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The Gendered Impacts of Out-Of-Pocket Payments for Healthcare on Women in Sub-Saharan Africa-a Narrative Review Dolapo Ruth Adu, Muhammad Saddiq

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Abstract

Background

Healthcare financing is central to achieving Universal Health Coverage (UHC). In Sub-Saharan Africa (SSA), limited public funding and high disease burdens have resulted in heavy reliance on out-of-pocket (OOP) payments. Although the negative effects of OOP spending on vulnerable populations are well documented, the specific gendered impacts on women remain insufficiently explored. Women generally have higher healthcare needs but face persistent economic and social constraints, increasing their vulnerability within OOP-dependent systems. This review examines how OOP payments affect women's access to healthcare, service utilisation, and health outcomes in SSA.

Method

A thematic narrative review of literature published between 2013 and 2023 was conducted using seven electronic databases. A systematic search strategy was applied, and eligible studies were critically appraised using the CASP checklist.

Results

Out of 1,370 identified publications, 19 studies met the inclusion criteria. Three major themes emerged: access to healthcare services, utilisation of healthcare services, and health outcomes. The findings show that OOP payments significantly restrict women's access to essential healthcare, often leading to delayed care, use of lower-quality services, or complete forgone treatment. Women frequently adopt harmful coping strategies and make health-related compromises due to financial pressures.

Conclusion

The review highlights the urgent need for gender-responsive health financing reforms. Addressing these disparities is essential for developing equitable healthcare systems that improve women's health and advance UHC in SSA.

1. INTRODUCTION

Universal health coverage (UHC), a key goal of the 2030 Agenda for Sustainable Development, is defined by the WHO as access to essential health services for all without financial hardship [1]. SDG target 3.8 similarly aims to ensure financial risk protection, access to quality health services, and affordable essential medicines [2]. However, many countries continue to face challenges in achieving both population and service coverage [3].

Sub-Saharan Africa (SSA) bears a high share of the global disease burden [4] while investing comparatively less in healthcare [5]. Health financing in SSA is characterised by limited government spending, emerging insurance schemes, heavy reliance on out-of-pocket (OOP) payments, and external donor funding [6]. As a result of low public health expenditure, OOP payments constitute a major source of health system financing in SSA. In 2017, countries including Cameroon, Equatorial Guinea, Nigeria, and Sudan reported OOP expenditures exceeding 70% of current health expenditure [7]. OOP payments include direct and indirect costs incurred at the point of care, such as consultation, medication, medical supplies, transportation, and service fees [8]. User fees refer to formal OOP payments made when accessing healthcare services [9].

While existing studies have examined OOP expenditures in SSA, they largely focus on poor populations and rarely address gender-specific impacts. Given women's distinct healthcare needs and their majority share of the global population [10], it is essential to examine how gender intersects with OOP payments to shape healthcare access and utilisation.

A feminist approach was adopted in this review to examine how OOP payments affect women's healthcare in Sub-Saharan Africa. However, approaches that overlook intersectionality risk failing to address gender-based discrimination affecting Black women [11]. Intersectional frameworks focus on how multiple, overlapping disparities interact to produce complex inequities, including socioeconomic and gender injustices [12]. Despite increasing interest in intersectionality within health equity research, empirical studies have largely paid limited attention to healthcare services and utilisation [13]. Addressing this gap, this study explored how an intersectional framework can inform understanding of the impact of OOP payment systems on women's health in Sub-Saharan Africa.

Given that women generally have greater healthcare needs across their life span yet fewer financial resources to meet OOP costs, it is essential to examine the economic implications of OOP payments for women. This includes assessing health consequences associated with delayed care-seeking, reliance on suboptimal care, and the compromises women make to afford healthcare. To address these issues, this study employed a thematic narrative review to examine the effects of OOP payments on women's health outcomes, access, and service utilisation. A systematic search of the literature indicates that this is the first review to examine the impact of OOP payments on women in Sub-Saharan Africa.

2. METHOD

A narrative review combined with a systematic search strategy was adopted as the research design for this study. Within this, a thematic review was chosen over other narrative review types, such as chronological reviews, as it facilitates the exploration of themes within the literature and the synthesis of information from selected sources [14].

2.1. Search Strategy

An advanced systematic search was conducted across seven electronic databases: CINAHL, Web of Science, JSTOR, PubMed, SCOPUS, Medline via Ovid, Cochrane Central Register of Controlled Trials (CENTRAL), covering the period from January 2013 to December 2023. These databases were selected because they reflected literature that was diverse and multidisciplinary in nature, covering research related to public health, nursing and allied healthcare, social sciences, human rights, and life sciences.

The Boolean technique was employed to combine the subsequent search terms as shown in Table 1, thereby facilitating the selection of pertinent literature for inclusion in the review.

Table 1
Search terms combined using the Boolean technique. The results of the search strategy are included in Appendix 2.

Search Term				
Population	AND	Phenomenon of Interest	AND	Geography
Gender		User fees		Sub-Saharan Africa
OR Women		OR Out-of-pocket payments		OR SSA
OR Female		OR OOPs		OR Sub Sahara
		OR User charges		OR Sub-Sahara
		OR Cost Recovery		
		OR Health expenditure		

2.2. Inclusion and Exclusion Criteria

Studies were eligible if they focused on women of all age groups, married and unmarried, investigated the effect of out-of-pocket payments on women's healthcare, focused on three core outcomes: accessibility to healthcare services, utilisation of healthcare services, and overall health outcomes, focused on countries in SSA, included all types of literature such as books, journal articles, reports, and study designs such as qualitative studies, quantitative studies, and randomised controlled trials to ensure that relevant information is obtained to answer the research question of this review, and were published in English between 2013 and 2023. Studies without primary data, those not disaggregated by gender, those outside the SSA context and those that focused on other health finance strategies were excluded.

2.3. Screening and Selection

The four-phase PRISMA flow diagram adopted by Moher et al. [15] was used to exclude publications that were not relevant to the study (Fig. 1). Search results (n = 1,370) were imported into Zotero for deduplication, after which screening of titles, abstracts and full-text was done. A total of 19 studies were eligible for inclusion after the full-text screening stage.

2.4. Data Extraction and Critical Appraisal

To ensure that the studies included in the analysis were of high quality and provided reliable information, the evaluation of studies incorporated in this review was conducted using the Critical Appraisal Skills Programme (CASP) tool, as recommended by the National Institute for Health and Care Excellence [16]. The extraction of data from the selected studies was done using evidence tables, a method adapted from the National Institute for Health and Care Excellence [17]. The evidence tables devised within the framework of this review were tailored to include essential information on the author, publication date, country, study design, participant demographics, research objectives, data collection methods, and results of the included literature, as shown in Appendix 3.

2.5. Data Synthesis and Analysis

The findings obtained through the data extraction process were synthesised and analysed using coding and thematic analysis. The inductive coding technique was used to develop 3 key themes tabulated in Appendix 4 to showcase the extent to which OOP payments for healthcare affect women's access, use of healthcare services and their health outcomes.

3. RESULTS

3.1. Key Findings

The 19 studies included in this review employed six study designs (Appendix 3). Twelve studies used cross-sectional designs, five adopted qualitative approaches, one used a quantitative design, and one involved secondary data analysis. Sample sizes varied widely, ranging from 56 participants to 28,601 records. This methodological diversity allowed for a nuanced synthesis of evidence [18].

The studies were conducted across multiple countries in Sub-Saharan Africa (SSA), including Zambia, Congo, Ghana, Kenya, Nigeria, Burkina Faso, Madagascar, Niger, Mali, Tanzania, Uganda, and Namibia (Fig. 2; Appendix 3). Four studies examined the impact of out-of-pocket (OOP) payments on women's access to healthcare [19–22], seven focused on healthcare utilisation [23–29], two assessed both access and utilisation [30, 31], and six explored health outcomes related to OOP payments [32–37]. Findings were organised into three themes (Fig. 3; Appendix 4).

3.2 Access to Healthcare Services

3.2.1 Socioeconomic status of women

Access to healthcare varied significantly by women's socioeconomic status. In Ghana, Gbagbo [22] found that younger women (< 24 years), particularly students and apprentices, perceived abortion services as unaffordable, limiting access to safe care. Similarly, Dalaba et al. [33] identified OOP payments as a major barrier to maternal healthcare access among poorer women.

In Nigeria, female-headed households, often comprising widowed, older, less educated, and unemployed women, were particularly vulnerable, with OOP costs discouraging healthcare-seeking when ill [31]. Overall, financial vulnerability compounded by OOP payments contributed to delayed or forgone care, worsening health outcomes.

3.2.2 Type of reproductive healthcare services

Three reproductive health services were consistently affected by OOP payments: facility-based delivery, abortion services, and antenatal care (ANC). In Zambia, Kaiser et al. [19] reported that compulsory delivery-related OOP costs (US$29.07/£22.86) discouraged rural and socially disadvantaged women from facility-based delivery, increasing home births. Abortion services were also financially inaccessible; Ilboudo et al. [21] found that induced abortion in Burkina Faso cost significantly more (US$89/£69.98) than spontaneous abortion care (US$56/£44).

ANC access was similarly constrained. In Mali, both actual and perceived OOP payments reduced uptake of intermittent preventive treatment for malaria in pregnancy (IPTp) during ANC visits [25]. In Nigeria, OOP costs were a key barrier to accessing ANC services in primary healthcare centres [26]. In Niger, women incurred higher OOP costs during first ANC visits compared to subsequent visits, reflecting additional charges at initial consultations [29].

3.2.3 Type of OOP Expenditure

Both medical and non-medical OOP costs hindered access to care. In Mali, women faced direct costs for ANC cards, incidental fees, and delivery expenses, discouraging routine ANC attendance [25]. Conversely, in Niger, incentives such as insecticide-treated bed nets and iron–folic acid supplements encouraged follow-up ANC visits among women who paid OOP costs [29].

Direct medical costs were substantial. In Ghana, drug costs constituted the highest expense (US$8/£6.29) [33]. In Nigeria, direct care costs limited access to intrapartum services, with some women reporting higher fees for male births or multiple births [26]. Non-medical costs were also significant. In Zambia, compulsory baby clothing averaged US$21.46 (£16.87) post-delivery [19]. Other expenses included disinfectants, gloves, cord clamps, and informal payments or gifts to health workers in Ghana and Nigeria [33, 26]. Transportation costs (US$3.9/£3) and long travel times further limited access [33].

3.3 Use of Healthcare Services

3.3.1 Management of chronic illnesses

The use of diagnosis and treatment services for chronic illnesses which usually incur more healthcare costs were found to be affected by OOP payments. In Nigeria, Nyengidiki et al. [23] reported a significant decline in cervical cancer screening following the introduction of user fees. In contrast, Dim et al. [27] found high willingness to pay for Pap smear screening, attributed to post-HIV counselling, although the study did not assess actual service use or ability to pay.

Breast cancer treatment was frequently delayed due to OOP costs. Foerster et al. [28] showed that women in Nigeria and Uganda experienced substantial treatment delays compared to Namibia, where cancer care was free. However, generalisability was limited due to selective access to specialised facilities. Additionally, Oshi et al. [24] found that frequent OOP spending on children's illnesses deterred women from seeking tuberculosis treatment for themselves, highlighting indirect effects of household healthcare costs.

3.3.2 Economic empowerment of women

Many studies revealed how women face financial constraints and how this contributes to gender-based differences in seeking medical care. The study by Onah and Govender [31] found that FHHs especially widows have low social and economic status which restricts them from utilising healthcare services when they are ill. This finding corroborates with that of Oshi et al. [24] in Nigeria where most of the female participants engaged in

farming and did not have enough money to pay transportation costs and health care costs. Widows were the most affected as they received no financial support from their husbands' relatives [24].

Gender norms on control of economic resources alleviates the vulnerable position of women. Interestingly, some of the studies found that even when women had the opportunity to obtain financial resources from their occupation, their husbands had control over their money. Ilboudo et al. [21] suggested that the lack of control women in Burkina Faso had over household resources could have contributed to their delay in seeking postabortion care. Ntoimo et al. [26] also found that women in Nigeria received little or no financial support from their husbands and had to forgo skilled birth deliveries because they didn't have the personal resources for out-of-pocket payments. These findings suggest that the presence of OOP payments for healthcare fosters gender inequality in households when women are restricted from using healthcare services due to economic constraints.

3.3.3 Financial decision-making power within households

Many of the studies revealed salient issues on how gender inequality for intra-household decision-making for health-seeking can be powerful in its effect. Some studies also found that healthcare funding decisions are a gender role assigned to husbands and in-laws. For instance, in the study by Klein et al. [25], many of the pregnant women mentioned that family patriarchs were the main decision makers and they had to get permission to attend ANC in Mali. The major reason found was because the husbands provided financial support which asserts the above findings on women's economic empowerment. Surprisingly, despite the lack of autonomy that women had, they still had to go find the resources to pay for their healthcare.

Oshi et al. [24] also found that educated women made decisions for TB treatment jointly with their husbands while those that were uneducated had no control over their earnings and their husbands dictated the amount to be spent on healthcare. However, by further probing, even the educated women still had to take approval from their husbands to seek TB care. These findings suggest that women who actually had a willingness to seek ANC care could have been limited by either the decision-making power of their husbands or their inability to find resources to pay OOP.

Men's perception of illness was seen to be important in their decision making for women's use of healthcare [31]. For instance, a male participant in the study by Onah and Govender [31] said: *"Women are more inclined to illness, thus making their health care costly. My wife always falls sick from even simple cold and so I spend too much on her health"*.

Such perceptions of women's health could suggest the lack of financial support given to women by their husbands when it comes to their healthcare needs. The above findings are important in this review because they prove how the presence of OOP payments leaves women weak and vulnerable when it comes to using healthcare services.

3.4 Outcomes

3.4.1 Catastrophic health expenditure

OOP payments frequently resulted in catastrophic health expenditure (CHE) across studies [19, 32–34, 36]. CHE was measured using thresholds of 40% of contributory capacity, 10% of household income, or 25% of total income. In Zambia, women spent up to one-third of household income on delivery-related costs [19]. In Congo, 16% of women experienced CHE, particularly those who were young, poor, unmarried, or had delivery complications [36]. Similar patterns were observed in Ghana and Kenya [33, 34].

Several studies linked CHE to delayed care and complications. Unsafe abortion practices due to high OOP costs led to severe complications requiring expensive treatment [20–22].

3.4.2 Inability to Pay

Inability to pay OOP costs resulted in adverse outcomes, including unskilled home births and hospital detention. In Ghana and Nigeria, financial dependence limited women's autonomy in seeking care [22, 30]. In Congo, women unable to pay delivery fees were detained in hospitals for up to 30 days [35, 37]. Detention disproportionately affected poor, young, widowed, or unmarried women and was associated with obstetric complications.

3.4.3 Coping Mechanisms

Women employed harmful coping strategies to manage OOP costs, including selling assets, incurring debt, using savings, and reducing essential consumption [21, 31, 36]. These strategies often led to further health deterioration, household conflict, abandonment, and long-term poverty. Post-discharge, many women forwent postnatal care, child immunisation, and treatment for other illnesses, perpetuating the "medical poverty trap."

4. DISCUSSION

4.1 Access to healthcare services

The findings show that women's access to healthcare services in SSA is shaped by socioeconomic status, the type of reproductive healthcare sought, and the nature of OOP payments. Guided by intersectional feminism, this review recognises that gender alone cannot explain lived experience, particularly for women experiencing multiple disadvantages [11]. The findings support Richman and Zucker's [12] argument that socioeconomic

status interacts with multiple disparities affecting women's lives. Pearson and Shoo [38] similarly note that most low-income countries lack universal access to skilled healthcare, with access unequally distributed by socioeconomic status.

This review shows that women with similar healthcare needs did not have equal access due to health facility OOP fees and additional costs such as transportation. The poorest women often paid more for care and were deterred from seeking services. This reflects intersectionality by highlighting differences within and between groups experiencing intersecting marginalisations [39]. Huber [40] describes a cyclical relationship between poverty and ill health, where illness increases poverty through reduced earnings and healthcare costs, while poverty increases illness through poor living conditions, inadequate nutrition, and limited access to care. As shown in this review, OOP payments intensify this cycle by restricting access and increasing financial burden on poor women, who spend an average of £17–£70 on healthcare.

Furthermore, despite user fee exemption or free maternal health policies in countries such as Burkina Faso, Kenya, Ghana, Madagascar, Zambia, and Mali, women continued to face high healthcare costs. These policies aim to ensure affordable, high-quality sexual and reproductive healthcare without OOP payments; however, McKinnon et al. [41] argue that eliminating user fees alone does not reduce socioeconomic inequalities, highlighting the need for targeted support for disadvantaged women.

The findings of this review also highlight that challenges in implementing free maternal health policies remain. Although these policies are intended to cover direct and indirect medical costs, women still made OOP payments in healthcare facilities [19, 25–26, 29, 30]. Dalaba et al. [33] found that both insured and uninsured women incurred OOP costs; insured women paid less but often made unofficial payments or were referred to private facilities due to shortages of medicines, laboratory equipment, or ultrasound machines.

Additionally, informal payments requested by healthcare staff were a major source of OOP expenditure, supporting Russel's [42] claim that exemptions are often not granted even when policies exist. This may relate to health workers' reliance on user fees for wages and perceptions of heavy workloads and exploitation [43]. However, OOP costs, including transportation, had less impact when health facilities were close to women's homes or when incentives such as insecticide-treated nets or iron folic acid supplements were provided [29, 30].

Women are known to use healthcare services more than men [44], possibly due to reproductive biology, higher morbidity, differences in health perception and symptom reporting, and greater use of preventive and curative care [45–47]. This review adds to the literature by highlighting the financial burden women face, particularly for maternal healthcare, which was the focus of 16 of the 19 included studies. This emphasis reveals a gap in evidence on the effects of OOP payments on other areas of women's health, underscoring the need for future research on services such as mental health and cancer care.

4.2 Use of healthcare services

This review shows that OOP payments affect the management of chronic illness, women's economic empowerment, and household financial decision-making, thereby influencing women's use of healthcare services. While women use maternal healthcare services more frequently, they are also affected by chronic illnesses such as cancer and tuberculosis. Cervical cancer is a major public health concern in SSA [48] and the leading cause of cancer-related death among women, affecting over 40 per 100,000 women [49]. Despite its high incidence, many women do not utilise cervical cancer screening services due to OOP costs. Nyegidiki et al. [23] found that women in Nigeria had limited financial resources and low control over household finances, which reduced their use of cancer screening services that required OOP payment.

Findings from this review further demonstrate women's limited economic empowerment. Ibuodo et al. [21] found that women in Burkina Faso lacked control over household financial resources. Similarly, Onah and Govender [31] and Oshi et al. [24] showed that female-headed households and widows in Nigeria had lower incomes than men. These findings align with Taylor et al. [50], whose study in Uganda found that many women, particularly female-headed households, lacked access to funds needed to meet their own and their families' needs.

Women's limited economic empowerment also affected household decision-making power and their ability to pay OOP costs for healthcare. The included studies showed that husbands often controlled household resources, and women's healthcare needs were not prioritised. Doss et al. [51] similarly demonstrated that women's control over household resources and income diversification is closely linked to empowerment. Klein et al. [25] found that pregnant women required permission from husbands or other family decision-makers before attending antenatal care. Annan et al. [52] reported that women who actively took decision-making power were more likely to use prenatal and antenatal services. This aligns with Freire's [53] argument that oppressed groups must initiate change themselves, as it cannot be granted by those within oppressive structures. Tam and Pilar [54] define decision-making power as a combination of access, capacities, and actions that influence life choices; however, such definitions often overlook intersecting power relations and resulting inequities.

Hemmings and Kabesh [55] critique empowerment frameworks for overemphasising individual choice within a liberal framework, placing responsibility on women. In SSA, women may avoid confronting family members due to complex social and emotional ties. Intersectional feminism centres women's lived experiences to capture multiple, overlapping forms of oppression [56]. This approach highlights how poverty, patriarchy, and historical inequalities intersect to limit women's access to resources and healthcare. Patriarchal systems in SSA concentrate power among men, restricting women's access to money and control over income [57]. Lucas and Nuwagaba's [58] qualitative study in Uganda similarly found that while men controlled household finances, women were primarily responsible for their own and their children's health. This imbalance increases women's

unpaid care burden, reduces income-generating opportunities, and reinforces a cycle of inequality. An intersectional lens therefore clarifies how OOP payments interact with patriarchy and inequality to shape women's healthcare utilisation.

4.3 Outcomes

The findings show that catastrophic health expenditure (CHE), reliance on coping mechanisms to meet OOP payments, and inability to pay for healthcare have serious negative effects on women's health and quality of life. Delays in seeking care and reliance on unskilled providers worsen clinical outcomes and increase the risk of complications and catastrophic costs. This is particularly concerning given that SSA accounts for approximately 66% of global maternal deaths, with obstetric complications being the leading causes of maternal mortality in the region [59, 60].

Women from lower socioeconomic groups were more likely to experience CHE than those from higher socioeconomic groups [21, 34, 36]. This may reflect both higher OOP payments among poorer women and their reduced ability to absorb healthcare costs. As shown in this review, inability to pay for healthcare had severe consequences, including hospital detention, spousal abandonment, and verbal or physical abuse, all of which negatively affected women's wellbeing.

The findings further demonstrate a strong relationship between healthcare affordability and ability to pay. Russell [42] defines healthcare costs as affordable when they do not prevent service use or force reductions in essential consumption and investment, such as education. When costs become unaffordable, intra-household resource reallocation occurs based on social position, as illness requires shifts in household time and resources [61]. In such contexts, decision-makers often prioritise economically productive members over women's healthcare needs.

When unable to pay for care, women and their households relied on coping strategies including selling assets, using savings, and borrowing from friends or family [21, 31]. Following discharge, women were frequently blamed for financial hardship and experienced mistreatment by spouses or family members. Many responded by engaging in strenuous work, reducing household food consumption, or forgoing postnatal and other healthcare to repay debts.

Historical studies support these findings, demonstrating that OOP payments negatively affect poor women's health outcomes through increased self-medication, reliance on informal care, and delayed care-seeking [62]. More than two decades later, similar patterns persist despite the introduction of user fee exemption policies.

One reviewed study found that despite OOP costs, HIV-positive women were willing to pay for cervical cancer screening [27]. While post-HIV counselling may have influenced this willingness, Russell [42] cautions that willingness to pay does not equate to ability to pay. Willingness may reflect social costs such as perceived illness severity, reported morbidity, and perceived quality of care [58]. However, willingness to pay does not address how women obtain resources or the consequences of payment strategies, which are explored in the following section.

4.5 Limitations of The Review

Narrative reviews are susceptible to researcher bias through the interpretation of findings because preserving impartiality while distancing oneself from one's own beliefs, experiences, and viewpoints is challenging. This review decreased bias, nevertheless, by employing a PRISM flow diagram to carry out the literature search methodically and a CASP checklist to ensure the evidence tables were organised and thematic analysis of included studies was conducted thoroughly. Due to time constraints, studies that examine the effects of eliminating or reducing user fee exemption policies were not included, which may have introduced bias into this review. These studies could have provided a wealth of relevant data that could have led to the exploration of new themes and provided more information about how OOP payments affect women. Additionally, only studies published between 2013 and 2023 were considered, potentially excluding other pertinent literature; nonetheless, this allowed for the inclusion of studies that might offer novel insights or close any gaps in the research on the effects of OOP payments on women's health. Finally, due in part to the inclusion criteria, the studies selected for this review primarily concern women's services like abortion, female cancers, and delivery services. It does, however, draw attention to the gap in the body of literature regarding how OOP payments affect other types of healthcare services women seek.

4.6 Strengths of The Review

This is the first review to explore this topic, according to a literature search on the effects of OOP payments on women in SSA. A major strength of this review is its inclusion of literature that provides evidence from a broad, geographical coverage of Sub-Saharan Africa. Additionally, this review has included studies from countries in SSA with existing free maternity care or user fee exemption policies. This provides stronger evidence that the implementation of such policies doesn't necessarily translate to an improved health outcome for women in SSA as there are more structural problems that must be addressed first, such as the patriarchy and poverty that interact with women's health.

Furthermore, thematic analysis of the available literature helped organise the framework of this review and provided a deeper understanding of the issues women in SSA face with regard to OOP payments and how this affects their health. The findings of this narrative review may be applied as direction for healthcare commissioners, researchers, practitioners, and policymakers, leading to more effective and efficient health financing policy formulation or reform that removes the financial barriers women face when accessing and utilising healthcare services. Finally, the findings of this review have closed the knowledge gap identified by Russell [42] by highlighting which populations and disease groups are most susceptible to, or least able to manage, healthcare costs, as well as how limited resources are allocated to meet the healthcare needs of individuals, particularly women.

5. CONCLUSION

This review reveals limited empirical evidence on the effects of user fees on women's health, as much of the existing research focuses on poverty without sex-disaggregated analysis. Despite these limitations, the review highlights key issues relevant to a gender-based assessment of OOP payments. While some identified themes apply to people with chronic illness and other vulnerable groups, women in SSA face distinct challenges. Despite having lower incomes and greater healthcare needs than men, women bear additional non-medical costs such as baby clothing, hospital consumables, and informal payments. The existence of user fee exemption policies does not eliminate these expenses, which can accumulate beyond women's financial capacity. To pay OOP costs, women often make compromises that lead to debt, use of traditional medicine, marital conflict, or neglect of their own health and other needs.

There is a need for policymakers and future research to assess whether OOP payments can generate revenue without discouraging essential healthcare use or placing undue burden on poor and vulnerable populations. Future studies should adopt intersectional approaches that examine how multiple, overlapping inequalities, such as gender and socioeconomic status, interact to produce complex inequities. This requires the collection of gender-disaggregated data across general and reproductive healthcare services, including mental health care, chronic disease management, STD treatment, and other services, alongside consideration of user fees and additional costs such as transportation and informal payments. Women's financial capacity should also be considered when designing cost-recovery mechanisms such as pre-payment systems and health insurance schemes.

Health economists and policymakers must further account for the realities of poor women's daily lives when proposing health system reforms, particularly those affecting reproductive health services. Applying policy analysis frameworks early in policy development can help identify contextual implementation challenges, address structural inequalities, and ensure that key actors, including women, are adequately represented.

This review identifies the effects of OOP payments on women's access to and use of healthcare, health outcomes, and the strategies women employ to manage healthcare costs. However, it also acknowledges the limited evidence on the health consequences of delayed care-seeking or reliance on low-cost but ineffective care. Future research should prioritise this area, as such evidence is essential for mitigating the harmful effects of current health financing policies on low-income women.

Abbreviations

OOP- Out-of-pocket; UHC- University Health Coverage; SSA- Sub Saharan Africa; WHO- World Health Organisation; FHHs- Female-Headed Households; MHHs- Male-Headed Households; SRH- Sexual and Reproductive Health

Declarations

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ETHICAL APPROVAL

The research methodology chosen for this study, particularly its reliance on secondary data, did not raise any issues on submission of ethical approval to the University of Sheffield, as evidenced in Appendix 1.

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Contributions

DA supervised by MS undertook the study as an independent Master's dissertation at the University of Sheffield.

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Figures

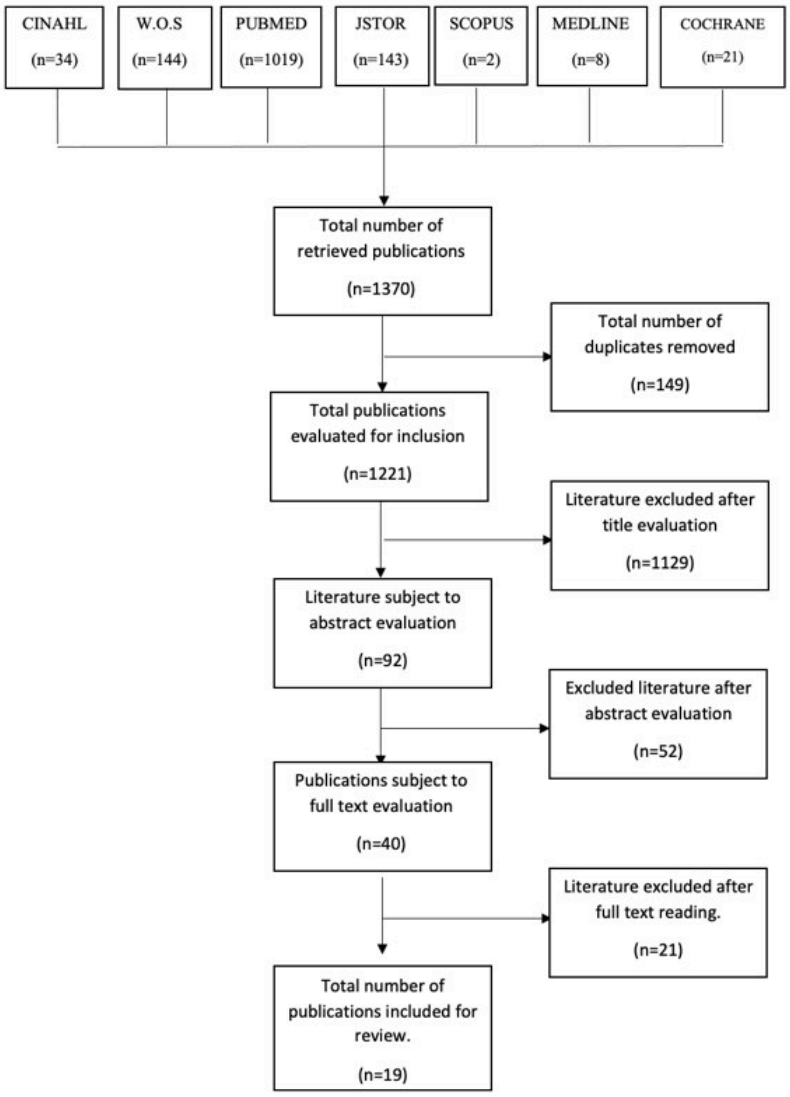

Figure 1

Flowchart of Included and Excluded Studies

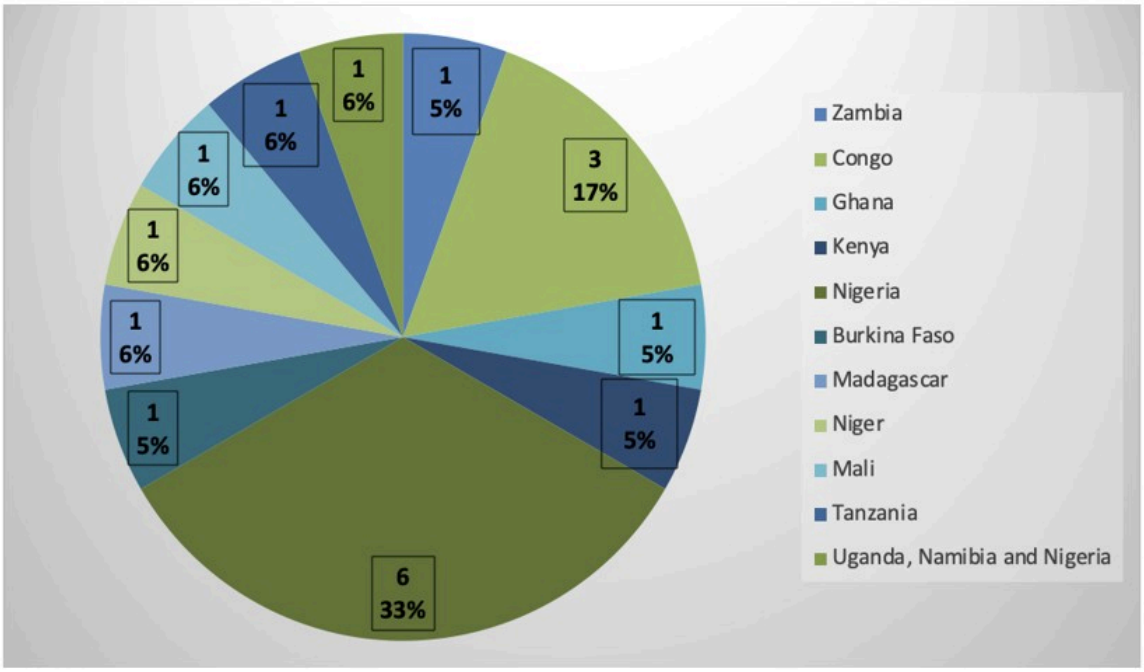

Figure 2

Geographical distribution of the 19 included studies

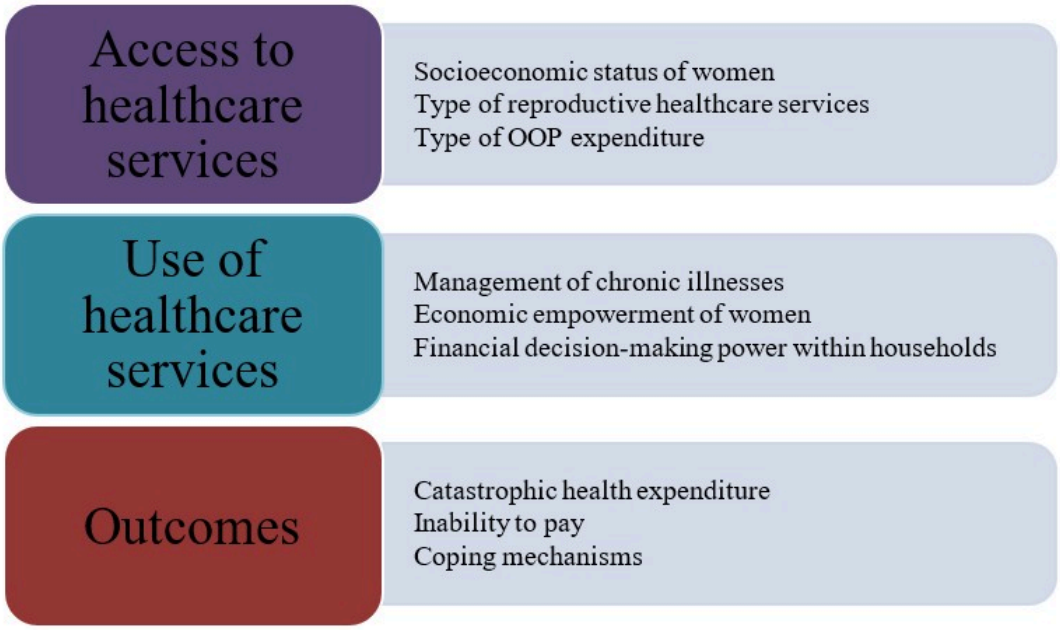

Figure 3

Identified Themes of Thematic Analysis

Supplementary Files

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- AppendixTHEGENDEREDIMPACTSOFOUTOFPOCKETPAYMENTSFORHEALTHCAREONWOMENINSUBSAHARANAFRICAANARRATIVEREVIEW.docx