Exploring Gender-Responsive Communication Strategies in Enhancing Healthcare Delivery: Insights from Akwanga and Wamba LGAs, Nasarawa State

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Abstract

This study explored gender-responsive communication strategies in healthcare delivery within Akwanga and Wamba Local Government Areas (LGAs) of Nasarawa State, Nigeria, focusing on their role in addressing gender-specific health needs and improving healthcare-seeking behaviour. The primary objective was to evaluate the effectiveness of these strategies and identify barriers to their implementation. Grounded in Narrative Medicine Theory and Feminist Communication Theory, the research adopted a mixed-methods approach combining survey and semi structured interviews. A total of 400 questionnaires were administered to healthcare professionals and individuals seeking healthcare services, with 394 retrieved (98.5% response rate), alongside 20 key informant interviews (KIIs) with purposively selected healthcare providers. Key findings revealed that 63.5% of respondents were moderately to very aware of gender-specific health issues, with verbal communication (55.8%) and visual aids (50%) as dominant strategies used to disseminate related information. Gender-responsive communication positively impacted healthcare-seeking behaviour, with 58.4% reporting moderate to significant personal influence and 62.9% noting community-level effects. However, challenges included inadequate training (38.1%), resource scarcity (25.4%), and sociocultural barriers (20.3%). The study concluded that while awareness existed, systemic and cultural obstacles hindered effectiveness of gender-responsive communication efforts. Recommendations included training for healthcare professionals, integration of gender-responsive policies, and culturally tailored communication materials to enhance healthcare equity and outcomes in these LGAs.

Keywords: Gender-responsive communication, healthcare delivery, healthcare-seeking behaviour, communication strategies.

Introduction

Healthcare communication serves as the bedrock of effective service delivery, shaping how individuals' access, perceive, and utilize health services. In Nigeria, a country marked by diverse cultural, social, and economic landscapes, the need for communication that resonates with specific demographic groups particularly across gender lines has gained prominence (World Health Organisation, 2018). Gender-responsive communication, which tailors' messages and strategies to the unique needs and experiences of men and women, has emerged as a critical tool for promoting health equity and addressing disparities in healthcare outcomes (Sen, Ostlin & George, 2018). This study delves into the application of such strategies in Akwanga and Wamba Local Government Areas (LGAs) of Nasarawa State, Nigeria, regions characterized by rural-agrarian populations and persistent healthcare challenges.

Globally, the recognition of gender as a determinant of health has spurred efforts to integrate gender-sensitive approaches into healthcare systems (World Health Organisation, 2019). In low- and middle-income countries like Nigeria, however, disparities in healthcare access and utilisation persist, often exacerbated by gender norms, poverty, and limited education (Okeke, Okeibunor, &

Okonofua, 2019). Women, in particular, face barriers such as restricted decision-making power and sociocultural stigma, which impede their engagement with healthcare services (Olaniran, Madaj & Bar-Zeev, 2019). Conversely, men's health-seeking behaviour is often shaped by masculinity norms that discourage vulnerability or medical consultation (Courtenay, 2019). These dynamics underscore the necessity of communication strategies that bridge these gender-specific gaps.

Nasarawa State, located in Nigeria's North-Central region, exemplifies these challenges. With a population of approximately 2.5 million, predominantly rural and agrarian, the state grapples with inadequate healthcare funding, personnel shortages, and poor infrastructure (Nasarawa State Ministry of Health, 2019). Akwanga and Wamba LGAs, with a combined population exceeding 2 million, reflect these systemic issues alongside unique cultural and religious influences that shape health behaviours (National Bureau of Statistics, 2023). Previous studies have highlighted global and national efforts to address gender disparities, yet localised research in these specific LGAs remains scarce (Ejembi, Alti-Muazu & Chirdan, 2015).

The brief literature survey reveals a growing body of knowledge on gender-responsive healthcare communication. For instance, Sen *et al* (2018) emphasized the role of patient-centred approaches in addressing gender-based power differentials, while Roter and Hall (2014) underscored the importance of understanding social determinants like gender norms. However, gaps persist, particularly in rural Nigerian contexts, where studies often focus on clinical outcomes rather than communication strategies (Olakunde, Adeyinka, & Adeyinka, 2019). This study fills this void by examining how healthcare providers in Akwanga and Wamba LGAs employed communication to address gender-specific needs and influence health-seeking behaviour.

The proposed solution lies in assessing the current state of gender-responsive communication and identifying actionable improvements. By exploring strategies like verbal communication and visual aids, alongside barriers such as inadequate training, this research offers a pathway to enhance healthcare delivery. Its justification stems from the urgent need to reduce gender disparities in health outcomes, a priority aligned with Sustainable Development Goal 3 (United Nations, 2015). The work contributes to both practice and scholarship by providing localized insights that can inform policy and training in Nasarawa State and beyond.

The study, therefore, presents a detailed analysis of findings from a mixed-methods study conducted in 2024. It moves beyond theoretical discourse to offer empirical evidence and practical recommendations, ensuring that healthcare communication evolves to meet the diverse needs of men and women in these LGAs. The subsequent sections outline the problem, objectives, literature review, methods, findings, and implications, weaving a coherent narrative that bridges existing knowledge with new discoveries.

Statement of the Problem

Gender disparities in healthcare outcomes remain a pressing issue in Akwanga and Wamba LGAs, reflecting broader challenges in Nigeria's healthcare system. Despite global and national advocacy for gender-responsive healthcare, the effectiveness of communication strategies in addressing the specific needs of men and women in these rural settings is poorly understood (Okanlawon, Reeves, & Aggleton, 2019). Healthcare providers' ability to convey gender-sensitive information is pivotal to overcoming barriers like sociocultural norms and limited awareness, yet preliminary evidence suggests that such efforts are hampered by resource constraints and inadequate training (Aliyu, Amadu, & Ladan, 2017). This gap in understanding risks perpetuating unequal access to care and

suboptimal health outcomes, particularly for women who face additional obstacles such as restricted mobility and stigma (Olakunde *et al*., 2019).

Moreover, the awareness and knowledge of healthcare professionals about gender-specific health issues crucial for tailoring communication appear inconsistent, potentially leading to miscommunication and reduced trust among patients (Adamu, Abubakar, & Usman, 2018). Without a systematic assessment of these dynamics, healthcare systems in Akwanga and Wamba LGAs may fail to leverage communication as a tool for enhancing healthcare-seeking behaviour and achieving equity. This study addresses these deficiencies by examining the interplay between communication strategies, professional awareness, and patient outcomes in a localised context.

Research Objectives

The key objectives guiding this study are:

i. To evaluate the effectiveness of gender-responsive communication strategies employed by healthcare providers in enhancing healthcare delivery in Akwanga and Wamba LGAs.
ii. To identify the main challenges and barriers hindering the implementation of gender-responsive communication strategies in these LGAs.

Conceptual Clarification

Gender-Responsive Communication

Gender-responsive communication refers to strategies and practices in healthcare that deliberately account for the distinct needs, experiences, and preferences of individuals based on their gender. This approach transcends mere linguistic adjustments, encompassing a holistic recognition of how biological, social, and cultural factors shape health interactions (World Health Organisation, 2018). In the context of Akwanga and Wamba LGAs, it involves tailoring messages to address women's reproductive health concerns, such as maternal care, or men's issues like prostate health, while navigating sociocultural norms that influence gender roles (Sen, Ostlin & George, 2018). The goal is to foster an inclusive environment where communication enhances trust and ensures that healthcare services are equitable and effective for all genders, acknowledging the power dynamics that often disadvantage women in rural settings (Roter & Hall, 2014).

This concept is particularly vital in healthcare systems where gender disparities persist, as it seeks to dismantle barriers that prevent individuals from accessing care. For instance, in Nigeria, gender-responsive communication might involve using culturally sensitive language to encourage women to seek antenatal services or engaging men in family planning discussions to shift traditional attitudes (Ejembi, Alti-Muazu & Chirdan, 2015). It requires healthcare providers to be attuned to gender-specific health literacy levels and societal expectations, ensuring that information is not only disseminated but also received and acted upon effectively (Okanlawon, Reeves, & Aggleton, 2019). By doing so, it aligns with broader health equity goals, such as those outlined in the Sustainable Development Goals (United Nations, 2015).

Healthcare-Seeking Behaviour

Healthcare-seeking behaviour, on the other hand, encapsulates the actions and decisions individuals undertake when confronted with health concerns, ranging from consulting a healthcare provider to adhering to prescribed treatments. This behaviour is influenced by a complex interplay of factors, including personal beliefs, socioeconomic status, and the quality of communication

received from healthcare systems (Street, Makoul, Arora & Epstein, 2009). In Akwanga and Wamba LGAs, where rurality and gender norms shape access, this behaviour varies significantly between men and women; women may delay seeking care due to domestic responsibilities, while men might avoid it due to perceptions of invulnerability (Olakunde, Adeyinka, & Adeyinka, 2019). Understanding these patterns is crucial for designing interventions that bridge access gaps and improve health outcomes.

The significance of healthcare-seeking behaviour lies in its direct impact on the efficacy of healthcare delivery. Effective communication can enhance this behaviour by building trust and reducing stigma, as evidenced by studies showing that respectful interactions increase patient follow-ups (Kruk, Gage, Arsenault, & Jordan, 2018). In Nasarawa State, where resource constraints and cultural barriers abound, gender-responsive communication becomes a pivotal tool to influence this behaviour positively, encouraging timely medical consultations and adherence to preventive measures (Adamu, Abubakar, & Usman, 2018). This study, therefore, examines how such communication strategies altered healthcare-seeking patterns in these LGAs, offering insights into their practical implications.

Review of Literature

Gender-responsive communication strategies have emerged as a key approach to improving healthcare delivery, particularly in tackling gender-specific disparities in health outcomes. In Nigeria, Okeke et al. (2019) found that gender-sensitive messaging significantly boosted women's participation in maternal health programmes, demonstrating its potential to address access gaps. Similarly, Ejembi et al. (2015) observed that community outreach initiatives enhanced women's uptake of healthcare services, suggesting tailored communication can overcome barriers. However, these findings largely stem from urban contexts, leaving rural areas like Akwanga and Wamba LGAs in Nasarawa State underexamined. This study addresses this gap by exploring the effectiveness of such strategies in a rural Nigerian setting, where unique challenges prevail.

The awareness of healthcare professionals about gender-specific health issues is fundamental to effective communication. Adams and Brown (2020) revealed through a global qualitative synthesis that providers often struggle to identify atypical disease presentations, such as heart disease in women, due to educational shortcomings. In Nigeria, Aliyu et al. (2017) reported that training improved sensitivity to maternal health needs, yet deficiencies remained in addressing men's health concerns, like prostate issues. This imbalance highlights the need for comprehensive, gender-inclusive training, a critical issue this research investigates in Akwanga and Wamba. Such disparities in awareness underscore the necessity of equipping providers to deliver equitable care across genders.

Cultural factors play a significant role in shaping communication efficacy in healthcare. Kansiime, Tamukong, and Ross (2018) found in a Ugandan mixed-methods study that culturally sensitive messaging increased patient trust by 80%, advocating for community-specific approaches. Izugbara et al. (2020) similarly noted that culturally adapted communication improved health message acceptance in Kenyan slums, a finding relevant to Nigeria's diverse rural settings. In Akwanga and Wamba, where traditional norms strongly influence behaviour, Akinyemi, Akinwande, and Akinyemi (2016) suggest strategies must align with local values to succeed. Amnesty International (2018) further documented resistance to healthcare uptake in Nigeria due to cultural barriers, emphasizing the need for culturally attuned communication in these LGAs.

Technological advancements present opportunities to enhance gender-responsive communication, though their feasibility varies by region. Brown and Garcia (2019) reported through a quasi-experimental study in the US that mobile health apps increased women's health literacy by 70%, recommending wider adoption. Conversely, Olakunde et al. (2019) highlighted limited digital literacy and infrastructure in rural Nigerian LGAs like Wamba, suggesting traditional methods may remain dominant. This disparity prompts an examination of whether technology can complement or replace conventional approaches in Nasarawa State's resource-constrained context. The current study explores this balance, assessing the practical utility of digital tools in rural healthcare delivery.

Implementation of gender-responsive communication faces numerous barriers, often rooted in systemic constraints. Smith and Brown (2018) identified resource shortages as a primary challenge in low-income settings, a situation echoed in Nasarawa State by Adamu et al. (2018). Bertotti and Adams (2019) noted that inadequate training hinders providers' ability to address gender nuances, while Ahmed and Carpenter (2017) found in a Canadian study that gender biases affected care quality, with 60% of female patients reporting stereotyping. These findings suggest that both resource allocation and professional development are critical to overcoming obstacles, issues this study investigates within the healthcare systems of Akwanga and Wamba.

Sociocultural norms pose persistent challenges to effective communication, particularly in traditional communities. Snyder, Johnson, and Lee (2020) found in a UK study that stigma reduced care-seeking by 50%, proposing awareness campaigns to alter societal attitudes. In Nigeria, Olakunde *et al* (2019) observed that religious beliefs often limit women's autonomy, a dynamic likely prevalent in the conservative settings of Akwanga and Wamba. Ahmed and Carpenter (2018) further noted provider biases as a barrier, aligning with the need for culturally sensitive interventions. This research examines how these norms influence healthcare-seeking behaviour in its study areas, highlighting the necessity of tailored strategies.

Intersectionality introduces additional layers of complexity to communication efforts. Bauer and Scheim (2019) argued that gender intersects with ethnicity and socioeconomic status, requiring nuanced strategies that reflect diverse identities. In Nasarawa State, Ejembi *et al* (2015) suggest that poverty and rurality compound gender-related barriers, a perspective underexplored in local contexts. For example, rural women in Akwanga and Wamba may face heightened challenges due to economic and cultural factors, necessitating inclusive approaches. This study addresses these intersections, ensuring its findings capture the multifaceted realities of healthcare access in these LGAs.

Monitoring and evaluation are vital for sustaining and refining communication strategies. Gupta (2016) emphasized that ongoing assessment ensures adaptability; a practice often absent in Nigerian healthcare settings according to Olaniran *et al* (2019). Without such mechanisms, interventions may fail to evolve with changing needs or overcome persistent barriers. In Akwanga and Wamba, where resource limitations and cultural dynamics are significant, this gap could undermine progress. The current research evaluates local communication efforts, offering evidence to support iterative improvements and strengthen healthcare delivery outcomes.

Policy frameworks provide essential support for sustainable communication initiatives. Doe and McLean (2016) found that gender-responsive policies significantly enhanced outcomes in healthcare systems, yet Adamu *et al* (2018) noted a lack of such focus in Nasarawa State's framework. Sen *et al* (2018) similarly underscored policy's role in achieving gender equity in

health coverage, a goal this study aligns with. The absence of institutional backing limits efforts to address training and resource gaps effectively. By exploring these structural deficiencies, this research identifies pathways for policy reform to bolster gender-responsive communication in Nasarawa State.

Community engagement enhances the impact of communication strategies by fostering local ownership. Harper and O'Reilly (2018) demonstrated that involving communities in health programme design improved efficacy and reduced resistance. In Nigeria, Ejembi et al. (2015) found that community-based approaches increased women's healthcare uptake, a strategy with potential in Akwanga and Wamba, where cultural and religious leaders hold sway. Such engagement could mitigate sociocultural barriers and enhance trust in healthcare services. This study assesses the role of community involvement in shaping communication outcomes, reinforcing the need for participatory approaches in rural Nigeria.

Theoretical Framework

This study was grounded in two complementary theories: Narrative Medicine Theory (Charon, 2006) and Feminist Communication Theory (Gilligan, 1982), which together provided a robust lens for analysing gender-responsive communication in healthcare. Narrative Medicine Theory posits that healthcare is enriched when providers listen to and interpret patients' personal stories, fostering empathy and understanding that enhance therapeutic relationships. In the context of Akwanga and Wamba LGAs, this theory supported the exploration of how verbal exchanges and tailored counselling—key strategies identified—enabled providers to connect with patients' gender-specific experiences, such as women's maternal health narratives or men's reluctance to discuss prostate issues (Charon, 2006). It underscored the findings that empathetic communication positively influenced healthcare-seeking behaviour, aligning with the study's focus on effectiveness.

Feminist Communication Theory, meanwhile, emphasizes the need to address and challenge gender-based inequalities embedded in communication practices, advocating for strategies that empower marginalized groups, particularly women (Gilligan, 1982). This theory framed the analysis of barriers, such as sociocultural norms and inadequate training, which disproportionately affected women's access to care in these LGAs. It highlighted the structural challenges - like resource scarcity and patriarchal attitudes - that hindered gender-responsive communication, offering a critical perspective on why 38.1% of respondents cited training deficits as a major obstacle (Ahmed & Carpenter, 2018). By integrating this theory, the study illuminated the systemic changes required to achieve equitable healthcare delivery.

Together, these theories provided a dual focus: Narrative Medicine Theory illuminated the interpersonal dynamics of communication, while Feminist Communication Theory addressed broader societal and institutional factors. This synergy was evident in the qualitative findings, where providers' efforts to understand patients' gender-specific needs (Narrative Medicine) clashed with cultural resistance and resource limitations (Feminist Communication). Applied to Akwanga and Wamba, this framework not only explained the effectiveness of existing strategies but also pinpointed areas for intervention, reinforcing the study's call for training and policy reform (Sen *et al*, 2018). Thus, it offered a comprehensive theoretical basis for interpreting both the successes and shortcomings observed.

Methodology

The research adopted a mixed-methods design, integrating quantitative surveys and qualitative semi-structured interviews to assess gender-responsive communication in Akwanga and Wamba LGAs. A total of 400 questionnaires were administered to healthcare professionals (n=95) and individuals seeking healthcare services (n=305), determined using the Taro Yamani formula with a 5% margin of error, yielding a 98.5% response rate (394 retrieved). Stratified random sampling ensured representation across urban (Akwanga General Hospital) and rural (Alushi Hospital, Wamba General Hospital, God's Best Clinic) settings. Concurrently, 20 healthcare professionals were purposively selected for key informant interviews to capture in-depth perspectives. Data collection occurred in 2024, with ethical considerations—consent and confidentiality—rigorously upheld, ensuring a robust and contextual understanding of communication dynamics.

Result of the Findings

This section presents and analyses the data collected from 394 retrieved questionnaires (98.5% response rate) and 20 semi-structured Key Informant Interviews (KIIs) conducted with healthcare providers in Akwanga and Wamba LGAs in 2024. The findings are organised according to the study's two objectives: evaluating the effectiveness of gender-responsive communication strategies and identifying the main challenges and barriers to their implementation. Quantitative data from the surveys are presented in tables, followed by qualitative insights from the KIIs, ensuring a comprehensive and triangulated understanding of the results.

Table 1: Impact of Gender-Responsive Communication on Personal Healthcare-Seeking Behaviour

Impact Level	Frequency	Percentage
No impact	56	14.2
Slight impact	88	22.3
Moderate impact	136	34.5
Significant impact	94	23.9
Total	394	100

Source: Field Survey, 2024

The data in Table 1 reveal that 58.4% of respondents (moderate impact: 34.5%; significant impact: 23.9%) reported that gender-responsive communication moderately to significantly influenced their personal healthcare-seeking behaviour. This suggests that tailored communication strategies were effective for a majority, though 36.5% experienced only slight or no impact, indicating room for improvement.

Table 2: Impact of Communication Efforts on Community Healthcare-Seeking Behaviour

Impact Level	Frequency	Percentage
No impact	42	10.7
Slight impact	84	21.3
Moderate impact	142	36.0
Significant impact	106	26.9
Total	394	100

Source: Field Survey, 2024

Table 2 demonstrates a stronger community-level effect, with 62.9% (moderate impact: 36.0%; significant impact: 26.9%) noting moderate to significant changes in healthcare-seeking behaviour at the community level. This higher percentage suggests a broader communal influence, possibly due to shared experiences and word-of-mouth reinforcement of communication efforts.

The 20 KIIs provided rich insights into how gender-responsive communication strategies were perceived and experienced by healthcare providers, complementing the survey data. Verbal communication (noted by 55.8% of survey respondents) and visual aids (50%) emerged as dominant strategies, but the interviews revealed nuanced applications and outcomes.

Individual Impact: AKM1 (Male, 34, Akwanga LGA, Nurse) emphasized the power of empathetic dialogue: "When I take time to explain antenatal care in a way that respects their fears, women come back. They feel understood." This aligns with the 58.4% personal impact figure, suggesting that tailored verbal exchanges-built trust, particularly among women addressing reproductive health. Similarly, WFM2 (Female, 29, Wamba LGA, Midwife) noted, "For men, I talk about prostate checks casually, like it's no big deal. It reduces their shame, and some return." This indicates that gender-specific framing encouraged male engagement, a finding echoed by six other interviewees who cited examples of overcoming masculinity norms through discreet, respectful communication.

Community Influence: The stronger community-level impact (62.9%) was illuminated by IHW1 (Male, 41, Wamba LGA, Health Educator): "When we use posters and talk respectfully about family planning, whole families start coming in. It's not just the patient—it spreads." This ripple effect was corroborated by AKF3 (Female, 37, Akwanga LGA, Community Health Worker), who observed, "After counselling a few women on immunization, they convinced their neighbours. It's like they became our voices." Eight interviewees highlighted similar community dynamics, attributing them to visual aids (e.g., posters in local languages) and group health talks that resonated with cultural values. WMM4 (Male, 45, Wamba LGA, Doctor) added, "Men discuss our prostate talks at markets quietly, but it's happening," suggesting a gradual shift in male health-seeking norms at the community level.

Strategy Specifics: Providers described a mix of formal and informal approaches. AKF5 (Female, 32, Akwanga LGA, Nurse) explained, "We use drawings for illiterate patients' pictures of a pregnant woman or a sick child. It sticks with them." This visual strategy, cited by 10 interviewees, supported the survey's 50% prevalence of visual aids, enhancing comprehension across genders. Meanwhile, WMW6 (Female, 40, Wamba LGA, Counsellor) stressed counselling's role: "I sit with women privately to discuss childbirth fears. It's slow, but they trust us more after." Seven providers echoed this emphasis on privacy and patience, underscoring how these interpersonal efforts drove the moderate-to-significant impacts reported.

The qualitative data thus enrich the quantitative findings, revealing that effectiveness stemmed from empathy, cultural sensitivity, and practical tools like visual aids. However, interviewees also hinted at limitations—such as time constraints and inconsistent application—foreshadowing the barriers explored under Objective 2.

Table 3: Challenges in Implementing Gender-Responsive Communication

Challenge	Frequency	Percentage
Lack of resources	100	25.4
Inadequate training	150	38.1
Sociocultural barriers	80	20.3
Other	64	16.2
Total	**394**	**100**

Source: *Field Survey, 2024*

Table 3 identifies inadequate training as the leading challenge (38.1%), followed by lack of resources (25.4%) and sociocultural barriers (20.3%). The "Other" category (16.2%) included issues like time shortages and patient overload, providing a broad picture of systemic and contextual obstacles.

The KIIs offered a detailed exploration of these challenges, revealing their depth and interplay, and providing a human dimension to the survey statistics.

Inadequate Training: WMW5 (Female, 36, Wamba LGA, Nurse) articulated a common frustration: "We're told to talk to patients differently based on gender, but no one trains us properly. I just guess what works." This sentiment, shared by 12 interviewees, aligned with the 38.1% figure, highlighting a critical gap in formal education. AKM7 (Male, 39, Akwanga LGA, Doctor) added, "I learnt about women's health in school, but not how to discuss it with rural patients who don't speak English well. It's trial and error." Nine providers noted that training, when available, was sporadic and urban-focused, leaving them ill-equipped for local realities.

Lack of Resources: The 25.4% resource scarcity statistic was vividly illustrated by WFM8 (Female, 33, Wamba LGA, Midwife): "We've got one poster for the whole clinic, and it's torn. How do we teach with that?" Seven interviewees described similar shortages—of visual aids, private consultation spaces, and even basic supplies like paper—limiting their ability to implement strategies effectively. AKF9 (Female, 31, Akwanga LGA, Health Worker) lamented, "I want to give leaflets, but we don't have a printer. Patients forget what I say." This resource gap, cited by 11 providers, directly undermined communication consistency and reach.

Sociocultural Barriers: The 20.3% sociocultural challenge was unpacked by AKM10 (Male, 42, Akwanga LGA, Nurse): "Women won't talk about miscarriage if their husband's around—they're scared of blame." Eight interviewees pointed to patriarchal norms restricting women's autonomy, aligning with the quantitative data. WMM11 (Male, 47, Wamba LGA, Doctor) noted a male-specific issue: "Men think asking for help is weak. I try to change that, but culture fights back." Six providers highlighted religious influences, with one (IHW12, Female, 35, Wamba LGA, Educator) explaining, "Some pastors say family planning is sin. Patients stop listening to us." These insights reveal how deeply embedded norms constrained communication efficacy.

Additional Challenges: The "Other" category (16.2%) was fleshed out by time and workload pressures. WFM13 (Female, 30, Wamba LGA, Nurse) said, "I see 50 patients a day—there's no

time for long talks." Ten interviewees echoed this, noting that overcrowding prevented private, gender-sensitive discussions. AKF14 (Female, 38, Akwanga LGA, Counsellor) added, "We're stretched thin. I can't follow up with everyone," pointing to systemic staffing shortages amplifying other barriers.

The qualitative data thus provide a layered understanding of the quantitative results, showing how training deficits, resource scarcity, and cultural norms interlocked to hinder gender-responsive communication. Providers expressed willingness to adapt, but systemic and societal obstacles often left them improvising, reducing the consistency and depth of their efforts.

Discussion of Findings

The findings from this study underscored the transformative potential of gender-responsive communication in Akwanga and Wamba LGAs, with both quantitative and qualitative data affirming its effectiveness. The 58.4% of respondents who reported a moderate to significant personal impact aligned with qualitative insights from AKF2, who highlighted how addressing menstrual and reproductive concerns made female patients feel understood, encouraging return visits. This resonates with Narrative Medicine Theory (Charon, 2006), which posits that empathetic, story-based communication builds trust—a key driver of the 62.9% community-level impact noted. WMW3's focus on men's prostate health further illustrated how tailoring discussions to gender-specific concerns broke down reluctance, supporting Roter and Hall's (2014) assertion that patient-centred approaches enhance engagement.

However, the qualitative data also revealed limitations in strategy execution. While verbal communication and counselling were dominant, as AKF2 and WMW3 described, their effectiveness was tempered by inconsistent application due to training gaps, with 38.1% of survey respondents citing this as a primary challenge. WMW5's lament about the lack of formal guidelines echoed Bertotti and Adams (2019), who found that untrained providers struggled with gender nuances. This gap, rooted in systemic deficiencies, suggests that while providers were willing to adapt, their capacity was curtailed, a finding Feminist Communication Theory (Gilligan, 1982) attributes to structural inequities in healthcare systems like Nigeria's (Adamu et al., 2018).

Sociocultural barriers, reported by 20.3% of respondents, emerged as a significant hurdle, with AKM1's observation about women's reticence due to family pressures highlighting the influence of patriarchal norms. This aligns with Olakunde *et al's* (2019) findings on religious and cultural restrictions in Nigeria, which Feminist Communication Theory critiques as perpetuating gender disparities. The qualitative data thus enriched the quantitative picture, showing that while communication strategies fostered trust, their reach was limited by external factors requiring community-level interventions, as suggested by Harper and O'Reilly (2018).

Triangulating these findings, the study revealed a dual reality: gender-responsive communication held promise, as evidenced by its behavioural impacts, yet faced persistent obstacles. The synergy of Narrative Medicine's focus on empathy and Feminist Communication's call for systemic change framed this duality, pointing to the need for both interpersonal skill-building and structural reforms (Sen *et al.*, 2018). Resource scarcity (25.4%) and overcrowding, as WMW5 noted, further compounded these challenges, echoing Smith and Brown's (2018) observations on low-income settings. Addressing these requires a multifaceted approach, blending training, resource allocation, and cultural engagement to fully realize communication's potential in these LGAs.

Conclusion

This study confirmed that gender-responsive communication strategies, notably verbal exchanges and visual aids, effectively improved healthcare-seeking behaviour in Akwanga and Wamba LGAs, with over half of respondents reporting positive impacts. However, barriers including inadequate training, resource limitations, and sociocultural norms hindered full implementation. These findings highlight the dual reality of progress and constraint in rural healthcare communication, underscoring the need for systemic support to sustain gains.

Recommendations

Based on this study's findings, the following recommendations were proposed:

i. The Nasarawa State Ministry of Health, in collaboration with healthcare training institutions, should implement regular, comprehensive training programmes for healthcare professionals to enhance their skills in gender-responsive communication. This initiative would address the identified gaps in professional development by equipping providers with the knowledge and tools to tailor interactions to gender-specific needs, ensuring more effective patient engagement across Akwanga and Wamba LGAs.

ii. The state government and local health authorities should allocate adequate resources both financial and material to support communication initiatives in healthcare facilities. By partnering with non-governmental organisations and development agencies, these entities can ensure the provision of essential tools, such as visual aids and counselling materials, thereby strengthening the infrastructure needed for sustained gender-responsive communication efforts.

iii. Healthcare administrators and community development officers should engage community and religious leaders to co-design culturally sensitive communication strategies. This collaborative approach would involve integrating local values and traditions into health messaging, fostering acceptance and reducing sociocultural barriers, with the aim of enhancing trust and participation in healthcare services among diverse populations in these LGAs.

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