

GENDER ROLES, MEDIA FRAMING, AND ACCESS TO HEALTHCARE IN NIGERIA: IMPLICATIONS FOR INCLUSIVE SOCIETIES

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Abstract

This study critically examines the influence of gender roles and media framing on access to healthcare in Nigeria, highlighting implications for building inclusive societies. It aims to examine how socially constructed gender roles influence who seeks care and who makes health-related decisions, analyse how media framing affects perceptions of men's and women's roles in healthcare, and identify structural, social, and cultural barriers that limit equitable access to health services. The study adopts the framing theory as a theoretical framework and uses a library research methodology to synthesise relevant scholarly literature, policy reports, and media analyses. The review highlights that women are often expected to manage family health, care for children, and support the elderly, while men are positioned as decision-makers and providers. These roles contribute to inequitable access to healthcare through financial dependence, restricted autonomy, long travel distances, and cultural pressures that discourage men from seeking preventive care. Media and public messaging are found to reinforce these stereotypes by portraying women as primary caregivers and men as strong, self-reliant figures, shaping health behaviours and family wellbeing. The study contributes to knowledge by linking gender norms, media influence, and systemic barriers to health inequities in Nigeria, emphasising the need for gender-sensitive policies, inclusive media campaigns, community education, and improved health service accessibility. Implementing these recommendations can support more equitable healthcare utilisation and better health outcomes for all Nigerians.

Keywords: Gender roles, Media Framing, Healthcare access, Inclusive Societies, Nigeria

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Introduction

The media plays an important role in shaping how people think, feel, and behave. Through repeated messages across television, radio, newspapers, and digital platforms, it reflects and reinforces what society considers normal. Over time, scholars have criticised the media for presenting men and women in fixed and stereotypical roles, most especially in relation to healthcare. Women are usually portrayed as responsible for family health, childcare, and the care of elderly relatives, while men are depicted as strong, independent, and less engaged in health-related matters. These portrayals influence how individuals understand gender responsibilities and can affect access to healthcare services (Agba, 2012). According to UNESCO (n.d), gender equity is the fair distribution of opportunities, resources, and responsibilities between men and women, taking into account their different needs and social conditions. It goes beyond equal treatment to

focus on fairness and the removal of barriers that limit individuals from achieving their full potential. In the context of healthcare, gender equity ensures that both men and women have equal access to medical services, health information, and support systems. When such equity is lacking, individuals may face challenges in accessing care, which can negatively affect their health, as well as the wellbeing of families and communities (WHO, n.d).

Asemah (2019) explains that the media also serves as an important channel for disseminating health information and promoting healthy behaviours. Through public awareness campaigns, news coverage, and social media content, it provides guidance and education that influence how people make decisions about their health. However, media messages often represent and reinforce traditional gender norms by presenting specific expectations for men and women. For instance, women are frequently encouraged to prioritise family health and attend regular medical

check-ups, while men are portrayed as resilient and less likely to seek medical help. Such representations can limit personal choices and discourage both men and women from taking equal responsibility for their own health (Agwu, Mbachu, & Onwujekwe, 2025). Scholars have further argued that media portrayals can shape power relations in healthcare decision-making. Women are often represented in supportive and dependent roles, which may reduce their perceived authority in making health decisions. In contrast, men are commonly portrayed as financial providers and decision-makers, creating pressure to conform to ideals of strength and self-reliance. This can discourage men from seeking medical care and reinforce the expectation that women should prioritise the health of others over their own. As a result, both men and women may experience constraints in accessing healthcare services and making informed health decisions (Goffman, 2009; Oduenyi et al., 2021).

Although some contemporary media campaigns attempt to promote gender equality, many of these efforts remain superficial and fail to challenge deeply rooted stereotypes. In Nigeria, traditional gender norms continue to influence media content, reinforcing unequal expectations about health responsibilities. These representations shape individual behaviour, limit autonomy, and contribute to unequal access to healthcare. This raises an important question: to what extent does the media promote genuine gender equity in healthcare, or does it continue to reproduce existing inequalities?

Against this background, this study examines gender equity and access to healthcare in Nigeria, with a focus on the role of the media and its implications for building inclusive societies.

Statement of the Problem

Gender inequality remains a persistent challenge in access to healthcare in Nigeria, despite increased awareness and policy attention. Empirical studies have shown that traditional gender roles continue to shape health-seeking behaviour, with women often bearing responsibility for family health while men are positioned as decision-makers and providers (Oduenyi, Banerjee, & Adetiloye, 2021). These role expectations influence who seeks care, who controls health decisions, and how healthcare resources are accessed. However, while existing studies have focused on structural, cultural, and economic barriers, limited attention has been given to the role of media representations in reinforcing or challenging these inequalities. In addition, media campaigns and public health programmes that claim to promote gender

equality often fall short of addressing deeply rooted stereotypes. Rather than transforming traditional norms, they frequently portray women as primary caregivers and men as strong and self-reliant, thereby reinforcing existing role expectations (Grau & Zotos, 2016). This creates a disconnect between the intended objectives of gender-sensitive communication and actual improvements in equitable healthcare access.

Although scholars such as like Asemah (2019) have examined gender portrayals in media, there is still insufficient research on how media framing specifically shapes perceptions of healthcare responsibilities and influences access to health services in Nigeria. The intersection between media messaging, gender expectations, and healthcare accessibility therefore remains underexplored. It is against this background that this study examines gender equity and access to healthcare in Nigeria, with a particular focus on the role of the media and its implications for building inclusive societies.

Objectives of the Study

The objectives of the study are to:

1. To examine how socially constructed gender roles influence health-seeking behaviour and access to healthcare services in Nigeria.
2. To analyse how media framing shapes perceptions of men's and women's responsibilities in accessing healthcare services
3. To evaluate the structural, cultural, and communication-related barriers that hinder equitable access to healthcare for men and women in Nigeria.

Theoretical Framework

This study adopts Framing Theory, first developed by Erving Goffman (1974), which explains how media and communication shape the way people perceive and interpret social issues. Rather than merely reporting facts, media outlets select and present information in ways that emphasize certain aspects while downplaying others. This selective presentation, or "framing," influences how audiences understand issues, assign importance, and form opinions. Entman (1993) further expanded the theory to show that media frames can shape public attitudes, behaviours, and social norms.

In the Nigerian healthcare sector, framing theory helps explain how media portrayals reinforce traditional gender roles. For instance, media often frames women as caregivers responsible for family health, children, and the elderly, while men are depicted as independent

decision-makers, financially responsible, and less involved in routine health matters. These portrayals shape societal expectations about who should seek care and who is accountable for health decisions, influencing health-seeking behaviour and access to healthcare services.

The main concepts of Framing Theory as applied in this study include:

1. Selection and emphasis: Media highlights certain aspects of gender and healthcare (e.g., women's maternal role) while downplaying others (e.g., men's participation in caregiving).
2. Interpretation and perception: Audiences interpret these frames as social norms, which can reinforce unequal healthcare access.
3. Behavioural influence: The framing of gender roles affects both men's and women's decisions to seek care, their engagement with healthcare services, and family health responsibilities.
4. Power and agenda-setting: Media content is shaped by societal priorities and cultural expectations, which may perpetuate or challenge gender inequities in healthcare.

With the application of this theory, the study examines how media coverage in Nigeria represents existing gender norms and also influences access to healthcare services. It highlights how framing can either reinforce inequalities by portraying women as caregivers and men as self-reliant; or promote gender equity, when media presents balanced and inclusive representations of health responsibilities. This approach allows for a proper understanding of the link between media portrayals, societal expectations, and equitable healthcare access for men and women in Nigeria.

Gender Equity in Healthcare

Gender equity in healthcare ensures that men and women have fair opportunities to access quality health services and participate in health-related decision-making without being constrained by gender. Achieving this equity requires more than providing facilities; it demands attention to social norms, economic conditions, education, and cultural expectations that shape how individuals seek and use healthcare. When these factors are ignored, certain groups, most especially women face limited access to services, undermining both individual and community wellbeing, (Adewoyin, Odimegwu, Basse, Awelewa & Akintan, 2022). In Nigeria, persistent gender inequalities affect healthcare utilisation and outcomes. Egbo (2025) highlights that women in rural areas encounter structural and social

barriers, including long distances to clinics, travel costs, and the shortage of female healthcare professionals. These obstacles are closely linked to cultural expectations and restricted decision-making power, rather than mere service availability. Consequently, women may forgo essential services such as antenatal care, adversely impacting their health and the wellbeing of their families.

Oduenyi, Banerjee, and Adetiloye (2021) note that in many developing countries, including Nigeria, public health funding and planning do not adequately address the distinct needs of men and women. Women and disadvantaged groups face disproportionate financial burdens, from transportation costs to out-of-pocket payments for medicines, which limits their ability to seek timely care. This unequal access perpetuates poor health outcomes and can exacerbate economic vulnerability, especially in households where women are primary caregivers. Positive interventions, however, shows that gender-focused strategies can improve outcomes. The World Health Organisation (2021) reports that in northern Nigeria, a home-visit programme engaging both men and women led to measurable improvements in maternal health. For instance, in Bauchi State (2015-2020), trained home visitors conducted regular visits to households with pregnant women and their spouses, providing guidance on maternal and child health, danger signs in pregnancy, and shared health responsibilities. This programme reduced social and cultural barriers, increased male involvement and support, and granted women greater autonomy in seeking care.

Influence of Gender Roles on Health-Seeking Behaviour and Access to Healthcare

Socially constructed gender roles strongly influence who seeks healthcare, how services are used, and who makes health-related decisions in Nigeria. In many communities, women are expected to manage family health, care for children, and attend to elderly relatives, while men are positioned as decision-makers and providers. These roles affect access to healthcare as women sometimes, require permission from male family members to seek care, face financial dependency, or lack the time and resources to attend clinics (Egbo, 2025). Oduenyi, Banerjee, and Adetiloye (2021) note that gender roles shape how health services are planned, funded, and delivered. Women in rural areas frequently encounter barriers such as long distances to health centres, a shortage of female healthcare workers, and additional costs for transportation and medicines. The tragic case reported by Lindaikejiblog on January 28, 2025, where a woman in Port Harcourt died from postpartum bleeding due to the absence of a nearby

hospital illustrates the real-world consequences of these structural and social barriers. Consequently, men may have better access to private healthcare, but cultural expectations to appear strong and self-reliant discourage them from seeking preventive care or acknowledging illness. Yaya et al (2020) reveal that men often view maternal and reproductive health as “women's responsibility” and feel less compelled to participate in related services or to support women's use of formal healthcare. These gendered patterns in healthcare utilisation indicate that the Nigerian health system does not equally meet the needs of men and women, resulting in gender disparities in health outcomes and access to care across the population.

Media and public messaging further reinforce these gendered patterns. Health campaigns that focus predominantly on women for maternal and child health while rarely involving men in caregiving or preventive care reinforce the perception that family health is primarily a woman's responsibility. This not only limits men's active participation in family healthcare but also increases women's workload and restricts their ability to address their own health needs (Agwu, Mbachu, & Onwujekwe, 2025). That aside, Oduenyi, Banerjee, and Adetiloye (2021) highlight that economic and educational disparities linked to gender exacerbate these inequalities. Women with lower income or limited education may lack awareness of available services or the means to afford transportation, medications, or treatment. Men, pressured to provide financially, may prioritise work over health and avoid medical visits.

Role of the media in shaping perceptions of men's and women's responsibilities in healthcare.

The Nigerian media does more than report health information. It actively shapes public perceptions of gender roles in healthcare. Drawing on Framing Theory, media messages highlight certain aspects of health while downplaying others, influencing how audiences interpret responsibilities, priorities, and behaviours (Asemah, 2011). In Nigeria, this framing perpetuates traditional gender norms rather than challenging them. Agwu, Mbachu, and Onwujekwe (2025) argue that while mass media, including radio, television, newspapers, and online platforms provide critical health information on maternal care, immunisation, and disease prevention, the patterns of coverage represent gendered assumptions. Women are consistently depicted as caregivers and health service users, whereas men are rarely shown participating in

family health and seeking preventive care. Coverage of maternal health programmes tend to highlight women attending antenatal clinics, but omits the role men can play in supporting or facilitating access to these services. This selective framing reinforces the belief that healthcare responsibility rests mainly with women, limiting male engagement and placing a disproportionate burden on women.

Social media has further made this complicated. Platforms like Instagram, Facebook, and Twitter allow women to share experiences, access peer support, and challenge myths about reproductive health (Okinoni, 2025). However, these platforms also propagate stereotypical narratives when content emphasises caregiving, domesticity, or beauty as inherently female roles. In contrast, posts and campaigns portraying men as strong, decisive, or independent discourage men from acknowledging health concerns or seeking medical help (Edge Funders, 2025). Edge Funders (2025) points out that studies on media and masculinity in Nigeria show that local newspapers, TV, and online platforms depict men as strong, in control, and natural leaders. These portrayals are not limited to work or public life and affect how men are expected to behave in their personal and family health. When men constantly see messages linking being masculine with being tough and never showing weakness, they may feel they should avoid going to the doctor, admitting pain and asking for help. This pressure can make men delay seeking medical care, ignore symptoms, or skip preventive check-ups, which raises the risk of serious health problems. At the same time, these messages reinforce the idea that women are the main caregivers, putting extra responsibility on them and creating an unequal burden in managing family health.

Daily Trust (2023) observes that media reporting on health issues can be biased against women. Nigerian newspapers usually show women as the main people using health services, while men who care for their families or provide advice are rarely featured. This makes it seem like looking after health is only a woman's responsibility. These repeated messages influence what society thinks men and women should do, and they can affect how people behave and who is expected to take care of health needs. From the foregoing, it can be deduced that the media in Nigeria does not merely inform but constructs social reality. It dictates who is seen as responsible for health, who deserves attention, and which behaviours are normative.

Barriers That Prevent Men and Women from Accessing Healthcare Equally

Studies show that gender inequalities in

healthcare access in Nigeria do not arise from a single cause but from several interlinked barriers that affect both men and women differently. One of the major influences is social and cultural norms. In many communities, traditional expectations position women as the primary carers of family health, while men are expected to be strong and self-reliant. This can discourage men from seeking preventive care and can restrict women's ability to make independent health decisions. In some households, women may have to wait for permission from husbands or male relatives before attending a clinic, which can delay care and worsen health outcomes (Oduenyi, Banerjee & Adetiloye, 2021). Aregbeshola and Olaniyan (2022) assert that costs related to travel, treatment and medication disproportionately affect women and low-income groups, limiting their ability to access services even when these are geographically available. In rural areas, long journeys to health facilities are a common deterrent, and the extra expense of transport can mean that care is postponed or foregone. Adewoyin et al. (2022) find that in some communities, health centres are poorly equipped, understaffed, or lack practitioners of the preferred gender. This can discourage care-seeking, especially for services linked to reproductive and maternal health where women may prefer female health workers. Men, in contrast, may be less willing to attend clinics that are perceived as geared towards women, creating a further divide in service utilisation.

A less obvious but important barrier relates to how health information is communicated. Yaya et al. (2020) show that health messaging often emphasises maternal and child health without similarly addressing preventive care or chronic disease for men. When health education does not speak to the specific needs of different groups, people may not recognise the relevance of services to their own health, limiting uptake and informed decision-making. These barriers also intersect with other forms of disadvantage. Women with limited education, living in remote areas, or without steady income face multiple overlapping challenges that make it harder to access care. A woman in a rural community, for instance, may encounter economic constraints, limited transport options, and social restrictions on movement simultaneously, which together compound her risk of poor health outcomes.

Empirical Review

Adewoyin, Odimegwu, Basse, Awelewa, and Akintan (2022) examined how gender relations influence the use of maternal healthcare

services among women in Nigeria. The study used data from the 2018 Nigeria Demographic and Health Survey to analyse information from nearly 30,000 women aged 15–49 across different regions. The findings showed that women's use of antenatal care and delivery in health facilities varied widely by region and was linked to gender roles and relations within households. Women with more supportive partners attended recommended health services, while those living in regions with stronger traditional gender norms had lower service use. The authors concluded that gender-sensitive policies are required to improve maternal health outcomes and ensure fair access to care for all women. Okeke and Ofonere (2023) studied the factors that affect women's use of maternal and child health services in Enugu State, Nigeria. Using data from women of reproductive age, the research identified social, economic, and accessibility barriers such as income, distance to health facilities, and educational level that limit women's ability to use important health services. These barriers were connected to broader gender inequalities that influence who can seek care and when. The study recommended that government and non-government organisations improve access to healthcare services in both urban and rural areas to reduce inequities and improve health outcomes.

Aregbeshola and Olaniyan (2022) examined horizontal inequities in the utilisation of maternal and reproductive health services in Nigeria. The study analysed data from the 2018 Nigeria Demographic and Health Survey to investigate patterns in the use of antenatal care, facility delivery, and family planning across socio-economic groups. The findings showed that women with similar healthcare needs did not access services equally; utilisation was significantly higher among women with greater wealth and education compared with poorer, less educated women. The inequities persisted even after controlling for health needs, suggesting that factors other than need such as socio-economic status and gendered barriers determine access. The authors concluded that addressing horizontal inequities requires policies that target socio-economic and gendered disparities in healthcare access to ensure that women with equal needs receive equal care. Yaya, Bishwajit, Udenigwe, and Shah (2020) investigated patterns and determinants of health-seeking behaviours among Nigerian women using the 2018 Nigeria Demographic and Health Survey. The study analysed information from over 25,000 women aged 15–49 to explore how socio-demographic factors, including age, education, wealth, and marital status, influenced use of maternal and reproductive healthcare services. The findings showed that women with higher education, greater

household wealth, and supportive spousal relationships were more likely to seek facility-based maternal care, while traditional gender norms and lower socio-economic status were associated with reduced utilisation. The authors concluded that interventions aimed at improving education, economic opportunities, and spousal support mechanisms are needed to increase equitable access to healthcare services for women.

Methodology

This study adopted the library research method, which involves the systematic collection, review, and analysis of existing literature. According to Asemah, Gujbawu, Ekharefo, and Okpanachi (2017), library research allows researchers to gather information from a variety of secondary sources, including textbooks, peer-reviewed journal articles, reports, policy documents, newspapers, and other relevant publications. This approach was selected because it enables the study to draw on established theories, concepts, and empirical findings on gender equity, healthcare access, and media influence on social perceptions. A structured search strategy was employed to identify relevant literature. Academic databases such as Google Scholar, JSTOR, PubMed, Scopus, and African Journals Online (AJOL) were systematically searched using keywords and combinations such as “gender equity in healthcare Nigeria,” “media framing and gender roles,” “healthcare access disparities,” and “maternal and reproductive health Nigeria.” The search focused on publications from 2010 to 2025 to ensure contemporary relevance, although seminal works predating this period were included when they provided foundational data. Sources were selected based on inclusion criteria, which required studies to focus on gender roles, equity, or healthcare access in Nigeria or comparable aspects of Africa; address the influence of media in shaping social perceptions or healthcare behaviours; and be published in peer-reviewed journals, reputable books, official reports, or recognised media outlets. Sources were excluded if they were unrelated to gender, healthcare, or media influence, lacked scholarly rigour, and were duplicates of previously reviewed studies.

The materials identified were analysed and synthesised thematically to align with the objectives of this study. Recurring patterns, points of convergence, and contradictions among studies were highlighted to provide a coherent understanding of how gender norms and media framing affect healthcare access in Nigeria. This process allowed the study to identify gaps in

existing research, regarding the intersection of media representation and equitable healthcare provision. Using this method, the study was able to explore how social norms, cultural practices, and media framing influence health-seeking behaviour among men and women, ensuring that the research is grounded in existing knowledge while highlighting areas where further inquiry is needed (Asemah, Gujbawu, Ekharefo, & Okpanachi, 2022).

Discussion

The literature indicates that socially constructed gender roles shape access to healthcare in Nigeria by influencing who seeks care, who makes health-related decisions, and how health services are utilised. Women are often assigned responsibility for managing family health, caring for children, and attending to elderly relatives, while men are positioned as providers and decision-makers (Egbo, 2025; Oduenyi, Banerjee, & Adetiloye, 2021). These roles create structural and social barriers. Women may depend on male relatives for permission, face financial constraints, and have limited time or resources to access clinics, whereas men may avoid seeking care due to societal expectations of strength and independence. The reviewed studies consistently emphasise that such gendered expectations contribute to unequal access to healthcare and can produce poorer health outcomes for both men and women in specific contexts.

Furthermore, media and public messaging are identified as key mechanisms that reinforce and challenge these gendered patterns in healthcare. Mass media including television, radio, newspapers, and social media platforms shape public perceptions of responsibility for family and personal health. Campaigns that focus predominantly on women for maternal and child health may unintentionally reinforce caregiving as a female duty, while men are frequently absent from narratives on preventive care or family health (Agwu, Mbachu, & Onwujekwe, 2025; Okinoni, 2025). Social media can provide women with platforms to share health experiences, access peer support, and challenge traditional norms, but it may simultaneously reinforce stereotypes through content emphasising passive caregiving or beauty roles. Similarly, traditional media portrayals of men as strong, independent, and in control can discourage both men and women from engaging in preventive healthcare, as men internalise pressures to appear invulnerable and women bear the bulk of caregiving responsibilities (Daily Trust, 2023; Edge Funders, 2025). This body of literature highlights how media framing both represents and reproduces social norms around gender and health.

In addition, Structural and intersectional

factors further worsen inequities in healthcare access. Cultural norms restrict women's autonomy in health decision-making and discourage men from preventive care, while financial limitations, geographic distance to facilities, shortages of gender-appropriate providers, and discriminatory practices by healthcare workers create additional barriers (Ogun & Ofonere, 2023). That aside, economic and educational disparities intersect with gender. Women with lower income or limited education encounter multiple obstacles, including inability to afford transport, medications, or treatment, while men may prioritise work over healthcare due to societal expectations to provide. These studies show that healthcare inequities in Nigeria are not only the result of individual behaviour but also of structural and systemic factors shaped by social norms, economic conditions, and institutional practices.

Conclusion and Recommendations

The reviewed literature indicates that gender roles, media framing, and structural factors all shape access to healthcare in Nigeria. Women's responsibilities for family care and men's positioning as decision-makers contribute to unequal health-seeking behaviour, while media representations reinforce these social norms by highlighting women as caregivers and men as strong and self-reliant. Structural barriers, including financial constraints, long distances to health facilities, and shortages of gender-appropriate healthcare providers, further limit equitable access. Social and economic disparities intersect with gender, exacerbating the challenges for vulnerable populations. With the evidence, it is concluded that achieving gender equity in healthcare requires interventions that address social norms, media influence, and systemic inequalities simultaneously.

Based on this synthesis, the study recommends the following:

1. Policymakers should design programmes that actively engage both men and women in healthcare decision-making and utilisation.
2. Health campaigns should be framed to involve men in preventive care and family health responsibilities while challenging traditional stereotypes. Media training for journalists, broadcasters, and social media content creators can ensure that messaging promotes equitable roles, reducing the burden placed solely on women.
3. Government and healthcare organisations should improve access by increasing the availability of gender-appropriate

healthcare providers, subsidising transportation and treatment costs for low-income populations, and establishing more local clinics in rural areas.

4. Initiatives that educate communities about equitable health-seeking behaviour can help shift cultural norms that restrict women's autonomy and discourage men from seeking care.

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