage, not consulting communities after core decisions have been made.

The linguistic findings reveal a dimension of co-creation that existing scholarship understates. Hajiya Safiya's account of her in-between position as someone trained in biomedical care but embedded in community linguistic and cultural practice trusted by both sides because she can translate between them, not just in language but in ways of understanding health itself specifies what genuine linguistic accessibility requires as a professional competency rather than merely a communication skill. This extends research on language and health communication in Africa (Airhihenbuwa, 1995; Dutta, 2008) by demonstrating that the barrier is not linguistic in the simple sense but epistemological: health messages must be translated between knowledge systems, not merely between languages. Hajiya Ramatu's four-condition formula right messengers, right

language, right setting, and consistency captures the structural architecture of genuine linguistic co-creation and makes explicit that linguistic accessibility is not achievable through language training alone but requires the institutional investment of sustained relational presence.

The narrative power findings from identifies a structural gap in how health communication reaches women. Chapter 4 documents through Mallama Rabiou's account that women's informal networks operating in domestic spaces outside male surveillance constitute the primary infrastructure through which women's health knowledge is produced, validated, and acted upon. This finding extends the CCA's argument about systematically excluded voices (Dutta, 2008) by demonstrating not only that exclusion occurs but how women exercise health knowledge agency within the constrained spaces available to them. The practical significance for programme design is that health communication reaching only formal institutional channels and male authority figures is structurally bypassing the actual decision-making infrastructure for women's health. This aligns with and extends feminist health communication scholarship (Hankivsky, 2012; Sen & Östlin, 2008) which has documented patriarchal barriers without specifying the parallel informal systems through which women navigate them.

Mallama Aisha's account of the topics that are almost completely invisible in formal health conversations such as reproductive health, mental health, the emotional weight of early marriage and constrained life choices identifies a category of health experience that the formal participatory processes structurally cannot address, because those processes are governed by the same patriarchal authority structures that render these topics unspeakable within them. This finding is important not only for its content but for its methodological implication: research conducted primarily through formal consultation with male community leaders will not simply

underrepresent women's perspectives but will systematically exclude the health experiences most shaped by the structural conditions the study seeks to understand.

The spiritual messaging findings establish the empirical foundation for two of the study's three original theoretical concepts, developed fully in the theoretical implications. Chapter 4 documents how Imam Tukur and Mal. Umar demonstrate through sustained practice that genuine theological engagement reframing health practices as the fulfillment of Islamic obligations rather than as biomedical recommendations produces a qualitatively different kind of community acceptance than institutional endorsement alone. The distinction running through both accounts is between a communicator who knows Islamic epistemology from the inside and one who deploys religious language from the outside for strategic effect. Chapter 4 further establishes, through Imam Mahmud and Mal. Shettima's accounts, that communities make this distinction reliably: authenticity is a structural requirement, not merely a communication preference, and communities withdraw trust when that boundary is crossed. These findings extend prior scholarship on faith-based health communication (Campbell et al., 2007; DeHaven et al., 2004) by specifying precisely what competencies and conditions make religious engagement credible and what happens programmatically when those conditions are absent.

Theoretical Contribution: The Culturally Embedded Norms Model

The central theoretical contribution of this study is the culturally embedded norms model (CENM) which proposes that social norms in religiously grounded communities are best understood not as behavioral regularities maintained through social sanctions but as the social expressions of epistemological commitments, as behaviors that derive their meaning and moral force from the knowledge systems through which communities make sense of health, illness, causation, and obligation. This reframing has direct implications for both Social Norms Theory

and the Culture-Centered Approach and introduces three original operational concepts that specify what culturally embedded normative engagement requires in practice.

Extending and Challenging Social Norms Theory

Social Norms Theory holds that behaviors are shaped by perceptions of what others do (descriptive norms) and what others approve (injunctive norms), and that normative change is achieved by shifting those perceptions (Bicchieri, 2017; Cialdini & Goldstein, 2004). The study confirms the relevance of these mechanisms while revealing two foundational assumptions of SNT that the Northern Nigerian context does not support. First, SNT assumes a peer-to-peer model of normative influence operating within epistemological frameworks shared between health communicators and communities. The data show a hierarchical model in which religious authority constitutes the primary axis of normative influence, with health workers lacking the epistemological credibility required to occupy the norm entrepreneur's role regardless of their medical expertise. Second, SNT treats norms as behavioral regularities without providing an account of what gives them their binding moral force. The data show that this moral force derives from theological grounding: norms understood as rooted in Islamic teaching carry a different quality of obligation than those that are merely socially customary, and health communication strategies that treat them equivalently will consistently underestimate the depth of the epistemological commitment they are asking communities to revise. The CENM addresses this gap by treating epistemological compatibility, rather than social influence, as the primary mechanism through which health norms change.

Extending and Challenging the Culture-Centered Approach

The CCA's critique of hierarchical health communication and its commitment to community voice, participatory co-creation, and respect for local epistemologies is confirmed

across all three research questions (Dutta, 2008). The study extends the CCA in three directions. First, the findings specify mechanisms of normative influence the four-pillar filtering architecture of RQ1, the facilitation and constraint dynamics of RQ2, the co-creation conditions of RQ3 that the CCA's general commitment to community voice does not provide. Second, the findings reveal that the CCA does not adequately address what happens when a community does not speak with a unified religious voice: when interpretive traditions are genuinely contested, partnerships with some religious voices can generate suspicion or rejection among others, and the CCA provides no framework for navigating this. Third, the CCA's participatory framework does not specify the point at which community participation becomes complicity in the exclusion of the most vulnerable community members. The findings make this limit real: the same community authority structures that participatory approaches depend on for legitimacy are the structures that enforce women's and girls' systematic exclusion from health decision-making. The three concepts developed below address each of these gaps.

Theological Health Literacy

Existing scholarships have shown that religious leaders are effective partners in health promotion (Campbell et al., 2007; DeHaven et al., 2004) but have not theorized what competencies health communicators require to engage with religious leaders as genuine co-designers rather than as endorsement providers. Theological health literacy addresses this gap as a structured set of three competencies.

The first is scriptural knowledge: the capacity to engage with Islamic texts and teachings on health-relevant domains hygiene, healing, the protection of life, the duty of care with sufficient depth to identify genuine theological alignment rather than surface-level religious framing. Imam Tukur's use of Quranic text to reframe medical care-seeking as an act of worship, and Mal. Umar's

Careful navigation of the linguistic register around child spacing to avoid the suspicion carried by family planning terminology, both demonstrate this competency in practice. The second is interpretive flexibility: an understanding that Islamic scholars exercise genuine agency in applying scripture to contemporary challenges, and that this interpretive dynamism Imam Mohammed's reframing of child spacing as Islamic stewardship, the Quranic framing of mosquito nets as protection of Allah's gift of life is a resource for health communication rather than a theological problem to manage. The third is epistemological respect: treating Islamic theology as a legitimate knowledge system with its own internal logic and evidentiary standards, rather than as a rhetorical resource for making biomedical recommendations more acceptable. Mal. Shettima's formulation captures the gatekeeping condition precisely: if you feel your message disrespects our culture, your message will not be accepted. But if it honors Allah, our culture, and tradition, then it will grow roots.

The structural implication is direct: theological health literacy is not a competency achievable through a cultural sensitivity workshop. It requires integration into health professional training curricula and should be treated as a hiring criterion for community health workers deployed in regions where Islamic epistemology structures health decision-making. The pattern documented across all three RQs that health programs that arrive without theological grounding generate not merely resistance, but epistemological rejection makes this a structural rather than an optional professional development recommendation.

Progressive Religious Engagement

Progressive religious engagement addresses the gap in the CCA identified above: what health communicators should do when a community's religious interpretive landscape is contested. It is defined as the intentional, strategically transparent, and ethically accountable practice of

collaborating with religious scholars who understand health advocacy as a dimension of their religious obligation, while navigating the broader landscape of competing interpretive voices with honesty about what health communicators are doing and why.

The concept is grounded in the data at multiple points. Imam Mohammed's facilitative reframing of child spacing and Imam Tukur's sustained theological engagement with maternal health, malaria prevention, and family care across eighteen years of community religious leadership both illustrate what the concept terms interpretive dynamism in practice: the ongoing scholarly work through which Islamic authorities apply scriptural principles to contemporary challenges. Communities can distinguish this authentic theological engagement from instrumentalized religious language, as Imam Mahmud's account makes clear: what shifted his willingness to carry an external health message was not biomedical evidence but its framing as something already within us, grounded in Islamic sources rather than arriving from outside them.

The concept advances the CCA in three specific ways. First, it requires transparency: health communicators who strategically amplify health-facilitative religious interpretations are intervening in a theological debate, and this intervention must be acknowledged openly rather than hidden within apparently neutral health messaging. Second, it requires genuine accountability to communities: decisions about which religious interpretations to elevate must emerge from authentic dialogue rather than from external health agendas. Third, it provides a concrete methodology for navigating communities where religious authority is distributed across competing interpretive traditions specifying not just that community participation is valuable, as the CCA argues, but how to engage competing religious voices with clarity and ethical integrity. Mallama Rabi'u's account of her unique capacity as a female religious teacher to address women's health within a religious framework while simultaneously addressing husbands through the language of

Islamic male responsibility also reveals that progressive religious engagement must extend beyond the dominant male religious authority structures to include female religious voices whose authority is both theologically grounded and gender specific.

Respectful Norm Contestation

Respectful norm contestation addresses the third gap in the CCA, which is the point at which cultural respect becomes complicity in harm. It is defined as the practice of engaging communities in sustained, honest dialogue about norms that serve their wellbeing while contesting those that cause harm without tolerating harmful norms in the name of cultural respect and without imposing external values under the guise of biomedical evidence.

The concept emerges empirically from Haj Ramatu's account of the women's association's advocacy for child spacing, which provides the study's clearest empirical model of respectful norm contestation in practice. The advocacy challenged a normative position that child spacing conflicted with religious obligation and cultural values around family size by first listening to what community members valued (a good mother, healthy children, stable families) and then demonstrating how birth spacing fulfilled those values. It built alliances with Imams as genuine partners rather than bypassing religious authority, and it allowed visible community evidence to accumulate before the normative challenge was extended. The resistance the women's association encountered from religious leaders, older women, and men demonstrates that respectful norm contestation generates friction even when pursued through entirely community-centered methods. But it also demonstrates that this friction is navigable through community-grounded processes.

The concept advances feminist health communication scholarship (Hankivsky, 2012; Sen & Östlin, 2008; Farmer, 2005; Jecker et al., 2021) beyond its current focus on documenting

patriarchal barriers toward a concrete methodology for navigating them. It specifies three practical strategies: working within existing epistemological frameworks to expand women's health access by reframing it as the fulfillment of religious and familial obligations rather than as a direct challenge to patriarchal authority; creating protected spaces for marginalized voices women-only associations, youth advisory groups, peer advocacy networks where community members excluded from formal participatory processes can exercise genuine agency; and sequential engagement, in which early intervention phases establish credibility within existing norms before later phases introduce more transformative challenges to harmful practices. Mallama Rabi'u's structural prescription more female health workers, more women-run clinics, more education for girls, but also engaging men, as one without the other will not last specifies the dual-track imperative that respectful norm contestation requires: building women's health agency from within available spaces while simultaneously contesting the patriarchal normative structures that constrain those spaces.

The Culturally Embedded Norms Model as Integrated Framework

The three concepts are not independent tools. They constitute structurally and functionally interconnected conditions that when practiced together generate the study's final theoretical argument. Theological health literacy functions as the foundational competency on which the other two depend: without authentic engagement with Islamic epistemological frameworks, progressive religious engagement lacks the credibility required to be effective, and respectful norm contestation cannot challenge harmful norms without generating the epistemological disrespect that the findings consistently identify as the primary driver of community resistance. Progressive religious engagement specifies how theological literacy is applied in contexts where religious authority is contested not by managing or circumventing religious frameworks but by participating

in their interpretive dynamism as a transparent and accountable actor. Respectful norm contestation defines the ethical limits of cultural accommodation and provides the sequential methodology through which those limits are maintained in practice.

Mal. Giwa's account of the successful antenatal programme provides the study's most comprehensive empirical illustration of the integrated model in practice. The implementing organization sought the blessing and partnership of community heads before delivering any health message theological health literacy establishing the relational and epistemological foundation. Health messages were communicated throughout in Hausa, framing antenatal care as consistent with Islamic teachings on protecting mothers and children progressive religious engagement locating the practice within the epistemological framework communities already inhabit. Women leaders were included as co-designers who activated the peer networks through which women's health decisions are actually made respectful norm contestation creating the protected spaces through which excluded voices could exercise genuine agency. Mal. Giwa's observation that ten programmes fail for every one that succeeds, and that the difference is always whether organizations come as partners or as teachers, names the integrated claim of the CENM: not three useful tools to be applied selectively but three dimensions of a single, indivisible practice of epistemological navigation.

Methodological Contributions

Beyond its theoretical contributions, this study makes several methodological contributions to health communication research in contexts characterized by religious epistemology, hierarchical authority structures, and gender-structured exclusion.

The use of purposive sampling to ensure diverse stakeholder representation Imams and religious teachers, community heads and traditional rulers, traditional healers, midwives and community health workers, women's association leaders, and community members across three distinct but comparable sites in Jigawa, Katsina, and AMAC enabled a multi-perspectival analysis of health communication dynamics that would not be visible from any single stakeholder position.

The analytical convergence documented across participants from different roles and locations particularly the independent articulation of the three-pillar normative framework by Alh. Shuaibu and Mal. Giwa provides methodological evidence of the collective, structurally embedded character of the normative patterns the study identifies.

The constructivist epistemological stance and the use of Braun and Clarke's (2006) reflexive thematic analysis, as described in Chapter 3, enabled the study to work inductively from participants' own language and meaning while remaining analytically engaged with the theoretical frameworks of SNT and the CCA. This approach generated the three original concepts through empirical grounding rather than theoretical deduction, which is the appropriate methodological basis for the conceptual contributions the study claims.

The gender imbalance in the sample, four of twenty participants were female was itself a methodological finding: the mechanisms through which women are excluded from formal health discourse in these communities are the same mechanisms that make conventional qualitative research designs inadequate for capturing women's health experiences. Standard participatory research approaches that rely on community gatekeepers to facilitate access, will systematically underrepresent the most marginalized voices, because those gatekeepers enforce the very exclusions the research seeks to understand. This study demonstrates, rather than merely reports, this methodological problem. Future research in similar contexts must build in strategies for female-majority samples from the design stage, including female research teams, women-only data collection settings, and member-checking conducted in participants' first languages.

The use of Hausa interpretation enabled access to participants who would not have been reachable in English but introduced some loss of cultural meaning, idiomatic expression, and

epistemological nuance. This trade-off points toward a methodological recommendation for the field: research in multilingual contexts with significant epistemological complexity should wherever possible include researchers with deep competence in the relevant linguistic and cultural registers as primary investigators rather than relying primarily on interpretation.

Practical Implications and Recommendations

For Policymakers and Health System Leaders

The structural failures documented throughout this study such as linguistic exclusion, epistemological misalignment, absent community agency and systematic exclusion of women from health decision making which cannot be corrected through improved individual practitioner behavior alone but require institutionalized solutions at the system level and the findings points to three implementation priorities.

First, Nigeria requires a National Framework for Culturally Responsive Health Communication establishing mandatory standards across the health system like health materials produced in local languages with genuine cultural interpretation; religious leaders engaged as programme co-designers from inception; and community participation protected by dedicated budgets rather than subject to resource competition. The centrality of religious authority across all three research questions makes Faith-Health Partnership Institutes staffed by interdisciplinary teams of health professionals, Islamic scholars, and community mobilization specialists which is a structural necessity rather than an enhancement.

Second, every health programme operating in Northern Nigeria should conduct gender analysis before implementation, followed by dual implementation strategies by engaging male leaders and existing authority structures on one track, and on the other hand simultaneously

creating protected spaces for women's autonomous health decision-making. Minimum female representation in health governance structures and dedicated funding streams for women's health programming would institutionalize this commitment and prevent its erosion under resource constraint.

Third, traditional healers should be formally recognized as partners within the health system with defined roles, referral relationships, and access to research funding for safety and efficacy evaluation. Mal. Inusa's observation that the best programs build on what already exists, and that outsiders need to recognize and resource existing community infrastructure rather than build parallel systems from scratch specifies what this partnership should look like in practice.

For Health Communication Practitioners

Two core practice changes emerge most directly from the findings; first, every health intervention should convene Community Message Development Teams such as religious leaders, traditional healers, women's representatives, and youth advocates including Mallama Aisha's generational constituency as substantive participants in message design from the earliest stages, not as consultees after design decisions have been made. Between twenty and thirty percent of total programme expenditure should be allocated specifically to community engagement processes, reflecting the consistent finding that these processes are central to programme effectiveness rather than preparatory.

Second, practitioners should systematically document and disseminate narratives from community members who have adopted health behaviors without incurring social or religious costs. Haj Binta's account of how the question people asked in Katsina shifted over fourteen years from why is she going to the hospital to how did she do it and where did she go captures the descriptive norm mechanism precisely: the most persuasive evidence for normative change is not

external health messaging but community-visible lived proof that change is possible and culturally acceptable. These narratives should be disseminated through locally trusted channels including female religious teachers, women's groups, and midwives, whose position in women's informal networks gives them the messenger credibility that formal institutional channels lack.

The narrative dimensions of health communication specifically affecting younger women reveal both content gaps and structural absences of safe spaces for dialogue. Mallama Aisha's account identifies reproductive health, mental health, and the pressures of early marriage as topics that remain almost completely invisible in health communication programming, with no sanctioned space for young women to express how these experiences feel. This invisibility is not inevitable but reflects a structural choice embedded in how health interventions are designed. When health communication interventions are genuinely co-created with communities, safe and positive spaces emerge where young people, especially women and girls, can speak about their lived experiences without those experiences being filtered through normative structures that silence them in formal channels. Health communication programs that center topics communities are invested in discussing, rather than exclusively topics external practitioners determine communities need to hear, are more likely to achieve genuine acceptance and sustained behavior change. This finding carries a direct implication for intervention design in Northern Nigeria co-creation is not merely a methodological preference but an ethical and strategic necessity for reaching the most marginalized community members.

For Researchers

Three research priorities emerge from the findings. Women-centered research is urgently needed to address the systematic underrepresentation documented in this study. Women-only focus groups, female research teams, and participatory action approaches that position women as

co-researchers rather than subjects are not methodological preferences but structural requirements for research that can genuinely engage the health experiences most shaped by the study's core dynamics. Longitudinal studies following communities and key actors over five to ten years are necessary to understand how the normative processes documented here including the fourteen-year trajectory described by Haj Binta and the slow, sustained advocacy work of Haj Ramatu's women's association evolve and produce durable outcomes. Comparative research examining Christian communities, traditional African religious contexts, and religiously pluralistic settings would test whether the patterns documented here reflect dynamics specific to Islamic epistemological contexts or common to religiously grounded communities more broadly.

Limitations and Future Directions

The study generated substantial insight was generated from the cultural and epistemological dimensions of health communication in Northern Nigeria, and several methodological limitations define the boundaries within which those insights apply.

The sample size of twenty participants drawn from three locations, while purposively designed for diverse stakeholder representation, limits generalizability across Northern Nigeria's considerable ethnic groups, languages, religious practices, and urban-rural diversity. The gender imbalance discussed above as a methodological finding limited direct access to women's accounts of their health experiences even as it documented the exclusionary mechanisms that produce those barriers. Future research must build on explicit strategies for female-majority samples, including female research teams, women-only data collection settings, and member-checking in participants' first languages from the design stage.

The impact of language through Hausa interpretation enabled access to participants but introduced some loss of cultural meaning and epistemological nuance. The cross-sectional design precluded the analysis of normative evolution over time as longitudinal designs are necessary to understand these processes in the depth that effective programme design requires. Despite Mal. Rabo's identification of youth exclusion from health discourse as a significant concern, no youth participants were included in the study; future research should treat youth participation as a priority. Social desirability bias may have led some participants to emphasize orthodox religious positions over actual practices; future studies should complement interview data with observational methods.

Conclusion

This study was carried out in response to a well-documented but insufficiently theorized problem: the persistent failure of health communication interventions in Northern Nigeria to achieve their intended outcomes despite decades of sustained effort. The study's four objectives, established in Chapter 1, were to understand how cultural and religious norms shape health-seeking behavior and health communication reception; to analyze the role of religious and cultural authorities in mediating health messages; to identify structural barriers and enablers to effective health communication; and to contribute theoretical and practical frameworks grounded in those findings. Chapters 4 and 5 have addressed each of these objectives in turn, through three research questions whose findings are analytically interconnected.

The answer to the study's core problem is clear. Health communication in Northern Nigeria fails not because communities lack knowledge but because interventions lack epistemological credibility within the knowledge frameworks those communities hold. Communities in Jigawa, Katsina, and AMAC do not approach health messages as passive recipients awaiting better

information. They bring to those messages a community-level epistemological architecture structured by Islamic religious authority, gender hierarchies, trust networks built on historical memory, and pragmatic navigation between traditional and biomedical knowledge systems through which all health claims are evaluated before their biomedical content is considered. As Imam Mahmud's account demonstrates, even the most skeptical community figures become willing carriers of health messages when those messages are presented as grounded in Islamic sources and compatible with community epistemological frameworks rather than as external impositions dressed in local language.

The Culturally Embedded Norms Model offers a theoretical framework adequate to this finding. By synthesizing Social Norms Theory and the Culture-Centered Approach and extending both with the concepts of theological health literacy, progressive religious engagement, and respectful norm contestation, the model provides health communication scholarship with a framework for taking religious epistemology seriously as a structural feature of normative influence rather than a cultural barrier to manage. The three concepts form an integrated operational framework: the knowledge to engage authentically, the strategy to engage effectively, and the ethical grounding to recognize when engagement alone is insufficient. Their empirical foundation in the accounts of Imam Tukur, Imam Mohammed, Mal. Umar, Haj Ramatu, Hajiya Safiya, Mallama Rabi'u, Mal. Giwa, and the other participants who gave this study its substance gives them credibility as practical resources rather than theoretical abstractions.

The practical stakes of the study's findings are reflected in the health disparities that motivated it: maternal mortality ratios between 800 and 1,200 deaths per 100,000 live births, infant mortality exceeding 74 deaths per 1,000 live births in some Northern Nigerian states, immunization coverage persistently below national targets. These disparities are not the inevitable

consequences of resource scarcity alone. They reflect the cumulative effect of health communication approaches that have consistently arrived as teachers rather than partners, as information providers rather than epistemological collaborators, as agents of biomedical authority rather than respectful participants in the interpretive traditions through which communities make sense of health and illness.

The study's contribution is not to resolve this problem but to name it with greater precision and to offer theoretical and practical resources adequate to it. Chapter 1 established that the aim of this study was to examine the normative mechanisms through which health messages are filtered, negotiated, accepted, or rejected and to identify community-based approaches for designing health communication that achieves both cultural resonance and behavioral impact. That aim has been addressed: the CENM and its three operational concepts provide theoretical language for naming what has gone wrong in previous interventions, and the evidence-based recommendations in Section 5.5 provide the practical framework for doing things differently. The measure of this study's contribution is not the elegance of its theory but whether it equips the practitioners, policymakers, and researchers working in contexts like Northern Nigeria with something they can act on beginning with the recognition that health communication is fundamentally an act of cultural translation, and that translation, done honestly and competently, is both possible and urgently needed.

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AI Use Disclosure Statement

Claude AI was used solely to assist with structuring and refining the presentation of this thesis. Specifically, it was employed to improve the clarity, flow, and professional tone of the writing to meet the standard expected of a master's thesis. At no point was AI used to generate ideas, produce content, or conduct analysis on behalf of the researcher. All intellectual contributions, arguments, interpretations, and conclusions are entirely the researcher's own. Full responsibility for the originality, accuracy, and integrity of this thesis rests with the author.

Appendix

Appendix A: Interview Guide (Semi-Structured)

Duration- 60-90mins

Research Title: Navigating Social Norms and Community Narratives: A Thematic Analysis of Health Communication Practices in Northern Nigeria

Thank you for agreeing to participate in this study. It will take 60-90minutes of your time, and at any point you feel like taking a break or quitting, please let me know. Please seek further clarification on questions that may be asked but may need more information or explanation. Note that it is going to be recorded and documented as a resource for the study.

Interview Guide (Semi-structured)

A. Demographic Information

Name:

Tribe:

Level of education:

Marital status:

Religion:

Ethnicity:

Age:

Level of Education

B. Content Mapping Questions

- a. What values or traditions guide the way your community talks about health and illness?
- b. In what ways do people in your community make sense of health messages based on cultural or religious beliefs?
- c. Are there examples where traditional stories, proverbs, or teachings influence how people understand a health issue?
- d. How do individuals or groups respond when health information conflicts with what they believe or have been taught?

C Content Mining Questions

- a. What are some common beliefs or behaviors that most people follow regarding health (e.g., childbearing, vaccinations, nutrition)?

- b. Who are the trusted figures people look to for guidance when health decisions need to be made?
- c. What makes a health message feel “right” or culturally appropriate for your community?
- d. Can you share a local story, event, or belief that people often refer to when discussing health issues?
- e. What role do religious leaders, traditional rulers, or other elders play in either reinforcing or changing these messages?
- f. In your view, what would a message look or sound like if it were truly created with the community, not just for the community?

D. Mapping Barriers and Mining for Collaborative Solutions

These questions map obstacles and mine for successful local adaptations and recommendations for future strategy:

- g. How do language, literacy, or access to trusted media (e.g., radio, community meetings) affect how messages are received?
- g. Can you describe a moment when the community came together to adapt or reshape a health initiative to make it work?
- g. What values, practices, or people should always be considered when creating health messages?
- g. Are there local methods like storytelling, drama, or group discussions that have helped shift harmful norms or build understanding?

WRAPPING UP

Thank you for spending time to be part of this interview and sharing your experience working in effective health communication in your community. If there is a need for further information, you will be contacted to be interviewed again.

Appendix B: Research Debriefing Statement

Project Title: Navigating Social Norms and Community Narratives: A Thematic Analysis of Health Communication Practices in Northern Nigeria.

Principal Investigator- Faridah Abraham, Master's in Communication Program, Faridah@ksu.edu

Thank you for participating in this study. It is crucial to share with you the purpose of the research, how it will be conducted, the reporting, and how it may be used after completion.

What the study really is about

Northern Nigeria faces severe public health challenges, including high maternal and infant mortality, low immunization rates, and limited access to reproductive health services. These problems are not just the result of limited resources but are deeply intertwined with cultural, religious and social norms that shape health behaviors and decision making. For example, traditional beliefs and the influence of community and religious leaders often discourage the use of modern medical care, while men typically control decisions about women's health and family planning. Misinformation, and district of government health campaigns further complicate efforts to improve outcomes

This proposal seeks to examine how social norms and community influences affect health behaviors in Northern Nigeria, with a focus on maternal health, immunization and family planning. By exploring the role of local beliefs, group expectations, and influential leaders, the project aims to identify why traditional health communication strategies often fail in this context. Instead of relying solely on providing information, this research will investigate how collective attitudes and social dynamics can be leveraged to encourage healthier behaviors. The findings will help design more effective, culturally sensitive health communication strategies that address the real barriers faced by communities, ultimately improving health outcomes for women and children in the region.

Taking part is voluntary

Although you will be asked to consent to participation, your involvement throughout the process is still voluntary, and you may choose to withdraw the data you provided prior to debriefing, without penalty. Withdrawing your submission will not adversely affect your relationship with the researchers or any of our affiliates.

Phases of Debriefing

- i. Post data collection & analysis: Participants will be debriefed after analysis to ensure that their voices are accurately captured and represent their lived experiences.
- ii. Completion of research report: Participants will be debriefed on the outcome of the study and how the report will be disseminated and used.

Privacy/Confidentiality

If you agree to allow us to use your data, here is how we will maintain confidentiality of the information. We will seek consent to state your name or otherwise use a pseudonym, your affiliation, or specific statement or testimony shared. The data will be stored in the cloud, and only people granted permission may have permission to access it.

The main researcher conducting this study is Faridah Abraham, a graduate student at Kansas State University. If you have any questions after the interviews or the study has been completed, please contact Faridah Abraham at Faridah@ksu.edu , or +2347032082317, or the faculty advisor, Dr. Sean Eddington at seaneddington@ksu.edu.

If you have any questions or concerns regarding your rights as a subject in this study, you may contact the Institutional Review Board (IRB) for Human Participants at the website comply@k-state.edu or call 785-532-3224

Please sign below if you do, or do not, give permission to have your data included in the study:

I have been debriefed by the research team, and I understand the true intent of and the purpose of my participation in the study titled “Navigating Social Norms and Community Narratives: A Thematic Analysis of Health Communication Practices in Northern Nigeria.” I agree that the data collected during the study may be included for the purpose of the study.

I have been debriefed by the research team, and I understand the true intent of and the purpose of my participation in the study titled “Navigating Social Norms and Community Narratives: A Thematic Analysis of Health Communication Practices in Northern Nigeria.” I DO NOT give permission for the data collected during the study to be included for the purposes of the study.

Appendix C: List of Tables

Summary of Gaps in Literature

Gap	Description	Key Issues Identified
1. Limited theorization of cultural mechanisms in Northern Nigeria	Existing studies acknowledge cultural influences on health communication but do not rigorously theorize <i>how</i> these mechanisms operate	i. Religious framing improves message acceptance, but mechanisms of religious authority and theological interpretation remain under-examined. ii. Community participation is linked to improved outcomes, yet distinctions between genuine and instrumental participation are unclear. iii. Limited analysis of how participatory processes navigate community power asymmetries
2. Weak integration of normative theory and cultural approaches	Scholarships often treat Social Norms Theory and cultural frameworks separately, resulting in incomplete analyses.	iv. Normative analyses lack cultural depth. v. Cultural analyses overlook normative mechanisms. vi. Few studies use both frameworks, and those that do rarely explore their complementarity or address tensions between them.
3. Limited research grounded in community epistemologies	Most studies rely on researcher-defined categories rather than community-generated meanings, leading to missed insights.	vii. Limited use of participants' own language and interpretive frameworks. viii. Researcher-imposed categories may obscure local meanings. ix. Participatory approaches that center community voices are rare. x. Insufficient engagement with religious frameworks, traditional healing systems, and gendered experiences on their own terms

Participant Characteristics

Name	Role	Gender	Approx. Age	Location	Yrs in Role	Duties
Imam Tukur	Rel. Leader	Male	52	Katsina	18	Community health advocate; delivers health messages during Friday prayers
Mal. Umar	Rel. Teacher	Male	45	Jigawa	15	Teachers at Islamic school; involved in malaria prevention campaigns
Mal. Giwa	Community Head	Male	61	Katsina	25	Traditional ruler; decision maker on community health initiatives
Imam Mohammed	Rel. Leader	Male	48	Katsina	12	Advocates for family planning through religious framing
Elder Shehu	Community Elder	Male	67	Katsina	N/A	Custodian of traditional knowledge and cultural practices
Mallama Rabi	Female Religious Leader	Female	39	Jigawa	10	Teaches women and girls; observes gender dynamics in health decisions
Hajiya Ramatu	Midwife	Female	43	Abuja	16	Works in community health center; intermediary for women's informal health networks
Mal Rabo	Community Leader	Male	55	Katsina	20	Advocates for youth inclusion in health
Imam Mahmud	Religious Leader	Male	50	Katsina	14	Vocal about mistrust of vaccines and government health programs
Elder Dantijoe Tijani	Community Elder	Male	64	Katsina	N/A	Remember colonial era medical exploitation; influential in trust dynamics
Mal Inusa	Traditional Healer	Male	58	Katsina	30	Practices herbal medicine; represents traditional healing knowledge
Mal Bitrus	Traditional Healer	Male	53	Jigawa	25	Integrates Quranic healing with herbal remedies
Hajiya Safiya	Midwife	Female	37	Abuja	11	Trained in biomedical care, bridges traditional and modern practices
Mal Shettima	Trad. Healer	Male	60	Abuja	28	Strong advocate for cultural respect in health messaging

Alh Shuaibu	Community Head	Male	57	Jigawa	13	Translates health messages from English to Hausa; cultural mediator
Haj Binta	Midwife	Female	41	Katsina	14	Observes how peer examples influence health behavior adoption
Mal Mustapha	Community Head	Male	59	Jigawa	24	Notes changing attitudes toward facility-based childbirth
Haj Ramatu	Women's Association Leader	Female	44	Abuja	8	Leads grassroots advocacy for child spacing and maternal health
Mallama Aisha	Community Health Worker	Female	28	Jigawa	5	Youngest Participant; represents generational shift in health attitudes.

Summary of Themes, Subthemes and Key Patterns

Research Question Themes	Sub-theme	Key Patterns
RQ1: How do individuals interpret and negotiate health messages within sociocultural norms?	Theme 1: Religious Authority, Gender Hierarchies, and Epistemological Filters as Mechanisms of Message Interpretation	1.1 Religious Authority- Religious texts and imams legitimize health messages - Male authority mediates women's health access
	Gatekeeper	1.2 Gender Hierarchies - Trust high for local actors, low for institutions - Traditional and biomedical systems coexist
	1.2 Gender Hierarchies as Access Mediators and Decision-Making Gatekeepers	1.3 Trust Networks as Credibility Determiners and Historical Memory Keepers - Historical memories shape institutional mistrust
	1.4 Traditional and Biomedical Epistemologies as Competing yet Coexisting Knowledge Validators	
RQ2: How do social norms facilitate or constrain health message uptake?	Theme 2: Social Norms as Dual Forces of Constraint and Facilitation	2.1 Cultural Alignment -Messages aligned with faith, family, culture succeed - Local leaders function as norm entrepreneurs
	2.2 Leadership Networks as Norm Entrepreneurship Platforms and Institutional Amplifiers	- Grassroots advocacy shifts norms sustainably - Traditional medicine remains normatively preferred
	2.3 Community-Driven Normative Shifts as Grassroots Transformation Mechanisms	- Norms are context-dependent and negotiable
	2.4 Traditional Medicine Preference as Normatively Entrenched Resistance Mechanism	
RQ3: How can community narratives inform co-creation of health communication?	Theme 3: Community Narratives as Co-Creation Foundations	3.1 Grassroots Mobilization as Ownership Mechanism -Participatory design fosters ownership - Hausa essential for trust and comprehension
	Platform and Sustainability	- Storytelling creates emotional connection and
	3.2 Language as	

Cultural Bridge, Trust Mechanism, and Comprehension Enabler	social proof - Religious framing transforms practices into spiritual duties
3.3 Narrative Power as Emotional Connection Generator and Social Proof Mechanism	- Communities are knowledge producers, not recipients
3.4 Spiritual Messaging as Religious Legitim�izer and Moral Affirmer	

Appendix D: IRB Approval

[IRB Approval](#)

