

THE ROLE OF CULTURAL NORMS IN SHAPING GENDER-RESPONSIVE HEALTHCARE COMMUNICATION IN NASARAWA STATE

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Abstract

This study investigated the intricate role of cultural norms in shaping gender-responsive healthcare communication in Nasarawa State, Nigeria. It tackled the pervasive problem of ineffective communication between healthcare providers and patients, a challenge compounded by deeply entrenched cultural beliefs that dictate gender interactions and health-seeking behaviours. The primary objectives were to scrutinise how cultural norms influenced provider-patient communication, pinpoint specific traditions affecting gender responsiveness, and propose actionable strategies to enhance communication effectiveness. The research was anchored on the Health Belief Model and Feminist Theory, employing a library-based methodology that synthesised secondary data from journals, books, reports, and empirical studies. Key findings indicated that patriarchal norms significantly curtailed women's access to healthcare information, with men's roles as household decision-makers dominating communication exchanges. Cultural taboos further stifled open dialogue on sensitive topics like reproductive health, disproportionately affecting women. The study concluded that these cultural underpinnings posed substantial barriers to gender-responsive communication, perpetuating health inequities in Nasarawa State. Key recommendations included the implementation of cultural competence training for healthcare providers by the state's Ministry of Health, collaboration with traditional leaders to reshape cultural norms, and the development of tailored, gender-sensitive health campaigns leveraging local media to bridge communication gaps effectively.

Keywords: Cultural norms, gender-responsive, healthcare communication, nasarawa state

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Introduction

Healthcare communication forms the cornerstone of effective healthcare services delivery, yet its success hinges on the cultural context in which it unfolds. In Nasarawa State, Nigeria, a culturally diverse region in the North-Central zone with approximately 2.5 million residents (National Population Commission, 2020), ethnic groups such as the Eggon, Gwandara, Alago, and Hausa shape how health information is shared and received. Deep-rooted traditions define gender roles, power structures, and access to healthcare, often placing men as primary decision-makers in households—a reflection of Northern

Nigeria's patriarchal norms (Oladepo & Fayemi, 2018). Previous studies, such as Eze, Okonkwo, and Nwosu (2020), highlight how these dynamics silence women's voices in healthcare settings, particularly for reproductive and maternal needs, necessitating an exploration of how cultural frameworks influence gender-responsive communication.

Gender-responsive communication seeks to equitably address the distinct health needs of men and women, yet in Nasarawa, cultural beliefs prioritising male authority over female autonomy pose significant barriers. Research by Adebayo and Iweala (2022) links these disparities to high maternal mortality rates,

underscoring the urgency of tailored communication strategies. For instance, women often require spousal approval for clinic visits, a norm that hampers direct provider engagement (Ahmed & Seid, 2019). Studies in similar contexts reveal that such gender-blind approaches exacerbate unequal access and health outcomes, particularly for women burdened by societal expectations of subservience (Olaniran & Williams, 2019). This evidence establishes a critical foundation for investigating culturally informed healthcare communication in Nasarawa.

The state's cultural landscape reveals a tension between tradition and modernity. Urban areas like Lafia show signs of progress towards gender equality, influenced by education and global health trends, while rural zones—home to most residents—cling to practices reinforcing gender inequities (WHO, 2024). Ahmed and Seid (2019) note that health campaigns, such as those promoting family planning, succeed in urban settings but falter rurally, where large families remain a cultural ideal. This urban-rural divide, documented in prior research (World Bank, 2018), complicates uniform communication strategies, highlighting the need for context-specific approaches grounded in local realities.

Nasarawa's understudied status and its value as a culturally diverse research site—while enhancing clarity and flow. The claim of Nasarawa's underrepresentation in health studies compared to states like Lagos or Kano is plausible and can be corroborated indirectly through existing literature patterns. For instance, the National Bureau of Statistics (2021) provides demographic data showing Nasarawa's population of over 2.5 million (projected from 2018 figures in Abdullahi et al., 2021) and its ethnic heterogeneity (e.g., Eggon, Gwandara, and Alago groups), yet health-focused studies in Nigeria often prioritise urban hubs like Lagos or Kano due to their larger populations and infrastructure (e.g., Eze et al., 2020, often cite southern or northern urban centres). This disparity suggests a research gap, as Nasarawa's rural and multi-ethnic context is less documented, making it a compelling case for localised inquiry.

Scholars like Eze et al. (2020) advocate for localised research to unpack socio-cultural determinants of health communication, aligning this study with global goals like SDG 5 on gender equality (WHO, 2021). By building on this foundation, the study addresses a gap in understanding how Nasarawa's cultural diversity shapes gender-responsive healthcare delivery. Practically, ineffective communication perpetuates disparities, disproportionately affecting women constrained by restricted mobility and male-

mediated health interactions (Ahmed & Seid, 2019). Low female literacy (45% versus 62% for men) and linguistic diversity—with over 20 local languages—further complicate exchanges (National Bureau of Statistics, 2021). Prior studies (Olakunde et al., 2019) confirm these barriers delay critical care, such as immunisations or obstetric interventions, reinforcing the need for culturally attuned strategies beyond generic messaging.

This study aims to dissect the interplay between Nasarawa's cultural norms and gender-responsive healthcare communication, arguing that ignoring these roots renders health interventions superficial. Drawing on previous research, it integrates empirical and theoretical insights to guide stakeholders—policymakers, providers, and community leaders—towards equitable solutions. The following sections detail objectives, theories, and findings, framing cultural norms as potential strengths rather than impediments to health system improvement in Nasarawa State.

Statement of the Problem

In Nasarawa State, the delivery of healthcare services faces a formidable obstacle: the pervasive influence of cultural norms on gender-responsive communication. Patriarchal traditions entrenched across ethnic groups like the Eggon and Gwandara often designate men as the primary decision-makers in health matters, relegating women to secondary roles with little autonomy to engage directly with providers (Oladejo & Fayemi, 2018). This dynamic manifests in tangible ways—women may be unable to seek care without spousal consent, or they may refrain from discussing sensitive issues like reproductive health due to cultural taboos, as evidenced by high maternal mortality rates and low contraceptive prevalence (Adebayo & Iweala, 2022).

For men, cultural expectations of stoicism and dominance deter participation in health programmes perceived as feminine, such as family planning, further skewing communication patterns (Okeke, 2023). These gendered barriers, compounded by low literacy and resource constraints in Nasarawa's healthcare system, undermine the effectiveness of service delivery, perpetuating inequities that demand urgent attention. Without a thorough understanding of these cultural influences, interventions risk being misaligned, leaving critical health needs unmet in a region already strained by infrastructural deficits (Eze et al., 2020).

Objectives of the Study

1. To examine how cultural norms in Nasarawa

State influence effective communication between healthcare providers and patients of different genders.

2. To identify specific cultural traditions and beliefs that shape gender-responsive healthcare communication in Nasarawa State,
3. To propose strategies for enhancing gender-responsive healthcare communication

Theoretical Framework Health Belief Model (HBM)

The Health Belief Model (HBM), developed by Rosenstock (1966), offers a robust framework for understanding how cultural norms shape healthcare communication behaviours in Nasarawa State. HBM posits that individuals' health actions are driven by their perceptions of susceptibility to illness, the severity of consequences, the benefits of action, and the barriers they face. In this context, cultural norms act as significant barriers, particularly for women, whose health-seeking behaviours are often mediated by societal expectations. For example, a woman might recognise her susceptibility to postpartum complications but refrain from seeking care if cultural norms dictate that her husband must initiate such decisions (Eze et al., 2020). This aligns with HBM's emphasis on perceived barriers, illustrating how tradition can override individual health beliefs and hinder communication with providers.

Furthermore, HBM's constructs of cues to action and self-efficacy provide actionable insights for improving communication. Community leaders, revered in Nasarawa's traditional structures, can serve as cues to action by endorsing health messages, thereby legitimising women's engagement with services (Oladepo & Fayemi, 2018). Similarly, enhancing women's self-efficacy through culturally sensitive education—such as workshops conducted in local languages—can empower them to overcome cultural constraints and communicate their needs effectively. By framing communication strategies within HBM, this study bridges individual perceptions with communal influences, offering a pragmatic lens for addressing Nasarawa's gendered health challenges.

Feminist Theory

Feminist Theory, rooted in the works of scholars like hooks (1984), complements HBM by focusing on the structural inequalities embedded in cultural norms. It critiques patriarchal systems that marginalise women's voices, a reality starkly evident in Nasarawa State where men's dominance in health decision-making restricts women's agency (Ahmed &

Seid, 2019). For instance, a woman requiring her husband's approval to attend a clinic reflects a power imbalance that Feminist Theory seeks to dismantle. This theory advocates for communication strategies that challenge such norms, promoting women's empowerment through dialogue that amplifies their perspectives rather than silencing them. In practice, this might involve training female health workers to engage women directly, circumventing male gatekeepers where culturally feasible.

Additionally, Feminist Theory's emphasis on intersectionality enriches this analysis by considering how gender intersects with other identities—ethnicity, religion, and socioeconomic status—in Nasarawa's diverse population. A Hausa Muslim woman practicing *purdah* faces different communication barriers than an Eggon Christian woman in a rural setting, necessitating tailored approaches (Eze et al., 2020). By integrating these intersectional insights, Feminist Theory not only critiques existing inequities but also guides the development of inclusive communication strategies. Together, HBM and Feminist Theory provide a dual lens—behavioural and structural—that illuminates the cultural dynamics of healthcare communication and proposes pathways for transformative change.

Conceptual Clarifications Cultural Norms

Cultural norms are the unwritten rules and shared expectations that govern behaviour within a society, often passed down through generations. In Nasarawa State, these norms are a product of ethnic diversity and historical practices, shaping interactions in profound ways. For instance, among the Gwandara, the cultural expectation that women prioritise domestic duties over personal health reflects a patriarchal norm that limits their engagement with healthcare providers (Oladepo & Fayemi, 2018). This is not an isolated phenomenon; across the state, traditions dictate that men, as heads of households, hold authority over health-related decisions, a practice that often delays women's access to timely care, particularly in rural areas where adherence to tradition remains strong. These norms are reinforced through social mechanisms like community gatherings and religious teachings, which uphold gender roles as sacrosanct. For example, in some communities, a woman discussing her reproductive health openly with a male provider might be seen as immodest, clashing with norms of propriety and thus stifling communication (Eze et al., 2020). This creates a vicious cycle where health needs go unaddressed, perpetuating disparities such as Nasarawa's maternal

mortality rate of 576 per 100,000 live births (National Bureau of Statistics, 2021). Providers unfamiliar with these norms risk miscommunication, underscoring the need for cultural literacy in healthcare settings.

Nevertheless, cultural norms are not immutable. In urban centres like Keffi, education and media exposure are gradually eroding rigid gender roles, with younger generations questioning traditions that once went unchallenged (WHO, 2021). Yet, in rural Nasarawa, where over 70% of the population resides, change is slower, and norms remain a formidable barrier to effective communication. This urban-rural disparity necessitates a dual approach—preserving cultural respect while gently nudging communities towards more equitable practices—a balancing act that this study seeks to inform.

Gender-Responsive Communication

Gender-responsive communication refers to the deliberate design of health messaging and interactions that address the unique needs, roles, and experiences of men and women. In Nasarawa State, this concept is vital given the stark gender disparities in health access and outcomes. For women, who often shoulder reproductive responsibilities, communication must be sensitive to cultural constraints like modesty or dependence on male approval, ensuring they feel safe and heard (WHO, 2021). For men, it involves engaging them as partners rather than obstacles, encouraging their participation in family health dialogues—an area where cultural norms often falter (Ahmed & Seid, 2019).

Achieving this balance requires overcoming significant hurdles. Women may need private consultation spaces to discuss issues like contraception, free from the cultural stigma of public exposure, while men require messaging that aligns with their societal roles as providers, reframing health engagement as a strength rather than a weakness (Eze et al., 2020). The absence of such tailored approaches in Nasarawa has led to low uptake of services; for instance, only 12% of women use modern contraceptives, a figure linked to poor communication (Adebayo & Iweala, 2022). Providers must therefore adapt their language, tone, and medium—whether verbal, written, or visual—to resonate with gendered cultural realities.

Ultimately, gender-responsive communication is about empowerment through inclusion. By fostering dialogue that respects cultural norms while challenging their inequities, healthcare systems can build trust and improve service delivery. In Nasarawa, where linguistic diversity adds another layer of complexity, this might mean training providers in local dialects or using

community health workers as cultural intermediaries—steps that align with global best practices (WHO, 2021). This study posits that such adaptations are not optional but essential for meaningful health progress.

Healthcare Services

Healthcare services encompass a broad spectrum of activities—preventive, curative, and promotional—delivered by trained professionals to improve wellbeing. In Nasarawa State, these services include immunisations, maternal care, and treatment for infectious diseases, primarily offered through public facilities like primary health centres (PHCs). However, these centres often grapple with shortages of staff, drugs, and equipment, a reality that amplifies the importance of effective communication to maximise limited resources (Eze et al., 2020). Cultural norms shape how these services are perceived and accessed, often determining their success or failure. For women, cultural restrictions on mobility or decision-making autonomy mean that services like antenatal care may be underutilised unless accompanied by culturally appropriate outreach. A woman in a rural village might forego a clinic visit if it requires travelling alone, a breach of norms around female seclusion (Oladebo & Fayemi, 2018). Men, conversely, may dismiss services like family planning as irrelevant to their culturally defined roles, leaving family health burdens on women (Okeke, 2023). These patterns highlight a disconnect between service provision and community expectations, necessitating communication that bridges this gap.

Thus, the effectiveness of healthcare services in Nasarawa hinges on culturally attuned communication. Initiatives like mobile clinics or community health education programmes have shown promise elsewhere in Nigeria, suggesting potential models for adaptation (Ahmed & Seid, 2019). By integrating cultural insights into service delivery—such as scheduling women-only clinic days or involving male community leaders in health talks—providers can ensure that services are not just available but accessible and acceptable to all genders, a critical step towards equity.

Influence of Cultural Norms on Healthcare Communication

Cultural norms exert a profound influence on healthcare communication in Nasarawa State, shaping interactions in ways that often reinforce gender inequities. The patriarchal framework prevalent across ethnic groups like the Alago and Hausa positions men as the primary gatekeepers of health decisions, a norm

that restricts women's ability to engage directly with providers (Oladepo & Fayemi, 2018). For instance, in many households, a woman experiencing symptoms of illness must first consult her husband or male relative before seeking professional care, a process that delays treatment and stifles open dialogue with healthcare workers. This dynamic is particularly pronounced in rural areas, where traditional authority structures remain dominant, and women's voices are subordinated to male oversight. Such norms not only limit women's agency but also place an undue burden on men to interpret and relay health needs, often without full understanding, leading to miscommunication and suboptimal care outcomes.

Moreover, these cultural influences extend beyond decision-making to the very nature of communication itself. Norms of modesty and deference, deeply ingrained in Nasarawa's social fabric, discourage women from discussing sensitive health issues—such as menstrual irregularities or sexually transmitted infections—with providers, especially if those providers are male (Eze et al., 2020). This reluctance stems from a cultural expectation that women maintain a veneer of propriety, avoiding topics deemed taboo or shameful. In a study conducted in North-Central Nigeria, participants revealed that female patients often withheld critical information during consultations due to fear of judgement, a pattern likely mirrored in Nasarawa given its similar cultural context. This silence compromises diagnostic accuracy and perpetuates health risks, underscoring how cultural norms act as a filter through which health messages must pass, often emerging distorted or incomplete on the other side.

In contrast, men's cultural roles afford them greater latitude in healthcare interactions, yet this too comes with caveats. The expectation of stoicism and resilience means that men may downplay their own health concerns or avoid seeking care altogether, perceiving it as a sign of weakness (Okeke, 2023). This norm can hinder providers' ability to engage male patients in preventive health discussions, such as those around prostate health or family planning, which are often dismissed as outside their domain. In Nasarawa, where men are culturally positioned as protectors and providers, health messaging that fails to align with these roles risks being ignored, leaving entire families vulnerable. For example, a campaign urging men to accompany their wives to antenatal clinics might falter if it does not frame such participation as an extension of their protective duties, illustrating the need for culturally congruent communication strategies.

However, cultural norms are not solely barriers;

they also offer opportunities for engagement when harnessed effectively. Studies from other Nigerian contexts suggest that involving male community leaders in health initiatives can shift communication patterns, as their endorsement lends legitimacy to messages targeting both genders (Ahmed & Seid, 2019). In Nasarawa, where traditional rulers wield significant influence, this approach could encourage men to support women's health-seeking behaviours while simultaneously fostering their own engagement with services. For instance, a chief publicly advocating for immunisation could counter cultural resistance, bridging the gap between providers and communities. This dual potential—obstacle and asset—highlights the complexity of cultural norms and the necessity of nuanced, context-specific interventions.

Nevertheless, the urban-rural divide in Nasarawa complicates these efforts. Urban women, exposed to education and media, are beginning to assert greater autonomy in healthcare interactions, a shift less evident in rural settings where norms remain rigid (WHO, 202). This disparity suggests that a one-size-fits-all approach to communication is untenable; urban campaigns might leverage digital platforms, while rural ones rely on face-to-face engagement with elders. The challenge lies in balancing respect for tradition with the imperatives of modern healthcare, a task that requires providers to be both culturally literate and adaptable. Thus, cultural norms in Nasarawa State are a double-edged sword, demanding strategies that neither dismiss nor uncritically accept them but rather reshape them towards gender equity.

Specific Traditions Shaping Gender Responsiveness

Several specific traditions in Nasarawa State distinctly influence gender-responsive healthcare communication, each deeply embedded in the region's cultural heritage. The practice of *purdah*, observed among some Hausa and Fulani Muslim communities, exemplifies this impact by physically and socially secluding women, thereby limiting their interactions with male healthcare providers (Eze et al., 2020). A woman in *purdah* might only access care through a female intermediary or forego it entirely if no female provider is available—a common scenario in understaffed Primary Healthcare Centres (PHCs) where male nurses often predominate (Abdullahi & Amzat, 2021). This tradition not only restricts physical access but also stifles verbal communication, as women may feel inhibited from speaking openly in mixed-gender settings, leaving their health needs unaddressed (Oladepo & Fayemi, 2018). Research by Salisu and Mohammed (2019) underscores how such seclusion

perpetuates silence around women's health concerns, particularly reproductive issues, due to cultural taboos and male-dominated care environments.

This dynamic reinforces gender disparities, as men encounter no comparable barriers and can engage providers directly, enjoying unhindered access to health communication (Ahmed & Seid, 2019). Studies in similar Northern Nigerian contexts reveal that these restrictions exacerbate delays in seeking care, with women requiring male permission or escorts, further entrenching inequities (Ismail & Bala, 2022). Adebayo and Iweala (2022) note that in Nasarawa, where PHCs often lack gender-balanced staffing, this seclusion amplifies disparities in maternal and child health outcomes. Collectively, these traditions highlight a stark inequity in communication access, underscoring the need for culturally tailored healthcare strategies to bridge the gap (WHO, 2024).

Similarly, cultural taboos surrounding topics like childbirth and menstruation further silence women, framing these as private matters unfit for public discourse (Oladepo & Fayemi, 2018). In Eggon communities, for example, discussing miscarriage with a provider might be seen as inviting spiritual misfortune, prompting women to suffer in silence rather than seek help. Providers unaware of these taboos may inadvertently alienate patients by probing such issues, mistaking reticence for disinterest rather than cultural inhibition. This communication gap is particularly detrimental in maternal health, where timely intervention hinges on open dialogue—a challenge compounded by Nasarawa's 35% skilled birth attendance rate (National Bureau of Statistics, 2024). Addressing these taboos requires providers to tread carefully, building trust through culturally sensitive approaches like using female community health workers as liaisons.

For men, traditions of masculinity shape communication in equally significant ways. The cultural ideal of men as stoic protectors discourages them from engaging in health discussions perceived as feminine, such as child nutrition or contraception (Ahmed & Seid, 2019). In Nasarawa, a man attending a family planning session might face ridicule for stepping outside his prescribed role, a norm that limits his participation and, by extension, his support for his wife's health needs. This tradition perpetuates a cycle where women bear sole responsibility for family health, yet lack the autonomy to act independently, while men remain disengaged from services that could benefit the household. Providers must therefore reframe health messaging to align with masculine identities, perhaps by linking family planning to economic stability—a

culturally resonant motivator.

Ethnic variations add another layer of complexity to these traditions. Among the Alago, communal decision-making is prized, meaning health choices might be debated in village councils rather than made individually, delaying women's access to care (WHO, 2024). A woman needing emergency obstetric services might wait for communal consensus, a process that clashes with the urgency of medical needs and complicates provider communication. In contrast, Gwandara traditions might prioritise male heirs, influencing communication around fertility treatments in ways that sideline female preferences. These ethnic-specific norms underscore the heterogeneity of Nasarawa's cultural landscape, demanding that communication strategies be as diverse as the communities they serve, tailored to each group's unique traditions.

Overcoming these traditional influences requires a delicate balance of respect and reform. Training providers to recognise and navigate practices like *purdah* or communal decision-making can enhance gender responsiveness, ensuring that communication respects cultural boundaries while gently pushing them towards inclusivity (Eze et al., 2020). For instance, deploying more female providers to areas with strict seclusion norms could bridge the gap, while engaging male elders to champion health initiatives could shift masculine norms. These traditions, while challenging, are not insurmountable; with informed interventions, they can be reframed to support rather than hinder effective healthcare communication.

Strategies for Enhancing Gender-Responsive Healthcare Communication

Enhancing gender-responsive healthcare communication in Nasarawa State necessitates innovative, culturally attuned strategies that address the barriers posed by norms and traditions. One promising approach is the implementation of cultural competence training for healthcare providers, equipping them with the skills to understand and respect local customs while fostering effective dialogue (Eze et al., 2020). For example, a nurse trained to recognise the significance of *purdah* could offer home visits or coordinate with female community health workers, ensuring women in seclusion receive care without breaching cultural norms. Such training should extend beyond awareness to practical skills, like using indirect questioning to elicit information on taboo topics, thereby building trust and improving patient-provider interactions across genders.

Additionally, community-based strategies that

leverage traditional structures offer substantial potential for reshaping communication patterns. Involving respected figures like chiefs and imams in health campaigns can legitimise messages, encouraging both men and women to engage with services (Oladebo & Fayemi, 2018). In Nasarawa, where traditional rulers command authority, a chief publicly endorsing immunisation could counter cultural resistance, while an imam framing family planning as a religious virtue could shift male attitudes. This approach has precedence in Northern Nigeria, where community leaders have successfully boosted polio vaccination rates, suggesting its adaptability to Nasarawa's context. By aligning health messages with cultural influences, providers can amplify their reach and resonance, bridging the gap between modern healthcare and traditional values.

Technology, particularly radio, presents another avenue for enhancing communication, given its widespread use in Nasarawa's rural areas. Tailored radio programmes in local languages like Eggon or Hausa can address gender-specific health needs, overcoming literacy barriers and cultural reticence (Ahmed & Seid, 2019). For instance, a programme featuring a female voice discussing maternal health in a culturally sensitive manner could empower women to seek care, while a male narrator linking health to family prosperity could engage men. Such initiatives have proven effective in other Nigerian states, with a Kano study reporting a 20% increase in clinic visits following targeted broadcasts (Musa & Ali, 2021). Adapting this model to Nasarawa could broaden access, provide content respects local norms and avoids alienating listeners. Furthermore, creating safe spaces for women—such as women-only clinics or consultation hours—can overcome cultural barriers to communication, offering environments where they feel free to speak (WHO, 2024). In a pilot project in Kaduna, such spaces increased female attendance by 15%, a model Nasarawa could emulate by repurposing underused PHCs. These settings respect norms of modesty while empowering women to articulate their needs, addressing the silence imposed by taboos. For men, parallel strategies like male-focused health talks at community gatherings could normalize their participation, reframing health as a shared responsibility. These physical and social spaces ensure that communication is not just delivered but received in ways that resonate with gendered cultural realities.

Ultimately, a multi-pronged approach combining training, community engagement, technology, and safe spaces is essential for sustainable change. Each strategy must be iteratively

evaluated—perhaps through pilot programmes in Nasarawa's 13 local government areas—to refine its cultural fit (Eze et al., 2020). By blending respect for tradition with innovative outreach, these interventions can transform healthcare communication, making it more inclusive and effective. The challenge lies in implementation, requiring collaboration between government, NGOs, and communities to ensure that strategies are not just theoretical but actionable, paving the way for a healthier, more equitable Nasarawa.

Review of Empirical Studies

Oladebo and Fayemi (2018) conducted a quantitative study in Southwest Nigeria, surveying 300 households to explore how gender roles influence healthcare access. Their findings revealed that cultural norms prioritising male decision-making significantly limited women's ability to seek care independently, with 68% of female respondents requiring spousal approval for clinic visits. This patriarchal structure mirrors Nasarawa's context, where men's authority similarly shapes communication dynamics, often delaying women's access to timely interventions like antenatal care. The study employed logistic regression to demonstrate a strong correlation between male dominance and reduced health-seeking behaviours among women, a pattern likely exacerbated in Nasarawa by lower literacy and rural isolation. The implications for Nasarawa are clear: communication strategies must engage men as allies rather than obstacles. Oladebo and Fayemi (2018) suggested integrating male community leaders into health education programmes, a recommendation supported by their data showing increased female attendance when men endorsed initiatives. While their study focused on Yoruba communities, its insights into patriarchal norms are broadly applicable to Nasarawa's multi-ethnic setting, where similar gender hierarchies prevail. However, the urban bias of their sample limits its direct relevance to Nasarawa's predominantly rural population, suggesting a need for localised adaptation.

Eze et al. (2020) undertook a qualitative study in North-Central Nigeria, including Nasarawa State, using focus groups and interviews with 120 participants to examine cultural influences on healthcare delivery. Their findings highlighted that taboos around reproductive health silenced women, with many avoiding discussions with providers due to fears of social stigma—a dynamic intensified by Nasarawa's conservative traditions. Participants recounted instances where female patients withheld symptoms of miscarriage or infertility, reflecting

cultural norms that deem such topics private, a finding that aligns with this study's focus on communication barriers. The study's strength lies in its regional specificity, offering direct relevance to Nasarawa. Eze et al. (2020) recommended training providers in cultural sensitivity, noting that those aware of local taboos were better equipped to elicit information indirectly, improving care quality. Their use of thematic analysis grounded in community narratives provides a robust model for understanding Nasarawa's challenges, though their small sample size calls for broader validation. Nonetheless, their emphasis on culturally tailored communication offers a blueprint for addressing Nasarawa's gendered disparities.

Ahmed and Seid (2019) conducted a mixed-methods study in rural Ethiopia, surveying 500 participants and conducting 20 interviews to assess gender and health communication. They found that involving men in health programmes improved outcomes when messages were culturally framed, with male participation rising by 25% when linked to family wellbeing—a strategy applicable to Nasarawa's patriarchal context. Women, however, faced barriers similar to those in Nasarawa, with cultural norms restricting their autonomy and communication with providers. Their findings underscore the potential of engaging men as partners in Nasarawa, where cultural ideals of masculinity could be leveraged to shift communication patterns. The study's use of statistical analysis alongside qualitative insights strengthens its credibility, though its Ethiopian focus requires contextual adaptation for Nigeria. Ahmed and Seid (2019) advocated for community radio as a communication tool, a method that could resonate in Nasarawa given its rural radio penetration, offering a practical avenue for further exploration.

The World Health Organization's 2024 report synthesised global case studies on gender-responsive health initiatives, including African examples relevant to Nasarawa. It found that culturally tailored communication increased service uptake by 30% in settings with strong traditional norms, such as Uganda, where female-only clinics addressed seclusion barriers. The report's qualitative analysis of programme outcomes highlighted the need for local adaptation, a principle directly applicable to Nasarawa's diverse ethnic landscape. For Nasarawa, the WHO (2024) findings suggest that gender-specific interventions—like women-only health spaces—could overcome cultural constraints, enhancing communication effectiveness. The report's global scope provides a broad comparative lens, though its lack of Nigeria-specific data limits granularity.

Nonetheless, its emphasis on cultural integration aligns with this study's objectives, reinforcing the value of context-driven strategies.

Adebayo and Iweala (2022) surveyed 150 women in Nasarawa State to investigate maternal health access, finding that cultural restrictions on mobility reduced communication with providers, with 60% of respondents citing male permission as a prerequisite for clinic visits. Their quantitative approach, using chi-square analysis, confirmed a significant link between cultural norms and low maternal service uptake, a finding echoed in Nasarawa's high maternal mortality rates. The study's local focus makes it highly relevant, offering empirical evidence of communication barriers specific to Nasarawa. Adebayo and Iweala (2022) proposed mobile clinics to circumvent mobility issues, a recommendation that could enhance gender responsiveness by bringing services to women's doorsteps. While their female-only sample omits male perspectives, it provides a critical foundation for understanding women's experiences, necessitating complementary research on men's roles.

Okeke (2023) explored male health attitudes in Northern Nigeria through interviews with 200 men, revealing that cultural norms of stoicism discouraged health engagement, with 70% avoiding preventive care due to perceived weakness. This mirrors Nasarawa's context, where men's disengagement from family health dialogues limits holistic communication. His thematic analysis identified masculinity as a key barrier, a finding that informs strategies to reframe health as a masculine duty. For Nasarawa, Okeke's (2023) work suggests that engaging men requires culturally resonant messaging, such as linking health to provider roles. His qualitative depth offers rich insights, though its regional breadth dilutes Nasarawa-specific detail. Nonetheless, his call for male-focused health education aligns with this study's aim to enhance gender responsiveness across both genders.

Musa and Ali (2021) assessed community health programmes in Nasarawa, analysing data from 10 PHCs and finding that culturally insensitive communication reduced service uptake by 40%. Their mixed-methods approach, combining surveys and facility audits, pinpointed providers' lack of cultural awareness as a key issue, with patients reporting discomfort discussing health with untrained staff. This study's direct focus on Nasarawa strengthens its relevance, offering concrete evidence of communication gaps. Musa and Ali (2021) recommended integrating cultural training into provider curricula, a strategy that could improve trust

and dialogue in Nasarawa's PHCs. Their facility-level analysis provides a practical lens, though broader community input could enhance its scope, aligning with this study's community-driven approach.

Methodology

This study adopted a library research methodology to advance a discourse on the role of cultural norms in shaping gender-responsive healthcare communication in Nasarawa State. This approach entailed a systematic review of existing literature, drawing on secondary data from diverse sources: peer-reviewed journal articles, book chapters, books, online resources, reports, and empirical studies. The choice of library research was justified by its ability to synthesise a wide range of perspectives without the logistical constraints of primary data collection, aligning with the study's conceptual focus on cultural dynamics. Sources were selected based on their relevance, recency (primarily post-2018), and credibility, ensuring a robust foundation for analysis. The inclusion of empirical studies provided contextual grounding, while theoretical works offered frameworks for interpretation.

Strategies for Improvement

Strategies to enhance communication—training, community engagement, technology, and safe spaces—emerge as viable solutions, supported by empirical and theoretical corroboration. Cultural competence training, recommended by Eze et al. (2020) and Musa and Ali (2021), equips providers to navigate norms, aligning with HBM's cues to action by fostering trust (Rosenstock, 1966). For example, a trained nurse might use indirect questioning to discuss taboos, improving women's self-efficacy. Community engagement, per Oladepo and Fayemi (2018), leverages leaders to shift norms, a Feminist Theory-aligned approach that empowers communities (hooks, 1984). Ahmed and Seid's (2019) success with radio in Ethiopia supports its use in Nasarawa, while WHO's (2021) safe spaces model addresses seclusion barriers.

Synthesising these, a pilot in Nasarawa could combine radio broadcasts featuring chiefs with women-only clinics, triangulating the Health Belief Model's (HBM) behavioural focus with Feminist Theory's equity lens. This dual strategy leverages community leaders to shift perceptions of healthcare benefits, as HBM posits (Glanz & Bishop, 2010), while addressing structural inequities highlighted by Feminist Theory (Amadiume, 2015). The findings suggest a multi-faceted approach, implemented iteratively, can transform communication, making it both culturally sensitive and

gender-responsive—a conclusion grounded in the literature's collective call for adaptation. Corroborating this, a study by Salisu and Mohammed (2019) in Northern Nigeria demonstrated that integrating traditional leaders into health campaigns, alongside gender-specific service delivery points, significantly increased women's healthcare uptake by 35% over six months, validating the efficacy of such culturally attuned interventions. This evidence underscores the potential for Nasarawa to adapt similar models, aligning with the broader push for responsive healthcare communication.

Conclusion

This study reveals that cultural norms in Nasarawa State significantly shape gender-responsive healthcare communication, often reinforcing inequities that undermine health outcomes, particularly for women. Patriarchal traditions, taboos, and masculinity norms create barriers that demand innovative, culturally informed solutions.

Recommendations

Based on the study's findings, several key recommendations emerged to strengthen gender-responsive healthcare communication in Nasarawa State. The Nasarawa State Ministry of Health should prioritise the implementation of mandatory cultural competence training for healthcare providers, to be rolled out within 12 months. This initiative aims to bolster gender sensitivity among staff, equipping them to navigate the state's complex cultural landscape effectively and address the specific health needs of men and women with greater awareness.

Additionally, collaboration between traditional leaders and health authorities is essential to promote inclusive health messaging, particularly in rural communities. By partnering with these influential figures, health authorities can leverage their authority to endorse and disseminate gender-sensitive health information, with a target for widespread outreach by 2026. This approach harnesses cultural respect to bridge communication gaps and enhance community trust in healthcare services.

Furthermore, non-governmental organisations (NGOs) should spearhead radio campaigns in local languages, scheduled for launch by mid-2025. These campaigns should engage both men and women, using culturally relevant content to broaden health awareness and encourage equitable participation in healthcare-seeking behaviours. Radio's wide reach in Nasarawa makes it an ideal medium for this purpose.

Lastly, the state government should commit to

establishing women-only clinics across five local government areas by 2027. This measure directly addresses seclusion norms, such as purdah, by providing safe, accessible spaces for women to seek care without cultural barriers, thereby fostering gender equity in healthcare access and communication. Together, these recommendations offer a cohesive strategy for transformative change.

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