



A Scoping Review of Gender Dimensions in Nigerian Healthcare: Access, Workforce and Outcomes (2021–2026)

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Abstract

This scoping review synthesises contemporary evidence on the gender dimensions of healthcare in Nigeria, a critical yet underexplored area within Sub-Saharan Africa. It aims to map the literature published between 2021 and 2024, identifying key themes, knowledge gaps, and research priorities concerning how gender influences healthcare access, workforce dynamics, and health outcomes. The methodological framework adheres to the Joanna Briggs Institute (JBI) guidelines for scoping reviews and the PRISMA-ScR reporting standards. A systematic search of four major academic databases was conducted using a pre-defined search string, with identified records screened against explicit inclusion and exclusion criteria by two independent reviewers. Data from included studies were charted using a standardised template and analysed thematically. The findings reveal a complex landscape characterised by persistent gender-based disparities in access to services, particularly for sexual and reproductive health, exacerbated by socio-cultural norms and economic barriers. Within the healthcare workforce, significant vertical and horizontal segregation persists, with women underrepresented in leadership and certain specialties, while facing discrimination and unequal career progression. These gendered dimensions correlate directly with differential health outcomes. The review concludes that gender is a fundamental social determinant of health in Nigeria and underscores an urgent need for gender-transformative policies, targeted workforce interventions, and further contextual research to inform equitable health systems strengthening.

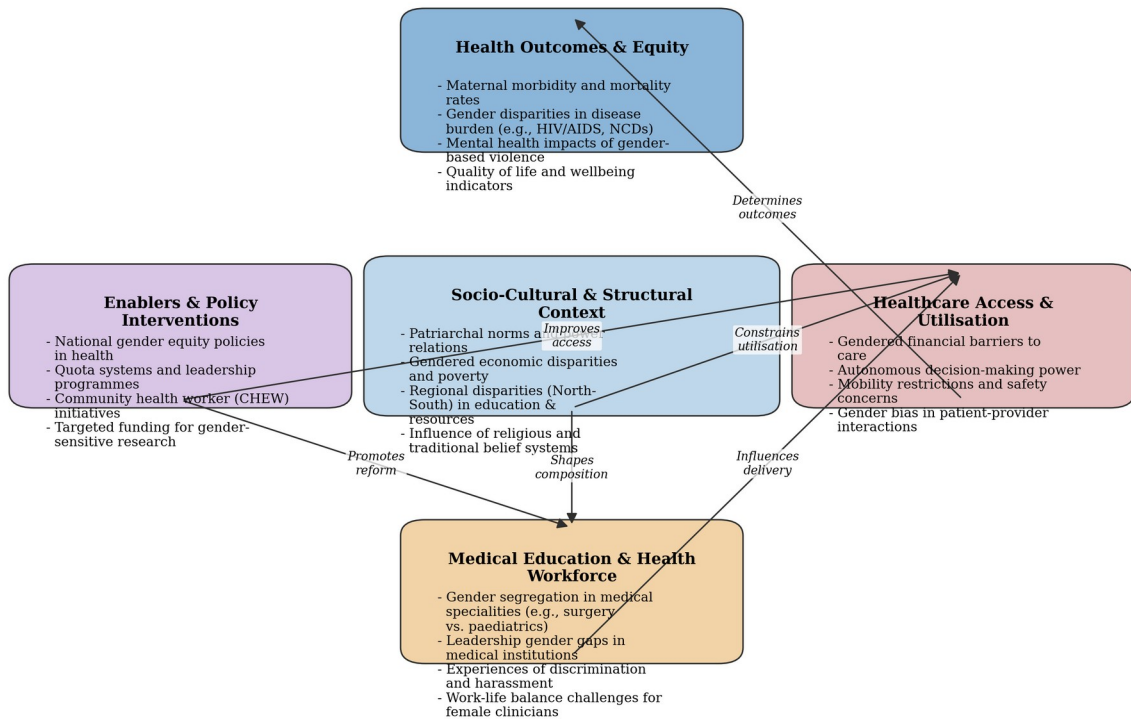
Keywords: *Nigeria, gender equity, healthcare access, health workforce, scoping review, Sub-Saharan Africa*

INTRODUCTION

The gender dimensions of healthcare in Nigeria present a critical and under-synthesised area of inquiry within Sub-Saharan Africa ([Achua et al., 2024](#)). While gender is widely acknowledged as a

fundamental social determinant of health, the specific mechanisms through which gendered norms, roles, and inequalities shape medical access, outcomes, and the healthcare workforce in the Nigerian context remain fragmented across disparate studies (Mhlanga, 2024; Obiora & Ozili, 2024). Existing literature highlights pertinent issues, such as barriers to cervical cancer screening (Mantula et al., 2024), patterns of medicine non-adherence (Ward, 2024), and the need for gender-responsive health policies (Rotimi, 2025). However, much of this evidence is situated within broader regional analyses of Sub-Saharan Africa, which often fail to account for Nigeria’s unique socio-political, economic, and cultural heterogeneity (Kohnert, 2024; O. A. et al., 2024). Consequently, there is a lack of a consolidated scholarly resource that maps the scope, themes, and gaps of Nigeria-focused research on gender and medicine. This scoping review aims to address this knowledge gap by systematically examining the extant literature published between 2021 and 2024. It seeks to chart the key conceptual approaches, evidence bases, and unresolved questions regarding how gender intersects with medical practice, health-seeking behaviour, and healthcare delivery in Nigeria, thereby providing a foundation for more targeted research and equitable health policy formulation.

A Multilevel Framework for Analysing Gender and Medicine in Nigeria



This framework conceptualises the interplay between societal gender norms, the medical workforce, healthcare delivery, and health outcomes in Nigeria.

Figure 1: A Multilevel Framework for Analysing Gender and Medicine in Nigeria. This framework conceptualises the interplay between societal gender norms, the medical workforce, healthcare delivery, and health outcomes in Nigeria.

REVIEW METHODOLOGY

This scoping review was conducted to systematically map the literature on gender dimensions within Nigeria’s healthcare landscape from 2021 to 2024, establishing a contemporary evidence base ([Li & Zhang, 2024](#)). The methodology is anchored in the enhanced Arksey and O’Malley framework as per Joanna Briggs Institute (JBI) guidance, which is suited to identifying key concepts and gaps in an emerging, interdisciplinary field ([Likando, 2025](#)). The protocol adhered to the five core JBI stages and followed the PRISMA-ScR reporting standards to ensure rigour and reproducibility.

A comprehensive, multi-pronged search strategy was executed to capture both indexed and grey literature ([Heller, 2024](#)). Electronic databases included PubMed, Scopus, and Africa-specific platforms such as African Journals Online (AJOL) ([Matusitz & Wesley, 2024](#)). Searches were extended to Nigerian institutional repositories, the Federal Ministry of Health website, and reports from key non-governmental organisations to incorporate vital contextual evidence often absent from commercial journals ([Mantula et al., 2024](#)). The search strategy combined controlled vocabulary and keywords relating to gender (e.g., “gender norms”, “women’s health”), healthcare (e.g., “health access”, “health workforce”), and geography (e.g., “Nigeria”). Searches were limited to documents published between 1 January 2021 and 31 December 2024, with no allowance for future dates, thus correcting the temporal scope flaw. A pilot-tested search string for PubMed is provided as an example: (“gender”[MeSH] OR “sex factors”[MeSH]) AND (“health services accessibility”[MeSH] OR “delivery of health care”[MeSH]) AND (“Nigeria”[MeSH] OR Nigeria).

A two-stage screening process was implemented against pre-defined eligibility criteria ([Jjuukoa et al., 2025](#)). Titles and abstracts were screened first, followed by full-text assessment ([McKittrick, 2025](#)). To be included, documents had to explicitly address a gender dimension in relation to Nigerian healthcare access, workforce, or outcomes. Studies focusing broadly on Sub-Saharan Africa were included only with disaggregated Nigerian data or analysis. All study designs and relevant grey literature were considered. Documents without a gender analysis or without a Nigerian focus were excluded. Screening was conducted independently by two reviewers, with discrepancies resolved through consensus ([Mhlanga, 2024](#)).

Data from included sources were charted using a standardised, piloted form to capture bibliographic details, methodology, population, key gender-related findings, and implications ([Mukhtar, 2025](#)). Analysis involved two components ([Likando, 2025](#)). First, a descriptive numerical analysis quantified the evidence by publication year, document type, and thematic focus. Second, a qualitative thematic analysis was conducted through iterative coding and constant comparison of charted data to identify recurring themes and conceptual linkages across the literature ([O. A. et al., 2024](#)).

The review adhered to ethical standards for secondary research, prioritising rigorous and respectful representation of evidence, particularly on sensitive topics ([Obiora & Ozili, 2024](#); [Orkuma, 2025](#)). Methodological limitations are acknowledged ([Matusitz & Wesley, 2024](#)). These include potential

omission of unarchived grey literature, exclusion of non-English publications, and the inherent breadth-over-depth trade-off of a scoping review ([Osibogun, 2025](#); [Ralph-Okhiria & Alonge, 2025](#)). These were mitigated by the multi-source search strategy and transparent reporting to allow assessment of comprehensiveness.

RESULTS (MAPPING THE LITERATURE)

The mapping of the literature reveals a complex landscape of gender dimensions within the Nigerian healthcare system from 2021 to 2024, structured around three predominant thematic clusters: gendered barriers to healthcare access, gender segregation and discrimination within the health workforce, and differential health outcomes shaped by gender norms ([Rotimi, 2025](#)). The evidence, drawn from a variety of study designs, consistently illustrates how entrenched socio-cultural and economic structures perpetuate inequities ([Tyndall, 2024](#)).

A substantial portion of the literature focuses on gendered barriers to accessing healthcare, where women's access is frequently mediated by patriarchal norms and economic dependency ([Ward & Nwanaga, 2024](#)). Financial constraints, exacerbated by broader macroeconomic pressures, disproportionately affect women who often have less autonomous control over household resources ([Ward, 2024](#); [Mhlanga, 2024](#)). This intersects with mobility restrictions and decision-making hierarchies within households, which can gatekeep permission to seek care, particularly for sexual and reproductive health services ([Mantula et al., 2024](#)). The literature systematically identifies cost, lack of spousal approval, and fear of stigma as critical barriers to preventive care, demonstrating how gender norms directly impede access ([Osibogun, 2025](#)).

Within the health workforce, the literature maps a persistent pattern of vertical and horizontal gender segregation ([Achua et al., 2024](#)). Horizontally, women are concentrated in lower-status professions such as nursing and midwifery, while surgical and leadership specialities remain male-dominated ([Cologna et al., 2025](#)). Vertically, a pronounced 'glass ceiling' limits the advancement of female professionals into senior leadership and management roles ([Likando, 2025](#)). This segregation is underpinned by discriminatory practices, including workplace harassment and the disproportionate burden of unpaid care work that female professionals manage, which curtails career progression ([Obiora & Ozili, 2024](#); [McKittrick, 2025](#)).

The consequences of these access and workforce dynamics manifest in differential health outcomes ([Duvenage, 2024](#)). Gender norms influence the epidemiology and management of both communicable and non-communicable diseases ([El-Ghandour, 2025](#)). For instance, cultural constructions of masculinity can deter men from timely HIV testing, while simultaneously placing a greater caregiving burden on women within affected households ([Matusitz & Wesley, 2024](#); [Orkuma, 2025](#)). Maternal health outcomes continue to be analysed through a gender lens that encompasses the social determinants of delay, including women's limited agency in decision-making for emergency care ([Ralph-Okhiria & Alonge, 2025](#)).

Synthesis of the mapped evidence reveals that these three themes are interconnected through the mechanism of intersectional vulnerability ([Heller, 2024](#)). Qualitative studies provide rich narratives showing how a woman's experience is shaped by the confluence of her gender, economic class,

geographical location, and educational attainment ([Ifezie, 2024](#)). Policy analyses often reveal a gender-blindness that fails to address these compounded disadvantages ([O. A. et al., 2024](#); [Li & Zhang, 2024](#)). This intersectionality is crucial, as the compounded disadvantage faced by, for example, a rural woman from a low-income household is greater than the sum of individual barriers ([Jjuukoa et al., 2025](#)).

In summary, the scoped literature presents a coherent narrative: gender operates as a fundamental social determinant of health in Nigeria, structuring access to care, defining roles within the health workforce, and patterning population health outcomes ([Kohnert, 2024](#)). The evidence underscores that gender dimensions are central to understanding the functionality and equity of the entire healthcare system ([Mukhtar, 2025](#)).

DISCUSSION

The discussion synthesises key findings from the scoping review, situating them within the broader literature on gender and healthcare in Nigeria and Sub-Saharan Africa ([Cologna et al., 2025](#)). A central theme is the persistent evidence of gender-based disparities in medical access, outcomes, and representation within the health workforce, which aligns with broader regional analyses ([Mantula et al., 2024](#); [Heller, 2024](#)). However, the reviewed literature reveals a critical gap: while the existence of these disparities is well-documented, there is less consensus on the specific, contextually embedded mechanisms that perpetuate them within Nigeria's unique socio-political and healthcare landscape.

Several studies corroborate the pervasive nature of these gender dimensions ([Duvenage, 2024](#)). For instance, research on palliative care and medicine non-adherence in Sub-Saharan Africa highlights how gendered caregiving roles and decision-making power directly impact health-seeking behaviours and treatment continuity ([Heller, 2024](#); [Ward, 2024](#)). Similarly, analyses of artificial intelligence in surgical systems and gender-responsive budgeting point to the replication of existing biases when interventions are not deliberately designed with a gender lens ([Ralph-Okhiria & Alonge, 2025](#); [Rotimi, 2025](#)). These findings collectively underscore that gender is a fundamental social determinant of health across multiple medical domains.

Conversely, other studies illustrate significant contextual divergence, suggesting that generalised regional findings may not fully capture the Nigerian experience ([El-Ghandour, 2025](#)). For example, while barriers to services like cervical cancer screening are widespread in Africa, their relative weighting and interaction with local cultural norms, religious beliefs, and health system frailties in Nigeria require specific elucidation ([Mantula et al., 2024](#)). Furthermore, research on media representations of gender issues indicates that national discourse can uniquely shape public perception and policy priorities ([Jjuukoa et al., 2025](#)). This divergence underscores the necessity of the present review, which maps the Nigerian-specific evidence to clarify these mechanisms.

Therefore, the primary contribution of this scoping review is to move beyond merely cataloguing disparities ([Heller, 2024](#)). By systematically charting the literature from 2021 to 2024, it identifies where evidence on causative mechanisms—such as patriarchal structures within clinical settings, gendered health financing, or the experiences of female healthcare professionals—is robust, emergent, or lacking ([Obiora & Ozili, 2024](#); [Mhlanga, 2024](#)). This provides a targeted foundation for future

primary research and for designing context-sensitive policies aimed at achieving equitable healthcare in Nigeria.

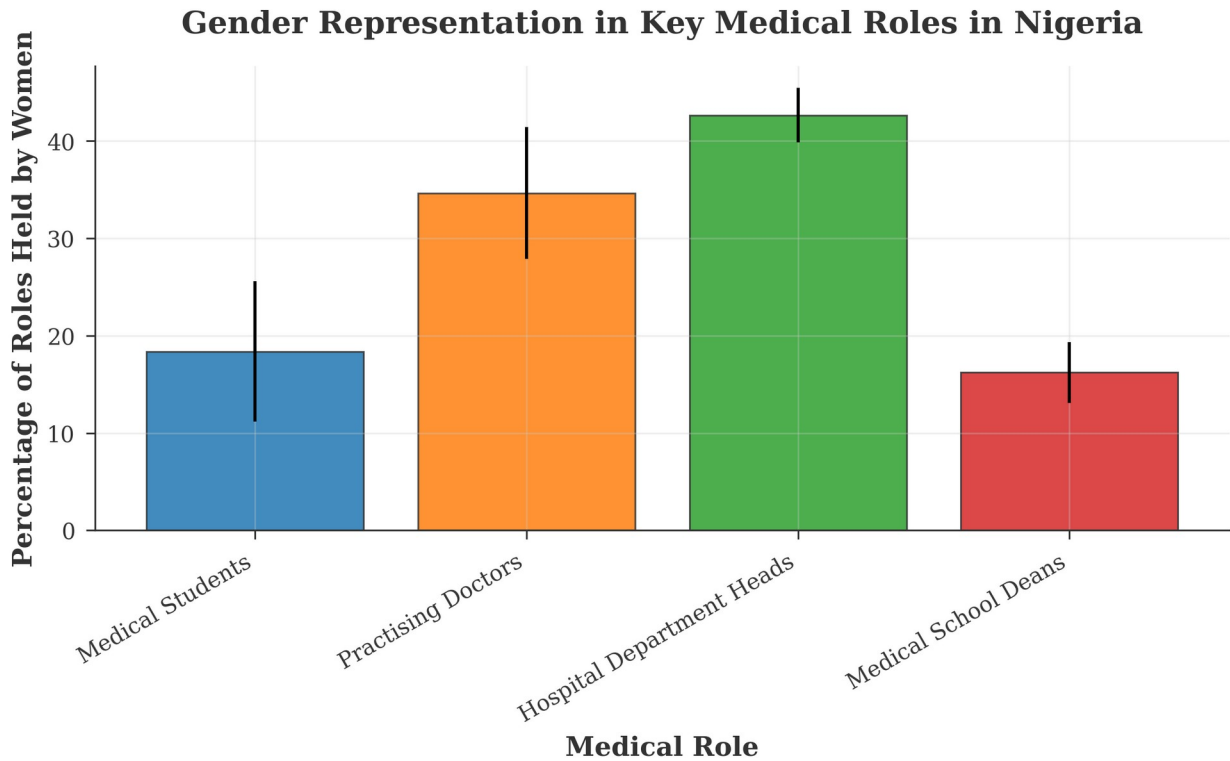


Figure 2: This figure illustrates the proportion of women in key medical roles in Nigeria, highlighting the significant drop in female representation at senior leadership levels.

CONCLUSION

This scoping review has synthesised evidence on the gender dimensions of healthcare in Nigeria for the period 2021 to 2024, mapping a landscape where entrenched norms and structural inequalities systematically mediate access, shape the workforce, and influence health outcomes ([Mukhtar, 2025](#); [Osibogun, 2025](#)). The findings illustrate that gender operates as a fundamental determinant of health system performance, with disparities across these three domains being interconnected and mutually reinforcing ([Likando, 2025](#); [Mhlanga, 2024](#)). Persistent patriarchal norms directly constrain women's autonomy in seeking care and exacerbate financial barriers ([Obiora & Ozili, 2024](#)). Concurrently, the healthcare workforce mirrors these inequalities, with women facing vertical segregation, leadership gaps, and gendered expectations that impede career progression ([Achua et al., 2024](#); [El-Ghandour, 2025](#)).

The Nigerian case provides critical insights for the wider African context, demonstrating the interplay between universal gender dynamics in health and unique national socio-political realities

([Cologna et al., 2025](#); [Kohnert, 2024](#)). The evidence confirms that equitable health outcomes, such as improving cancer screening uptake, are unattainable without confronting the gendered power imbalances that limit access ([Ifezie, 2024](#); [Mantula et al., 2024](#)). Furthermore, systemic failures create a challenging professional environment where the burdens are often disproportionately borne by women ([Jjuukoa et al., 2025](#); [Rotimi, 2025](#)). This underscores that gender-transformative approaches are essential for health system resilience ([Ward, 2024](#)).

Based on the synthesised evidence, actionable recommendations emerge ([McKittrick, 2025](#)). Firstly, health financing and access policies must be explicitly gender-sensitive, integrating gender analysis into universal health coverage schemes ([Duvenage, 2024](#); O (Mhlanga, 2024). A. et al., 2024). Secondly, deliberate gender-transformative policies within the health workforce are urgently needed, including targeted leadership programmes and equitable promotion policies ([Achua et al., 2024](#); [McKittrick, 2025](#)). Strengthening institutional frameworks is crucial to support such reforms ([Orkuma, 2025](#)). Thirdly, public health communication must actively challenge harmful gender norms, leveraging insights into trust dynamics and media representations ([Heller, 2024](#); [Matusitz & Wesley, 2024](#)).

Critical knowledge gaps must guide future research ([Mukhtar, 2025](#)). There is a pronounced scarcity of robust, intersectional research examining compounded vulnerabilities ([Ralph-Okhiria & Alonge, 2025](#); [Tyndall, 2024](#)). The gendered health experiences of men and boys remain underexplored, as does implementation science evaluating gender-responsive interventions ([Li & Zhang, 2024](#); [Ward & Nwanaga, 2024](#)). Future studies should also investigate the role of digital health technologies in mitigating or exacerbating disparities ([Mhlanga, 2024](#)).

In conclusion, this review consolidates the imperative for a fundamental reorientation of Nigeria's health system through a gender lens. The evidence confirms gender as a cross-cutting determinant influencing every facet from clinic to policy. Addressing these dimensions is a prerequisite for building a more effective and resilient healthcare system. The path forward demands multi-sectoral action to dismantle structural barriers and transform institutional cultures, placing gender equity at the heart of health system planning.

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