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# Gender Norms and Modern Healthcare Utilization Among Rural Women in Gombe State

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## Abstract

Gender norms play a crucial role in shaping women's health-seeking behavior, especially in rural areas where sociocultural expectations often dictate access to and usage of healthcare services. This study explores the connection between gender norms and the utilization of modern healthcare among rural women in Gombe State, Nigeria. The objective is to evaluate the effect of religious beliefs about modesty on women's preferences for healthcare providers, influence of religiously-informed gender norms on women's access to maternal healthcare services, and the effects of religious gender norms on the general utilization of maternal health services such as antenatal care, skilled delivery, postnatal care, and primary healthcare facilities. A mixed-methods cross-sectional approach was utilized, incorporating a structured household survey along with focus group discussions. Quantitative data were analyzed using descriptive statistics, and qualitative data were used to support the quantitative data in the analysis to offer contextual insights into the experiences of women. The study revealed that restrictive gender norms particularly limited autonomy in household decision-making, and reliance on male approval posed significant obstacles to timely and adequate access to modern healthcare services. The findings aim to enhance understanding of the sociocultural factors affecting women's health in rural northern Nigeria and provide evidence that can inform gender-sensitive health policies and community-based interventions. By emphasizing the impact of gender norms, the study aims to promote strategies that enhance women's autonomy and improve equitable access to modern healthcare services in Gombe State.

**Keywords:** *Gender Norms, Female Seclusion, Health-seeking Behavior*

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**Background to the Study**

Gender norms are widely recognized as a critical social determinant of health, shaping patterns of healthcare access and utilization, particularly in low-resource rural settings. In northern Nigeria, including Gombe State, these norms are deeply embedded within religious and socio-cultural systems that define women's roles, mobility, and decision-making authority. Consequently, women's engagement with modern healthcare services is not determined solely by structural factors such as availability or cost, but is profoundly mediated by culturally prescribed expectations surrounding gender, modesty, and family hierarchy.

In many rural communities in Gombe, religiously-informed gender norms emphasize female modesty (purdah), restricted mobility, and male guardianship, thereby constraining women's autonomy in health-seeking decisions. Empirical studies across northern Nigeria show that women often require spousal or familial consent before accessing healthcare, a dynamic that contributes to delays in seeking care and reduced utilization of formal health services (Doctor et al., 2018; Okedo-Alex et al., 2019). Furthermore, norms surrounding modesty frequently limit women's willingness to interact with male healthcare providers, particularly in maternal and reproductive health contexts, where privacy concerns are heightened (Wall et al., 2020). These constraints are exacerbated in rural areas where shortages of female health personnel remain a persistent challenge. The implications of these gendered constraints are particularly evident in maternal healthcare utilization. Despite ongoing public health interventions, rates of antenatal care attendance and skilled birth delivery remain suboptimal in northern Nigeria, with gender norms identified as a significant barrier (National Population Commission [Nigeria] & ICF, 2019; Adedini et al., 2020). Women's reliance on home-based care, traditional birth attendants, or faith-based healing is often not merely a matter of preference but reflects negotiated responses to restrictive socio-religious environments. Such patterns contribute to persistently high maternal morbidity and mortality rates in the region.

Consequently, gender norms intersect with broader structural determinants, including poverty, limited education, and weak health infrastructure, to produce compounded barriers to healthcare utilization. However, their influence is particularly pervasive because they shape not only physical access to services but also perceptions of illness, acceptable treatment pathways, and trust in biomedical systems (Mberu et al., 2022). This underscores the need for analytically isolating gender norms as a distinct but interacting determinant within the healthcare utilization framework. This study situates gender norms at the center of the analysis of modern healthcare utilization among rural women in Gombe State. By looking at how religious interpretations of gender roles and modesty influence access, provider preference, and service uptake, the research contributes to a clear understanding of the socio-cultural mechanisms underpinning health behavior. Such insights are essential for designing culturally responsive interventions that move beyond infrastructural provision to address the normative constraints shaping women's healthcare decisions in rural northern Nigeria.

**Statement of the Problem**

Access and utilization of modern medical services are expected to be determined primarily by need, availability, affordability, and quality of care. Within such a system, all individuals

regardless of gender, cultural background, or religious affiliation should be able to seek timely and appropriate healthcare without social or normative constraints. For women in particular, global health frameworks emphasize equitable access to maternal and reproductive health services, including antenatal care, skilled birth attendance, and postnatal services, as essential components of improved health outcomes and reduced maternal mortality. In this ideal situation, healthcare delivery systems are designed to be culturally responsive while ensuring that socio-cultural norms do not impede access to life-saving medical interventions. However, the reality in many rural areas in northern Nigeria, including Gombe State, deviates significantly from this ideal. In these communities, healthcare utilization is embedded within a complex socio-religious environment where gender norms often reinforced by religious interpretations play a decisive role in shaping women's health-seeking behaviors. Evidence from this study indicates that norms surrounding female modesty, seclusion, and male authority constrain women's autonomy, limit their mobility, and influence their interactions with healthcare providers. Women frequently require permission from male household heads before accessing healthcare, and discomfort with male providers further discourages facility-based care. As a result, many women delay or avoid seeking modern medical services, opting instead for home-based care, traditional birth attendants, or faith-based interventions.

These gendered constraints have profound implications for maternal healthcare utilization in rural Gombe. Despite the presence of healthcare facilities, uptake of essential services such as antenatal care and skilled birth attendance remains suboptimal. The persistence of these patterns contributes to poor maternal and child health outcomes, reinforcing existing health inequalities in the region. While structural barriers such as poverty, distance to facilities, and inadequate infrastructure are well documented, this study highlights that socio-cultural and religiously-informed gender norms constitute equally critical, yet often less visible, barriers to healthcare utilization. Notwithstanding growing scholarly attention to the social determinants of health in sub-Saharan Africa, there remains a significant gap in context-specific understanding of how religiously-informed gender norms operate to influence healthcare utilization in rural Gombe. Existing studies often treat religion or culture as broad explanatory variables without unpacking the specific mechanisms through which gender roles, modesty norms, and authority structures shape women's healthcare decisions. Furthermore, limited empirical research has systematically examined how these norms affect different dimensions of healthcare utilization, including access, provider preference, and actual service uptake, within a single analytical framework.

This lack of clear, empirically grounded understanding constitutes a major obstacle to the design of effective, culturally sensitive health interventions. Without clearly identifying how gender norms function within specific religious and community contexts, health policies risk being inadequately targeted or culturally misaligned. Therefore, this study seeks to bridge this gap by providing a detailed analysis of the ways in which religiously-informed gender norms influence modern healthcare utilization among rural women in Gombe State. By doing so, it aims to generate actionable insights for policymakers, healthcare providers, and community stakeholders working to improve maternal health outcomes in the State and Nigeria at large.

**Research Questions**

1. How does religiously-informed gender norms influence women's access to maternal healthcare services in rural Gombe?
2. What is the effect of religious beliefs about modesty on women's preferences for healthcare providers, particularly regarding gender?
3. How does religious gender norms affect utilization of maternal health services such as antenatal care and skilled birth attendance among women in rural Gombe?

**Research Objectives**

1. To examine how religiously-informed gender norms influence women's access to maternal healthcare services in rural Gombe.
2. To assess the effect of religious beliefs about modesty on women's preferences for healthcare providers, particularly regarding gender.
3. To evaluate how religious gender norms, affect utilization of maternal health services such as antenatal care and skilled birth attendance among women in rural Gombe.

**Literature Review: Gendered Religious Norms and Maternal Healthcare**

Religiously-informed gender norms significantly shape the utilization of maternal and child health services in rural Gombe, where patriarchal family structures and religious values often intersect to limit women's autonomy in health decision-making. Islamic teachings on modesty and gender separation, combined with similar conservative Christian values, create specific barriers to care for women, particularly in maternal health contexts where male providers may be involved. Research indicates that "Muslim women prefer to have same gender doctors and nurses in order to follow rules of modesty" (EthnoMed, 2023), a preference that can limit care options in rural areas with limited healthcare personnel.

The concept of privacy in both Islamic and conservative Christian contexts extend beyond physical exposure to include personal information about women's health, which can discourage women from discussing reproductive health issues with providers, particularly males. This religiously-informed modesty can delay care-seeking and reduce compliance with preventive health recommendations. Studies have shown that "religious norms emphasizing female seclusion and male decision-making are significant predictors of lower rates of facility-based deliveries and skilled birth attendance among women in rural households" (Hughes, P., et al. 2021), demonstrating the tangible health impacts of these values. Male decision-making authority in both Muslim and Christian rural households significantly influence maternal healthcare utilization, with women often requiring spousal permission to seek care, obtain finances for treatment, or travel to health facilities. This dynamic can create significant delays in obtaining timely care, particularly for emergency obstetric situations where treatment delays measurably worsen outcomes. Research in northern Nigeria has documented how "religious interpretations of gender roles and modesty affect the accessibility and uptake of maternal health services, including antenatal care and skilled birth attendance" (Hughes, P., et al. 2021), highlighting the need for gender-sensitive approaches to maternal health in these contexts.

Religious values also shape family planning behaviors and reproductive health decisions, with conservative religious teachings often discouraging modern contraceptive methods. This can result in higher fertility rates, shorter birth intervals, and reduced use of prenatal and postnatal care services. Research indicates that "religion influences all sorts of health behaviors besides those related to health care seeking" including "sexual practices" (Koenig, 2003), demonstrating how religious values shape the entire reproductive health continuum. These patterns contribute to Nigeria's persistently high maternal mortality rate, particularly in northern rural regions. Despite these challenges, religious institutions also serve as potential allies in improving maternal health outcomes. Mosques and churches can function as venues for health education, distribution points for health commodities, and sources of social support for pregnant women. Research has shown that "faith communities and programs within faith communities can influence health care practices and health care planning, especially in high-risk populations" (Koenig, 2003). Programs that engage religious leaders as advocates for maternal health have shown promise in increasing facility-based deliveries and skilled birth attendance in religious rural communities.

**Religious Beliefs and Gender nexus on Maternal Healthcare Utilization**

Maternal healthcare utilization represents a particularly important domain where religious beliefs significantly influence health-seeking behaviors in rural areas. Research across Sub-Saharan Africa demonstrates that religious affiliation and religiosity significantly affect decisions about antenatal care, facility delivery, and postnatal care. In Nigeria, studies show significant disparities in maternal healthcare utilization based on religious affiliation, with Christian women generally utilizing maternal health services more than Muslim women (Umar, 2017). A focused ethnographic study in Kogi State, Nigeria, examined how cultural and religious structures influence women's use of maternal health services (Pew Research Center, 2022). The research identified several religious factors affecting maternal healthcare utilization, including the use of prayer houses instead of health facilities, dependency on God for safe delivery, and religious interpretations that limit women's autonomy in health decisions. These factors operated alongside cultural practices such as the use of herbal medicine and the influence of family elders on health-seeking behaviors.

Research in north-central Nigeria found that both Muslim and Christian women expressed preference for facility-based services, with uptake limitations relating mainly to distance from clinic and socioeconomic dependence on male partners rather than direct religious restrictions (Adefolaju, 2011). However, religious influences operated indirectly through gender norms, economic factors, and community health beliefs. Neither Muslim nor Christian women expressed provider gender preferences, emphasizing instead provider competence and positive attitude. These findings suggest that religious influences on maternal healthcare utilization may be more nuanced than often assumed, operating through complex pathways that interact with other social determinants. The fourth research hypothesis addresses how religiously-informed gender norms shape maternal healthcare utilization, proposing that norms emphasizing female seclusion and male decision-making predict lower rates of facility-based deliveries and skilled birth attendance. This hypothesis is supported by research across northern Nigerian contexts, where patriarchal interpretations of religious

teachings often limit women's mobility and decision-making power regarding healthcare. In rural Gombe, where traditional gender norms are strongly influenced by religious teachings, these factors likely create significant barriers to maternal healthcare utilization, particularly for services requiring travel to health facilities or interaction with male providers.

Conceptually, religious influences on maternal healthcare utilization can be understood through the PEN-3 cultural model, which identifies how religious factors operate within cultural domains of relationships, expectations, and empowerment (Pew Research Center, 2022). This model helps explain why similar religious teachings may produce different health behaviors depending on how they are interpreted and implemented within specific cultural contexts. For instance, Islamic teachings about modesty may lead some women to prefer female healthcare providers while leading others to avoid facility-based care altogether. Understanding these nuanced influences is essential for developing effective interventions to improve maternal healthcare utilization in religiously conservative rural areas.

**Theoretical Framework**

This study adopted Health belief model as its theoretical framework. The Health Belief Model (HBM) is a widely used theoretical framework that explains health-seeking behavior based on individuals' perceptions and beliefs about illness and healthcare. The model assumes that people are more likely to take health-related action when they perceive themselves to be susceptible to a health condition and believe that the condition has serious consequences. It further posits that individuals will engage in health behavior, such as utilizing modern healthcare services, if they perceive clear benefits in doing so and believe that these benefits outweigh any perceived barriers. Additional components of the model include cues to action such as advice from significant others or community influencers and self-efficacy, which refers to an individual's confidence in their ability to take the required action.

In the context of gender norms and modern healthcare utilization among rural women in Gombe State, the Health Belief Model provides a useful lens for understanding how socio-cultural and religious factors shape health decisions. While women may recognize their susceptibility to maternal health risks and the severity of complications during pregnancy, their ability to act on this awareness is often constrained by perceived barriers rooted in gender norms, such as the need for male permission, restrictions on mobility, and concerns about modesty when interacting with male healthcare providers. At the same time, religious leaders and family members may serve as important cues to action, either encouraging or discouraging the use of modern healthcare services. Thus, healthcare utilization among rural women in Gombe is not determined solely by medical need but by a complex interplay of perceived risks, benefits, and culturally embedded constraints that align closely with the assumptions of the Health Belief Model.

**Methodology**

The research targeted married couples between the age of 18 and above living in rural areas of Gombe State, it comprised both male and female from all religious and ethnic background. The study used 424 sample size which was drawn from the general population using a multi-

stage sampling method. At the first stage, Gombe was clustered into Gombe South, Gombe North and Gombe Central, thus, a simple random sampling was used to select one local Gombe from each cluster giving the total of three LGAs. Again, simple random sampling was used to select two wards from each of the selected LGA making 6 wards in all. Finally, a systematic sampling technique was used to select the households at certain interval while accidental sampling technique was adopted to select the respondents that meet the criteria, who is available and willing to participate in the research. The data obtained was both quantitatively and qualitatively analyzed. For the quantitative, a simple percentage, crosstabulation and chi square were used for the analysis while qualitative data were analyzed to complement the relevant data in quantitative analysis. The data were collected using questionnaire and focus group discussions.

## Analysis and Presentation of Data

**Table 1**: Gender Norms and Healthcare Utilization among Women in Rural Areas of Gombe State.

| Items | Responses | Frequency | Percent |
|---|---|---|---|
| Preference for Male or Female Healthcare Providers Due to gender norms | Male | 163 | 38.4 |
| | Female | 170 | 40.0 |
| | No preference | 91 | 21.4 |
| | Total | 424 | 100 |
| Refusal to Receive Maternal Healthcare Services due to female seclusion | Yes | 168 | 39.6 |
| | No | 144 | 34.0 |
| | Sometimes | 73 | 17.2 |
| | Unsure | 39 | 9.2 |
| | Total | 424 | 100 |
| Discomfort in Discussing maternal Health Concerns with Male healthcare Providers | Male | 177 | 41.6 |
| | Female | 166 | 39.1 |
| | No preference | 81 | 19.1 |
| | Total | 424 | 100 |
| Low Maternal Healthcare utilization due to gender norms | Yes | 183 | 43.1 |
| | No | 102 | 24.0 |
| | Sometimes | 101 | 23.8 |
| | Unsure | 38 | 8.9 |
| | Total | 424 | 100 |
| Changing Maternal Healthcare Providers Due to Discomfort with Provider's Gender | Yes | 189 | 44.6 |
| | No | 117 | 27.5 |
| | Sometimes | 70 | 16.5 |
| | Unsure | 48 | 11.3 |
| | Total | 424 | 100 |
| Preference of home delivery and reliance on traditional birth attendants due to gender norms | Yes | 163 | 52.5 |
| | No | 177 | 27.5 |
| | Sometimes | 50 | 11.8 |
| | Unsure | 34 | 8.0 |
| | Total | 424 | 100 |
| Existence of the Expected Benefits of Increasing Female Healthcare Providers in Rural Areas | Yes | 205 | 48.2 |
| | No | 142 | 33.4 |
| | Unsure | 77 | 18.1 |
| | Total | 424 | 100 |
| Need for permission to attend antenatal and maternal healthcare services | Yes | 210 | 49.4 |
| | No | 116 | 27.3 |
| | Unsure | 98 | 23.1 |
| | Total | 424 | 100 |

**Source:** Field Survey, 2024.

The data in table 1 above indicate that a substantial proportion of respondents reported that religiously-informed gender norms significantly restrict women's access to maternal healthcare services. Specifically, 49.4% of respondents agreed that women require permission from husbands or male guardians before seeking healthcare, while about 39.6% indicated that norms of female seclusion limit women's mobility outside the household. These figures demonstrate that restricted autonomy is a widespread phenomenon within the study population. The inferential analysis further confirms this relationship. The Chi-square test examining the association between gender norms (female seclusion and male authority) and access to healthcare services yielded a $\chi^2 = 6.054$, $p = 0.0417$, indicating a statistically significant association. This implies that women operating under stricter gender norms are significantly less likely to access healthcare services independently. Qualitative findings reinforce these statistical results. Participants in focus group discussions emphasized that;

"*A woman cannot go to the hospital without her husband's consent*"

They clearly noted that seeking care independently may be perceived as disrespectful or culturally inappropriate. Others noted that even in emergency situations, delays occur due to the need to obtain male approval. These narratives highlight how gender norms operate as social control mechanisms, constraining access beyond physical or economic barriers. The data further revealed that a clear majority of respondents prefer female healthcare providers due to religious expectations of modesty. 40.0% of respondents indicated a preference for female providers, while about 41.6% reported discomfort receiving maternal care from male providers. Additionally, 44.6% of respondents stated that they had changed healthcare providers due to provider gender, demonstrating the practical implications of these preferences. Inferential statistics confirm the strength of this relationship. The Chi-square test assessing the association between modesty norms and provider gender preference yielded $\chi^2 = 5.494$, $p = 0.0482$, indicating a statistically significant relationship. Similarly, the association between gender norms and changing providers due to discomfort with provider gender was also statistically significant. Qualitative evidence provides deeper insight into these patterns. Respondents explained that exposure to male healthcare providers violates norms of modesty, with statements such as

*"It is not acceptable for a man to attend to woman's private health issues".*

Thus, some participants reported avoiding healthcare facilities entirely when only male providers were available. These findings suggest that provider gender is not merely a preference but a culturally enforced condition for healthcare utilization. The data also revealed that gender norms significantly influence the utilization of maternal healthcare services. 43.1% of respondents reported low utilization of antenatal care among women adhering to strict gender norms, while about 52.5% indicated a preference for home delivery or reliance on traditional birth attendants. These figures suggest that utilization patterns are closely tied to socio-religious expectations. The inferential analysis supports this observation. The Chi-square test examining the relationship between gender norms and maternal healthcare utilization produced $\chi^2 = 6.757$, $p = 0.0344$, indicating a statistically significant association. This confirms that adherence to restrictive gender norms significantly reduces the likelihood of utilizing modern healthcare services. Qualitative findings further illuminate this

relationship. Many respondents described maternal healthcare decisions as being shaped by family authority and religious expectations. Statements such as;

*"Women deliver at home because it is more comfortable and acceptable" and*
*"God will protect the woman during childbirth"*

This insight from qualitative reflect how spiritual beliefs and gender norms interact to influence behavior. These narratives reveal that non-utilization of healthcare is often a socially negotiated outcome, rather than a simple lack of awareness or access.

**Discussion of Findings**

The findings of this study demonstrate that religiously-informed gender norms significantly constrain women's access to maternal healthcare services in rural Gombe. The statistical evidence confirms that norms such as female seclusion and male decision-making authority are strongly associated with limited healthcare access. This aligns with existing studies in northern Nigeria, which show that women's autonomy is often restricted by patriarchal household structures, thereby delaying or preventing timely healthcare utilization (Doctor et al., 2018; Okedo-Alex et al., 2019). From a theoretical standpoint, this finding supports the Health Belief Model, which posits that perceived barriers significantly influence health-seeking behavior. In this context, gender norms act as social barriers, reducing women's perceived ability to access care even when services are available. Similarly, the findings resonate with the Social Ecological Model, where interpersonal and community-level factors such as family authority and cultural expectations shape individual health decisions. The qualitative evidence further deepens this interpretation by illustrating how these norms are internalized and reproduced within households. Women's dependence on male approval reflects not only structural inequality but also a culturally legitimized system of control. This suggests that improving healthcare access in rural Gombe requires interventions that address household power dynamics, not just physical availability of services.

The study also finds that religious norms of modesty significantly influence women's preferences for healthcare providers, with a strong preference for female practitioners. The statistically significant association between modesty norms and provider gender preference confirms that cultural expectations directly shape healthcare interactions. This finding is consistent with prior research indicating that Muslim and conservative Christian women often prefer same-gender providers to maintain modesty and privacy (Wall et al., 2020). This result can be interpreted through the lens of Healthcare Acceptability, a key dimension of access. While healthcare services may be physically available, they are not fully utilized if they do not align with patients' cultural and religious expectations. The findings therefore highlight a critical gap between health system design and patient values, particularly in rural settings where female healthcare providers are scarce. Qualitative insights further reveal that provider gender is not simply a matter of comfort but a moral and religious obligation. Women's reluctance to interact with male providers reflects deeply ingrained beliefs about propriety and dignity. This underscores the importance of culturally sensitive healthcare delivery systems that incorporate gender considerations into workforce planning and service provision.

The findings reveal that gender norms significantly reduce the utilization of maternal healthcare services, including antenatal care and skilled birth attendance. The statistically significant relationship indicates that women adhering to stricter gender norms are less likely to utilize formal healthcare services. This supports existing evidence from the Nigeria Demographic and Health Survey, which shows lower utilization of maternal health services in regions with stronger patriarchal norms (NPC & ICF, 2019). From a sociological perspective, this finding reflects the concept of structural constraint, where individuals' choices are shaped by social norms and expectations rather than purely rational decision-making. Women's reliance on home delivery, traditional birth attendants, or faith-based healing should therefore be understood as adaptive responses to restrictive socio-cultural environments rather than mere lack of awareness. The qualitative data reinforce this interpretation by showing that healthcare decisions are often framed within religious narratives, such as reliance on divine protection during childbirth. This aligns with Healthcare Narrative Theory, which emphasizes that individuals interpret health and illness through culturally embedded belief systems. In this case, religious narratives interact with gender norms to produce healthcare behaviors that diverge from biomedical expectations. Generally, the findings revealed the following; At the access level, they restrict women's mobility and decision-making autonomy, at the interaction level, they shape preferences for provider gender while at the outcome level, they reduce the utilization of maternal healthcare services.

These results confirm that healthcare utilization in rural Gombe is not simply a function of infrastructure or economic resources but is deeply embedded in religiously-informed social structures. This supports broader scholarship in medical sociology, which emphasizes that health behaviors are shaped by the interaction of cultural, social, and institutional factors (Mberu et al., 2022). Importantly, the findings suggest that interventions aimed at improving maternal health must go beyond supply-side solutions. While increasing the number of healthcare facilities is necessary, it is insufficient without addressing the normative environment that governs women's health decisions. Engaging religious leaders, promoting community dialogue on gender norms, and increasing the availability of female healthcare providers are critical strategies for bridging this gap.

**Conclusion**

The findings highlight that gender norms are not peripheral but central determinants of healthcare utilization among rural women in Gombe State. Their influence is statistically significant, socially embedded, and reinforced through both religious teachings and everyday practices. Addressing these norms is therefore essential for improving maternal health outcomes and achieving equitable healthcare access in the region.

**Policy Recommendations**

1. Community-based Gender Norms Transformation: There is a need to promote programs that challenge restrictive gender norms and support women's autonomy in healthcare decisions through community dialogue and education.
2. Engagement of Religious Leaders: involve religious leaders in health promotion to influence positive attitude toward modern healthcare using sermons and religious platforms.

3. Increase Female Healthcare Providers: Expand the number of female health workers in rural areas to address cultural and religious concerns about modesty and provider gender.
4. Culturally Sensitive Healthcare Delivery: Adapt healthcare services to respect local beliefs and practices, ensuring privacy, dignity and trust in service provision.
5. Promote Male Involvement in Maternal Health: Educate and involve men in maternal health decisions to reduce delays and improve support for women seeking care.

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